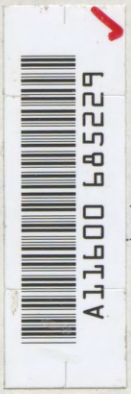
HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE



HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

EIGHTY-NINTH CONGRESS

FIRST SESSION

ON

S. 595 and H.R. 3141

BILLS TO AMEND THE PUBLIC HEALTH SERVICE ACT TO IMPROVE THE EDUCATIONAL QUALITY OF SCHOOLS OF MEDICINE, DENTISTRY, AND OSTEOPATHY, TO AUTHORIZE GRANTS UNDER THAT ACT TO SUCH SCHOOLS FOR THE AWARDING OF SCHOLARSHIPS TO NEEDY STUDENTS, AND TO EXTEND EXPIRING PROVISIONS OF THAT ACT FOR STUDENT LOANS AND FOR AID IN CONSTRUCTION OF TEACHING FACILITIES FOR STUDENTS IN SUCH SCHOOLS AND SCHOOLS FOR OTHER HEALTH PROFESSIONS, AND FOR OTHER PURPOSES

SEPTEMBER 8, 1965

Printed for the use of the
Committee on Labor and Public Welfare

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HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE

WEDNESDAY, SEPTEMBER 8, 1965

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:08 a.m., in room 4234, New Senate Office Building, Senator Lister Hill, chairman, presiding.

Present: Senators Hill, Yarborough, Javits, and Murphy.

Committee staff members present: Robert W. Barclay, professional staff member; Roy H. Millenson, minority clerk; and Stephen Kurzman, minority counsel.

The CHAIRMAN. The subcommittee will kindly come to order.

The Subcommittee on Health is meeting this morning to receive testimony on S. 595 and H.R. 3141, the Health Professions Educational Assistance Amendments of 1965.

(S. 595 and H.R. 3141 follow:)

89TH CONGRESS
1ST SESSION

S. 595

IN THE SENATE OF THE UNITED STATES

JANUARY 19, 1965

Mr. HILL introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act to improve the educational quality of schools of medicine, dentistry, and osteopathy, to authorize grants under that Act to such schools for the awarding of scholarships to needy students, and to extend expiring provisions of that Act for student loans and for aid in construction of teaching facilities for students in such schools and schools for other health professions, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Health Professions Educational Assistance Amendments of 1965".

EDUCATIONAL IMPROVEMENT GRANTS AND SCHOLARSHIP GRANTS TO SCHOOLS OF MEDICINE, DENTISTRY, AND OSTEOPATHY

SEC. 2. (a) Title VII of the Public Health Service Act is amended by adding at the end thereof the following new parts:

"PART E—GRANTS TO IMPROVE THE QUALITY OF SCHOOLS OF MEDICINE, DENTISTRY, AND OSTEOPATHY

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 770. There are authorized to be appropriated $20,000,000 for the fiscal year ending June 30, 1966, and such sums as may be necessary for each of the four succeeding fiscal years, for grants under this part to assist schools of medicine, dentistry, and osteopathy to improve the quality of their educational programs.

"BASIC IMPROVEMENT GRANTS

"SEC. 771. (a) The Surgeon General may make basic improvement grants as follows:

"(1) For the fiscal year ending June 30, 1966, each school of medicine, dentistry, or osteopathy whose application for a basic improvement grant for such year has been approved by the Surgeon General shall be paid the sum of $12,500 plus the product obtained by multiplying $250 by the number of full-time students in such school.

"(2) For each fiscal year in the period beginning

July 1, 1966, and ending June 30, 1970, each such school whose application has been approved for such a grant for such year shall be paid the sum of $25,000 plus the product obtained by multiplying $500 by the number of full-time students in such school.

"(b) For purposes of this part and part F, regulations of the Surgeon General shall include provisions relating to determination of the number of students enrolled in a school, or in a particular year-class in a school, as the case may be, on the basis of estimates, or on the basis of the number of students enrolled in a school, or in a particular year-class in a school, in an earlier year, as the case may be, or on such basis as he deems appropriate for making such determination, and shall include methods of making such determinations when a school or a year-class was not in existence in an earlier year at a school.

"(c) For purposes of this part and part F, the term 'full-time students' (whether such term is used by itself or in connection with a particular year-class) means students pursuing a full-time course of study leading to a degree of doctor of medicine, doctor of dentistry or an equivalent degree, or doctor of osteopathy.

"SPECIAL IMPROVEMENT GRANTS

"SEC. 772. From the sums appropriated under section 770 for any fiscal year and not required for making grants

under section 771, the Surgeon General may make an additional grant for such year to any school of medicine, dentistry, or osteopathy which has an approved application therefor and for which an application has been approved under section 771 if he determines that the applicant needs additional financial assistance in order to strengthen its curriculum or to improve the quality of its education. No grant to any school under this section for any fiscal year may exceed $100,000 for the fiscal year ending June 30, 1966; $200,000 for the fiscal year ending June 30, 1967; $300,000 for the fiscal year ending June 30, 1968; or $400,000 for the fiscal year ending June 30, 1969, or the succeeding fiscal year.

"APPLICATIONS FOR GRANTS

"SEC. 773. (a) The Surgeon General may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) by which applications for basic or special grants under section 771 or 772 for any fiscal year must be filed.

"(b) To be eligible for a grant under this part, the applicant must (1) be a public or other nonprofit school of medicine, dentistry, or osteopathy, and (2) be accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education, except that the requirement of this clause (2) shall be deemed to be satisfied if, (A) in

the case of a school which by reason of no, or an insufficient, period of operation is not, at the time of application for a grant under this part, eligible for such accreditation, the Commissioner finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the school will meet the accreditation standards of such body or bodies prior to the beginning of the academic year following the normal graduation date of students who are in their first year of instruction at such school during the fiscal year in which the Surgeon General makes a final determination as to approval of the application, or (B) in the case of any other school, the Commissioner finds after such consultation and after consultation with the Surgeon General that there is reasonable ground to expect that, with the aid of a grant or grants under this part, having regard for the purposes of the grant sought, such school will meet such accreditation standards within a reasonable time.

"(c) The Surgeon General shall not approve or disapprove any application for a grant under this part except after consultation with the National Advisory Council on Medical and Dental Education (established by section 774).

"(d) A grant under this part may be made only if the application therefor is approved by the Surgeon General upon his determination that the application meets the eligi-

bility conditions set forth in subsection (b) of this section, sets forth plans for using the grants which the Surgeon General finds give reasonable promise of strengthening and improving the school's faculty and curriculum, contains such additional information as he may require to make the determinations required of him under this part and such assurances as he may find necessary to carry out the purposes of this part, and provides for such fiscal-control and accounting procedures and reports, and access to the records of grant recipients, as he may require to assure proper disbursement of and accounting for Federal funds paid to the applicant under this part.

"(e) In considering applications for grants under section 772, the Surgeon General shall take into consideration the relative financial need of the applicant for such a grant, the relative effectiveness of the applicant's plan in strengthening and improving its faculty and curriculum and in contributing to an equitable geographical distribution of opportunities for high-quality training of physicians, dentists, and osteopaths; and such other factors as he, after consultation with the National Advisory Council on Medical and Dental Education, may deem relevant.

"NATIONAL ADVISORY COUNCIL ON MEDICAL AND DENTAL EDUCATION

"SEC. 774. (a) There is hereby established in the Public Health Service a National Advisory Council on Medical and Dental Education consisting of the Surgeon General, who shall be Chairman, and twelve members appointed without regard to the civil service laws by the Surgeon General with the approval of the Secretary of Health, Education, and Welfare, and such appointments may be made for specified staggered terms. The appointed members of the Council shall be selected from among leading authorities in the fields of medical and of dental education, respectively, except that not less than three of such members shall be selected from the general public.

"(b) The Council shall advise the Surgeon General in the preparation of general regulations and with respect to policy matters arising in the administration of this part and part F, and in the review of applications under this part.

"(c) The Surgeon General is authorized to use the services of any member or members of the Council in connection with matters related to the administration of this part

or part F, for such periods, in addition to conference periods, as he may determine.

"(d) Appointed members of the Council, while attending conferences or meetings of the Council or while otherwise serving at the request of the Surgeon General, shall be entitled to receive compensation at rates to be fixed by the Secretary but not exceeding $100 per day, including travel time; and while away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government service employed intermittently.

"PART F—SCHOLARSHIP GRANTS TO SCHOOLS OF MEDICINE, OSTEOPATHY, OR DENTISTRY

"SCHOLARSHIP GRANTS

"SEC. 780. (a) The Surgeon General shall make grants as provided in this part to each public or other nonprofit school of medicine, osteopathy, or dentistry, which is accredited as provided in section 721(b)(1)(B) or section 773(b)(2), for scholarships to be awarded annually by such school to students thereof.

"(b) The amount of the grant under subsection (a) to each such school shall be equal to $2,000 multiplied, (1) for the fiscal year ending June 30, 1966, by one-tenth of the number of full-time first-year students of such school;

(2) for the fiscal year ending June 30, 1967, by one-tenth of the number of full-time first-year students and second-year students of such school; (3) for the fiscal year ending June 30, 1968, by one-tenth of the number of full-time first-year students, second-year students, and third-year students of such school; and (4) for the fiscal year ending June 30, 1969, and for the succeeding fiscal year, by one-tenth of the number of full-time students of such school. For the fiscal year ending June 30, 1971, and for each of the two succeeding fiscal years, the grant under subsection (a) shall be such amount as may be necessary to enable such school to continue making payments under scholarship awards to students who initially received such awards out of grants made to the school for fiscal years ending prior to July 1, 1970.

"(c) (1) Scholarships may be awarded by schools from grants under subsection (a)—

"(A) only to individuals who have been accepted by them for enrollment as full-time first-year students, in the case of awards from such grants for the fiscal year ending June 30, 1966;

"(B) only to individuals who have been so accepted, and individuals enrolled and in good standing as full-time second-year students, in the case of awards from such grants for the fiscal year ending June 30, 1967;

"(C) only to individuals who have been so accepted, and individuals enrolled and in good standing as full-time second-year or third-year students, in the case of awards from such grants for the fiscal year ending June 30, 1968;

"(D) only to individuals who have been so accepted, and individuals enrolled and in good standing as full-time students, in the case of awards from such grants for the fiscal year ending June 30, 1969, or for the succeeding fiscal year; and

"(E) only to individuals enrolled and in good standing as full-time students who initially received scholarship awards out of such grants for a fiscal year ending prior to July 1, 1970, in the case of awards from such grants for the fiscal year ending June 30, 1971, or the two succeeding fiscal years.

"(2) Scholarships from grants under subsection (a) for any school year shall be awarded to students, particularly students from low-income families, on the basis of need for financial assistance in pursuing a course of study at the school for such year. Any such scholarship awarded for a school year shall cover such portion of the student's tuition, fees, books, equipment, and living expenses at the school making the award, but not to exceed $2,500 for any year, as such

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school may determine the student needs for such year on the basis of his requirements and financial resources.

"(d) Grants under subsection (a) shall be made in accordance with regulations prescribed after consultation with the National Advisory Council on Medical and Dental Education.

"(e) Grants under subsection (a) may be paid in advance or by way of reimbursement, and at such intervals as the Surgeon General may find necessary; and with appropriate adjustments on account of overpayments or underpayments previously made."

(b) Section 724 of such Act (containing definitions) is amended by striking out "As used in this part" and inserting in lieu thereof "As used in this part and parts C, E, and F"; and section 740(a) of such Act is amended by striking out "(as defined in section 724)".

EXTENSION OF CONSTRUCTION PROGRAM FOR MEDICAL, DENTAL, AND OTHER HEALTH PROFESSION SCHOOLS

SEC. 3. (a) Effective with respect to appropriations for fiscal years beginning after June 30, 1966, section 720 of such Act is amended to read as follows:

"SEC. 720. There are authorized to be appropriated for the fiscal year ending June 30, 1967, and for each of the

four succeeding fiscal years, such sums as may be necessary for—

"(1) grants to assist in the construction of new teaching facilities for the training of physicians, pharmacists, optometrists, podiatrists, or professional public health personnel;

"(2) grants to assist in the construction of new teaching facilities for the training of dentists; and

"(3) grants to assist in the replacement or rehabilitation of existing teaching facilities for the training of physicians, pharmacists, optometrists, podiatrists, professional public health personnel, or dentists.

Sums so appropriated shall remain available until expended."

(b) Subsection (a) of section 721 of such Act is amended to read as follows:

"(a) The Surgeon General may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) by which applications for grants under this part for any fiscal year must be filed."

EXTENSION OF, AND IMPROVEMENTS IN, PROGRAM FOR STUDENT LOANS

SEC. 4. (a) Subsection (b) (4) of section 740 of such Act is amended by striking out "July 1, 1966" and inserting in lieu thereof "July 1, 1971".

(b) Subsection (a) of section 741 of such Act is

amended by striking out "may not exceed $2,000" and inserting in lieu thereof "may not exceed $2,500".

(c) Subsection (a) of section 742 of such Act is amended (1) by inserting "(other than section 744)" after "to carry out this part", and (2) by striking out that part of the first sentence that follows "June 30, 1966," and inserting in lieu thereof the following: "and such sums as may be necessary for the fiscal year ending June 30, 1967, and each of the four succeeding fiscal years. There are further authorized to be appropriated to the Secretary such sums for the fiscal year ending June 30, 1972, and each of the two succeeding fiscal years as may be necessary to enable students who have received a loan under this part for any academic year ending before July 1, 1971, to continue or complete their education."

(d) Section 743 of such Act is amended by striking out "1969" wherever it appears therein and inserting in lieu thereof "1974."

(e) Section 744 of such Act is amended by adding at the end thereof the following new sentences: "There are hereby authorized to be appropriated such sums as may be necessary to carry out the purposes of this section, but not to exceed a total of $2,500,000. Loans made by the Surgeon General under this section shall mature within such

period as may be determined by the Surgeon General to be appropriate in each case, but not exceeding fifteen years."

TECHNICAL AMENDMENTS

SEC. 5. (a) Clause (B) of section 721 (b) (1) of such Act (relating to the accreditation of new schools of medicine, etc.) is amended by (1) striking out ", upon completion of such facility," and (2) inserting the following after "meet the accreditation standards of such bodies": "(i) prior to the beginning of the academic year following the normal graduation date of the first entering class in such school or (ii) if later, upon completion of the project for which assistance is requested and other projects (if any) under construction or planned and to be commenced within a reasonable time."

(b) Clause (1) of section 843 (f) of such Act (relating to accreditation of new schools of nursing), is amended by striking out "new school" and the remainder of such clause and inserting in lieu thereof the following: "new school (which shall include a school that has not had a sufficient period of operation to be eligible for accreditation), (A) upon completion of such project and other construction projects (if any) then under construction or planned and to be commenced within a reasonable time, or (B) if later, then prior to the beginning of the first academic year fol-

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lowing the normal graduation date of the first entering class in such school;".

89TH CONGRESS
1ST SESSION

H. R. 3141

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 2 (legislative day, SEPTEMBER 1), 1965
Read twice and referred to the Committee on Labor and Public Welfare

AN ACT

To amend the Public Health Service Act to improve the educational quality of schools of medicine, dentistry, and osteopathy, to authorize grants under that Act to such schools for the awarding of scholarships to needy students, and to extend expiring provisions of that Act for student loans and for aid in construction of teaching facilities for students in such schools and schools for other health professions, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Health Professions Educational Assistance Amendments of 1965".

EDUCATIONAL IMPROVEMENT GRANTS AND SCHOLARSHIP GRANTS TO SCHOOLS OF MEDICINE, DENTISTRY, OSTEOPATHY, AND OPTOMETRY

SEC. 2. (a) Title VII of the Public Health Service Act is amended by adding at the end thereof the following new parts:

"PART E—GRANTS TO IMPROVE THE QUALITY OF SCHOOLS OF MEDICINE, DENTISTRY, OSTEOPATHY, AND OPTOMETRY

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 770. There are authorized to be appropriated $20,000,000 for the fiscal year ending June 30, 1966, $40,000,000 for the fiscal year ending June 30, 1967, $60,000,000 for the fiscal year ending June 30, 1968, and $80,000,000 for the fiscal year ending June 30, 1969, for grants under this part to assist schools of medicine, dentistry, osteopathy, and optometry to improve the quality of their educational programs.

"BASIC IMPROVEMENT GRANTS

"SEC. 771. (a) Subject to the provisions of subsection (b), the Surgeon General may make basic improvement grants as follows:

"(1) For the fiscal year ending June 30, 1966, each school of medicine, dentistry, osteopathy, or optometry whose application for a basic improvement grant for such year has

been approved by the Surgeon General shall be paid the sum of $12,500 plus the product obtained by multiplying $250 by the number of full-time students in such school.

"(2) For each fiscal year in the period beginning July 1, 1966, and ending June 30, 1969, each such school whose application has been approved for such a grant for such year shall be paid the sum of $25,000 plus the product obtained by multiplying $500 by the number of full-time students in such school.

"(b) The Surgeon General shall not make a grant under this section to any school unless the application for such grant contains or is supported by reasonable assurances that for the first school year beginning after the fiscal year for which such grant is made and each school year thereafter during which such a grant is made the first-year enrollment of full-time students in such school will exceed the highest first-year enrollment of such students in such school for any of the five school years during the period July 1, 1960, though July 1, 1965, by at least 2½ per centum of such highest first-year enrollment, or by five students, whichever is greater. The requirements of this subsection shall be in addition to the requirements of section 721 (c) (2) (D) of this Act, where applicable.

"(c) For purposes of this part and part F, regulations of the Surgeon General shall include provisions relating to

determination of the number of students enrolled in a school, or in a particular year-class in a school, as the case may be, on the basis of estimates, or on the basis of the number of students enrolled in a school, or in a particular year-class in a school, in an earlier year, as the case may be, or on such basis as he deems appropriate for making such determination, and shall include methods of making such determinations when a school or a year-class was not in existence in an earlier year at a school.

"(d) For purposes of this part and part F, the term 'full-time students' (whether such term is used by itself or in connection with a particular year-class) means students pursuing a full-time course of study leading to a degree of doctor of medicine, doctor of dentistry or an equivalent degree, doctor of osteopathy, or doctor of optometry or an equivalent degree.

"SPECIAL IMPROVEMENT GRANTS

"SEC. 772. (a) From the sums appropriated under section 770 for any fiscal year and not required for making grants under section 771, the Surgeon General may make an additional grant for such year to any school of medicine, dentistry, osteopathy, or optometry which has an approved application therefor and for which an application has been approved under section 771, if he determines that the re-

quirements of subsection (b) are satisfied in the case of such applicant.

"(b) No special improvement grant shall be made under this section unless such grant is recommended by the National Advisory Council on Medical, Dental, and Optometric Education and the Surgeon General determines that such grant will be utilized by the recipient school (1) to contribute toward the maintenance of, or to provide for, accreditation, or (2) to contribute toward the maintenance of, or to provide for, specialized functions which the school serves.

"(c) No grant to any school under this section may exceed $100,000 for the fiscal year ending June 30, 1966; $200,000 for the fiscal year ending June 30, 1967; $300,000 for the fiscal year ending June 30, 1968; or $400,000 for the fiscal year ending June 30, 1969.

"APPLICATIONS FOR GRANTS

"SEC. 773. (a) The Surgeon General may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) by which applications for basic or special grants under section 771 or 772 for any fiscal year must be filed.

"(b) To be eligible for a grant under tthis part, the applicant must (1) be a public or other nonprofit school of medicine, dentistry, osteopathy, or optometry, and (2) be

accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education, except that the requirement of this clause (2) shall be deemed to be satisfied if, (A) in the case of a school which by reason of no, or an insufficient, period of operation is not, at the time of application for a grant under this part, eligible for such accreditation, the Commissioner finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the school will meet the accreditation standards of such body or bodies prior to the beginning of the academic year following the normal graduation date of students who are in their first year of instruction at such school during the fiscal year in which the Surgeon General makes a final determination as to approval of the application, or (B) in the case of any other school, the Commissioner finds after such consultation and after consultation with the Surgeon General that there is reasonable ground to expect that, with the aid of a grant or grants under this part, having regard for the purposes of the grant sought, such school will meet such accreditation standards within a reasonable time.

"(c) The Surgeon General shall not approve or disapprove any application for a grant under this part except after consultation with the National Advisory Council on Medical, Dental, and Optometric Education (established by section 774).

"(d) A grant under this part may be made only if the application therefor—

"(1) is approved by the Surgeon General upon his determination that the applicant meets the eligibility conditions set forth in subsection (b) of this section;

"(2) contains or is supported by assurances satisfactory to the Surgeon General that the applicant will expend in carrying out its functions as a school of medicine, dentistry, osteopathy, or optometry, as the case may be, during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Surgeon General) from non-Federal sources which are at least as great as the average amount of funds expended by such applicant for such purpose in the three fiscal years immediately preceding the fiscal year for which such grant is sought;

"(3) contains such additional information as the Surgeon General may require to make the determinations required of him under this part and such assurances as he may find necessary to carry out the purposes of this part; and

"(4) provides for such fiscal-control and accounting procedures and reports, and access to the records of the applicant, as the Surgeon General may require to

assure proper disbursement of and accounting for Federal funds paid to the applicant under this part.

"(e) In considering applications for grants under section 772, the Surgeon General shall take into consideration the relative financial need of the applicant for such a grant and the relative effectiveness of the applicant's plan in carrying out the purposes set forth in clauses (1) or (2) of subsection (b) of section 772 and in contributing to an equitable geographical distribution of schools offering high-quality training of physicians, dentists, and optometrists.

"NATIONAL ADVISORY COUNCIL ON MEDICAL, DENTAL, AND OPTOMETRIC EDUCATION

"SEC. 774. (a) There is hereby established in the Public Health Service a National Advisory Council on Medical, Dental, and Optometric Education consisting of the Surgeon General, who shall be Chairman, and twelve members appointed without regard to the civil service laws by the Surgeon General with the approval of the Secretary of Health, Education, and Welfare, and such appointments may be made for specified staggered terms. The appointed members of the Council shall be selected from among leading authorities in the fields of medical, dental, and optometric education, respectively, except that not less than three of such members shall be selected from the general public.

"(b) The Council shall advise the Surgeon General in

the preparation of general regulations and with respect to policy matters arising in the administration of this part and part F, and in the review of applications under this part.

"(c) The Surgeon General is authorized to use the services of any member or members of the Council in connection with matters related to the administration of this part or part F, for such periods, in addition to conference periods, as he may determine.

"(d) Appointed members of the Council, while attending conferences or meetings of the Council or while otherwise serving at the request of the Surgeon General, shall be entitled to receive compensation at rates to be fixed by the Secretary but not exceeding $100 per day, including travel time; and while away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government service employed intermittently.

"PART F—SCHOLARSHIP GRANTS TO SCHOOLS OF MEDICINE, OSTEOPATHY, DENTISTRY, OR OPTOMETRY

"SCHOLARSHIP GRANTS

"SEC. 780. (a) The Surgeon General shall make grants as provided in this part to each public or other nonprofit

school of medicine, osteopathy, dentistry, or optometry, which is accredited as provided in section 721 (b) (1) (B) or section 773 (b) (2), for scholarships to be awarded annually by such school to students thereof.

"(b) The amount of the grant under subsection (a) to each such school shall be equal to $2,000 multiplied (1) for the fiscal year ending June 30, 1966, by one-tenth of the number of full-time first-year students of such school; (2) for the fiscal year ending June 30, 1967, by one-tenth of the number of full-time first-year students and second-year students of such school; (3) for the fiscal year ending June 30, 1968, by one-tenth of the number of full-time first-year students, second-year students, and third-year students of such school; and (4) for the fiscal year ending June 30, 1969, by one-tenth of the number of full-time students of such school. For the fiscal year ending June 30, 1970, and for each of the two succeeding fiscal years, the grant under subsection (a) shall be such amount as may be necessary to enable such school to continue making payments under scholarship awards to students who initially received such awards out of grants made to the school for fiscal years ending prior to July 1, 1969.

"(c) (1) Scholarships may be awarded by schools from grants under subsection (a)—

"(A) only to individuals who have been accepted

by them for enrollment as full-time first-year students, in the case of awards from such grants for the fiscal year ending June 30, 1966;

"(B) only to individuals who have been so accepted, and individuals enrolled and in good standing as full-time second-year students, in the case of awards from such grants for the fiscal year ending June 30, 1967;

"(C) only to individuals who have been so accepted, and individuals enrolled and in good standing as full-time second-year or third-year students, in the case of awards from such grants for the fiscal year ending June 30, 1968;

"(D) only to individuals who have been so accepted, and individuals enrolled and in good standing as full-time students, in the case of awards from such grants for the fiscal year ending June 30, 1969; and

"(E) only to individuals enrolled and in good standing as full-time students who initially received scholarship awards out of such grants for a fiscal year ending prior to July 1, 1969, in the case of awards from such grants for the fiscal year ending June 30, 1970, or the two succeeding fiscal years.

"(2) Scholarships from grants under subsection (a) for any school year shall be awarded only to students from low-

income families who, without such financial assistance could not pursue a course of study at the school for such year. Any such scholarship awarded for a school year shall cover such portion of the student's tuition, fees, books, equipment, and living expenses at the school making the award, but not to exceed $2,500 for any year, as such school may determine the student needs for such year on the basis of his requirements and financial resources.

"(d) Grants under subsection (a) shall be made in accordance with regulations prescribed by the Surgeon General after consultation with the National Advisory Council on Medical, Dental, and Optometric Education.

"(e) Grants under subsection (a) may be paid in advance or by way of reimbursement, and at such intervals as the Surgeon General may find necessary; and with appropriate adjustments on account of overpayments or underpayments previously made."

(b) Section 724 of such Act (containing definitions) is amended by striking out "As used in this part" and inserting in lieu thereof "As used in this part and parts C, E, and F"; and section 740(a) of such Act is amended by striking out "(as defined in section 724)".

EXTENSION OF CONSTRUCTION PROGRAM FOR MEDICAL, DENTAL, AND OTHER HEALTH PROFESSION SCHOOLS:

SEC. 3. (a) Effective with respect to appropriations for fiscal years beginning after June 30, 1966, section 720 of such Act is amended to read as follows:

"SEC. 720. There are hereby authorized to be appropriated $480,000,000 for the three fiscal years in the period beginning July 1, 1966, and ending June 30, 1969, of which not more than $160,000,000 may be available for grants before July 1, 1967, and not more than $320,000,000 may be available for grants before July 1, 1968, for—

"(1) grants to assist in the construction of new teaching facilities for the training of physicians, pharmacists, optometrists, podiatrists, or professional public health personnel;

"(2) grants to assist in the construction of new teaching facilities for the training of dentists; and

"(3) grants to assist in the replacement or rehabilitation of existing teaching facilities for the training of physicians, pharmacists, optometrists, podiatrists, professional public health personnel, or dentists.

Sums so appropriated shall remain available until expended."

(b) Subsection (a) of section 721 of such Act is amended to read as follows:

"(a) The Surgeon General may from time to time set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) by which applications for grants under this part for any fiscal year must be filed."

(c) Section 721 (c) (2) (D) of such Act is amended by inserting immediately before the semicolon at the end thereof the following: ", and the requirements of this clause (D) shall be in addition to the requirements of section 771 (b) of this Act, where applicable".

EXTENSION OF, AND IMPROVEMENTS IN, PROGRAM FOR STUDENT LOANS

SEC. 4. (a) Subsection (b) (4) of section 740 of such Act is amended by striking out "July 1, 1966" and inserting in lieu thereof "July 1, 1969".

(b) (1) Subsection (a) of section 741 of such Act is amended by striking out "may not exceed $2,000" and inserting in lieu thereof "may not exceed $2,500".

(2) Section 741 of such Act is further amended (A) by redesignating subsections "(f)", "(g)", and "(h)" thereof as subsections "(g)", "(h)", and "(i)", respectively, and (B) by adding immediately after subsection (e) thereof the following new subsection:

"(f)" Where any person who obtained one or more loans from a loan fund established under this part—

"(1) engages in the practice of medicine, dentistry, or osteopathy in an area in a State determined by the appropriate State health authority to have a shortage of and need for physicians or dentists; and

"(2) the appropriate State health authority certifies to the Secretary of Health, Education, and Welfare in such form and at such times as the Secretary may prescribe that such practice helps to meet the shortage of and need for physicians or dentists in the area where the practice occurs; then 10 per centum of the total of such loans, plus accrued interest on such amount, which are unpaid as of the date that such practice begins, shall be canceled thereafter for each year of such practice, up to a total of 50 per centum of such total, plus accrued interest thereon."

(c) Subsection (a) of section 742 of such Act is amended (1) by inserting "(other than section 744)" after "to carry out this part", and (2) by striking out that part of the first sentence that follows "June 30, 1966," and inserting in lieu thereof the following: "and $25,000,000 each for the fiscal year ending June 30, 1967, and each of the two succeeding fiscal years. There are further authorized to

be appropriated to the Secretary such sums for the fiscal year ending June 30, 1970, and each of the two succeeding fiscal years as may be necessary to enable students who have received a loan under this part for any academic year ending before July 1, 1969, to continue or complete their education."

(d) Section 743 of such Act is amended by striking out "1969" wherever it appears therein and inserting in lieu thereof "1972".

(e) Section 744 of such Act is amended by adding at the end thereof the following new sentences: "There are hereby authorized to be appropriated such sums as may be necessary to carry out the purposes of this section, but not to exceed a total of $1,500,000. Loans made by the Surgeon General under this section shall mature within such period as may be determined by the Surgeon General to be appropriate in each case, but not exceeding fifteen years."

(f) (1) Subsection (a) of section 740 of such Act is amended by inserting "pharmacy, podiatry," immediately after "dentistry,".

(2) Subsection (b) (4) of section 740 of such Act is amended by inserting immediately after "doctor of osteopathy," the following: "bachelor of science in pharmacy or

doctor of pharmacy, doctor of podiatry or doctor of surgical chiropody,".

(3) Subsection (b) of section 741 of such Act is amended by inserting immediately after "doctor of osteopathy," the following: "bachelor of science in pharmacy or doctor of pharmacy, doctor of podiatry or doctor of surgical chiropody,".

(4) Subsection (c) of such section 741 is amended by inserting "pharmacy, podiatry," immediately after "dentistry,".

(5) The amendments made by paragraphs (1), (2), (3), and (4) of this subsection shall only be effective with respect to periods beginning on or after July 1, 1966.

TECHNICAL AMENDMENTS

SEC. 5. (a) Clause (B) of section 721 (b) (1) of such Act (relating to the accreditation of new schools of medicine, etc.) is amended by (1) striking out ", upon completion of such facility," and (2) inserting the following after "meet the accreditation standards of such body or bodies": "(i) prior to the beginning of the academic year following the normal graduation date of the first entering class in such school or (ii) if later, upon completion of the project for which assistance is requested and other projects

(if any) under construction or planned and to be commenced within a reasonable time."

(b) Section 843 (f) of such Act (relating to accreditation of new schools of nursing), is amended (1) by striking out "any program of nurse education means a program accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education" and inserting in lieu thereof the following: "any program of nurse education, offered by a diploma school of nursing, means a program accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education and, when applied to any collegiate or associate degree program of nurse education, means a program provided by an educational institution approved or accredited by either a regional accrediting agency or a State approval agency", and (2) by striking out "new school" and the remainder of such clause and inserting in lieu thereof the following: "new school (which shall include a school that has not had a sufficient period of operation to be eligible for accreditation), (A) upon completion of such project and other construction projects (if any) then under construction or planned and to be commenced within a reasonable time, or (B) if later, then prior to the beginning of the first academic year following the

normal graduation date of the first entering class in such school;".

Passed the House of Representatives September 1, 1965.

Attest: RALPH R. ROBERTS,

Clerk.

The CHAIRMAN. As we know, this legislation would extend and expand the program enacted in 1963 for the expansion of our training capacity for health manpower. Testimony presented to this committee at that time revealed that we would have to increase our graduates in medicine by 50 percent and our graduates in dentistry by 100 percent in order to maintain existing ratios of these essential health workers to population in the years ahead.

Our experience to date indicates that the 1963 legislation has been effective in expanding our training capacity for health manpower. The legislation we are considering today would extend and expand the program of grants for construction and loans for needy students. In addition, two new programs would be added.

First, a program of scholarships for talented students in need of financial assistance.

Second, a program of improvement grants to assist in strengthening and improving the quality of educational programs.

In approving H.R. 3141 the House of Representatives amended the bill to require schools to expand enrollment by 2½ percent or five students, whichever is greater, to qualify for improvement grants, I am particularly interested in obtaining the views of our witnesses on this amendment and also with respect to the amendment to the Nurse Training Act of 1964 regarding accreditation.

The National League for Nursing is now recognized as the accrediting agency by the Department of Health, Education, and Welfare. The provisions of H.R. 3141, however, would authorize a regional accrediting agency or a State approval agency to serve as the accrediting agency for baccalaureate or associate degree nursing programs.

Secretary Cohen, we are very happy to have you here with us and to have with us also Dr. Dempsey and Dr. Hundley, as well as your new assistant, all of you gentlemen. We shall be happy now to have you proceed in your own way.

STATEMENT OF WILBUR J. COHEN, UNDER SECRETARY; ACCOMPANIED BY DR. EDWARD W. DEMPSEY, ACTING ASSISTANT SECRETARY, HEALTH AND MEDICAL AFFAIRS; DR. JAMES M. HUNDLEY, ASSISTANT SURGEON GENERAL FOR OPERATIONS, PUBLIC HEALTH SERVICE; AND DR. WILLIAM L. KISSICK, SPECIAL ASSISTANT TO ASSISTANT SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. COHEN. Thank you, Senator Hill. I am also accompanied here by Dr. Kissick, special assistant to Dr. Dempsey.

The CHAIRMAN. Good. Doctor, we are very happy to have you here with us. We welcome you.

Mr. COHEN. Mr. Chairman, I have a very brief statement.

The CHAIRMAN. They say brevity is the soul of wit, you know.

Mr. COHEN. I will try to be brief but not witty this morning.

The CHAIRMAN. All right. Well, if you are brief, you are witty. That is the proposition.

Mr. COHEN. Thank you, sir.

I can preface my statement, Senator, by saying that we are wholeheartedly for S. 595, which you have introduced.

Before directing my remarks to the particular legislation which is before you today, may I take this opportunity of expressing the administration's appreciation to this committee and particularly to its distinguished chairman, Senator Hill, for helping to make history in this session of the Congress with the important health legislation that has been considered and enacted. This session will long be remembered as the health session, due in large part to the efforts of this committee. The Department wishes to express its appreciation for the splendid cooperation it has received at all times from this committee.

The CHAIRMAN. May I say there, Mr. Secretary, that anything that this committee may have accomplished has been made possible by the very wonderful help and support which we have received from you and from the Department of Health, Education, and Welfare.

Mr. COHEN. Thank you very much, Senator.

I appear before you today in support of S. 595, the Health Professions Educational Assistance Amendments of 1965, introduced by Senator Hill. The legislation under consideration today derives its importance and urgency from the pressing needs in every area of health.

Many factors have combined to increase the demands for additional manpower across the entire range of the health sciences. The population is growing at a greatly accelerated rate, with the growth proportionately greater in the younger and older age groups, the two groups which require the greatest amounts of medical services. Great progress has been made in reducing financial barriers to needed medical care, and there has been an increasing rise in the use of personal medical services. The swift growth in the biological medical sciences has created parallel demands for increasing numbers of highly trained scientists. Moreover, developments in both research and practice of medicine have led to the creation of new technical and supportive disciplines essential to high quality work. The enactment of the medicare bill will also necessitate additional manpower and services.

Health manpower is the key to the achievement of all our health objectives. The report of the President's Commission on Heart Disease, Cancer, and Stroke emphasized that "trained manpower, devoting its full time and talent to problems of heart disease, cancer, and stroke, is an absolutely essential element of progress against these diseases." This can be said with equal truth in every other area of health.

The legislation which you are considering today authorizes several programs which complement each other. In concert, they have the potential of overcoming the shortage of physicians, dentists, and other health professionals which is becoming increasingly critical each year. These programs will assist in the establishment of new schools and in increasing the capacity of existing schools. They will assist in improving the quality of the training provided, and will enlarge the potential pool of students by enabling needy talented students to enter these schools. The ultimate purpose and effect of these programs will be to improve the availability and quality of medical care to the people of this country.

No other piece of health legislation is so fundamental to the achievement of all health objectives. We cannot too strongly urge its

enactment. And I say that, Mr. Chairman, after considering all the health legislation that you have passed this session, as well as that which you have now pending. Without this bill, there is such a gap as to make the completion of all the other pieces of legislation very difficult. This is the key, it seems to me, to all that we have been trying to do.

The CHAIRMAN. Well, to carry on the programs under this other legislation, you have to have personnel; is that not true?

Mr. COHEN. That is correct, Senator.

However, I should like to call attention to one or two provisions included in the bill passed by the House which cause us concern and which we have discussed in some detail in our report to you on that bill.

The legislation proposed in the Senate bill (S. 595) has, as one of its purposes, provisions which can strengthen several of the weaker medical schools which are now in a precarious position, both financially and academically. The bill passed by the House (H.R. 3141) contains an amendment requiring applicant schools to enlarge their classes in order to qualify for the improvement grants. We believe this amendment might further lower the quality of education provided by the weaker schools. We therefore urge that this amendment in the House bill be deleted.

Likewise, the House added an amendment dealing with the accreditation of schools of nursing. Since this amendment provides for accreditation by regional and State agencies which accredit or approve the educational institution as a whole and do not in their accreditation process evaluate or accredit the quality of the nurse education program conducted by the schools, its effect could adversely affect the quality of nursing education. We therefore also urge that this amendment be deleted.

Finally, two other amendments were made in the House-approved bill. These deal with eligibility of students for scholarship assistance from funds provided under this legislation, and with certain provisions for forgiveness of loans to students who, after graduation, practice in rural areas. We believe these amendments to be entirely acceptable although, as our report states, a minor modification in the forgiveness-of-loans amendment is desirable.

The CHAIRMAN. What would be that minor modification, please?

Mr. COHEN. That minor modification is to provide that, where a student obtains a loan at the going rate, it shall continue to be—during the entire duration of the loan—at the rate that he received the loan. This would avoid a changing rate of interest, which merely complicates repayment and the administrative process.

It would be in the nature, as I see it, of a simplification for the person who borrowed the money, the loaning institution, as well as the Government.

Mr. Chairman, we wish to thank you for giving us this opportunity to express our views before you today on this significant legislation which has so recently been passed by the House of Representatives.

I would like to repeat again my statement that all of the other legislation that you have considered and all of the other legislation that is still coming before you—that I know this committee and the Congress and the President would like—cannot be really put into the effect without the passage of this most important legislation, dealing

with both the quantity and the quality of our health personnel in the country. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Secretary. Dr. Dempsey?

Dr. DEMPSEY. Thank you, Mr. Chairman.

Senator YARBOROUGH. Mr. Chairman, may I ask a question or two at this point?

The CHAIRMAN. Yes; certainly.

Senator YARBOROUGH. They pertain to the paper. First, Mr. Cohen, I congratulate you on your statement. When you say this is the most urgent of all the bills to improve public health in this country, you are coming to the committee with the right chairman. In my opinion, no American living or dead has done more for medicine in this country than our distinguished chairman. This goes back to the Hill-Burton Hospital Act and all of these other medical and educational acts which have been enacted in the past few years, some of which you mentioned in your statement. I will not enumerate all of them here.

I have had the privilege of serving on this subcommittee with our chairman some 6 or 7 years, and I have found that he has always been the pusher of these acts, and not the person to hold them back. He has pushed their enactment, he has held hearings promptly, and he has put them through the Senate. We are most fortunate in having him as the chairman of this committee.

The CHAIRMAN. I thank the distinguished Senator from Texas for his generous words. I would like to say that no member on this committee has been finer, more constructive, or more helpful in the enactment of our health legislation than the distinguished Senator from Texas.

Senator YARBOROUGH. That is a very generous statement, Mr. Chairman.

Mr. Cohen, I want to ask you a question or two. Some 2 years ago we were having testimony on the health educational assistance bill, and we were furnished some data on medical schools which indicated that about 4 years ago, in 1 year's time in the United States, we licensed some 8,000 medical doctors, 6,300 of whom were educated in American medical schools, and the remaining 1,700 of whom were emigrees from other countries, educated in foreign medical schools, who came here to make up the quota of doctors that we absolutely needed to replace other medical doctors who were leaving the profession, due to death or retirement.

Now, do you have data available there with you—if you do not, I can get it from you later—as to what happened over the past 3 or 4 years?

Mr. COHEN. I remember now that you raised this question 2 years ago, I believe when we were discussing the original Health Professions Act.

Senator YARBOROUGH. It was when we were trying to give more American boys and girls a chance for a medical education, so that we would not have to drain the medical help of other foreign countries. Some of them do come here, anyway, but we did not think we ought to drain them, because our own people ought to have an opportunity for a medical education.

Mr. COHEN. Let me give you a few statistics that I think are, in a way, astounding, about the status of our medical practioners in this country.

In the year 1963–64, 17.2 percent of the physicians licensed in the United States were from foreign medical schools.

Over the past 10 years, the number of foreign medical school graduates licensed to practice has risen from less than 500 to about 1,600 a year, which it was in 1963–64. The percentage is a little bit lower than it was at the high point of 1960–61, when it was 19.2 percent; but 17.2 percent is very large. The situation, however, is even more startling if you look at internships and residencies.

Senator YARBOROUGH. What is the total number of graduates?

Mr. COHEN. The total number of graduates licensed for the first time in 1963–64 was 9,294, of whom 1,600 were from foreign medical schools.

Senator YARBOROUGH. To me, it is just shocking that we do not give American boys and girls a chance to obtain a medical education so that they can serve their own people. We have been recruiting them to go overseas with activities such as the Peace Corps, but we do not train them to serve here at home.

Mr. COHEN. That is right.

Now, let us go to internships and residencies, where the situation is even more pointed.

In 1963, 27 percent of all internships in the United States were filled by foreign graduates, and 24 percent of all the residencies were filled by foreign graduates. There were 2,566 foreign graduates who filled internships and 7,052 in residencies in 1963.

Now let me mention one other thing that sticks in my mind: The Soviet Union, as I recall—I will look up the exact figures—is graduating about three times as many medical graduates as we do. It is true that they have a shorter and less adequate medical education than we have, and I am not commenting on the quality. But as a result of this, they are not only able to meet all of their domestic needs, but they can export doctors to the world, which in my opinion is one of the most important areas of international cooperation.

I mean, regardless of political differences in the world we live in, every nation understands the problems of medical care and the problems of bringing public health up to date and eliminating diseases. To me, it is shocking to think that the Soviet Union can graduate three times as many medical students and meet its needs, and export them, while the United States has to get 17 percent of its graduates from foreign countries, as well as 27 percent of its internships and 24 percent of its residencies. I think I would rest my entire case on the need for expansion of our whole medical profession, almost solely on that one point—which, of course, I do not.

Senator YARBOROUGH. I think that one point alone ought to require the passage of this act, as well as the need for medical education where the States are unable to or have not put up the money for medical education.

Mr. COHEN. That is right, Senator.

Of course, the problem that we are faced with as brought out by the fine report by Mr. Frank Bane in 1959, the so-called Bane report for the 1963 act, is: Without the 1963 act and this act and as a result of the increasing population, the increasing number of children, the increasing number of aged people, all the research that we need, and so on, we would be worse off 5, 10, 15 years from now than we are today. With the population increasing, as well as the need for more

medical services, the need for these practitioners in all these areas, to take care of all these problems, we have to run as fast as we can with this legislation to stay in the same place that we are in today.

That is why I said before that this is the key to all the other pieces of legislation. Because if you pass all these other pieces of legislation and do not pass this, we are just making our situation more complicated for everyone.

Senator YARBOROUGH. I would say, judging by your data, that we are using all our new medical doctors to replace the existing ones. The Soviet Union produces three times enough for their domestic needs, so it is patently clear that they are making more progress over the world in this direction. In many areas of the world, the medical missionary makes progress a lot faster than the religious missionary or the political commissar who is sent out. Their medical missionaries would be more influential than the political commissars or our religious missionaries, both combined.

Mr. COHEN. Could I make another point here while I think about it?

The Soviet Union not only graduates more than three times as many medical graduates as we do, but they do one thing which to me is very important: They use many, many more women in medical education than we do. I think it runs to something like 70 percent of their graduates.

Now, this is not only important for the whole area of pediatrics and child care, but more generally. I think women are especially good doctors in their field, and there is plenty of room in the United States for more women to get into medicine and do a splendid job. At the same time, both from a national defense standpoint as well as others, it is good to have more women in the medical profession, because if you have national defense needs, you have to send your men abroad, as we are asking doctors to go to Vietnam. Somebody has to stay home and take care of the people at home.

I think it has been extremely shortsighted, in the whole development of this area, both from the standpoint of individual interest and the national interest, that we have not been able to expand our medical education and utilize more women.

Senator YARBOROUGH. I agree with you thoroughly.

Of course, we have had a lot of opposition up until recently within the medical profession. They were afraid it would become overcrowded. I know that branches of the medical profession were very much opposed to these foreign students coming in and being licensed. But there was an impossible situation. They were opposing the broadening of medical education, not in the sense of subsidies, but in the sense of producing more doctors to fill the gap. The gap was widening between the demands of people for medical attention and the number of doctors who could render it.

I hope that in the future the medical associations will support this legislation. The American Medical Association did support the Medical Educational Assistance Act, but a number of the State medical societies opposed it. The States were opposed, while the national association supported it.

Senator JAVITS. Mr. Chairman?

Mr. COHEN. Could I just make one point, Senator Javits? Because I know the Senator was asking for this in connection with the educational legislation.

There is one other important fact here that to me is a great need for change and expansion. In 1963, while 20 percent of all American families had $10,000 or more, 49 percent of the families of medical students and 41 percent of the families of dental students were in this group.

In other words, another thing we have to give consideration to is, because of the whole matter of education and the cost of education, there are a lot of able and talented young people from the lower income groups who are not able to get into the medical professions and medical education, because of the cost.

Senator YARBOROUGH. They are just priced out of it.

Mr. COHEN. They are priced out. Their parents are priced out, not only priced out at the time they go into the medical school, but priced out as undergraduates and even in high school.

Since this committee deals with education generally, I think there should be consideration of even more legislation to make it possible for these lower income students to get into the medical profession. If this were done, that alone would account for a tremendous potential expansion to meet our needs.

Senator YARBOROUGH. Thank you very much. I could not agree with you more, Mr. Cohen.

As you know, we have had the medical education loans, hoping to overcome some of this situation. I do not think there is enough of it available. We hope that there will be a larger number of medical students and a larger enrollment.

I appreciate your comment here where you point out that even if we do everything that has been recommended in all of this legislation, we are only going to be working hard to stay where we are now; we are not taking care of the needs of the future. I think this country must face up to this, and the Congress might supply this medical education, whether the State medical associations approved or not.

I have one other question in connection with this measure. In your statement you recommend that the amendment adopted by the House be stricken that permits regional and State agencies to accredit the nurses' educational schools.

Now, the nurses' association was very much opposed to that amendment, the so-called Rogers amendment. In my State and in some other States that I have heard from, the junior colleges of America are very much for that. They say two things that I remember: first, that this makes accreditation of their educational institutions dependent upon a trade or professional group, rather than upon educational groups.

They say, too, that their standards are high, and that the national associations have not accredited them. In my own State, with some more than 50 junior colleges, I believe, they tell me that the national association has accredited only three junior colleges in nursing courses, and that they cannot get accreditation.

As a result, they say that to leave this accreditation with the national nurse's organization will strangle the purposes of this, to provide some of the great shortages in our nurses that we have.

What comment do you have, Mr. Cohen, on this conflict between the educational community and the nursing community as you see it? I have talked with both of them, have heard both sides, and I find it is a very difficult thing to answer.

Mr. COHEN. Let me say this: While we have up to now been talking mainly about quantity, I hope, as an expression of general principle, that nothing that we do in this bill would in any way impair the quality of medical education or in any of the health professions.

The medical profession has been very zealous about that, as we have in the Department, and I would want to be extremely hesitant and careful before any amendment was adopted which could even remotely be thought of as impairing the quality of medical education.

Now, I think you have to deal with this matter. There are certainly administrative and financial problems, but there is also a matter of principle here, Senator. I think that when you come to professional education as a component in higher education, accreditation, which is so extremely important, should be done by a group of the profession's peers.

The problem is, in a university or a college, made up of a lot of different components, that is accredited as a whole. When you are talking about medical education or a nursing education or a dental education, or if you are talking about social work, or any other field, the accreditation, in order to be professionally acceptable and to deal with quality, the question should not be as to whether the institution as a whole is a good institution, but whether that component that you are talking about meets the standards set up by their peers.

So I feel rather strongly that we should not deviate from the principle that these different medical areas should be accreditated by the groups who are their peers.

Senator YARBOROUGH. I agree with you on the need for quality. In the effort toward quantity, there should not be any letup in the quality of the medical profession, the medical personnel educated in this country.

But does the Department have any personnel to go out and personally inspect any of these junior colleges to see whether they meet reasonable criteria? They come to me and say that the nurses' association just will not accredit them.

Now, if we leave the accrediation in the nurses' association, do we stifle the purpose of all this? They say that the nurses do not get around to examining them and accrediting them, and they are meanwhile losing the opportunity to train these people. Let us find out if the colleges are right about that.

Is your Department making an examination to see, if this is turned over entirely to the nurses, whether the complaints of the colleges are valid? They claim they are doing excellent work of a high caliber.

Mr. COHEN. Let me say first that there is a matter of very great principle involved here. Basically, accreditation is done by nongovernmental agencies. There may be an exception that I am not aware of.

Senator YARBOROUGH. But licensing to practice is done by governmental agencies. There are State licensing boards. If these nurses have the power vested in them under the law, and if these schools do not meet the teaching criteria, they cannot pass the examination.

There is a hiatus in this. The licensing is not up to you or the Federal Government, but it is done by each State with its board. Those State boards would be ready to accept the graduates of these schools and let them take that examination, but there is a national organization which says that you cannot even go to that school.

There appears to be a conflict, so that we need somebody else to look into this other than the college boards or the nurses' organization. That is the reason I am trying to put this monkey on your back, Mr. Cohen. I want you to look at this. I want some disinterested agency to look at this thing, not with their minds already made up.

We have fine, intelligent, honorable people, who would not misstate anything, coming to see us about this on both sides. Now, somebody is just honestly mistaken, and I do not know which side it is.

Mr. COHEN. Let me say two things. First, let me put it this way: Of course, there is a big difference between the areas of public responsibility for licensing and the standards setting up the functions for accreditation. Those have been two different areas in the picture.

I believe that while there are some problems growing out of the fact that accreditation is a nongovernmental responsibility generally, although recognized indirectly and directly by both Federal and other laws, you would not want to have the Federal Government get into the accreditation process per se, or it would in effect be intervening in the whole area of education.

Senator YARBOROUGH. But when we put this money in here, we are saying under what conditions this money may be used. We are to this extent making a recommendation on where the money should go, because I hope we are about to authorize this money and to appropriate it to do something about this tremendous shortage of nurses.

I have heard your Department give us some data in the past, and it may be in some of these next papers, on the tremendous shortage and what we have to expect in the future.

So the Federal Government is involved to the extent of pulling money in here to try to alleviate the great shortage of nurses in the United States, and I do not think it ought to take over the accreditation and licensing. But I think that the very fact that we are pulling this money in indicates that there should be some control, so that there is some reason in how this thing is done. To be responsible, we in Congress should make recommendations, without total authority saying you have to do this or that. But to be in a position to issue recommendations, we should have the expert advice of the Department of Health, Education, and Welfare. I am sure that this whole committee wants to do what is best for nursing and fair to all the parties concerned. This important problem should be studied and understood thoroughly so that no injustice will be done.

Mr. COHEN. Let me say first, in all honesty, that I have had these same points made rather extensively to me in the past couple of weeks. I have tried to go into them, but I have not had both parties in the room at the same time, and I think you will recognize that there is a certain difficulty if you try to conduct sort of an ex parte investigation of this. There has been such a short time since this was adopted in the House. I recognize that there are a lot of those implications. The Department would be very willing to try to bring all of the interested people together—that is both the nursing groups, the accreditation bodies, and the junior college people—to try to sift out many of these problems.

The difficulty is, I think, that there would not be time to do it between now and the completion of this session. If the committee would be willing for us to do it, we would do it, but we would have to have some time for it. The evidence is rather conflicting, but there is a great matter of principle here, and I think before we can make any shift in it, we should be very careful.

Senator JAVITS. Will the Senator yield for a suggestion?

Senator YARBOROUGH. Yes, indeed.

Senator JAVITS. Mr. Cohen, I was going to ask you this question. I am under terrible time pressure, so I hope you will forgive me for interrupting.

Senator YARBOROUGH. Certainly.

Senator JAVITS. But I did want to suggest, with reference to what Senator Yarborough very properly brought out, that perhaps you would submit to us for this bill the rationale of the Department's position as it now stands, as to why you want the Rogers amendment deleted and why you believe that the accreditation administration is just, notwithstanding the fact that it is in quasi-private hands. I think that is really the essence of this complaint, which has a long history. We all know the nurses very well, and have the highest regard for them. But I do think you ought to tell us why, and give us the evidence that you have, as to why this has been fairly administered, and then make the promise that you will look into it and make recommendations, not just merely look into it.

Mr. COHEN. Yes.

Senator JAVITS. Then I think we might have a suitable basis for saying we will pass it this time. But we would need to be convinced, I should think, Ralph, on both those scores.

Mr. COHEN. May I also say this, Senator, in connection with this: The reason why I would want to go into it carefully and make recommendations is, I think there are inherent in here, if you try to solve this point with regard to the nurses, the same kinds of questions with regard to physicians and dentists, and we should not be precipitate in making some fundamental amendment arising out of the problem here, so that we precipitate a whole series of very far-reaching changes in the whole accreditation process.

Senator JAVITS. Will you set that out for us?

Mr. COHEN. Yes.

(Subsequently the following information was supplied for the record:)

STATEMENT ON ACCREDITATION BY THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The independence of institutions of higher education to determine the scope and content of their academic and professional programs without the interference of Government has been a major principle of educational policy in the United States. This has been pursued through vesting responsibilities for accreditation in nongovernmental organizations. The Federal Government has recognized this principle by specifying that institutional eligibility for "grants-in-aid" be limited to those accredited by, "* * * recognized body or bodies approved for such purpose by the Commissioner of Education." The certification of the qualifications of individual professionals is a responsibility of the licensure agencies of the individual States.

It is recognized that problems in accreditation can be anticipated in institutions wherein there is multiple accreditation. Thus one can find a graduate program in clinical psychology accredited by one organization located in a university that is accredited by one of the six regional bodies. This and similar problems led the

National Commission on Accreditation to call a conference in February 1963 on accreditation in the health professions. Representatives of the Department of Health, Education, and Welfare have been involved in subsequent meetings and discussions of these issues.

The amendment in the House of Representatives to H.R. 3141 even though restricted to the accreditation of nursing programs would establish a precedent in the broad area of education of health manpower and could have very widespread consequences. The critical needs for health manpower and the anticipated rapid expansion of educational programs in numerous disciplines requires prudence in decisions affecting the mechanisms for certifying the quality of programs and encouraging the development of high standards.

The Department is, therefore, opposed to the amendment at this time. We propose to study the issues thoroughly with the representatives of appropriate national, regional, and State educational and professional organizations, examine the alternative courses of action for resolution of the existing conflict between the National League of Nursing, and the American Association of Junior Colleges, and subsequently report to the Congress with recommendations for legislation, if necessary. Any delay represented by the approach is, in our opinion, justified because passage of the amendment to H.R. 3141 would permit the expenditure of Federal funds for the development and expansion of programs in nursing such that quantity might be achieved at the sacrifice of quality. Moreover, the possible ramification for other health professions could be serious.

Senator YARBOROUGH. Will the Senator yield for one question?

Senator JAVITS. Yes.

Senator YARBOROUGH. There is a vast difference involved here. The person taking dentistry or preparing to be a medical doctor, whether man or woman, generally practices that profession all of his life, for the most part, at least the overwhelming percentage of the people. However, these ladies who become nurses often quit to rear a family, and may come back in later years to nursing, but often quit for good. The turnover is much faster in the case of nurses than in medical doctors and dentists; is that not true?

Mr. COHEN. Unfortunately, yes.

Senator YARBOROUGH. And you want to train them.

Mr. COHEN. We want more nurses to enter training. We need them. The shortage of nurses is even more desperate than the one in regard to physicians.

Senator YARBOROUGH. Well, in the case of doctors and dentists, they remain in that profession the rest of their lives, but when it comes to nurses, you have to train many more than you need, because they are going to go off and marry and decide to give up nursing. This happens over and over.

Mr. COHEN. Yes, sir.

Senator YARBOROUGH. Even in my own life, I have known quite a number of ladies who were formerly nurses, but who did not practice nursing any more.

Mr. COHEN. I feel certain that either I or someone else is going to come back here with amendments to the Nurse Act that you passed, to amplify that, because that shortage is so intense that we cannot meet these objectives we have talked about.

Senator JAVITS. Mr. Secretary, let me finish, please. I have to leave for an executive session in another committee.

Senator YARBOROUGH. Thank you, Senator Javits.

LOANS FOR STUDY ABROAD

Senator JAVITS. I have one question, which you may not be able to answer. If not, just give us your answer later.

We are asked whether it might not be possible to make loans under this bill available to Americans studying medicine abroad. This may involve major policy questions. But in view of the shortage of medical facilities here and the fact that many Americans are studying abroad, could the loan provision be made applicable to them? Would you want to answer that later?

Mr. COHEN. I would be glad to give it some thought and let you know, Senator.

(Subsequently the following material was supplied for the record:)

STATEMENT ON LOANS TO U.S. CITIZENS STUDYING MEDICINE IN FOREIGN UNIVERSITIES, BY THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

It is not legally possible under the current provisions of the act to make loans to students who attend foreign medical schools, for the following reasons:

(1) The Secretary is authorized to enter into an agreement for the establishment of a loan fund only with a school "which is located in a State" (sec. 740(a)).

(2) Participating schools in the United States are precluded from making loans to such students since each agreement is required to provide "that the fund shall be used only for students of the school * * *" (sec. 740(b)(3)).

(3) The Secretary is not authorized to make loans directly to students; instead, "Sums appropriated * * * shall be alloted among loan funds at schools which have established loan funds * * *" (sec. 742(a)).

It would not appear to be desirable or appropriate to authorize the Secretary to make loans directly to individual students nor for collection of repayment of the loans to be undertaken by the Federal Government.

The provisions of the legislation restrict eligibility for loans to medical students, "* * * attending medical schools accredited by body or bodies recognized by the Commissioner of Education." This proposal raises policy questions of far-reaching consequence involving other Federal agencies in addition to the Department of Health, Education, and Welfare. We would not consider it feasible to authorize the establishment of loan funds in foreign medical schools. The mechanics of such a program would be difficult if not impossible from an operational standpoint.

We hope that the need for such a program will be mitigated through increases in the capacity of medical schools in the United States as a result of the programs authorized by the Congress so that any student who attends foreign medical schools will do so as a matter of choice rather than necessity.

Senator YARBOROUGH. Mr. Chairman, I have a communication here from the American Association of Dental Schools. It is a copy of one addressed to you. I ask that this statement be placed in the record, which supports Mr. Cohen's recommendation for the deletion of the amendment that would require the applicant to enlarge classes arbitrarily in a certain percent in order to gualify for grants.

The CHAIRMAN. We will be glad to have that put in the proper place in the record.

(The communication referred to appears on p. 81.)

The CHAIRMAN. Mr. Secretary, I realize that the Educational Assistance Act of 1963 has been on the statute books only a short time, and you and I well know that even after you pass an act, it sometimes takes a little time to get the appropriations needed. Then it takes time to work out the details and provisions of the program under that. So this act has not been effective too long.

Could you submit for the record a statement showing how the Health Educational Assistance Act has expanded our capacity to train health manpower?

Mr. COHEN. Yes.

The CHAIRMAN. Then, could you also submit for the record your estimate as to the increase in training capacity that the pending bill would make possible?

Mr. COHEN. I would be glad to, Senator.
The CHAIRMAN. All right, fine.
(Subsequently the following material was supplied for the record:)

Summary of Public Law 88–129 accomplishments—Projects approved and funded through the June 1965 council (as of July 9, 1965)

Discipline	Number	Federal share	New 1st-year places
Medical, total	24	$71,245,291	725
New schools	6	32,147,159	404
Existing schools	18	39,098,132	321
Dental, total	14	33,655,746	372
New schools	1	1,232,127	96
Existing schools	13	32,423,619	276
Public health, total	4	7,925,455	226
New schools	1	735,000	35
Existing schools	3	7,190,455	191
Nursing, total	16	8,875,920	783
New schools	2	1,381,419	134
Existing schools	14	7,494,501	649
Pharmacy, total (existing schools)	3	2,259,104	137
Optometry, total (existing schools)	2	1,156,079	36
Total, all disciplines	63	125,117,595	2,279
New schools	10	35,495,705	669
Existing schools	53	89,621,890	1,610

Source: Program Evaluation and Reports Branch, Division of Hospital and Medical Facilities, July 9, 1965.

Public Law 88–129 accomplishments—Projects approved and funded through June 1965 council (as of July 9, 1965)

MEDICAL (24)

Application No.	Project and location	Federal share	Increase 1st-year students
18	Loyola University, Chicago, Ill	$7,964,973	20
20	University of Utah, Salt Lake City, Utah	235,125	9
27	Bexar County Hospital District (N), San Antonio, Tex	9,000,000	[1] (100)
29	University of Kansas, Kansas City, Kans	878,022	12
33	University of Maryland, College Park, Md	5,485,040	27
34	Columbia University, New York, N.Y	1,052,300	9
43	University of California:		
	Berkeley, Calif	757,502	25
44	____do	68,784	[2] (25)
45	Los Angeles, Calif	4,000,000	56
53	University of New Mexico (N), Albuquerque, N. Mex	1,705,336	48
56	University of Colorado Denver, Colo	1,723,728	20
57	University of Texas (N), San Antonio, Tex	3,948,581	100
62	University of North Carolina, Chapel Hill, N.C	2,388,195	25
76	University of California (N), San Diego, Calif	8,035,247	96
78	University of Vermont, Burlington, Vt	$2,372,917	25
84	Rutgers University (N), New Brunswick, N.J	4,337,519	64
87	University of Hawaii (N), Honolulu, Hawaii	2,090,677	48
88	Washington University, St. Louis, Mo	1,960,900	20
101	University of Miami, Miami, Fla	2,319,748	20
104	Mary Fletcher Hospital, Burlington, Vt	2,020,936	[3] (25)
123	University of North Carolina, Chapel Hill, N.C	803,487	[4] (25)
126	Georgetown University, Washington, D.C	2,015,837	29
140	Boston University, Boston, Mass	3,050,638	24
141	University of Arizona (N), Tucson, Ariz	3,029,799	48
	Total	71,245,291	725

[1] Increase counted in application No. 57.
[2] Increase counted in application No. 43.
[3] Increase counted in application No. 78.
[4] Increase counted in application No. 62.

NOTE.—(N) indicates new school.

Public Law 88–129 accomplishments—Projects approved and funded through June 1965 council (as of July 9, 1965)—Continued

DENTAL (14)

Application No.	Project and location	Federal share	Increase 1st-year students
02	University of the Pacific, San Francisco, Calif	$3,805,785	42
14	Western Reserve University, Cleveland, Ohio	3,229,679	20
15	University of Michigan, Ann Arbor, Mich	5,034,265	53
35	University of Nebraska, Lincoln, Nebr	2,545,000	21
36	University of Pittsburgh, Pittsburgh, Pa	1,084,226	20
46	University of California, (N), Los Angeles, Calif	1,232,127	96
60	Loyola University, New Orleans, La	3,060,043	24
62	University of North Carolina, Chapel Hill, N.C	2,847,929	25
64	University of Pennsylvania, Philadelphia, Pa	619,416	10
65	Do	56,200	[5] (10)
83	University of Southern California, Los Angeles, Calif	2,003,500	9
127			
128	Georgetown University, Washington, D.C	3,348,810	26
143	Loyola University, Chicago, Ill	4,731,039	26
157	Western Reserve University, Cleveland, Ohio	57,727	[6] (20)
	Total	33,655,746	372

PUBLIC HEALTH (4)

25	Johns Hopkins University, Baltimore, Md	$2,666,658	38
50	University of Pittsburgh, Pittsburgh, Pa	1,500,000	30
61	University of California, Los Angeles, Calif	3,023,797	123
87	University of Hawaii (N), Honolulu, Hawaii	735,000	35
	Total	7,925,455	226

NURSING (16)

03	East Carolina College, Greenville, N.C	$506,252	51
07	Illinois Wesleyan University, Bloomington, Ill	158,278	20
13	Western Reserve University, Cleveland, Ohio	1,170,204	73
17	Loyola University, Chicago, Ill	684,922	73
21	Alverno College, Milwaukee, Wis	563,460	36
30	D'Youville College, Buffalo, N.Y	612,783	84
55	Arizona State University, Tempe, Ariz	440,924	26
56	University of Colorado, Denver, Colo	293,367	60
86	University of Bridgeport, Bridgeport, Conn	330,833	20
92	St. Xavier College, Chicago, Ill	100,500	28
93	Cincinnati University, Cincinnati, Ohio	1,586,103	54
97	Texas Women's University, Denton, Tex	458,135	68
98	University of Nevada, Reno, Nev	389,118	28
117	Murray State (N), Murray, Ky	576,748	45
129	Dillard University, New Orleans, La	199,622	28
149	Ball State Teachers College (N), Muncie, Ind	804,671	89
	Total	8,875,920	783

PHARMACY (3)

08	University of Oklahoma, Norman, Okla	$40,000	
94	University of Illinois, Urbana, Ill	594,421	71
100	University of the Pacific, Stockton, Calif	1,624,683	66
	Total	2,259,104	137

OPTOMETRY (2)

75	Indiana University, Bloomington, Ind	$859,055	26
107	Pacific University, Forest Grove, Oreg	297,024	10
	Total	1,156,079	36

[5] Increase counted in application No. 64.
[6] Increase counted in application No. 14.

NOTE.—(N) Indicates new school.

Health professions student loan program—Summary of operations, fiscal year 1965 (June 30, 1965)

Type of program	Number of schools participating	Number of students enrolled	Number of borrowers	Percent borrowers	Total amount borrowed	Average amount of loan
Medical	87	31,416	7,260	23	$6,663,227	$918
Dental	46	12,954	3,170	24	2,910,172	918
Osteopathic	5	1,651	614	37	411,357	670
Optometric	9	1,409	387	27	290,722	751
Total	147	47,430	11,431	24	10,275,478	899

ESTIMATED NUMBER OF NEW FIRST-YEAR PLACES WHICH WILL BE CREATED UNDER H.R. 3141 AS PASSED BY HOUSE

Assuming that the trend of fund utilization during the next 3 years will continue along the same lines as has occurred during the first 2 years of the program's operation, the Public Health Service estimates that additional first-year places will be created as follows:

Type of school	Federal funds	New 1st-year places
Medical	$300,000,000	2,000
Dental	120,000,000	1,200
Public health	25,000,000	625
Pharmacy	15,000,000	1,000
Optometry	15,000,000	1,000
Podiatry	5,000,000	175
Total	480,000,000	6,000

In addition to the new first-year places created with these anticipated appropriations, other schools will be modernized, remodeled, and replaced to preclude the curtailment of enrollment or deterioration in the quality of training.

The CHAIRMAN. Dr. Dempsey?

Dr. DEMPSEY. Thank you, Mr. Chairman. It is a great pleasure and privilege to appear before you and your committee again today, sir. I am particularly grateful to have the opportunity to testify in favor of the legislation which is being considered today.

I have a prepared statement, Mr. Chairman, which at your pleasure I might introduce into the record and give just a brief summary.

The CHAIRMAN. It will appear in full in the record, Doctor, and you may make any supplementary statements you see fit.

Dr. DEMPSEY. I would like to say merely that following Mr. Cohen's statements of the need for medical manpower, in my opinion the need is very great and very urgent. This opinion is buttressed by a variety of reports that have been made in the past several years, beginning, as Mr. Cohen indicated, with the Bane report, and followed last year by a report of the President's Commission on Heart Disease, Cancer, and Stroke, which contained a statement that the first hard fact to be faced was that there was not enough health manpower to meet the needs of the American people.

Then, still more recently, Dr. Coggeshall made a report in which he also called attention to the shortages that exist and the difficulties facing medical education today.

The present bill has a variety of suggestions and measures designed to improve the existing situation. Specifically, I might just mention them.

It would extend for 5 years the construction grant program for medical, dental, and other health professions schools authorized under the Health Professions Educational Act, as well as the loan programs under that same act.

It would authorize a new 5-year program for basic and special improvement grants to improve the quality of schools of medicine, osteopathy, and dentistry, and would authorize a new 5-year program of scholarships for students of medicine, osteopathy, and dentistry.

It would also establish a National Advisory Council on Medical and Dental Education.

We believe that these measures are directed toward the problems in medical education today and, if enacted, a very significant advance will be made.

We believe particularly that the basic and special improvement grants will go far toward stabilizing those schools which are presently in grave financial difficulty.

It seems futile to propose construction grants to build new medical schools and to increase the number of students in the United States, for at the same time we risk the absolute bankruptcy of a few of the institutions we now have.

These basic special and improvement grants are designed to meet that difficulty.

Special improvement grants are also designed to permit improvement of the educational quality in those institutions adjudged to have difficulties in this regard, and also to provide for possible experimenting for improving the quality of medical education in general.

Finally, the scholarships which Mr. Cohen has mentioned will meet many problems whereby qualified students in the past have been prevented from entering medical schools because of financial difficulties.

We believe, Mr. Chairman, that physicians and dentists, as well as other medical workers, are the hard core of our need for the distribution of medical care. We think that no matter what we do today, it will be a long time, because of the long leadtime, before increasing numbers of highly trained professional people will be available to the United States, and we believe that the need is very urgent.

We therefore wholeheartedly recommend that you pass this bill. Thank you.

The CHAIRMAN. It takes time, does it not, Doctor?

Dr. DEMPSEY. It takes approximately 10 years today to train a specialist in medicine, and more than 80 percent of all of the graduates in medicine today are becoming specialists.

Senator YARBOROUGH. May I ask a question here, Mr. Chairman?

Dr. Dempsey, the recommendation for the amount of the scholarship grants to these schools is $2,000, multiplied by one-tenth of the number of full-time, first-year students of the school. Then, for the next year, one-tenth the full-time, second-year students; and for the third fiscal year, one-tenth of the full-time, second-, and third-year students.

Do you think that starting off with 10 percent of one class is enough to offer the opportunities that Mr. Cohen was asking about for students from these low- and middle-income families?

I think in previous years some of you gentlemen here, or people in your relative positions, have testified that it costs about $35,000 to

educate a medical student from his working toward his bachelor's degree and on to his medical degree and internship.

Dr. DEMPSEY. Yes.

Senator YARBOROUGH. Would that be enough money? We have a limitation of not over $2,500 in any one year. Would you say that that amount, plus one-tenth of the full-time, first-year students, would be enough to give these students from low-income families an opportunity to receive their medical education and help relieve the shortage of doctors?

Dr. DEMPSEY. I don't believe, Senator Yarborough, that this procedure will curtail all of the troubles; no. I think that further assistance is necessary.

However, many of the medical schools do have private funds for scholarships for medical students. We have been advised that it would be unwise to attempt to handle all of the problems at the Federal level, that it seems wiser to undertake measures in which both the public and the private sources of funds are put together in such a way that they assist each other, rather than one replacing the other.

Senator YARBOROUGH. I hope these students know that they are borrowing money put up by the Federal Government, and will not be trained to go out and tell all their patients that the Federal Government is the enemy of the people. I have many people tell me that they can hardly get treated, the doctors take so much time cussing the Federal Government. I think these students should know that they are not tainted just because they borrowed the money from the Government.

Mr. COHEN. We have thought of printing something on the money we give them, Senator, to tell them that. You have made a very good point.

There are communities that do not know that the Hill-Burton hospitals were built with Federal funds. They don't realize that the Federal Government is supporting medical research to the extent of a billion dollars a year in this country. They don't realize that 25 percent of all of the cost of health and medical care is paid out of public funds.

Senator YARBOROUGH. And they do not know that a good part of the salaries of teachers in the medical schools are paid by the Federal Government under the name of research.

Mr. COHEN. Yes.

Senator YARBOROUGH. I would like to get a letter from you, Dr. Cohen, to save time, giving me the statistics here. I want to carry it around in my pocket so that I can insert it in speeches.

Mr. COHEN. I would be glad to, Senator. This is a point which I have felt very strongly about over the years.

The CHAIRMAN. Mr. Secretary, what I think we should do is have that information put in the record here, too, so that it would be available to all of us.

Mr. COHEN. Fine. We would be glad to.

(The information referred to follows:)

STATEMENT OF PUBLIC EXPENDITURES FOR HEALTH AND MEDICAL CARE

Total expenditures for health and medical care for fiscal year 1964 totaled $35.4 billion, of which $9 billion (25 percent) represented public (Federal, State, and local) funds. Major expenditures for health within the public sector of the economy include the following:

	Millions
General hospital medical care	$2, 387. 8
Vendor medical payments for public assistance recipients	1, 147. 0
Biomedical research	1, 134. 3
Veterans hospitals and medical care	1, 070. 9
Defense Department facilities and medical care for dependents of service personnel	985. 6
Medical facilities for construction	717. 5

Federal expenditures of $4,413 million during calendar 1963 represented 12.9 percent of total expenditures. Major items included the following:

	Millions
Hospital care	$1, 763
Physician's services	187
Dentist's services	108
Nursing home care	186
Medical activities in Federal units	642
Government public health activities	246
Research	1, 004
Medical facilities construction	371

From July 1947 to June 1964 the Hill-Burton program has invested $2,166.0 million as the Federal share of a $6,837.0 million construction program providing 313,762 beds in hospitals, nursing homes, and other health facilities.

Federal expenditures for medical and health related research from 1947 to 1964 total approximately $5,700.0 millions.

Senator YARBOROUGH. I think that perhaps with the limited enrollment available in schools, the limited number in the classrooms, these loans might fill the need and fill these classrooms.

Dr. DEMPSEY. These figures were calculated in such a way as to give an appreciable assistance to the scholarship programs of medical schools. For a class of 100 students, there would be 10 students in the first year of the program; 10 students times $2,000 would be $20,000, going up then in subsequent years to $40,000, $60,000, and $80,000 of scholarship assistance.

This, in a percentage fashion, is a considerable increase to the scholarship funds available. We did not think it was overdoing the matter. We thought, on the contrary, that this was a prudent and effective way to make a move toward the scholarship needs of the medical students.

Mr. COHEN. Could I put it this way: We want to be sure that whatever we do in this legislation is additive and does not supplant what has been done. That is the reason we did that. In the course of our experience, if that proves not to be adequate, I can tell you that we are going to be back asking for more.

Senator YARBOROUGH. I agree that we should not pass laws here to relieve States, areas, professions from the obligation that we have had over generations and decades and years of educating their own. But it is to aid in stimulating this, because that is lagging behind the national need.

Mr. COHEN. That is right.

Senator YARBOROUGH. Thank you.

The CHAIRMAN. Dr. Hundley?

Dr. HUNDLEY. I think Secretary Cohen and Dr. Dempsey have covered the subject very well, unless you have specific questions for us.

The CHAIRMAN. I agree that you have covered it very well. But is there anything you wanted to add? We would be glad to hear you.

Senator YARBOROUGH. I want to say that there has been a vast amount of information put in here in a few minutes.

The CHAIRMAN. Yes. Gentlemen, you have offered some very fine and helpful testimony. We deeply appreciate it, and we thank you very much.

Mr. COHEN. Thank you, Senator.

The CHAIRMAN. As indicated before, Dr. Dempsey's full prepared statement will appear in the record at this point.

(The prepared statement of Dr. Dempsey follows:)

PREPARED STATEMENT OF DR. EDWARD W. DEMPSEY, ACTING ASSISTANT SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman and members of the subcommittee, I am pleased to appear before this subcommittee in support of legislation designed to meet the Nation's critical need for more professional health personnel.

The health of the Nation can be no better than the knowledge and skills of the physicians, dentists, and others to whom we entrust it. It is essential that we have a sufficient supply of such talent, drawn from the best and most gifted men and women in the land. But the harsh fact is that we are presently faced with a critical shortage in our supply of professional health personnel, and the situation will persist in the years ahead unless we take concerted action now.

The President's Commission on Heart Disease, Cancer, and Stroke recommended forthright and diversified Federal support of programs designed to increase the supply of physicians, dentists, and medical scientists. Concern was expressed about both the need to increase the supply of physicians, and the need to improve the quality of their training. The Commission stated, "The first hard fact to be faced is that there is not enough health manpower to meet the needs of the American people."

More recently, the great need for a concerted effort to increase the Nation's supply of health manpower was repeatedly emphasized in a report of a committee, chaired by Dr. Lowell T. Coggeshall, to the Executive Council of the Association of American Medical Colleges entitled "Planning for Medical Progress through Medical Education."

The Nation now lacks enough well-qualified physicians and dentists o give care to all the people who need it. When individuals who could be helped by skilled doctors suffer pain, endure handicaps or die prematurely, the whole country's vitality is diminished. Health manpower alone will not assure the availability of the best health care for all Americans, regardless of age or geography or economic status. But if we are to progress toward the goals of adequate health care, we must have enough skilled personnel to man the facilities and provide the services required.

In 1963, under the distinguished leadership of the chairman of your committee, the Congress enacted the Health Professions Educational Assistance Act (Public Law 88–129) which authorized Federal matching grants for the construction of new, and the expansion or rehabilitation of existing, teaching facilities for the medical, dental, and other health professions, and also authorized a program of loans for students of medicine, dentistry, and osteopathy. We cannot urge too strongly the continuation of these programs which are making essential contributions toward relieving the Nation's critical shortage of health manpower. But much more needs to be done before the health manpower problem can be taken off the Nation's critical list.

In his health message of January 7, 1965, President Johnson pointed out that the need for trained health personnel continues to outstrip the supply; high operating costs and shortages of operating funds are jeopardizing our health professions educational system; the high costs of medical schools must not be permitted to deny access to the medical profession for able youths from low and middle income families; the number of physicians, dentists, and other health professionals must be sharply increased if we are to be able to meet future needs.

The President made a number of recommendations for legislation to help relieve the critical health manpower shortages. S. 595 embodies the administration's

legislative proposal to carry out the President's recommendations. In its major aspects the bill would amend the Public Health Service Act to:

(1) Extend for 5 years the construction grant program for medical, dental, and other health professions schools authorized under the Health Professions Educational Assistance Act;

(2) Extend for 5 years and improve the loan program under that same act for students of medicine, dentistry, osteopathy, and optometry;

(3) Authorize a new 5-year program of basic and special improvement grants to improve the quality of schools of medicine, osteopathy, and dentistry;

(4) Authorize a new 5-year program of scholarships for students of medicine, osteopathy, and dentistry;

(5) Establish a National Advisory Council on Medical and Dental Education.

The challenges to which this legislation is addressed are widely recognized.

The Nation's capacity to train professional health personnel must be further expanded.

The supply of able and dedicated students must be increased.

The quality of education in existing as well as new medical and dental schools must be assured.

The Nation's welfare demands adequate responses to these challenges.

Mr. Chairman, I should like to discuss the different provisions of the bill in some detail.

CONSTRUCTION GRANT PROGRAM

S. 595 would extend for 5 years the existing program of grants for construction of new facilities or for the replacement or rehabilitation of existing facilities for the training of physicians, dentists, pharmacists, optometrists, podiatrists, or professional public health personnel. H.R. 3141, as approved by the House, extends this program for 3 years through June 30, 1969, and authorizes appropriations during that additional period of $480 million. These House amendments are acceptable to us.

As you know, the Health Professions Educational Assistance Act which authorized appropriations for construction grants for fiscal years 1964, 1965, and 1966, was not enacted until September of 1963. No moneys were appropriated for these purposes for fiscal year 1964, and the appropriation for fiscal year 1965 did not become law until September 1964. Therefore, we have had only a year's experience under this program. However, the initial reaction to this legislation has confirmed the wisdom of enacting it and has demonstrated the necessity of a more comprehensive program. The availability of construction funds has encouraged schools to develop programs and proposals for the expansion of enrollment and replacement and modernization of existing obsolete facilities to prevent curtailment of enrollment. A total of almost $365 million has been requested in applications received from eligible schools. As of today, 63 of these applications have been approved and funded for construction projects which would entail first-year enrollment increases of 2,282 of which 725 are medical, 372 dental, 226 public health, 786 nursing, and 36 optometry. An additional 76 letters indicate an intention to construct. Only 60 of these letters of intent include cost figures but they alone forecast the need for an additional $454 million in Federal aid. Only $100 million was available for fiscal year 1965. The full authorizations which have been appropriated for 1966 will provide $75 million more. The current authorizations will, therefore, fall far short of meeting the demand.

To begin to meet the Nation's health needs, the number of new physicians graduated each year must increase by at least 50 percent by 1975, and the number of new dentists must increase at least 100 percent. (This means, for example, that to attain the goal for medical graduates there must be at least 12,700 first-year places by 1971 to train the 11,500 medical graduates of 1975. This is 3,500 more than the 9,200 first-year places in 1963–64.) The construction program must be markedly expanded and accelerated if we are to meet these goals. We therefore strongly urge that the program be extended with an authorization of significantly increased appropriations in order to make a substantial alleviation of the growing shortage of professional health personnel and at the same time be realistically tailored to needs.

EXTENSION OF STUDENT LOAN PROGRAM

S. 595 would extend for 5 years—i.e., through the fiscal year ending June 30, 1971—the student loan program for schools of medicine, dentistry, osteopathy, and optometry authorized by the Health Professions Educational Assistance Act. The House approved bill extends the program for 3 years through June 30, 1969, and authorizes the annual appropriation of $25 million, and authorizes the program to be extended also to schools of pharmacy and podiatry.

The House bill would also authorize the appropriation of $1.5 million for the loans (authorized by sec. 744 of the Public Health Service Act) to schools to help finance deposits required of institutions which establish a student loan fund. Loans made to institutions are to mature within the period determined by the Surgeon General, but not exceeding 15 years. Failure to provide a separate appropriation for institutional loans was, we understand, merely an oversight when the Health Professions Educational Assistance Act was enacted.

Both S. 595 and H.R. 3141 would increase the maximum amount which may be borrowed by a student for any academic year from $2,000 to $2,500. This increase in the maximum loan amount recognizes the increasing costs of medical and dental education and makes the program comparable to the annual maximum loan amount now available under the National Defense Education Act for graduate and professional students.

The loan program is in its first year of operation. Of the 152 schools of medicine, dentistry, osteopathy, and optometry which are eligible, 147—or 97 percent—have established health professions student loan funds to assist students to pursue their professional education. The entire sum authorized and appropriated is now in use; in 1965 this amounts to $10.2 million. As with the construction program, need for funds has far exceeded the amounts authorized and appropriated. The degree of response to this program by schools and students demonstrated the great need for it. Despite the need for scholarships to supplement this program, these repayable loans should constitute the hard core of basic, dependable support for health professional students with limited resources.

The house approved bill also includes a provision under which up to 50 percent of a student loan would be canceled at the rate of 10 percent for each year during which a physician or dentist practices in an area determined by the State health authority to be an area in which there is a shortage of and need for physicians or dentists. As indicated in our report on H.R. 3141 as approved by the House of Representatives, we recommend that this provision be amended by adding a requirement which was included in S. 576 approved earlier this year by the Senate namely, that the State determinations of shortage areas be in accordance with regulations promulgated by the Secretary.

With this amendment, the House approved provisions relating to the student loan program are acceptable to the Department.

SCHOLARSHIPS

S. 595 would provide for a 5-year program of grants to schools of medicine, osteopathy, and dentistry for scholarships to be awarded annually by the schools to their students.

The amount of the grant to each school in the first year of the program would equal $2,000 times one-tenth the number of first-year students in the school. In the second year of the program, the grant would increase to $2,000 times one-tenth the number of first- and second-year students. In succeeding years the grant would be enlarged until by the fourth and fifth year it equalled one-tenth of the total enrollment of the school.

Scholarships of up to $2,500 could be awarded to individual students. The amount would depend upon need and would be determined by the school. The proposed scholarship grants would enable schools of medicine, osteopathy, and dentistry to compete more equally with other graduate fields for outstanding students. It would also enlarge the group seeking admission to the schools by attracting bright students for whom such costly education even with loans available is not possible without scholarship aid.

A high school graduate who desires to be a doctor must anticipate that his education will cost $20,000 to $30,000 over an 8- to 12-year period. Few scholarships or fellowships are available to medical and dental students.

This high cost is a strong deterrent to young people otherwise eager to become physicians or dentists. In 1963–64 the average annual expense reported by medical students (fees and living expenses) was $3,577—$3,220 at public schools and $3,931 at private schools. For single students, the average expense was

about $2,700. For married students, and about two out of five are married, the costs averaged more than $4,800 a year.

A disproportionate number of medical and dental students are drawn from families which are able to pay for 4 expensive years of professional education. Among medical students in 1963, nearly half, 49 percent, were from the 20 percent of the Nation's families having incomes of $10,000 or more. And 29 percent came from the 5 percent of families with incomes of $15,000 or more.

At present, considerable aid is available for graduate study leading toward the Ph. D. degree. More than four-fifths of graduate students in the life sciences received nonrefundable grants in 1962–63, and the average grant was $2,700. In contrast, less than one-third of the medical students in 1963–64 received nonrefundable grants of any kind. Of those who did, the average scholarship was only $760.

In the interest of improving the quality of medical personnel as well as of more equal educational opportunity, medicine and dentistry must not become the professions open only to the rich. At the very least, a more nearly equal opportunity should be provided the low-income student to choose medicine or dentistry if he wishes rather than the better supported related fields.

The House approved bill differs from the S. 595 scholarship provisions in that the program is authorized for 4 years instead of 5 years, it provides that scholarships may be awarded only to students from low-income families who without such financial assistance could not pursue a course of study at the school, and it extends the program to cover students enrolled in schools of optometry. These modifications are acceptable to the Department.

IMPROVEMENT GRANTS

To turn now from the plight of the studen s to the plight of the schools. S. 595 would authorize a new 5-year program of grants to assist schools of medicine, dentistry, and osteopathy to improve the quality of their educational programs. Grants would be of two types: Basic improvement grants and special improvement grants. The bill would authorize the appropriation of $20 million for the fiscal year ending June 30, 1966, for these two types of improvement grants. (This sum is only about 2 percent of the amount of money currently made available by the Federal Government for the support of health research.) Such sums as may be necessary would be authorized for each of the 4 succeeding fiscal years. In the first year of the program, every school meeting accreditation standards would be eligible to receive a basic improvement grant of $12,500 plus an allowance of $250 for each full-time student. In the second and subsequent years of the program each school would be eligible to receive $25,000 plus an allowance of $500 for each student.

From sums appropriated, but not required for making basic improvement grants, S. 595 would authorize the Surgeon General to make special improvement grants to those schools of medicine, dentistry, or osteopathy whose applications for basic improvement grants had been approved, and which have been determined to be in need of additional aid in order to improve the quality of their curriculums. A special improvement grant to a school could not exceed $100,000 for fiscal year 1966, $200,000 for fiscal year 1967, $300,000 for fiscal year 1968, or $400,000 for fiscal year 1969 or 1970.

The number of medical and dental students must be sharply increased if we are to meet the future needs of the Nation for physicians and dentists. The burden of training these students falls on the Nation's medical and dental schools and the costs to these schools of providing high quality training have been steadily mounting.

Medical and dental schools are in jeopardy because of shortages of operating funds. These schools face increasing problems in raising enough operating money to pay their faculty and finance their teaching programs, with tuition and fees representing only a small part of these costs.

Several medical and dental schools are in serious financial difficulty. Other schools are on the border of trouble. Attempts to expand enrollment will only exacerbate these financial difficulties.

Medical and dental schools are in dire need of operating funds just to maintain basic educational programs for their undergraduate students. Yet increasingly the Nation looks to these schools to broaden their educational responsibilities by providing specialty training to medical graduates, by providing continuing education for practicing physicians, and by providing training for ancillary health workers such as technicians and other paramedical personnel. Ten years ago medical school faculties taught one intern or resident for every five undergraduate

medical students; now the ratio is nearly one for every two. Increasing teaching responsibility has also come with the increase in the numbers of clinical fellows, nurses, practicing physicians in continuing education, and a variety of others in allied health professions and services. This is in addition to an expanding group of graduate students in the basic medical sciences, many of whom contribute indirectly to the provision of patient care. Altogether, undergraduate medical students today constitute far less than half of the students (in terms of full-time medical student equivalents) taught in medical schools. To promote the development of high-quality health services generally, medical schools should continue to help educate a broad range of health personnel. But the drain placed by such functions on funds otherwise available for teaching undergraduate medical students must be recognized.

The basic improvement grant would have the effect of relieving the financial stringencies of the poorer schools. It would provide a larger proportion of the budget of these poorer schools than it would of the budgets of schools more adequately endowed. It would directly reward any school that increased its enrollment.

For the underfinanced schools, the special improvement grant would provide the incentive and the means for specific programs and departments within the school to seek the educational standards attained in some of the Nation's outstanding institutions. The better schools could use these grants to develop educational programs in fields now experiencing a rapid expansion of scientific knowledge; e.g., genetics and biophysics. Ideally, programs of this type would generate improved educational objectives, principles, and methodologies which upon adoption would benefit all medical, dental, and osteopathic schools.

H.R. 3141, as approved by the House, contains a number of different provisions relating to these educational improvement grants from what are contained in the Senate bill. In brief, the House bill authorizes the program for 4 years rather than 5, prescribes annual appropriation ceilings for each of the 4 years, extends the program also to include schools of optometry, and redefines in a number of respects the conditions which must be met before grants are approved.

Except for the House amendment which would require a school to increase its first-year enrollment of students in order to be eligible to receive a basic improvement grant, the Department does not object to the House-approved bill as it relates to educational improvement grants. As we indicated in our report to you on H.R. 3141, we recommend deletion of the proposed expansion of enrollment requirement.

NATIONAL ADVISORY COUNCIL

S. 595 would also authorize the establishment of a National Advisory Council on Medical and Dental Education, to advise the Surgeon General in the preparation of regulations and on policy matters arising in the administration of the improvement grant and scholarship programs and in the review of applications for improvement grants. The council would consist of the Surgeon General, as Chairman, and 12 members selected from among leading authorities in the field of medical and dental education, except that not less than 3 of such members must be selected from the general public.

The House-approved bill makes no revisions in this provision except to change the name of the Council to include reference also to optometric education since schools of optometry have been included by the House as eligible recipients of educational improvement and scholarship grants.

TECHNICAL AMENDMENTS

Finally, Mr. Chairman, S. 595 contains a few technical amendments which would facilitate the administration of the act and increase its effectiveness. The House-approved bill retains these technical amendments and also includes an additional amendment relating to the determination of accreditation status for collegiate and junior college nursing programs under the Nurse Training Act. As we indicated in our report to you on H.R. 3141, we recommend deletion of this amend ment. I should also like to call your attention to our recommendation in that report for an additional technical amendment relating to interest rate provisions for health professions and nursing student loans.

Mr. Chairman, this proposal embraces components that are so closely related that each affects the other. The construction grants which will help finance new schools as well as expand existing ones will increase the enrollment capacities of professional health schools. This action, in turn, will create a corresponding need for more faculty which the improvement grants are designed to help

meet. The improvement grants will also stimulate the quality of instruction, permitting specific weaknesses to be eliminated in the less favorably financed schools and at the same time encouraging curricular innovations in other schools. Such improvements would have far-reaching effects on professional health education and on the health of the Nation.

Scholarships and loans, too, will have their impact on the quality of medical care. Medicine and dentistry need their share of the best minds of each generation in order to maintain leadership in these professions. Aid supporting part of the crushing burden of money, time, and energy which now must be borne will surely help in attracting inspired young men and women from low-income families to enter medical and dental schools. Only by attracting students of the highest quality can the Nation provide health care of the greatest excellence.

Mr. Chairman, physicians, dentists, and other medical workers are the indispensable and irreplaceable core at the center of the provision and distribution of medical care. With the increasing demand for more complete health services, the pressures for more health personnel are great. We cannot legislate today and have more health personnel tomorrow. No matter what is done, we can expect continuing shortages during the next several years, and we must plan with full knowledge of this situation. We must act now to alleviate these shortages. The legislation before you today embodies a program for concerted action. We strongly urge its enactment.

The CHAIRMAN. Now, the American College of Physicians. Dr. Edward C. Rosenow.

STATEMENT OF DR. EDWARD C. ROSENOW, JR., EXECUTIVE DIRECTOR, AMERICAN COLLEGE OF PHYSICIANS

The CHAIRMAN. Dr. Rosenow, we are very happy to have you here, and will be glad to have you proceed any way you see fit.

Dr. ROSENOW. Thank you, Senator Hill.

For the record, I am Dr. Edward Rosenow, of Philadelphia, executive director of the American College of Physicians.

In connection with 20 years in the practice of medicine, I have always taken part in the education of medical students, interns and residents as a clinical professor of medicine. Currently, I am an adjunct clinical professor of medicine at the University of Pennsylvania School of Medicine.

The CHAIRMAN. The oldest medical school in the country, is it not?

Dr. ROSENOW. Yes, sir. I am also, parenthetically, on service at the oldest hospital in the United States.

The CHAIRMAN. The Philadelphia General Hospital?

Dr. ROSENOW. Yes.

The CHAIRMAN. Benjamin Franklin had a great deal to do with bringing that into being, I believe.

Dr. ROSENOW. Yes.

This morning my interns and residents excused me to come down and visit with you a little bit about their future.

The CHAIRMAN. Well, we are happy to have you, Doctor.

Dr. ROSENOW. Thank you. The president of the American College of Physicians, Dr. A. Carlton Ernstene, of Cleveland, has asked me to present a statement in support of S. 595, the bill to improve the educational quality of schools of medicine, dentistry, and osteopathy, which was introduced in the Senate by the chairman of your full committee, Senator Lister Hill. This statement has been approved formally by the board of regents of the American College of Physicians.

Many of you know the American College of Physicians is 50 years old this year and represents 12,400 specialists in internal medicine

and related fields. The reputation of the college in promoting postgraduate education for practicing physicians through its publication, Annals of Internal Medicine, through sponsorship of 2 national scientific meetings, 25 regional scientific meetings, and 18 postgraduate courses each year, is recognized among professional societies.

Probably most of the full-time teachers in medical departments of medical schools are members of the college. At least 85 percent of our members who practice in cities which have medical schools, hold clinical appointments on the faculties of these schools. Even in cities where there is no medical school, college members spend much time teaching interns, residents, and nurses.

In addition to the educational activities of our individual members, the college participates in a variety of activities to aid in maintaining high standards of medical education and practice. For example, it participates in the administration of the American Board of Internal Medicine, the certifying agency for the internists; the residency review committee in internal medicine, the body which approves residency training programs; the Joint Commission on Accreditation of Hospitals; and the Commission on Professional and Hospital Activities.

The above facts make us feel competent to judge the effects of this important legislation. Anyone who deals closely with medical students is aware of the great financial burden they must assume because of the limited scholarship and loan programs available to them.

Parenthetically—and this is not part of my statement—I don't know the exact figure, Senator Hill, but in competition with the Ph. D. candidate in the university going toward his science Ph. D., about three-quarters of the Ph. D. candidates have scholarship help which covers about 75 to 80 percent of their tuition costs of education.

In contrast, only about a third or less of medical students have any scholarship help at all, and, of those that have scholarship help, probably less than a quarter or nearly a quarter of the cost is covered.

Incidentally, I might also say that one other thing, which is not part of this bill, and which I believe would stimulate an interest in supporting young students with limited funds in medical school, would be for the Congress to think seriously of making some effort to give tax relief to people who are willing to support young people in medical schools or even in other graduate schools.

For example, neither of my children wants to be a doctor; two of my nephews do. If they were my children, although I couldn't get any scholarship help for them, I could at least take a little tax benefit off this and maybe help someone else. But with the two nephews, this comes out of non-tax-deductible income.

The CHAIRMAN. We are happy to have your views on it, Doctor.

Dr. ROSENOW. The course of the study of medical students itself is so demanding and important that students should be able to devote all of their energies to learn all they can without working odd hours at nonmedical jobs to earn enough to stay in school. Thus, we enthusiastically endorse these provisions of the bill.

The pressure for increasing the number of physicians is enormous. In order to develop the kind of physicians and other health personnel who will be adequately trained to meet the manifold health needs of the people, medical schools must be supported in every possible way.

We think this bill will give such support. Finally, we think the plan to establish the National Advisory Council on Medical Dental Education will aid materially in the successful operation of this program.

The American College of Physicians therefore strongly supports the provisions of S. 595 and commends Senator Lister Hill and his committee for sponsorship of this legislation.

Although the House bill which has just been passed and amended did not give us time to have a formal action on these two amendments, I would be glad to give a personal opinion about the amendment which has to do with increasing the number of students.

The CHAIRMAN. We would be very happy to hear from you about that, Doctor.

Dr. ROSENOW. I would be opposed in general to such a blanket, arbitrary rule that a school has to have some more students, for several reasons: one, this might handicap some schools which have just increased their enrollment up to the limit of their financial resources, and they would be handicapped. Certain other schools couldn't possibly increase it, because of their present situation. It would not necessarily force the strong schools to take the number they should take. Some of the stronger schools should take more than this minimum, and this does not do anything to encourage that.

Finally, I believe that it would be professional judgment that some schools would probably be more effective in teaching medical students if they had fewer students, rather than more students.

For most reasons, I would personally think that this amendment could well be deleted, and that schools should be encouraged to increase their enrollment.

Thank you very much for the opportunity to appear before you.

The CHAIRMAN. Doctor, I realize your association had no opportunity to consider the amendment with respect to the accreditation of nursing programs, but do you have any particular views on that?

Dr. ROSENOW. I would like to defer this to see the report that Secretary Cohen will bring out.

The CHAIRMAN. All right, sir. Do you have any questions, Senator Yarborough?

Senator YARBOROUGH. Doctor, thank you for this very brief, cogent statement, that gives us the position in such a certain amount of time.

But I want to say that we had a very sharply controverted public issue in my State a few years ago, and 90 percent of the medical doctors were on the one side and 90 percent of the faculties of the medical schools were on the other side. We found there was quite a difference in the public approach to matters between the teaching medical doctors and the practicing medical doctors.

I must say I thought the teachers were on the right side of that issue.

Dr. ROSENOW. Well. Senator Yarborough, one of the things I enjoy particularly in working for the American College of Physicians is that this is an organization to which teaching faculty members and practicing physicians belong in equal percentage amounts, and it is a place where we meet on pretty friendly terms; and I like this.

Senator YARBOROUGH. It gives you a chance to explore these differences of opinion between the groups.

Dr. ROSENOW. Yes. Thank you.

Senator YARBOROUGH. Thank you, sir.

The CHAIRMAN. Doctor, we certainly appreciate your statement. You come from the oldest medical school and one of the most famous medical schools in the country. In fact, we speak about Philadelphia as being the cradle of American liberty. I think in many ways Pennsylvania has been the cradle of American medicine.

Senator YARBOROUGH. Is that not the school from which I understand the chairman holds an honorary degree?

Dr. ROSENOW. Yes.

The CHAIRMAN. Yes. One of the proudest and highest privileges of my life is the fact that the University of Pennsylvania gave me this honorary degree. I had the honor of being with you, of seeing you, Doctor, on the 23d day of January to celebrate your 200th birthday.

Dr. ROSENOW. Wonderful. We were glad to have you. Thank you very much.

The CHAIRMAN. Doctor, we certainly appreciate your statement. I hope you will convey to the president of your organization our appreciation for your appearance here this morning, and the appreciation of this subcommittee. Thank you very much.

Now, the Association of Medical Colleges. Dr. George A. Wolf.

STATEMENT OF DR. GEORGE A. WOLF, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES (AAMC), AND VICE PRESIDENT FOR MEDICAL AND DENTAL AFFAIRS, TUFTS UNIVERSITY; ACCOMPAINED BY DR. ROBERT C. BERSON, EXECUTIVE DIRECTOR; DR. JOHN PARKS, DEAN, GEORGE WASHINGTON UNIVERSITY MEDICAL SCHOOL; AND DR. THOMAS B. TURNER, JOHNS HOPKINS MEDICAL SCHOOL

Dr. WOLF. Mr. Chairman, may I invite my colleagues to join me?

The CHAIRMAN. Yes, certainly. We are glad to have them.

Dr. WOLF. Mr. Chairman, I am Dr. George A. Wolf, Jr., president of the Association of American Medical Colleges and also vice president for Dental and Medical Affairs at Tufts University, and executive director of the Tufts-New England Medical Center.

Dr. Robert Berson here is executive director of the AAMC; Dr. John Parks is dean of the George Washington University Medical School; and Dr. Thomas Turner is dean of the Johns Hopkins Medical School.

The CHAIRMAN. We are glad to have you. These gentlemen are all old friends. That is not a reference to your age, but they have been most helpful to the committee in the past. We are glad to have all of them here.

Dr. WOLF. Thank you, sir. May I proceed?

The CHAIRMAN. You may proceed, sir.

Dr. WOLF. A long time ago when I was dean of the University of Vermont College of Medicine, I testified in favor of S. 1323 before your Senator Hill and the late Senator Lehman. For those of you who are junior to the three of us, S. 1323 also proposed support of medical education. As the official transcript shows, we were all young men but have matured since. I am still in favor of support of medical education, and your Senator Hill has achieved an international reputation among medical educators and others in the health field for his accomplishments. Your first name pays tribute to the discoverer of

antiseptic surgery, as you undoubtedly know, but your last name will live in the minds of those of us who are interested in health when the name Lister is forgotten.

It is apparently appropriate for the Members of the Senate to offer compliments to their colleagues. I see no reason why an ordinary citizen cannot do so, too.

S. 595 is today of the utmost importance, in all of its aspects, to medical education.

When I testified on S. 1323, I spoke for myself as a dean. Now I am privileged to speak for all of the medical schools in the country, not because of my title of president of the Association of American Medical Colleges, but because with my colleague, Dr. Robert Berson, executive director of the Association of American Medical Colleges, I had an unusual experience. Starting late in July, he and I, members of the staff, and Executive Council of the Association of American Medical Colleges, met in Washington, Chicago, Dallas, New York, and Los Angeles in small groups with over 175 of the deans and faculty members of the medical schools of this country to discuss the medical manpower problem.

These experiments command me to say that the leadership of the medical schools of this country is responsive to the manpower problem. It recognizes the need for more physicians and allied health professional personnel in providing not only more but better medical care to people.

The medical schools however need help in meeting social demands for medical care, and S. 595 provides this help.

From these experiences, it is also clear that some medical schools need help to maintain and improve the quality of their programs. It is, therefore, suggested that the proposed basic improvement grants be not limited to only those schools which can increase enrollment, but also be made available to selected schools on the basis of individual applications for basic improvement in program.

Now I would like to turn the testimony over to Dr. Berson, who has a very fine statement, I think, containing some data for the record.

The CHAIRMAN. All right, Doctor.

Dr. BERSON. Thank you, Mr. Chairman.

As for my prepared statement, I would like to submit this information for the record and then summarize it.

The CHAIRMAN. The statement will appear in full in the record at the conclusion of your testimony, Doctor.

Dr. BERSON. Thank you, sir.

The first thing I would like to summarize deals with the physician-to-population ratio. In that, I would like to emphasize the inclusion in those figures of foreign medical emigres that were commented upon upon by Mr. Cohen and discussed briefly a while ago, which presents a somewhat padded figure.

The medical schools are convinced that we should be concerned with admission and graduation from our own medical schools. This is our responsibility and the thing that we can do the most about.

In the written statement there are some figures which were quoted this morning about the number of foreign graduates now in internships and residencies.

The next point about these figures that I would like to emphasize is that maintaining the present physician-to-population ratio is really a minimum objective, because that gross figures tells nothing about the distribution of physicians by geography or specialty, nothing about the availability of other trained workers in the health field, and particularly it ignores the phenomenon of the rising demand for medical services of all sorts, and there has been a real rise in demand.

Some of the legislation that Congress is considering or has passed will help to meet that demand, but the demand is there, in any case.

The next point I would like to call attention to is that the medical schools of this country have really done a little more to respond to the manpower problem already than most people realize. In the period from 1957 to 1963, the number of medical students enrolled increased 9 percent; the number of fellows enrolled in these institutions increased 61 percent.

The CHAIRMAN. Sixty-one percent?

Dr. BERSON. The number of graduate students increased 300 percent, and in the hospitals closely affiliated with medical schools, the number of interns increased 63 percent, and the number of residents increased 86 percent. The students in allied fields in the same medical center institutions increased 255 percent.

We don't think this is enough. I mention it to illustrate that these institutions have been responding, but they need to respond more effectively. We agree that physicians and dentists are the hard core of the need for medical manpower. But the other members of the full team are also tremendously important, although in many instances, they are not trained in our institutions.

The next point I would like to make is the national characteristic of each medical school. To some extent, each medical school is a national institution. Its graduates spread out all over the country and, to some extent, all over the world. It is interesting to notice how many physicians have to be recruited into the Public Health Service or the Veterans' Administration each year to keep their corps up to strength; and at any given time, 12 percent of the physicians in this country are in these two services.

So, in a sense, every medical school is a national resource.

The CHAIRMAN. Doctor, may I interrupt you there?

Dr. BERSON. Yes, sir.

The CHAIRMAN. Nothing has contributed so much, I think, to the present high-quality medical care that we give in our veterans hospitals as their affiliation with our medical schools. That has made the greatest difference in the world, is that not true?

Dr. BERSON. Yes, it certainly is. That is a key to the high quality of that program at this time.

Up to now, medical students have been supported from a variety of sources. We think that it is time for the Federal Government to provide forthright support for the institutions total operations. The provision of support for special programs and research has been tremendous. It needs to be continued. But institutional support is also needed at this time.

Now, about the provision for the basic improvement grant requiring expansion of enrollment for eligibility, we hope that this will be changed by the Senate, particularly because of concern for two cate-

gories of schools. One category is a very weak school whose very continuity is threatened by the weakness of its resources. It simply cannot expand its enrollment without jeopardizing the quality of its program and even its existence, and it can be greatly helped by this sort of institutional support.

The other category is a rather short list of schools that have made significant expansion of enrollments within the last few years. They cannot make additional expansion for at least several years. But we would hope that the institutional support would be available to that category of schools as well.

We consider the scholarship program tremendously important in opening the door, in providing educational opportunity in these professional fields that is not now effectively available to children from families with the least money. For one thing, we believe that some young people who have grown up under those circumstances, but who have the right characteristics, can be tremendously helpful in dealing with some of the health problems that are concentrated among the unfortunate citizens of our country, because they from infancy have had an insight into those problems.

We think the scholarship program is very sound and badly needed. It is really a very modest program as it is proposed in this bill.

One point about the National Advisory Council, and that is that I would emphasize that as the bill is written, this will bring to the consideration of these programs the principle of peer judgment.

The point I would like to emphasize is that where you are considering a program so important to the medical school as a whole and to the university as a whole, the real peers are university chancellors and presidents, deans of medical schools, men who have had responsibility for these institutions. I would hope the Surgeon General would select them with that in mind.

Now, the construction program has already demonstrated that it was badly needed. I have included some figures that show that it is already oversubscribed and that the known intentions of institutions will require all of the money that is authorized in this legislation. What the needs will be after this period, I believe, will come into sight during the operation of the program. But it would be tragic if this were not continued and expanded as it is proposed.

One final point about the student loan funds and the provision to increase the amount that an individual can borrow: Again, the oversubscription of the student loans already provided indicates that there was a real need and it is being partially met.

The cost of going to medical school is so high that we think it is quite appropriate to raise the ceiling from $2,000 to $2,500 per year per student.

In closing, Senator, I think that it is terribly important that these programs operate, as I believe they will, to stimulate the support of the medical education from other sources, State, local, private, and voluntary. This has been true in the research facilities construction program, in the Hill-Burton program, in the educational construction so far, and we hope that it will continue to be true with the other programs.

The CHAIRMAN. We should invite collaborative action on the part of all the different bodies; is that right, Doctor?

Dr. BERSON. Yes, sir.

The CHAIRMAN. Doctor, are there any existing medical schools in danger of losing their accreditation because of inadequate budgets for their teaching programs?

Dr. BERSON. Yes, sir. There are several who are weak enough to be a real concern to those of us who have the responsibility for their approval.

The CHAIRMAN. How many did you say, sir?

Dr. BERSON. I said several.

The CHAIRMAN. Seven?

Dr. BERSON. Several. It is hard to be specific.

The CHAIRMAN. I know it is, and I do not ask you the names of these several.

Doctor, I realize that this amendment was passed just a short time ago. Have you any observations, however, any views to express on this matter of accreditation with reference to nurses?

Dr. BERSON. Dr. Wolf?

Dr. WOLF. I think not, sir.

Dr. BERSON. Sir, there is one point I would like to make as an individual. There has been no opportunity for this to be discussed among the national organization.

The CHAIRMAN. I appreciate that.

Dr. BERSON. Mr. Cohen touched on this.

It would be unfortunate if an amendment such as this were used as a precedent to make similar changes in such a field as medical education. In medical education the accreditation of schools by the joint efforts between our association and the AMA, has worked effectively. It has operated to produce high quality, and we believe it can be consistent with the quantitative needs as well.

If such an amendment as this became a precedent for extending the same sort of thinking into other parts of the health field, I would think it would be very unfortunate and certainly should not be done before there had been very full consideration of all sides of the matter.

The CHAIRMAN. Well, you had the Joint Commission on Accreditation of Hospitals, too; did you not?

Dr. BERSON. Yes. And it does not operate to inhibit quantity. It does operate to improve quality.

The CHAIRMAN. Dr. Parks?

Dr. PARKS. Senator, I think the testimony here today has been very complete, and most encouraging. I simply want to say that I concur with my colleagues in their high esteem for you and for your introduction of this bill for our medical support.

I can assure you, too, sir, that there are schools of medicine who are using every available laboratory for the teaching of medicine and have expanded their programs to the fullest, and that there are several schools that are working on deficit financing, which this legislation would make no longer necessary.

The CHAIRMAN. Dr. Turner?

Dr. TURNER. I have nothing to add to this fine testimony, Senator, and particularly I would like to endorse the laudatory comments about yourself.

The CHAIRMAN. Thank you, sir.

Well, my dear sir, action is stronger than words. And you took action on May 25 of last year. Do you recall when I had the honor of being with you at the celebration of your 75th birthday?

Dr. TURNER. It was our privilege.

The CHAIRMAN. We are aware of the fact that Johns Hopkins Medical School was the first medical school, I believe, to require a baccalaureate degree for admission. Is that correct?

Dr. TURNER. That is right.

The CHAIRMAN. And you have maintained high standards throughout all these many years.

Senator Yarborough?

Senator YARBOROUGH. Dr. Berson, I want to comment briefly on this last paragraph on page 6, where you mention the benefits of the GI bill.

Dr. BERSON. Yes, sir.

Senator YARBOROUGH. You mentioned there the thrust that medical education was receiving for those GI's.

The Senate has passed a GI bill for the cold war veterans this session by a vote of more than 4 to 1, which bill came out of this committee. The bill is now pending in the House. Many different people in our educational community testified that when these GI's came on the campuses, they were studying harder and making higher degrees and displaying higher motivation than the other students who had not been through that experience. Is that true in the medical schools?

Dr. BERSON. Very much so. There was really a tremendously encouraging group of students. They were mature. They knew what they wanted. They were very fine people, and many of them said that they had never thought that they could study medicine, so they had made no serious plan to do it. It was just out of their reach.

But when they came out of the service and the GI bill provisions were there, they had the opportunity, and I think that they have turned out to be very excellent physicians.

Senator YARBOROUGH. Well, we are very hopeful that the present GI bill will pass and give these young men the same opportunity. Only 40 percent are required to serve now, of the total young manpower, because of the greatly expanded population.

Of course, with less than 3 million men under arms, contrasted with 16 million in World War II, the percentage is smaller.

I think the disadvantage they feel is relatively greater, because practically everybody who was able to participate and serve was in World War II, except in some critical scientific, medical, agricultural, or other category where they had to keep the war production going. The shortage of doctors was so great, I know, in some counties in my State, where every single medical doctor had left, that they called back some retired physicians who were 85 to 90 years of age, and who would be the only practicing physician in the county during World War II, just because of the demand for the people to come back.

But in your comments on the National Advisory Council, you strongly endorsed that, and you say that:

> We would like to emphasize, however, that in this provision for "peer" judgment in programs of such great importance to medical schools and their parent universities, the "peers" are to be found among the presidents and chancellors of universities and deans of medical schools.

Dr. BERSON. Yes.

Senator YARBOROUGH. Would you extend that opinion to all branches of instruction in the healing arts?

Dr. BERSON. Oh, yes, sir; I would. Yes, very definitely.

Senator YARBOROUGH. In your tables there is something I wanted to ask a question about. In table 2, the last line, you give the increase of medical and graduate students, fellows, interns, residents and "other." What is embraced in that word "other"?

Dr. BERSON. Nurses and technicians, mostly. But the technicians are in several different categories, and the nurses are in several different categories. In the collection of these figures, the methods that we use, we do not break them down.

Senator YARBOROUGH. In other words, that would generally be medical personnel engaged in the healing arts, but not with as high training as the medical doctor?

Dr. BERSON. Yes; not physicians.

Senator YARBOROUGH. They would be at the nurse and technician level.

Dr. BERSON. Mostly not at the level of Ph. D. or M.D.

Senator YARBOROUGH. Thank you.

Dr. BERSON. Now, of course, a lot of similar personnel are trained in other institutions. This reflects what it was in——

Senator YARBOROUGH. Well, the nurses might not be trained in a medical school, of course. They would be trained in a nursing school.

Dr. BERSON. Yes; but a good many are trained in these great teaching complexes.

Senator YARBOROUGH. Thank you.

The CHAIRMAN. We certainly want to thank you gentlemen for your very fine and highly intelligent testimony. It has been most helpful, and we appreciate it.

Dr. WOLF. We have appreciated the opportunity, Senator.

The CHAIRMAN. Thank you, sir. And your prepared statement will appear in the record at this point in full.

(The prepared statement of Dr. Berson follows:)

PREPARED STATEMENT OF DR. ROBERT C. BERSON, EXECUTIVE DIRECTOR, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

It is an honor and a pleasure to testify before your committee, whose chairman and members have already done so much to advance the health of the people of this Nation. It would be difficult to exaggerate the importance of your contribution in recommending the passage of the Health Professions Educational Assistance Amendments of 1963, which is now Public Law 88–129. This represented a long step toward providing for the future health of this Nation, and you are now considering legislation which will take additional and badly needed steps in this direction.

In 1959, a group of consultants on medical education reported to the Surgeon General of the U.S. Public Health Service. They took the position that the minimal objective should be expanding the enrollment of medical schools enough to maintain the physician-to-population ratio at the level it has been for the last two decades, and they indicated clearly that it would take a 50-percent increase in the number of physicians graduating from our medical schools each year to accomplish this minimal objective by 1975. At the time the consultants published their report, their estimates of the physician-to-population ratios were generally accepted by most of those who were knowledgeable in the field. Since then, several years have passed and there have been further discussions of this whole matter.

In 1964, after a conference called by the Health Resources Advisory Committee, it was decided to include foreign-trained interns and residents, plus physicians with temporary foreign addresses and others whose addresses are temporarily not known, in the calculation of the total number of physicians. The population groups to be included were also further defined.

If these new definitions are applied to the figures used by the Surgeon General's consultants, the physician-to-population ratios they reported are changed. For 1950, the ratio becomes 149 instead of 144 per 100,000; for 1955, it becomes 150; for 1960, it becomes 148; and for 1963, it becomes 149.3. In my opinion, the ratio for 1965 will be 150 per 100,000.

The consultants were not optimistic that the physician-to-population ratio would be maintained even as long as 1965, so these recalculated figures are somewhat encouraging. It should be emphasized, however, that these figures include graduates of foreign medical schools, whether they are serving as interns or residents or have obtained licenses and settled permanently in this country. In the last few years, there has been an unexpected and substantial increase in the number of such foreign medical graduates coming to this country each year. The Association of American Medical Colleges is convinced that our attention should be focused on the number of students enrolled in and graduating from our own medical schools each year. This country should not be dependent for its medical care upon a substantial flow of medical graduates from countries which need them far worse than we do.

I have included as the last part of my statement a table which shows that there are now about 2,500 foreign medical graduates serving as interns in this country and not all of the internships are filled. There are also about 7,000 foreign medical graduates serving as resident physicians and not all of the residencies are filled.

DEMAND FOR HEALTH CARE

In a recent report,[1] Dr. Lowell Coggeshall summarized some trends of great importance:

"A continuing trend is the growing need for physicians. In centuries past, the physician's concern was with life and death. Now, with increased capabilities, he is concerned more and more with care in illness and preventive care. The consequence of this development, as well as the many others cited earlier, is a growing need for physicians.

"The recently published report of the President's Commission on Heart Disease, Cancer, and Stroke, in commenting on the resources America has to provide needed health services, emphasizes that 'the first hard fact to be faced is that there in not enough health manpower to meet the needs of the American people.' It goes on to note that 'the physician supply is beyond question the most critical single element in manpower for health service.'

"Virtually all persons directly responsible for or indirectly associated with providing medical service, and persons representing consuming groups, are well aware of the need for practicing physicians in the decades ahead. Although medical schools have increased their capacities to educate physicians, the increase in the supply is not keeping up with the needs, nor are methods for increasing the productivity of physicians yet developed sufficiently or effectively enough to close the gap.

"There is every indication that the future will see more health care demanded and provided than ever before. In light of the growing need for physicians, despite the hopeful offsetting factors, it is clear that more physicians must be trained as quickly as possible, and that the result of an increased number of physicians will be 'healthy,' not only for the health needs of the Nation but the profession itself."

Up to this time the operation of health professional schools in this country has been supported by alumni, individual donors, universities, foundations, corporations, and local and State governments. With this broadly based support, medical schools have made a more strenuous effort to respond to the quantitative needs of society than most people realize.

From 1957 through 1963, the number of medical students enrolled increased 9 percent, the number of fellows 61 percent, and the number of graduate students 300 percent, while in the affiliated hospitals, the number of interns increased 63 percent and the number of residents 86 percent. Also the number of students in the fields allied to medicine, for which the medical schools had some responsibility, increased 255 percent.

During this period of an overall increase of enrollments of 126 percent, the funds to support the basic operation of the schools increased only 74 percent.

The association is convinced that the time has come for the Federal Government to join the other sectors of our society in providing basic support for education in the health professions. Such additional support is literally necessary if

[1] "Planning for Medical Progress through Education," Lowell T. Coggeshall, M.D., AAMC, Evanston, Ill., April 1965.

we are to make greater progress at meeting the needs and demands of the people of this country for more and better medical care.

The precedent for Federal support of institutions serving a clear and pressing need of the people of this country was established long ago in relation to land-grant colleges.

Every medical school serves in part as a national institution. Its graduates spread out to all parts of the country and serve the total range of needs for medical care. It is worthy of some emphasis that accomplishing the missions of the Department of Defense, the Public Health Service, and the Veterans' Administration now requires the annual intake of about 3,900 physicians, or more than half as many as graduate from all the medical schools. They serve for an average of about 4 years, and about 22,000, or 12 percent of all the physicians in the country, are on full-time duty with these 3 agencies.

The medical schools of this country vary enormously, not only in age and location but also in strength and stability. At one end of the spectrum are a small number of schools so weak and poorly financed that it is doubtful they can continue to provide acceptable education without more institutional support. The grants proposed in this legislation will be enormously helpful to them. At the other end of the spectrum are 15 or 20 very fine, well-established institutions with large and complex programs. The grants proposed will be modest in relation to their total expenditures, but they will make it possible for these fine institutions to continue to pioneer in the development of programs in which newly developed knowledge offers great promise. In the middle are the majority of schools with hardly enough money to keep their present programs of proven value and expand enrollments. The grants proposed will be of great help toward doing some or all of those things.

If the committee decides as the House did, that the "basic" or "special" improvement grants should be used as additional incentive to expand enrollment, we think it is very important that the needs of two categories of schools which cannot expand enrollments in the next few years be met. There are a small number of medical schools whose financial and other needs are now so great their very existence is threatened. It would be very unwise for them to expand enrollment before their current weaknesses are corrected. There are also a number of other schools which have stretched their present resources to the limit by expanding their enrollment significantly in the last few years. Surely this program should be designed to help them rather than leaving them out because they have responded to the public need so recently they cannot expand enrollment further in the next few years.

The scholarship program provided by this legislation is needed so that some young people from families of medium or low incomes can have an opportunity to enter the health professions. The characteristics desirable in a physician—intelligence, compassion, sustained interest, skill in dealing with people, and capacity for hard work—are distributed broadly among our people, with no particular relation to family income. On the other hand, disease, disability, and premature death are distributed unevenly, with heavy concentration among the poor and the very old. If some gifted individuals who have grown up in less-fortunate families can become physicians, they may be particularly helpful in dealing with these medical problems.

This is a modest proposal that will provide scholarships for about 10 percent of the students with the limitation that no student will receive more than $2,500 per year. From the student's standpoint, the average cost of attending medical school is about $3,700 per year for single students. In 1963, 81 percent of the graduate students in the "life sciences" received nonrefundable grants which averaged $2,700, or more than the maximum provided in this legislation.

The committee may be interested in knowing that only 67 percent of the physicians in this country are engaged in private practice, and by no means all of them fit into the popular image of having a full practice of patients willing and able to pay full fees. Quite a number of physicians in practice serve patients whose ability to pay is limited indeed and 37 percent of all physicians are in a wide variety of public service positions.

The medical schools had an interesting experience after World War II, because we had a large wave of students who were benefiting from the GI bill of rights and men who had previously not thought of studying medicine found that they could, and they entered medical schools and most medical educators found that generation of medical students some of the most promising and satisfactory people we have seen going through medical school. So we are confident that this rather modest program that would provide scholarships for up to about 10 percent of students will be of tremendous benefit.

NATIONAL ADVISORY COUNCIL ON MEDICAL AND DENTAL EDUCATION

We strongly endorse the provision for a National Advisory Council on Medical and Dental Education. We would like to emphasize, however, that in this provision for "peer" judgment in programs of such great importance to medical schools and their parent universities, the "peers" are to be found among the presidents and chancellors of universities and deans of medical schools.

EXTENSION OF CONSTRUCTION PROGRAM FOR MEDICAL, DENTAL, AND OTHER HEALTH PROFESSIONAL SCHOOLS

On the recommendation of your committee, the 88th Congress took a great step forward in the passage of the Health Professions Educational Assistance Amendments of 1963, which is now in operation as Public Law 88–129. As you know, that legislation authorized a 3-year program of matching grants toward the construction of schools of medicine, dentistry, public health, nursing, optometry, and pharmacy, and authorized the appropriation over the span of the 3 years of $175 million for this purpose.

At the time that legislation was being considered, our association recommended that it be a 10-year program and that the authorization of funds be somewhat higher after the first 2 years of the program.

Funds to implement this program did not become available until the fall of 1964, but applications are already on file for Federal grants totaling $299 million toward the construction of facilities costing a total of approximately $584 million. In addition, letters of intention to file applications, which include cost figures, request a Federal share totaling $305 million toward the construction of facilities costing about $552 million. Medical schools have filed applications for a total of $209 million as the Federal share toward facilities costing a total of $412 million and have sent in letters of intention to apply for a total of $239 million toward facilities costing a total of $417 million.

The applications on file, plus those letters of intent which are specific about the expansion of enrollment involved, indicate the creation of 465 additional first-year places in entirely new medical schools and 505 places in medical schools in which plans for expansion of enrollment are pretty definite. As the plans of institutions become more definite, we are confident that a considerable further expansion of enrollment will be provided.

I think it is worthy of some emphasis that the existence of this program even in its first year of operation has stimulated the flow of funds from other sources to match Federal funds. The applications on hand indicate that funds from non-Federal sources in the amount of $305 million will be used to match $299 million of Federal funds for this badly needed construction.

The figures above indicate that there is a clear and pressing need to extend this construction program and increase the amount of funds available for it each year.

EXTENSION OF, AND IMPROVEMENTS IN, PROGRAM FOR STUDENT LOANS

Section 4 of this legislation will extend the student loan program for 5 years and raise the amount which may be loaned to any one student in any one academic year from $2,000 to $2,500 per year.

As with the construction program, the response to the student loan program was immediate and marked, although it did not get underway until the fall of 1964. The request for student loans was so great that the Federal funds available were sufficient to meet only 57 percent of the requests in the fiscal year 1965. The present indications are that during fiscal year 1966, the Federal funds authorized will be sufficient to meet only about 75 percent of the requests.

I am convinced that the response demonstrates a need for this important program and that it should be continued for 5 years as this legislation provides. Increasing the amount which may be loaned to any one student in any one year to $2,500 will make this comparable with the National Defense Education Act which seems clearly equitable.

Mr. Chairman, in closing I want to emphasize that as necessary as all parts of this legislation are, perhaps the greatest importance will be realized if other sectors of our society are stimulated to provide increased support so the rising tide of demand and need for health care will be met. The construction grants and loan funds require matching with non-Federal funds. I am confident the medical schools will try to meet the needs for more physicians, but the quality of their educational programs would surely decline if they expanded much more rapidly than the total support of their basic operations.

TABLE 1.—*Ratio of foreign-trained physicians filling internships and residencies to total internships and residencies filled in the United States, 1950–63*

Year	Internships filled			Residencies filled		
	Total	By foreign-trained M.D.'s	Percent by foreign-trained M.D.'s	Total	By foreign-trained M.D.'s	Percent by foreign-trained M.D.'s
1950	7,030	722	10.3	14,495	1,350	9.3
1951	7,866	1,116	14.2	15,851	2,233	14.1
1952	7,645	1,353	17.7	16,867	3,035	18.0
1953	8,275	1,787	21.6	18,619	3,802	20.4
1954	9,066	1,761	19.4	20,494	3,275	16.0
1955	9,603	1,859	19.4	21,425	4,174	19.5
1956	9,893	1,988	20.1	23,012	4,753	20.6
1957	10,198	2,079	20.4	24,976	5,543	22.2
1958	10,352	2,315	22.4	26,758	6,042	22.6
1959	10,253	2,545	24.8	27,590	6,912	25.0
1960	9,115	1,753	19.2	28,447	8,182	28.8
1961	8,173	1,273	15.6	29,637	7,723	26.0
1962	8,805	1,669	19.0	29,239	7,062	24.2
1963	9,636	2,566	26.6	29,485	7,052	23.9
Total	125,910	24,786	19.7	326,895	71,138	21.8

Source: AMA Directory of Internships and Residencies, 1964.

TABLE 2.—*Increases in medical and graduate students, interns, and residents and other students and expenditures for basic operations, 1956–57 to 1962–63—Students for whom medical faculties have total or substantial responsibility*

	1956–57 [1]	1962–63 [2]	Percent increase
Medical students	28,852	31,491	9.1
Graduate students	2,552	4,105	60.8
Fellows	1,163	4,649	299.7
Interns	2,537	4,134	62.9
Residents	7,267	13,539	86.3
Other	29,719	105,427	254.7
Total	72,090	163,345	126.6
Expenditures for basic operations	[3] $146,415,313	[4] $256,095,643	74.9

[1] JAMA, vol. 165, No. 11, p. 1417.
[2] JAMA, vol. 186, No. 7, p. 701.
[3] JAMA, vol. 168, No. 11, p. 1494.
[4] JAMA, vol. 190, No. 7, p. 616.

The CHAIRMAN. Now, the American Dental Association. Dr. Hine, do you want to take a seat here with your associates?

STATEMENT OF DR. MAYNARD K. HINE, PRESIDENT-ELECT, DEAN, SCHOOL OF DENTISTRY, INDIANA UNIVERSITY, ACCOMPANIED BY DR. A. RAY BARALT, JR., DEAN, SCHOOL OF DENTISTRY, UNIVERSITY OF DETROIT, AND MR. REGINALD H. SULLENS, EXECUTIVE SECRETARY, AMERICAN ASSOCIATION OF DENTAL SCHOOLS, AND MR. HAL M. CHRISTENSEN, DIRECTOR OF THE WASHINGTON OFFICE OF THE AMERICAN DENTAL ASSOCIATION

Mr. HINE. Thank you, Mr. Chairman.

I might say that I have with me Dr. Ray Baralt, Jr., dean of the University of Detroit School of Dentistry; Reginald H. Sullens executive secretary of the American Association of Dental Schools and Hal M. Christensen, director of the Washington Office of the American Dental Association.

The CHAIRMAN. It is nice to have you gentlemen here. We are glad to have you. You may proceed in your own way now.

Dr. HINE. Mr. Chairman and members of the subcommittee:

My name is Dr. Maynard K. Hine. I am dean of the University of Indiana School of Dentistry and president-elect of the American Dental Association. I am here today representing the American Dental Association as well as the American Association of Dental Schools. Though testifying jointly, Mr. Chairman, we would like to submit separate statements for the record.

Our two organizations are in agreement with respect to the splendid achievements of Public Law 88–129 thus far and recommend that the law be extended as proposed in the legislation under consideration by the committee.

I will summarize our statements, but I would like to say that Public Law 88–129 has done much to help meet the impending shortage of health manpower. Under the law thus far, 12 dental schools have received construction funds and 12 additional applications have been filed. If approved and funded, these would provide from 700 to 725 new, first-year places.

In fact, however, many of these applications cannot be funded under the existing appropriation, despite the fact that all are well planned and badly needed. Under the present law, $43.75 million is available to dental schools. To fund these applications would require some $84 million. Thus, a deficit of $40 million exists already just in relation to applications on hand.

Such a backlog is not too surprising since the need for Federal assistance in this area is of long standing. Our associations, as did others, petitioned Congress for many years prior to the passage of Public Law 88–129. No one knows this better than the chairman of this committee, for it was his strong and consistent leadership that made enactment finally possible.

But, because the accumulated need was so great, it was to be expected that an immediate and sharp demand would be evident as soon as funds became available.

H.R. 3141 calls for a 3-year extension of Public Law 88–129, which we believe is desirable and necessary.

A brief survey of available projections makes it apparent how essential continuation is. There are presently 105,000 dentists in the

United States, representing a ratio of approximately 1 to every 1,900 people. To maintain this ratio we will need, by 1980, approximately 139,000 dentists.

If the current rate of dental graduates remains constant, however, we will fall short of maintaining this ratio by more than 10,000 dentists. And this is a most conservative estimate since it makes no allowance whatever for increased demand for health services.

The American Dental Association and the American Association of Dental Schools believe that section 720 of Public Law 88-129 should be extended in such a way as to give us the realistic hope of eliminating this impending deficit.

The associations believe that the $480 million allocated by H.R. 3141 will accomplish this purpose. Were this sum allocated, it would make annually available to dental schools approximately $34 million. This total is arrived at by adding to a proposed $25 million annually for construction of new dental facilities, $8.75 million annually as dentistry's share of the funds for replacement and rehabilitation.

In reference to construction, the associations would like to take this opportunity to commend publicly the administration of this section of the law by the Public Health Service's Division of Dental Health. Its work, in our opinion, has been expert, efficient, and thoroughly in compliance with congressional intent.

The associations would also urge the extension of the student loan program in the way envisioned by S. 595 and H.R. 3141. Thus far, under the law, some $18 million has been distributed to 147 health professions schools with a total enrollment of nearly 49,000. Forty-six dental schools are included in this total, with the average loan to a dental student being $950.

Professional education is an expensive process. In regard to dentistry, the total cost involved in undergraduate education, dental school itself, and the establishment of an office, is about $35,000.

When you consider this in light of the fact that the median family income is less than $7,000 a year, it is obvious that either we must offer financial assistance to students or candidly admit that only the wealthy can send their children to dental school. Surely we can all agree that this latter alternative is undesirable.

In regard to dental schools alone, it is our information that this year some 5,500 students were identified as being in need of assistance, with the total amount required exceeding $7 million. The amounts authorized in H.R. 3141 reflect this need.

The associations also believe that the provision increasing the annual maximum loan per student to $2,500 is desirable. Such a change recognizes the fact of heavy costs and also keeps the program comparable to loans available to graduate and professional students under the National Defense Education Act.

Finally, the associations support that amendment of H.R. 3141 that encourages physicians and dentists to practice in shortage areas, because we too recognize the problem is not merely numbers but also distribution of professional people.

In addition to providing for extension of the construction and loan sections of Public Law 88-129, S. 595 and H.R. 3141 would establish scholarships for students from low-income families and grants to schools. The associations support enactment of both these programs.

In regard to scholarships, it should be clear that this is not a device for merely increasing the assistance available to present dental students. Even under the loan program, there are those whose resources are such that the costs alluded to earlier remain powerfully inhibiting. It should also be kept in mind that, at present, 88 percent of the dental students from lower income families graduate with an average debt of $9,000. Scholarships would do much to mitigate this undesirable situation.

Furthermore, provision of scholarships would do much to improve the competitive position of the health professions in attracting the best talent. When it comes time for a young man of scientific talent and bent to make a career decision today, he will find that if he chooses one of the life sciences, there is considerable opportunity for him to receive fellowships. For example, a recent survey showed that 80 percent of the life science graduate students received some form of nonrefundable support averaging $2,700. By comparison, comparable figures for dental students are 19 percent and $430.

What is being asked is the establishment of a comparable fellowship program for the health professions. The bill refers to them as scholarships, but in point of fact they are indistinguishable from what are often defined as fellowships.

In regard to the provision for improvement grants, the associations I represent believe the following figures demonstrate the need for this assistance:

In 1949, the operating expenses of the Nation's dental schools averaged $500,000. In 1964, they averaged $1.4 million. This represents an increase of 300 percent in 15 years.

THE CHAIRMAN. 300 percent, Doctor?

Dr. HINE. 300 percent since 1949.

The per student expenditure, over the same span, has more than doubled, from $1,800 to $3,700.

Finally, the portion of the total cost met by the student's payment has decreased through the years from about 50 percent in 1924 to about 32 percent in 1949 to about 26 percent at the present time.

Every expert estimate indicates that expenditures will increase in coming years. By 1974, the present per student expenditure of $3,700 will probably have risen to $5,300.

All of this, of course, is the opposite side of the coin from the remarkable progress in preventing and controlling disease that has been made in recent years. If we are to maintain and better that rate of improvement of the Nation's health, assistance to the dental schools is necessary. The grants proposed would offer such assistance and should be approved.

The associations believe, however, that one of the amendments adopted by the House of Representatives to H.R. 3141 will create some serious problems. The amendment would prohibit the Surgeon General from making a basic or special improvement grant unless a school agreed to increase its first-year enrollment by 2½ percent or five students, whichever is greater. Over the regular 4-year course of instruction, a school would have to accommodate a minimum of 20 additional students.

The associations believe that this amendment runs counter to the objective of improving the quality of medical and dental education. Many of the schools now experiencing the greatest financial diffi-

culties and most in need of improving their quality are now filled to reasonable capacity. Yet, there will be great pressure on such schools to add even more students to their already overcrowded facilities in order to meet this amendment's specifications.

Clearly, the result will be to diminish rather than to enhance the level of education presently offered. This is particularly apparent in the case of dental education which requires special laboratory and clinical space for each student.

The associations believe that increased enrollment properly should remain as a requirement under the construction grant program; but to require increased enrollment without regard to the availability of adequate physical facilities is, in our opinion, a serious mistake.

For these reasons, it is clear that the amendment is incompatible with the avowed purpose of the basic and special improvement grants and we urge that it be deleted from the bill.

We also support the position taken by Mr. Cohen this morning regarding the nurse training accreditation program, the amendment on accreditation.

We believe that it is best to have one national accrediting agency for nursing, just as it has existed and has worked so well for dentistry and medicine in this country.

Mr. Chairman, this concludes our oral testimony. I want to thank you for this opportunity to present our viewpoints. My colleagues and I are here to provide any answers to questions you may have.

The CHAIRMAN. Is there anything your colleagues would like to add at this time?

Dr. HINE. Do you have anything to add?

Dr. BARALT. No.

Mr. SULLENS. No.

Mr. CHRISTENSEN. No.

Dr. HINE. I speak loud enough and fast enough to take care of all of them.

The CHAIRMAN. Very well.

I think this would be a good place to put in the record the letter of September 3 that we had with reference to this last amendment of which you are speaking.

Dr. HINE. I wish you would, sir, as well as the testimony which we have already given you.

The CHAIRMAN. Yes, right in with your testimony.

Dr. HINE. Yes.

The CHAIRMAN. Senator Yarborough, do you have any questions?

Senator YARBOROUGH. I have no questions, Mr. Chairman. It was very fine testimony.

The CHAIRMAN. Yes, it is very fine testimony.

I want to thank you, Doctor, and your associates. This has been very fine testimony. We deeply appreciate it.

Dr. HINE. Thank you very much.

The CHAIRMAN. Your prepared statements will appear in the record at this point, along with the letter I referred to before.

(The material referred to previously follows:)

PREPARED STATEMENT OF DR. MAYNARD K. HINE, PRESIDENT-ELECT, AMERICAN DENTAL ASSOCIATION

Mr. Chairman and members of the subcommittee, my name is Dr. Maynard K. Hine. I am dean of the University of Indiana School of Dentistry and president-elect of the American Dental Association. I am here today representing that association as well as the American Association of Dental Schools.

Seated with me is Dr. A. Ray Baralt, Jr., dean of the University of Detroit School of Dentistry.

Accompanying us are Mr. Reginald H. Sullens, executive secretary of the American Association of Dental Schools, and Mr. Hal M. Christensen, director of the Washington office of the American Dental Association.

We asked to testify together, Mr. Chairman, in order to conserve the time of the committee. With your permission, however, we will submit separate statements for the record. Our two organizations are in agreement with respect to the splendid achievements of Public Law 88–129 thus far and recommend that the law be extended as proposed in the legislation under consideration by this committee.

In 1963, when dental witnesses had the privilege of coming before a congressional committee to discuss the legislation that led to enactment of Public Law 88–129, they said: "This measure is aimed at relieving what is probably the most critical problem in the health field today: the impending shortage of health personnel."

That problem remains with us, but in the short time that activities authorized by Public Law 88–129 have been going on, considerable progress has been made in meeting it.

CONSTRUCTION

On the basis of the most recent figures available to us in construction, for example, we note that a total of 12 dental applications have now been funded under the law. Of these, one is a totally new school, nine are institutions that are engaged in major expansion and substantial replacement of their existing facilities and two are involved in less major renovation or rehabilitation. Schools in the East, in the Midwest, on the west coast and in the South are included. These projects alone will increase the number of first-year dental student places by about 372, an increase of more than 10 percent in this 2-year period.

In addition to the applications that have been approved and funded, we understand that 12 more applications have been submitted and, in some cases, have had at least some action taken on them.

Twenty-four dental applications, then, have been or will be filed by the end of fiscal 1965. Were all these applications to be approved and funded, it would mean providing a total of from 700 to 725 new, first-year places.

The fact is, however, that many of these applications cannot be funded under the existing authorization, despite the fact that they are all well planned and badly needed. Under the current 3-year authorization, $43.75 million is available for construction, expansion, and rehabilitation of dental schools. According to our information, there is a need for about $84 million, leaving a deficit of more than $40 million just in relation to those applications that are already on file.

The fact that a backlog has already developed is not, in the association's opinion, surprising. The need for Federal assistance in constructing schools of the health professions is of long standing. The American Dental Association, together with a number of other health groups, petitioned Congress on this subject for a number of years before legislation was finally passed. The chairman of the committee is, of course, well acquainted with these facts as it was his strong and consistent leadership as much as anyone's that made enactment finally possible.

Since the situation dates some years back, then, it was to be expected that when legislation was passed, the accumulated need of the Nation's schools of health would exert an immediate and sharp pressure on the available funds. It is essential, in the association's opinion that, while we can take pride in what has already been accomplished, we recognize at the same time that our efforts must continue at least at the same pace for the foreseeable future.

H.R. 3141 calls for a 3-year extension of the construction and student loan sections of Public Law 88–129. The association believes that such a time limit is desirable in that it both satisfies the need for continuity in administration and recognizes that Congress rightfully should have an opportunity to review all such legislation periodically.

A brief survey of available projections concerning dental manpower is sufficient to demonstrate the fact that it is necessary to continue the work begun in 1963 with passage of this law.

At present, the total dentist supply in the United States is approximately 105,000. This amounts to a ratio of about 1 dentist to every 1,900 people. If we are to maintain this ratio, we will need approximately 139,000 dentists by 1980.

If the current rate of dental graduates remains constant, however, we will not be able to maintain this ratio. We will fall short of maintaining it by some 10,000 dentists. And this is a most conservative estimate since it makes no allowance whatever for the increased demand for dental care that can be reasonably foreseen.

What the American Dental Association believes is minimally necessary, then, is that section 720 of Public Law 88–129 be extended in such a way as to enable the Nation's dental schools to have the prudent expectation of at least coming close to making up this deficit of 10,000 dentists.

The association believes that the $480 million allocated by H.R. 3141 will accomplish this purpose. Were this sum allocated and distributed in the manner indicated in this House report,[1] it would make available to dental schools the annual sum of approximately $33.75 million.

This total is arrived at by adding to a proposed $25 million annually for construction of new dental facilities, $8.75 million annually as dentistry's share of replacement and rehabilitation funds. This is in accord with the present division and the association believes it to be equitable. As we have noted, the House Committee on Interstate and Foreign Commerce apparently agrees.

Given this annual allocation of roughly $34 million, it may be possible to be graduating by 1980 nearly twice as many dentists annually as would be possible if this law were not extended. The association, thus, believes that such allocations are realistic in light of what we can expect in the future. We urge the committee to authorize these sums in extending section 720 of Public Law 88–129.

ADMINISTRATION OF CONSTRUCTION SECTION OF PUBLIC LAW 88–129

Finally, before concluding our remarks on the construction aspects of Public Law 88–129, the association would like to take this opportunity to commend publicly the excellent administration of this section of the law that has been provided by the Public Health Service's Division of Dental Health. Every experience we have had and everything we have heard from schools applying for assistance demonstrates that the Dental Division's administration has been considerate, efficient, and thoroughly in compliance with congressional intent.

LOANS

The American Dental Assohiation would also urge the extension of the student loan program. Thus far, under the law, some $18 million has been distributed to 147 health professions schools with a total enrollment of nearly 49,000. Forty-six dental schools are included in this total and recent surveys have shown that the average loan made to a dental student under this program is $950.

In talking about the health needs of the Nation, we are more accustomed to speaking in terms of millions or tens of millions of dollars. On that scale, an average loan of $950 doesn't seem substantial. Yet the information we have indicates that it can—and has—made the difference between a student being able to continue his studies or face the possibility of interrupting or terminating them.

Education for a profession is an expensive process. The average cost to students of a 4-year dental education is well above $15,000. This comes on top of the costs of the 3 or 4 years of undergraduate education that is a requisite for entry into the professional school. Indeed, the most recent studies indicate that with preprofessional college, dental school itself and then establishment of an office, the average total cost nears $35,000

When one considers this in light of the fact that the median family income in the United States is less than $7,000 a year, it is all too clear that one of two things must happen: either financial assistance must be made available to students so they can be admitted on the basis of their scholarly promise and professional commitment or we will have to admit frankly that only the sons of the well-to-do can become dentists. Surely we can all agree that this latter alternative is

[1] Health Professions Educational Assistance Amendments of 1965, report of the Committee on Interstate and Foreign Commerce on H.R. 3141, Aug. 12, 1965, p. 9.

undesirable. Achievement in this country is traditionally and rightly based on the ability and effort of the individual, not on the income of that individual's father.

A number of studies have been made on this question of financial need of students and the concomitant need of schools for assistance in helping the students. A few citations from these studies might serve to bring this matter into clearer perspective.

A 1962–63 survey revealed that 32 percent of the Nation's dental students applied for and received loans. An additional 23 percent reported a need for financial assistance but for one reason or another the university was not able to help them. More often than not, the reason was simply that the available funds were too scarce to go around. Again, nearly 2 out of every 10 dental students report an interruption averaging 2.4 years. Further, 70 percent of the dental students in a recent year reported that they were forced to hold full or part-time jobs during the school year.

Finally, our understanding is that in fiscal 1965, when a maximum of $10.4 million was available for loans, the health professions schools identified a need for loans totaling $19.7 million. And in the present fiscal year, when a maximum of $15.4 million is available, the schools identify a need for $20.9 million.

We cannot, of course, Mr. Chairman, speak with any authority as to the needs of medical or osteopathic students in the coming years. But in regard to dental schools alone, it is our information that in the current year, the schools identified some 5,500 students as being in need of assistance and requested an allocation of some $7 million. With this in mind, then, the American Dental Association agrees with the provisions of H.R. 3141 that extend the loan section of Public Law 88–129 so that $25 million is annually available. The dental schools of the Nation will thus receive from it the amount realistically necessary to satisfy the demonstrated need.

The association also believes that the provision in H.R. 3141 for increasing the maximum loan amount per student to $2,500 is desirable. It recognizes the fact of heavy costs and also keeps the program comparable to loans available to graduate and professional students under the National Defense Education Act.

The association also supports the House amendment that encourages physicians and dentists to establish practices in shortage areas.

SCHOLARSHIPS

S. 595 and H.R. 3141, in addition to extending the present provisions of Public Law 88–129, would establish two new programs. One would grant scholarships to a maximum of $2,500 per student. As we understand this provision, it would extend this type of assistance to talented young people from low-income families and would be allocated on the basis of approximately 10 percent of a given class. Within these prescribed limitations, the association believes this new program to be well advised.

There are two points regarding this new section that we would like to discuss briefly.

The first is that scholarships and loans are not identical and by supporting the establishment of scholarships, the association is not merely identifying another way of increasing the assistance available to present dental students.

As has already been said, dental education is a highly expensive proposition for the student. Even with the provision of loans, we are still not opening it to all who are capable of undertaking it. There are still young people from families whose incomes are such that the costs remain a powerfully inhibiting factor. In addition to the total cost of $35,000 that was alluded to earlier, it must be kept in mind that the average dental student today is heavily in debt when he graduates. Among those who come from lower income families, 88 percent are in debt at the time of graduation and the average indebtedness is nearly $9,000. The provision of scholarships would do much to mitigate this undesirable situation.

The second point we should like to make bears on the competitive position of the health professions in relation to those disciplines commonly referred to as the life sciences.

When it comes time for a young man of scientific talent and bent to make a career decision, he will find that if he chooses one of the life sciences there is considerable opportunity for him to receive fellowships while working toward his doctorate or when pursuing postdoctoral studies. Through the years, as this committee is undoubtedly aware, Congress has enacted a number of fellowship programs in the life sciences.

For example, a recent survey showed that 80 percent of the life science graduate students receive some form of nonrefundable support. The average amount is $2,700. Among dental students, only 19 percent receive such support and here the average sum is $430. What is being requested is the establishment of a similar fellowship effort for the health professions. The bill refers to them as scholarships but in point of fact they are indistinguishable from what are defined as fellowships in the life science area.

The fact of the matter is that the Nation will be needing more dentists, as well as other health professionals, in the foreseeable future. In addition to financial assistance in terms of construction and loans, the profession needs to be in a position where it can fairly compete with other career fields for the best available talent. Federal activity in providing fellowships in the life sciences have unquestionably put dentistry and the other health professions at a competitive disadvantage. Provision of similar fellowships for the health professions would redress this disadvantage.

IMPROVEMENT GRANTS

We have twice in our testimony alluded to the fact that a dental education is expensive for the student. It is also expensive for the school that provides it. In recent years, the expenses the school must bear have risen so sharply that some are now in a serious situation and may well find it impossible to continue to provide the kind of quality education they should. S. 595 and H.R. 3141 provide a partial solution to this difficulty by proposing the establishment of a section providing basic and special improvement grants for schools of dentistry, medicine, and osteopathy.

In 1949, the total operating expense of the Nation's dental schools was $20 million, an average of $500,000 per school. By 1964, total operating expenses had risen to $66 million, an average of nearly $1.4 million per school. In the past 15 years, then, the operating expenses of the Nation's dental schools have risen nearly 300 percent.

The same trend can be seen when you consider the per student expenditure of the schools. In 1949, this amounted to $1,800. By 1964, it has risen to $3,700.

Through the years, the proportion of cost that is borne by the student through payment of tuitions, fees, and other charges has markedly decreased. In 1924, the student payment met approximately half the school's operating costs. By 1949, this had decreased to about one-third of the total cost and by 1964, student payments met only 26 percent of the schools' operating costs. Further, dental schools do not have any real access to supplementary funds. Nineteen of the dental schools are totally without any source of support from private endowment income, gifts, non-Federal grants, or other private sources. An additional 21 schools receive less than $50,000 a year from such sources.

Nor is there reason to expect that operating costs will decrease or even stabilize. Indeed, every expert estimate with which we are familiar indicates the opposite. By 1974, it is estimated that the per student expenditure that today is $3,700 will have risen to $5,300.

In contrast to the actual level of expenditures in 1964 for regular program (as distinct from research program), which was $51 million, the dental schools report that $81 million is required for truly adequate operation. Of this additional $30 million, some 70 percent is needed, according to the schools, for improvement of the present teaching program. The additional amount is needed for such new but essential programs as teacher preparation, hospital dentistry, care of the chronically ill, and preventive dentistry.

Based on these estimates, the average unmet financial need per school is about $625,000. The amount currently needed to bring per student expenditures to the desirable level averages about $3,000 per student.

Under the improvement grants section of H.R. 3141, approximately $4.1 million would be distributed to the dental schools in fiscal 1966 and a minimum of $8 million during subsequent years. This would not wipe out the current operating deficit in the majority of schools but it would give them much needed stimulus to undertake the new programs they know are necessary as well as improve the effectiveness of current programs.

These difficulties facing dental schools and the schools of other health professions, are, of course, only the opposite side of the coin from the remarkable improvements in preventing and controlling disease that have been made within recent years. The body of knowledge that must be taught today is immeasurably broader; the armamentarium of the dentist is considerably more diverse and complex than it was; the research possibilities are infinitely greater and, finally the Nation's commitment to public health measures has increased.

No one, surely, would want to trade the level of health care possible today for what was possible 20 or 30 years ago. Our hope is that the Nation will be even healthier 10 years from now than it is today. But the process is expensive and the schools have carried the burden with current resources too long.

The Federal Government has a proper and legitimate interest in health as a national resource. Establishment of this assistance to dental schools is one way for the Federal Government to make concrete its legitimate interest in this matter and the American Dental Association therefore supports in principle the establishment of the improvement grant programs provided in S. 595 and H.R. 3141.

The association believes, however, that one of the amendments adopted by the House of Representatives to H.R. 3141 will create serious problems. The amendment would prohibit the Surgeon General from making a basic or special improvement grant unless a school agreed to increase its first-year enrollment by 2½ percent or five students, whichever is greater. Over the regular 4-year course of instruction, a school would have to accommodate a minimum of 20 additional students.

The association believes that this amendment runs counter to the objective of improving the quality of medical and dental education. Many of the schools now experiencing the greatest financial difficulties and most in need of improving their quality are now filled to reasonable capacity. Yet, there will be great pressure on such schools to add even more students to their already overcrowded facilities in order to meet this amendment's specifications. Clearly, the result will be to diminish rather than to enhance the level of education presently offered. This is particularly apparent in the case of dental education which requires special laboratory and clinical space for each student.

The association believes that increased enrollment properly should remain as a requirement under the construction grant program, but to require increased enrollment without regard to the availability of adequate physical facilities is, in our opinion, a serious mistake.

For these reasons, we believe it is clear that the amendment is incompatible with the avowed purpose of the basic and special improvement grants and we urge that it be deleted from the bill.

There is one further comment the association would like to make in connection with the improvement grant program. The association believes that those who would be charged with the responsibility for administering this section of the law would not expect or want to exercise any control over the curriculum, teaching personnel, or other aspects of the education process. Those who framed the bill assumed, we are sure, that the school itself would continue to be the sole judge of such matters.

In order that this be crystal clear, however, the association strongly requests that the committee make it explicit that this long-standing policy remains in force. It is recommended that the committee make section 762 applicable to all of title VII of the Public Health Service Act. Section 762 at present reads:

"Nothing contained in this part shall be construed as authorizing any department, agency, officer, or employee of the United States to exercise any direction, supervision, or control over, or impose any requirement or condition with respect to, the personnel, curriculum, methods of instruction, or administration of any institution."

There is one final comment the association would like to make with regard to a technical amendment to H.R. 3141 concerning accreditation of certain nurse training programs. The effect of this amendment, as we understand it, would be to nullify the authority of the Commissioner of Education to select a single agency competent to establish national standards for nursing education. While dentistry is not directly involved in the amendment, the association believes as a general principle that there should be uniform standards of quality required in the education of health personnel and is thus opposed to this amendment.

AMERICAN ASSOCIATION OF DENTAL SCHOOLS,
Chicago, Ill., September 3, 1965.

Senator LISTER HILL,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: In behalf of the membership of the American Association of Dental Schools, may I express our appreciation for the opportunity of submitting a statement in support of S. 595, "The Health Professions Educational Assistance Amendments of 1965." The association's statement on this important

legislative proposal will be presented to your committee on Wednesday, September 8, 1965, by Dr. Maynard J. Hine, dean of the School of Dentistry, Indiana University, and past president of the association. In addition to the supportive statement on S. 595, which your committee will receive, may I request the privilege of having the following views of the American Association of Dental Schools on certain provisions of H.R. 3141, as approved by the House of Representatives on September 2, included in the record of your committee hearing.

The dental schools in the United States, which the American Association of Dental Schools represents, are extremely concerned about part E, section 771(b) of H.R. 3141, In the judgment of dental administrators and educators, the implementation of this section, which would require an enrollment increase of 2½ percent or five students each year in addition to the requirements presently imposed under the construction grant provisions of Public Law 88–129, would result in a most difficult situation for virtually every dental school in the country. The House amendment of the basic improvement grant provision might well, in fact, create a dilution in the quality of dental education in many institutions rather than the improvement envisioned in the original legislation.

As I am sure you are aware, the association and the dental schools in the United States are anxious to contribute in every possible manner to expanding the number of dental graduates in our country. Evidence of this concern and the progress which is being made is contained in our formal statement which will be submitted to your committee on September 8th. The association has, and will continue, to support the requirements for enrollment increase related to construction grants. It should be noted that those dental schools which have received grants for the construction of educational facilities have, in fact, planned expansion considerably greater than stipulated in Public Law 88–129. We have evidence to demonstrate that those institutions which will be constructing facilities under the extension of Public Law 88–129 will continue to follow this commendable pattern.

The formal statement which the associatlon will submit for the record presents clear and convincing data on the present financial needs of the dental schools, thus all of these facts will not be repeated in this communication. It should be emphasized, however, that there is now a demonstrable need for substantial financial support to improve the quality of existing enrollment. Even if space were available in the dental schools to increase enrollment, which is not the case in most institutions, it would be necessary to employ additional faculty and to incur further operating deficits which would, in turn, dilute or perhaps eliminate the benefits which might otherwise be realized from the basic improvement grant program proposed in S. 595.

Since the publication of the report of the committee on Interstate and Foreign Commerce on H.R. 3141, the association has conducted a survey of the dental schools to determine the extent and nature of the problems which would be encountered by the amended part E, section 771(b). On the basis of replies from more than three-fourths of the dental schools, there is not a single institution which presently has sufficient basic science, preclinical and clinical science space to accept an additional five students for each of the next 4 years without overcrowding facilities to a point that would adversely affect the quality of its educational program. In this regard, the association would like to call to the attention of the committee the fact that dental education requires special laboratory and clinical space for each student. The schools which are in existence today are operating at capacity and cannot add laboratory areas and clinical units without additional time, planning, and financing.

It should be noted also that the amendment approved by the House of Representatives provides that the enrollment increases required under part E are in addition to the requirements specified under part B—construction grants. At the present time, 12 dental schools have received construction grants under Public Law 88–129, and an additional 12 schools have submitted applications prior to the July 1, 1965, deadline. Many months and hundreds of thousands of dollars have been invested in developing the plans on which these construction programs are based and, in some cases, construction is already underway. It would be virtually impossible for these institutions, which have demonstrated their concern for the national dental manpower problem by proceeding promptly with the building programs, to alter their programs to accommodate an additional total enrollment of 20 students.

The American Association of Dental Schools urges the Committee on Labor and Public Welfare to support the basic improvement grant program as contained in S. 595 and to lend its greatest effort to the elimination of the amendment proposed by the House of Representatives.

Respectfully yours,

REGINALD SULLENS, *Secretary.*

PREPARED STATEMENT OF AMERICAN ASSOCIATION OF DENTAL SCHOOLS

The American Association of Dental Schools is pleased to have this opportunity to present a statement in support of S. 595, the Health Professions Educational Assistance Amendments of 1965. This bill, if enacted by the Congress, will have a positive and substantial impact on the future dental health of the American public by making it possible to increase the number of doctors of dentistry, by providing assistance for improvements in the teaching programs of dental schools, and by providing loans and scholarships for young scholars who otherwise will not be able to consider a career in dentistry. In the opinion of this association, S. 595 identifies three of the most crucial problems facing dental and other health professional education today.

Before commenting specifically upon the provisions of S. 595, the association wishes to indicate that it is aware that the House of Representatives has approved an amended version of a similar bill (H.R. 3141). While the association is pleased that the House of Representatives has seen fit to endorse the general principles of the bill, strong objection is taken to the amendments added by the House of Representatives which would require expansion in student enrollment beyond that stipulated to qualify for construction or rehabilitation of educational facilities in order to be eligible to receive basic or special improvement grants. The reasons for opposing these requirements are contained in a separate letter sent on September 3d to the chairman of the Committee on Labor and Public Welfare. It is the sincere hope of the association that this committee and the Senate will endorse the basic and special improvement grant programs contained in S. 595 and lend their efforts to opposing the enrollment increase amendments proposed in part E of H.R. 3141.

The association will first present testimony in favor of the extension and expansion of Public Law 88–129 to continue Federal grants-in-aid for constructing dental teaching facilities and for providing needed improvements in the current program for dental student loans. In addition, the association will present evidence in support of the urgent need for the new programs which would be made possible through the enactment of S. 595; namely, basic and special improvement grants for raising the quality of dental education, and the enstablishment of a program of federally supported scholarships for dental students.

EXTENSION OF THE CONSTRUCTION GRANT PROGRAM

During the past decade, the American Association of Dental Schools and the American Dental Association have appeared repeatedly before committees of the Congress to call attention to the growing seriousness of a shortage of dentists. In addition, this problem has been reviewed on several occasions by special governmental and public commissions which have, in each case, supported the need for expanding the number of professionally educated health personnel to care for the physical well-being of our people. With the support of this distinguished committee, the Congress enacted Public Law 88–129 in September, 1963 which provided for Federal grants-in-aid for the construction of new and expanded facilities and for the rehabilitation of existing dental educational institutions. Figures will be presented in this statement to show the impact which Public Law 88–129 has already had but, first, the association would like to emphasize the urgency of prompt action on extending the construction grant program in order to assure that the progress which has been made will result in maximum benefit to the citizens of our country.

Under the existing legislation an application for Federal assistance for construction of a dental school could not be considered unless it was submitted to the Surgeon General prior to July 1, 1965. Although Public Law 88–129 was enacted in late 1963, the appropriation of funds and the development of full-scale planning was not achieved until the fall of 1964. Since that time, as will be pointed out later in this statement, a tremendous momentum in new and expanded facility planning has developed to the point where we can anticipate really significant accomplishment in meeting the dental manpower needs, if the Congress authorizes the extension and expansion of the Health Professions Educational Assistance Act promptly.

In 1963, there were 105,950 dentists in the United States, including those who were retired, or were employed in positions in which they did not practice dentistry, providing a ratio of 54.6 dentists to each 100,000 individuals. To maintain even this ratio of dentists to population, which is considered low by most officials, the dental schools will need to graduate more than 70,000 dentists between now and 1980. At the present rate of graduation, only slightly more

than 55,000 graduates can be anticipated by that time which would leave a deficit of over 15,000 in the number of dentists graduating between now and 1980. With such a deficit, the projected ratio of dentists to population would decline to about 50 dentists to each 100,000 persons.

The enactment of the Health Professions Education Assistance Act of 1963 was a significant step in the direction of alleviating the shortage of dental manpower. As of July 1965, 12 dental construction applications had been approved and funded. These projects will, when completed, increase the number of first year places in dental schools by approximately 375. In addition, the applications of three schools for construction grants have been approved but have not been funded, one school's application has been provisionally approved and four schools' applications have been deferred pending extension of Public Law 88–129. Four additional schools have filed applications for construction of facilities for expansion which have not yet been officially reviewed. The total expansion in dental school enrollment for all applications filed under Public Law 88–129, whether approved or deferred pending extension of the bill, would be approximately 680 students. The total amount requested in Federal funds for this expansion is nearly $84 million of which only about $34 million in Federal funds has been made available under the authorization of Public Law 88–129. It is apparent, therefore, that the dental schools of the Nation are prepared at this moment to expand their enrollment by more than 300 students over those expansion projects already approved if financial assistance can be made available to them. A backlog of requests for Federal funding in excess of $50 million already existed at the expiration of Public Law 88–129. Dental schools, university administrators, and State legislatures have demonstrated their desire and capability to expand the numbers of dentists they will educate, but they must receive substantial assistance if this objective is to be met.

Based on applications presently funded, it is estimated that the number of first year places will be increased to 4,300 by 1980. As helpful as this increase will be, however, an expansion of educational capacity in this amount will not keep pace with the needs of the population for it is predicted that the ratio of dentists to population will decrease to about 50.6 to 100,000 by 1980, without an extension of Public Law 88–129.

In early 1965, the association undertook a survey of existing dental schools as well as universities which have reported an interest in considering the establishment of a school of dentistry. Results from that survey showed an interest on the part of nearly every dental school in the country in expanding its enrollment capacity and eight universities, in addition to three that have filed applications, indicated a fairly definite intent to embark upon a dental education program. The projected plans of these several institutions indicated the potential of expanding first-year places in dental schools by an additional 1,250 provided adequate Federal assistance can be anticipated. Although an expansion of this magnitude would go a long way toward supplying the number of dentists estimated as necessary by 1980, the task cannot be accomplished without an extension and a substantial expansion of the present Federal assistance program.

As has already been indicated, applications are presently on file for an additional $50 million of Federal assistance beyond the funds authorized in Public Law 88–129. The 1965 survey of dental school program plans and needs, to which reference has already been made, produced an estimated cost for construction projects planned by existing and new dental schools in a total amount of nearly $288 million. The projected Federal share of this construction, which would be undertaken within the next 10 years, was $157 million. It was learned from the survey that a total of 53 construction projects are underway or being planned, including the total replacement of expanded facilities for 23 existing schools, additions to or renovation of the facilities for 19 institutions and the possible construction of 11 new dental schools.

As a result of the momentum which has been started by Public Law 88–129, many of these planned construction projects are at a stage where they can and will proceed as promptly as Federal matching funds become available. The survey revealed, for example, a projected need for more than $86 million of Federal matching funds during the next 3 years. The American Association of Dental Schools, based upon the backlog which will accumulate in the remaining life of Public Law 88–129 and upon the clearly demonstrated need for additional educational facilities in the future, recommends that a minimum of $25 million annually be provided for new and expanded dental school facilities during the period of time covered by S. 595.

In addition to new and expanded construction, Public Law 88–129 provided assistance for the replacement or rehabilitation of existing dental educational

facilities, the funds for which are shared with other health professions. Under the existing program, there has been administrative agreement that one-fourth ($8.75 million) of the total authorization will be utilized for the support of dental school rehabilitation. Although the funds currently available specifically for rehabilitation and renovation of dental educational institutions have not been adequate to meet the need, the association is in agreement with the proration pattern which has been established and urges that it be continued during the extension of the Health Professions Educational Assistance Act. It is also recommended that the committee give consideration to identifying a minimum authorization of $35 million per year to be utilized for the rehabilitation or renovation of the health professional education institutions included in the legislation.

The association would like to express one concern related to the interpretation of the function of a modern school of dentistry. Dental schools are perhaps unique among the health professional schools in that they must, within their own facilities, attempt to provide the student with a total orientation and experience for professional practice. Included in this educational process should be the opportunity for a dental student to learn, in some detail, the proper and effective utilization of dental auxiliary personnel and an opportunity to become familiar with the training and experience which these personnel can be expected to have when called upon by the dentist in practice. Additionally, a substantial portion of the advanced educational programs which are needed to prepare dental research scientists, teachers, and specialty practitioners are offered within the confines of the school of dentistry. It is, therefore, important to view the dental educational institution as a complex and comprehensive facility which should have the capacity for conducting all facets of dental education which are of importance in providing the public with the highest possible level of dental care.

In recognition of this concept, the house of delegates of the American Association of Dental Schools adopted a resolution in July 1965 urging "that any extension of Federal legislation related to grants-in-aid for dental education facilities be designated to encompass the total spectrum of dental education, including the facilities for advanced educational programs and auxiliary education."

It is hoped that the committee will concur with this description of the function and responsibilities of a modern dental school and provide assurance, through any means considered appropriate, for the use of Federal matching funds in the construction or renovation of a complete dental educational facility.

The American Association of Dental Schools would also like to request the committee's consideration of an additional need related to the construction grant program. Perhaps one of the most critical stages in the development of a professional educational institution is the planning which must be done prior to the preparation of an application proposal and the beginning of construction. It is at this stage that many decisions are made which will have an important and permanent influence on the adequacy and adaptability of the facility which is to be constructed. Although the amount of money involved in the planning of a dental educational institution varies a great deal, experience has shown that this amount is sometimes sufficient to delay the planning process by many months or years or, even more unfortunate, to result occasionally in planning which was not as forward looking as it might have been because of the lack of adequate planning funds. The association urges, therefore, that the committee add a provision to S. 595 which would make Federal funds available on a 1-to-1 matching basis to be used for the planning of dental educational facilities.

In concluding its comments on this section of S. 595, the American Association of Dental Schools wishes to record its appreciation for the excellent manner in which the staff of the Division of Dental Health of the U.S. Public Health Service has carried out the administration of the construction grant program under Public Law 88–129. The efficiency and untiring efforts of the Division staff, coupled with the extensive service which has been provided by the Dental Review Panel, have resulted in a truly remarkable administration of a large and complex program.

EXTENSION OF THE STUDENT LOAN PROGRAM

The American Association of Dental Schools vigorously endorses the provisions of S. 595 which would extend the availability of loans for students of dentistry and which would raise the ceiling on these loans to $2,500 per year for each full-time student qualifying for the loans. The rising costs of dental education have resulted in sharply increased tuition fees. The cost of instruments and books increased yearly and, of course, the cost of living has also increased. It is not only important, therefore, that the major source of loan funds presently available

to dental students be continued but the total appropriation and the maximum loan per student must be adjusted upward if we are to meet the rising costs of dental education.

In the 1965 survey of dental school program plans and needs, dental school deans were asked to answer certain questions related to their experience with the health professions educational assistance student loan program under Public Law 88–129. Eighty-eight percent of the deans indicated that most of the applications for these loans were approved for amounts less than requested due to the necessity of distributing the available funds among as many dental students as possible. The average loan made to dental students was $950. Eighty-three percent of the deans reported considerable difficulty in meeting all loan requests. About one-quarter of the dental students enrolled at reporting schools received a loan under the auspices of this program and it was necessary to reject 18 percent of the loan applications primarily due to lack of funds.

The association has recently conducted a study of the financial needs of dental students in cooperation with the Division of Dental Health of the Public Health Service. Although not yet published, preliminary tabulations from that study reveal some interesting observations which are related directly to problems of dental manpower. The study showed that 16 percent of the dental students found it necessary to interrupt their educational program between college and dental school and that 50 percent of this group were compelled to make this delay because of a lack of sufficient funds. The average period of interruption was 2.4 years, which means that, with financial assistance, 8 percent of the dental students might have entered dental school more than 2 years earlier than they did. Therefore, for an entering class of 3,800 students, 304 (8 percent) might have had over 2 years added to their productive professional life if financial assistance had been available to them.

Additional arguments related to the need for increased financial aid for dental students are included in later portions of this statement. The association would, however, like to record its full support of the student loan provisions of S. 595 and to urge the committee to provide a substantial increase in support for this important program.

BASIC AND SPECIAL IMPROVEMENT GRANTS

Part E of S. 595, which would provide grants to improve the quality of schools of medicine, dentistry, and osteopathy, represents a most important and urgently needed expansion of the Health Professions Educational Assistance Act and is strongly endorsed by the American Association of Dental Schools. Although the ingredients which are essential to educational excellence are many and varied, there can be no doubt that adequate financial support and stability is an absolute requirement. As will be indicated later in this statement, education in dentistry is an increasingly expensive undertaking for any university, and indeed, some institutions may soon be confronted with the undesirable alternatives of either withdrawing from this field of professional education or tolerating an educational program which is of questionable quality. Neither in principle nor in reality can either of these alternatives be endorsed, thus every possible effort must be made to secure prompt and substantial financial assistance in the interest of our professional schools and the public which their graduates serve.

Before commenting on the specific provisions of S. 595 which relate to basic and special improvement grants, the association would like to request a clarification within this part of the proposed legislation. Although it is assumed that section 726 of Public Law 88–129, "Noninterference with administration of institutions," is intended to be applicable to parts E and F of S. 595, there does not appear to be a specific provision to this effect in the legislation under consideration. In order that there be no doubt regarding noninterference with the personnel, curriculum, methods of instruction or administration of any institution which participates in the expanded programs proposed under S. 595, the American Association of Dental Schools urges the committee to make it perfectly clear that section 726 of Public Law 88–129 does and will apply to both parts E and F of S. 595.

Section 771. Basic improvement grants

Although the quality of dental education in the United States today is unexcelled by that of any other country in the world, increasing costs and rapidly expanding enrollments necessitated by a burgeoning population make it imperative that we find additional assistance for our professional educational programs. As is well known to this committee, the principle of providing Federal assistance

for various facets of higher education in this country has a long-established precedence. The concept of general public support for at least a part of the cost of educating the dentist in this country is equally well established, for the cost of dental education is not now, nor is it likely to be, borne entirely by the student. Recognizing themselves as the recipients of the ultimate benefit of education for health professions, the public has assumed some responsibility for underwriting the cost of dental education through private donations, foundation support, and extensive appropriations by State legislators. The magnitude of this type of support is suggested in the fact that the operating expenditures of dental schools (excluding sponsored research programs) was in excess of $51 million last year.

In the 1965 survey of dental school program plans and needs conducted by this association, it was revealed that the total operating costs of the dental schools in the United States have more than trebled in the past 14 years (1949–64). This experience, typical of the spiraling cost of education for the health professions, has occurred in spite of the fact that undergraduate dental student enrollment in the same period of time has been increased by only 22 percent.

Dental schools accept as their two primary functions the education of dental personnel and the performance of dental research and other sponsored programs which enhance the teaching program and contribute to dental knowledge. These two functions, as has been emphasized many times by dental educators, are inestricably related and the performance of each function is of vital concern to every dental school. Both must be supported adequately in the interest of national health.

Facts, however, point to an increasing imbalance between the support of sponsored and research programs and the teaching programs in dental schools. In the association's survey, it was revealed that support of research and other sponsored programs in dental schools has increased by a factor of 15 in the past 15 years while support for the teaching programs in the schools responding to the survey increased by a factor of only 2.6. Support for sponsored research programs is extremely important to the understanding and elimination or control of dental diseases and disorders and the proliferation of new knowledge which has resulted from the support of these programs is impressive. The Federal Government has played the largest single role in the support of these sponsored programs. The American Association of Dental Schools emphatically agrees, as has been demonstrated by its annual statements before the Appropriation Committees of Congress, that sponsored research programs must continue and expand in the public interest. The association, however, is equally convinced that increased support must be found for the teaching obligations of dental schools if the public is to receive full benefit of sponsored programs and if the quality of dental education is to continue and improve.

The rapidly expanding operating costs of dental schools can be illustrated by the following figures. In 1925, the total cost of the teaching program per enrolled dental student was $491, adjusted to 1964 dollars. Today, the operating cost per student is $3,693 and it is expected to rise to a conservatively estimated $5,284 by 1975. When the total operating cost, including sponsored programs, for the average dental school is computed, the cost per student in 1964 was $4,758. At the same time, as these costs have increased, the proportion of the cost borne by the student has decreased in an equally dramatic fashion. In 1925, the dental student paid for nearly one-half the cost of his education. By 1964, even though average tuition rates had quadrupled, the student paid for only one-quarter of the cost of his education. These costs per student are based on current realities. In the recent survey of dental school needs, deans of the Nation's dental schools indicated that an average operating expenditure of $6,620 per student would be necessary for the conduct of teaching programs which they felt would be desirable today.

Typically, the deficit between income and operating expense in dental schools is underwritten by the parent university. The relatively high cost of operating a dental school has resulted in some instances in a reluctance on the part of universities to consider the establishment of a new dental school even though there may be a demonstrated need for a new school in the geographic area. Basic improvement grants for dental teaching programs would, in the opinion of the association lower this resistance and would facilitate implementation of the dental school construction provisions of S. 595. Equally important, some of those institutions which have been in existence for decades may not be able to continue and expand the contributions which they have already made to the dental health of our people unless Federal assistance is made available.

In discussing the quality of any education, it is universally agreed that the ratio of teachers to students is extremely important. In dentistry, as in the

other health professions, this ratio is particularly important due to the complexity of the basic knowledge and clinical skills to be assimilated by the student. In the 2-year period of dental education in which a student typically performs professional dental services for patients, this ratio becomes especially critical. Students require nearly constant supervision, evaluation, and guidance during this period and the quality of their education can be directly related to the availability of instructors to advise them. With the growth of student enrollment due to expanded facilities and the construction of new dental schools, the procurement of faculty will be perhaps the most serious single problem faced by dental school administrators. Without markedly increased financial support, this problem will be insoluble.

In 1950, the ratio of full-time equivalent clinical faculty members was 1 to 8.7 students. In 1964, this average ratio has been reduced to 1 faculty member to each 6.8 students but there are still institutions which, because of financial limitations, are compelled to operate with a ratio as high as 1 teacher to 15 students. As shown by the recent survey, the average in the schools with the most favorable ratio was one full-time clinical instructor to four students. In order to achieve this level in all of the dental schools, and thereby improve the quality of teaching, it would be necessary to secure approximately 1,400 additional clinical faculty members, an impossible task without additional financial support.

The lack of funds to secure full-time faculty has led many dental schools to rely heavily upon the services of part-time faculty members, particularly in the clinical aspects of dental education. As essential as part-time clinical faculty members are, dental educators agree that the dental schools could and should improve the quality of their teaching programs by enlarging the number of full-time faculty members. In comparing a survey made in 1958 to the recent study conducted by the association, it appears that there has been little change in the ratio between full-time and part-time faculty members during the past 7 years, again, largely because funds simply are not available to employ highly qualified clinical teachers on a full-time basis.

The procurement of qualified dental faculty, of necessity, depends heavily upon the ability of the educational institution to offer financial incentives comparable to those available to practicing dentists. In dental education, because of lack of financial resources, it has not been possible to meet this objective. The average salary of a dental faculty member today is $13,500 as compared to an annual average income of more than $16,000 for the dental practitioner. The individual trained beyond the dental degree, as is the typical dental educator, can frequently command substantially more than the average dentist's income in specialty practice or fields of endeavor other than education. Based upon these observations, it seems clear to this association that the dental schools of the Nation and the American public would benefit from financial support which would make possible the employment of additional dental teachers.

In the 1965 Survey of Dental School Program Plans and Needs, dental deans were asked to describe the kinds of programs they would instigate to improve dental teaching and the dental curriculum if funds were made available. The following is a partial tabulation of their responses:

Improvements or additional teaching programs desired:	*Percent of schools*
Additional inservice or preservice teacher education programs	44
Additional or improved programs in hospital dentistry education	44
Instruction in research methodology	36
Improvements in the teaching of community, social, and preventive dentistry	81
Dental care for the special patient:	
1. Geriodontics and care for the chronically ill	39
2. Care for the homebound	19
3. Teaching of the team concept for the treatment of oral congenital anomalies such as cleft palate	25
4. Special teaching programs for maxillo-facial prosthesis	22
Improvement of educational media:	
1. Audiovisual equipment	6
2. Programed instruction	3

These, it should be emphasized, are only those activities to strengthen the dental curriculum which were mentioned with considerable frequency. Each of the additional programs or improvements in teaching programs listed above is in the obvious interest of increasing the quality of dental education and preparing the dental student to recognize and meet the increasingly complex dental needs of the public. Other improvements in the dental curriculum, such as special programs for the gifted dental student, should also be mentioned as necessary and desirable. It is worthy of note that 97 percent of the responding deans would inaugurate or strengthen one or more of the programs listed above.

Reference has been made previously to the fact that the regular operating expenditure of the dental schools in 1964 was $51.1 million. However, when queried as to the amount of funds which would be required for operation at the level which they considered desirable, the deans of dental schools projected a current expenditure level of $81 million, with about $20.4 million of these funds needed for improvement of their present teaching programs and $9.6 million for the inauguration of new educational activities considered important to modern dental education. Although an increase in operating income of this magnitude will be impossible, this projection is cited to reemphasize the current financial plight of dental education—a circumstance which cannot but worsen as operating expenditures continue to climb and as enrollments increase.

The American Association of Dental Schools gives its strongest encouragement to the Committee on Interstate and Foreign Commerce to consider favorably section 771 of S. 595.

Section 772. Special improvement grants

As is undoubtedly true in all areas of higher education, the Nation's dental schools vary considerably in the amount of financial support which they have for the conduct of their educational programs, thus there is need for special measures to assist some institutions in achieving a desirable level of educational quality. The American Association of Dental Schools urges, therefore, that the special improvement grant authorization in S. 595 be approved as an essential part of the program designed to strengthen and improve dental education in the United States.

In 1964, according to the recent survey conducted by the association, the average regular program cost for educating a dental student was $3,693 per year. This same survey revealed, however, that 1 school was able to invest less than $2,000 per student while 16 of the dental schools operated with an annual expenditure per student of less than $3,000. Although there is perhaps not a perfect correlation between cost of education per student and quality of education, there is unquestionably a sufficiently high degree of relationship to compel the conclusion that some of our dental schools simply do not have the financial resources to offer the quality of education that is desirable. This observation has been confirmed recently by action of the Council on Dental Education of the American Dental Association, the recognized accrediting agency for dental education, in which three dental schools have been placed on provisional accreditation, largely because of inadequacies which could be remedied by more adequate financial support.

As a general rule, it is well known that the financial support available to private institutions is below that given to State-supported schools. As indicated by the following figures, this situation exists in dental education. The average expenditure for education per student in privately supported institutions in 1964 was $3,263 compared to $4,180 per student in publicly supported schools. At the present time, 25 of the Nation's dental schools are in privately supported universities but it is clear that the private institution is finding it increasingly difficult to support the high cost of professional education. During the past 4 years, three privately supported dental schools have found it necessary to affiliate with State-supported institutions in order to achieve financial stability. It is significant also to point out that only two of the eight dental schools established since 1950 have been in privately supported institutions and one of these has since become State supported.

In terms of full-time clinical teacher to student ratios the Nation's publicly supported dental schools fare somewhat better than those which depend on private sources of revenue. The following table compiled from the association's 1965 survey illustrates this point and also shows that some institutions in both categories are conducting clinical educational programs with an extremely unfavorable faculty-student ratio.

Ratio of students to full-time clinical instructors (based on full-time equivalents)

Private schools (N=25)		Public schools (N=23)	
Students to faculty	Number of schools	Students to faculty	Number of schools
1 to 3	2	1 to 3	1
3 to 4	1	3 to 4	2
4 to 5	0	4 to 5	7
5 to 6	0	5 to 6	3
6 to 8	10	6 to 8	4
8 to 10	9	8 to 10	5
10 or more	3	10 or more	1
Median: 7.8		Median: 5.2	
Range: 1.5 to 14.9		Range: 2.8 to 10.3	

Most of the figures which have been presented thus far in this section refer to present levels of operating expenditures which, it should again be emphasized, are by no means adequate. As has been indicated previously, the deans of dental schools reported earlier this year a need for increasing the annual expenditure per student from an average of about $3,700 to more than $6,600 in order to improve the quality of the regular educational program and to add to the curriculum those activities which are deemed desirable for present-day dental education. In this regard, the association would like to mention again the increasing educational burden which the dental schools are being called upon to bear. Continuing education programs for dental practitioners are more and more centered in the dental schools. The demand of the public for additional specialty practitioners requires expanded programs of advanced education. The dental schools have an ever-broadening responsibility for providing educational opportunities and consultation for the dental hygienist, dental assistant, and dental laboratory technician. These additional commitments place greater strain on the already limited financial resources of the dental schools and will, unless increased support can be found, inevitably lead either to further dilution of the quality of the educational program for dentists or to neglect of several other important obligations of our dental educational institutions.

SCHOLARSHIP GRANTS FOR DENTAL STUDENTS

A final, and very essential, provision of S. 595 is that relating to scholarship grants to schools of dentistry, medicine, and osteopathy. Before commenting on the need for this type of financial assistance for dental students, the association would like to make a suggestion for the consideration of the committee. Education for the health professions is, both in level and scope, a graduate discipline within the university. In addition, there can be little disagreement with the proposition that manpower in the health professions is as essential to the welfare and security of our country as is the scientific manpower required in the physical and life sciences. Through various national agencies, the Federal Government has long and well-established programs of support for fellowships in many graduate study disciplines—programs which have contributed substantially and importantly to the progress of the country. The American Association of Dental Schools believes that the proposed scholarship program for students in the health progessions is comparable, in concept and in need, to the fellowship programs which have been supported for many years by the Federal Government and, therefore, suggests that part F of S. 595 should be viewed as a fellowship program in the health professions.

An examination of sources of funds used to finance dental education reveals that the student and his familly bear the major share of the cost with only about 3 percent of the cost being provided through some kind on nonrepayable income. This is in direct contrast to the experience of graduate students in nonprofessional schools where the great majority of students are supported by nonrepayable grants. As an example, more than 80 percent of graduate life science students receive grants averaging $2,700 per year while only 15 percent of the dental students receive awards averaging $425. Thus, the dental student, with generally higher fees to pay and with a curriculum which makes part-time employment extremely difficult, has much less opportunity for financial support than graduate students in the life sciences.

This comparison of nonrepayable support available to dental students with that available to graduate students in other scientific disciplines is extremely important. Increased demands for persons with graduate training have resulted in the creation of many new graduate programs as well as expansion in existing programs. The establishment of National Defense Education Act programs to provide college teachers in critical areas is a good case in point. As graduate programs have increased, the student with outstanding ability has become the object of vigorous recruitment efforts. Students with the best scores on graduate record examinations can anticipate a choice of several programs in their field of interest; each offering stipends, fee waivers, and allowances for dependents. In contrast, the student interested in a health profession can expect only limited help. There is unquestionably a need for fellowship support in the physical and life sciences, as the Congress has already recognized. There is, the association believes, also a need for support in the health sciences if we are to assure the continued progress and growth of the health professions.

Fortunately, in terms of quantity of applicants, the situation in dental education has improved in the past 3 years. The ratio of applicants to accepted students has risen from a low of 1.6 to 1 in 1961–62 to the present level of 2.4 to 1. Dental educators are convinced that this more favorable ratio has had a beneficial effect on the quality of students accepted for dental education. Educators are concerned, however, that this improved ratio might be diminished as the cost of dental education continues to increase and as the competition from other scientific disciplines expands. If we are to increase the number of dental school positions available by twofold by 1975, as it is hoped, the number of dental school applicants will need to increase by at least the same ratio by that time. Without corresponding increases in dental school applicants, the ratio of applicants to accepted students would drop below the 1961–62 level.

Continued progress in the fight against dental disease will be related to the extent to which students of exceptional ability are attracted to dental research and dental education. The applicant who can be expected to make a contribution as a dental research scientist or as a dental educator will normally have had several opportunities for substantial or complete support of his graduate training in the life sciences. Dentistry, of course, benefits from many discoveries which are made in the purely physical or biological sciences. However, for the ultimate benefit of dental education and dental research, dentistry must be in a position to compete for these highly qualified individuals. Once they have acquired a dental education, they frequently continue their education beyond the dental degree and return to teach or perform research in the field of dentistry. At the present, however, dentistry has little incentive to offer the superior candidate in comparison to the fellowships available to him in other sciences.

Because a dental education must usually be supported heavily from family resources, it is frequently restricted to students from middle or upper income families. As an example, in 1963 when only 4.8 percent of all the families in the United States had incomes of $15,000 per year or more, 22 percent of all dental students were from families belonging to this group. Similarly, whereas 29.1 percent of the families in the United States had annual incomes of less than $4,000 per year, only 11.7 percent of dental students were from families belonging to this group. Surely in a nation as affluent as our own, an effort can and should be made to make educational opportunity available to our finest minds without restrictions based upon economic considerations.

In summary, the American Association of Dental Schools is convinced that part F of S. 595 is extremely important to dentistry and to the other health professions. Fellowship aid in keeping with that available in the life sciences needs to be made available to the dental student. The association is convinced that the availability of fellowship aid will have a significant effect on both the quality and quantity of the dental school applicant and will provide opportunities for the qualified applicant who, for economic reasons, could not otherwise pursue a dental education.

CONCLUSION

The American Association of Dental Schools is deeply appreciative of this opportunity to comment in support of the provisions of S. 595. The association views as vital the provisions to extend and expand programs of dental school construction and expansion and the extension of the dental student loan program. In addition, the provision of basic and special improvement grants for dental schools and the establishment of fellowship programs for dental students will provide benefits to the Nation's citizens far beyond the cost of such programs.

53-366—65——7

The association urges the Committee on Labor and Public Welfare to give prompt and favorable support to each of the provisions of the Health Professions Educational Assistance Amendments of 1965.

The CHAIRMAN. Now, the American Nurses' Association. Mrs. Margaret Dolan.

Mrs. Dolan, we are happy to have you here. Is there anyone you would like to have sit with you?

STATEMENT OF MRS. MARGARET B. DOLAN, AMERICAN NURSES' ASSOCIATION

Mrs. DOLAN. Mr. Chairman, Senator Yarborough, we greatly appreciate this opportunity to appear before this subcommittee and to testify in support of S. 595.

I am Mrs. Margaret B. Dolan, professor and head, department of public health nursing, school of public health, University of North Carolina. I am a member of the board of directors of the American Nurses' Association and its immediate past president.

The ANA is the professional organization of registered nurses. It has constituent associations in the 50 States, the Canal Zone, the District of Columbia, Puerto Rico, and the Virgin Islands.

SUPPORT OF S. 595, THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE AMENDMENTS OF 1965

We support the intent of S. 595 to assit other professional schools in the health field, and their students, through grants for construction of facilities, improvement grants and scholarships and loan programs. The need for such assistance has been well documented by the professions most directly affected by this legislation. We also approve the language in section 773(b)(2) of S. 595, which states:

> To be eligible for a grant under this part, the applicant must * * * (2) be accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education, * * * .

Evaluation and accreditation of professional schools, made by competent members of the particular profession, gives the best assurance that the educational program will produce competent practitioners and that the public, recipients of the professional services, will be well served.

We oppose, and urge you to reject, the provision in section 5(b) of H.R. 3141, as reported by the House Committee on Interstate and Foreign Commerce, which reads:

> (b) * * * Section 843(f) of such Act (relating to accreditation of new schools of nursing), is amended (1) by striking out "any program of nurse education means a program accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education" and inserting in lieu thereof the following: "any program of nurse education, offered by a diploma school of nursing, means a program accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education and, when applied to any collegiate or associate degree program of nurse education, means a program provided by an educational institution approved or accredited by either a regional accrediting agency or a State approval agency" * * *.

Acceptance of this language would amend section 843(f) of the Nurse Training Act of 1964. National accreditation of baccalaureate and associate degree programs in nursing would no longer be require-

ment for eligibility to apply for Federal funds under the act. While the provision on accreditation with respect to all other schools is retained and appears in H.R. 3141 just as in S. 595, H.R. 3141 proposes a different approach to accreditation of nursing schools, and would alter the intent of the Nurse Training Act of 1964, which is to build quality into educational programs preparing nurses, as well as increasing the quantity.

STATE APPROVAL

In the early 1900's nurses worked for the enactment of nursing practice legislation as the most effective, expedient means of establishing and maintaining at least minimum standards for the preparation of nurses. But legal standards for nursing are minimum. Furthermore, the standards vary from State to State just as standards for general education vary.

When the Commissioner of Education named the NLN as the accrediting agency for purposes of the Nurse Training Act, he remarked:

> * * * that the procedures and standards for licensure of nurses and approval of programs of nurse education in the several States vary so widely that it does not seem feasible at this time to identify State accrediting or approval agencies for the purpose of this act. Though it may become necessary eventually to name one or more State bodies, I prefer at present to defer this aspect of the matter for further consideration. (National Commission of Accrediting. Reports, January 1965, No. XV–2, p. 3.)

The policy of the National Commission on Accrediting is against the inclusion of State agencies on lists of officially recognized accrediting agenices for general, specialized or professional programs of higher education. The Commission grants recognition only to nongovernmental, national organizations. The Commission points out:

> Accreditation, as a form of guidance for and control of higher education in the United States, has been developed primarily as a nongovernmental function. It is companion to but distinct from the governmental function of licensure or certification of individuals. These two functions—accreditation of institutions or of specific programs of study and licensure of individuals—provide a balance to each other in which nongovernmental and governmental agencies assume their respective and complementary functions. If government in the United States were to dominate both of these functions, the effective balance among government, education, and the professions, which has been developed during the present century, would be undermined and destroyed. (National Commission on Accrediting. Reports, April 1965, No. XV–3, p. 6.)

Had nurses been satisfied that legal standards were sufficient to insure not only a safe practitioner but a highly competent one, there would have been no movement toward national voluntary accreditation. But the need for standards above and beyond those required by law was recognized by the profession itself. It would be ironic if a government which has demonstrated its very great interest in all education and has enacted such significant legislation in support of education were now, through this amendment, to sanction the lowering of quality in nursing education.

VOLUNTARY ACCREDITATION

Voluntary accreditation is carried out by two types of agencies. One is regional and is composed of representatives of the colleges and universities of an area who evaluate the institutions of higher education

of that area. The other professional, its standards are national, and it is composed of members of the profession.

The regional agency accredits the institution as a whole, considering how well objectives are met, its administration, financing, faculty strength, teaching conditions, library support, student health program, and provisions for general education in specialized programs. The regional agency does not accredit specialized programs within an institution. The professional accrediting agency evaluates programs of study for the purpose of maintaining educational standards; for protecting society from inadequately prepared practitioners; and for assisting students in the selection of recognized programs of study.

RECORD OF NATIONALLY ACCREDITED SCHOOLS OF NURSING

Programs in nursing that are nationally accredited attract, retain, and graduate the largest number of students. Records show that 98,533 students, 76.2 percent, are enrolled in the 717 fully accredited programs. Seventy-seven percent of all graduates for the period September 1, 1963, to August 31, 1964, were from nationally accredited programs. A higher proportion of graduates of nationally accredited programs pass the State licensing examination and are admitted to practice as shown in table 1.

(The tabulation referred to follows:)

TABLE 1.—*Number of candidates and percent failing State board examinations, 1963–64*

Type of program	Accredited		Not accredited	
	Number of candidates	Percent of failures	Number of candidates	Percent of failures
Baccalaureate	3,696	6	744	19
Associate degree	144	10	1,133	25
Diploma	20,118	13	5,950	24

Source: National League for Nursing, Aug. 6, 1965.

Mrs. DOLAN. As you will note, there was a rate of 25 percent of failure for those from nonaccredited programs, a rate 2½ times that of the graduates from accredited programs. And we have not really produced a nurse until she is licensed to practice.

POSITIONS OF DIRECTORS OF NURSING IN THE 50 STATE HEALTH DEPARTMENTS AND THE TERRITORIAL HEALTH DEPARTMENTS

On August 10, 1965, the Association of the State and Territorial Directors of Nursing, meeting in Washington, D.C., unanimously accepted a resolution supporting the accreditation standards as originally implemented in the Nurse Training Act of 1964. This resolution was submitted to the American Nurses Association and is attached. We request that it be included in the record of these hearings.

The CHAIRMAN. Yes, that can be included in the record at this point.

(The resolution referred to follows:)

RESOLUTION OF THE ASSOCIATION OF STATE AND TERRITORIAL DIRECTORS OF NURSING

The Association of State and Territorial Directors of Nursing is concerned with quality and safety of nursing care. We believe the quality of nursing care is directly affected if nurses are not adequately prepared to give safe, therapeutically effective and efficient care. Further, we believe that the role of government in protecting the safety of the public should be through State licensure of individual practitioners under healing arts legislation. Standards for educational preparation should be established by peer groups in the appropriate field (in this instance nursing) and carried out through voluntary nationwide participation. The recognized national accrediting body for nursing education programs is the National League for Nursing. In nursing the national application of this principle is particularly important because of the mobility of nurses.

Therefore, we wish to go on record as supporting the accreditation standards as originally implemented in the Nurse Training Act of 1964 and are opposed to the provisions of the technical amendment attached to H.R. 3141 (health professions amendment, sec. (5)(B)(1)) currently being considered.

Mrs. DOLAN. These directors of nursing will be very involved in the implementation of the Social Security Act Amendments of 1965, especially in relation to home health services and to the posthospital extended care services. They feel an obligation to insure that the nursing services provided through Public Law 89–97 are of high quality. While the demand for nurses will be increased, especially intensified will be the need for highly skilled practitioners, who must take the lead and the responsibility for planning the nursing service and supervising the licensed practical nurses and auxiliary personnel who will also be participating in the care of patients.

OBJECTIONS TO SPECIALIZED ACCREDITATION CITED IN THE REPORT OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

The junior colleges have expressed the fear that if nursing programs are accredited by a specialized body, a precedent will be established and other groups will seek to accredit programs within the institution.

The National Commission on Accrediting, which speaks for more than 1,300 colleges and universities, recognizes only 2 specialized accrediting bodies for junior colleges. These are the American Dental Association and the National Association of Schools of Music. The Commission has also identified that a need exists for professional accreditation of engineering technology programs and associate degree programs in nursing.

At its annual meeting, April 2 and 3, 1965, the Board of the Commission declares:

> * * * it has been and continues to be the policy of the National Commission of Accrediting * * * to recognize national professional or specialized agencies for accreditation of particular or specialized fields of study only when the Commission considers that a social need exists for such accreditation. (National Commission on Accrediting. Reports, April 1965. No. XV–3, p. 2.)

Such a policy is a protection for the junior colleges against the demands of several groups seeking to accredit specialized programs. Another objection, noted in the report of the Committee on Interstate and Foreign Commerce on H.R. 3141, is that:

> A number of schools, primarily junior colleges, have experienced difficulties because of delays in the processing of applications for accreditation and the expense associated with this process which runs as high as $1,000 in the case of some institutions.

Since passage of the Nurse Training Act in August 1964, a total of 167 programs applied for "Reasonable Assurance of Accreditation": 49 associate degree, or junior college programs; 27 bachelors degree programs; 91 diploma programs. An additional 49 have submitted materials for the September 1965 meetings of the review panels. Of these 167 schools, 133 were granted "reasonable assurance."

The CHAIRMAN. Mrs. Dolan, what is "reasonable assurance"?

Mrs. DOLAN. "Reasonable assurance" is an indication that an investigation has been made of the program and the National League for Nursing has said that it gives reasonable assurance that by the time the school graduates its first class, it will have reached the standards for accredition. This is for new schools that are just getting starterd, or who have not graduated its first class and are therefore ineligible for full accreditation.

Of the 167 schools, 133 were granted "reasonable assurance": 32 of the 49 associate degree programs; 15 of the 27 bachelors programs; and 66 of the 91 diploma programs. Four of the bachelors programs and five of the diploma programs are now accredited. This indicates to us that when application for reasonable assurance was made it was acted upon promptly. There seems no reasonable basis for the statement that there were delays in processing applications.

The cost for reasonable assurance of accreditation is $100, to assist with covering costs of processing materials and convening review panels. Travel and expenses of two visitors are also charged to institutions offering programs too new to be eligible for accreditation. Visits are not made to nonaccredited established programs since they can supply extensive information about the institution, the faculty, curriculum, students and graduates, and a site visit is not considered necessary.

CONCLUSION

One of ANA's purposes is to promote the professional and educational advancement of nurses and its platform further commits it to elevating standards of nursing education and to promoting legislation that will provide public funds for scholarships, research, and programs for continued improvement in nursing education.

Very significant legislation to assist nursing has been enacted by the Congress during the past 10 years—the graduate nurse and public health traineeship programs, the Health Professions and Educational Assistance Act, and the Nurse Training Act.

In seeking assistance for nursing education, the ANA has always urged that public funds go only to programs that give assurance of quality preparation. In testifying in 1964 on the Nurse Training Act, it made this statement:

> The American Nurses' Association believes that certain safeguards are essential to insure the best use of the Federal funds that H.R. 11241 would make available. It is most important that only schools of nursing accredited by a recognized national accrediting body be eligible to receive funds for construction, apply for project grants, and establish and operate loan funds. These are the schools that have met standards set by the National League for Nursing, the recognized accrediting body for schools of nursing. There will be instances where evidence can be given that a nonaccredited program will meet accreditation standards within a reasonable time. In cases of this kind we recommend consultation with the accrediting agency before assistance is extended.

The position on national accreditation as a prerequisite to eligibility for Federal assistance, and support of the National League for Nursing as the accrediting body, was further emphasized by the ANA Board of Directors in January. This position statement was sent to the U.S. Commissioner of Education and is attached. We request that it be included in the record of these hearings.

The CHAIRMAN. We shall be happy to have it included in the record as part of your testimony.

Mrs. DOLAN. Thank you.

(The statement referred to is as follows:)

POSITION OF THE AMERICAN NURSES' ASSOCIATION ON ACCREDITATION OF ALL BASIC NURSING EDUCATION PROGRAMS

The American Nurses' Association recognizes and supports the National League for Nursing as the national accrediting agency for all basic nursing education programs. NLN accreditation is directed toward strengthening and maintaining quality of nursing education for the protection of both the student and the public. Such accreditation, we believe, is most essential at the present time for the effective development of associate degree programs which are providing rapidly increasing numbers of candidates for licensure as registered nurses.

We support your designation of the National League for Nursing as the accrediting agency for the purposes of awarding Federal funds for nursing education, and urge that NLN accreditation be maintained as a requirement for Federal assistance to associate degree programs as well as for diploma and baccalaureate programs.

Mrs. DOLAN. The associate degree programs in nursing have developed rapidly, from 5 programs in 1952 to 131 in 1965, with a marked acceleration in the past 5 years.

To help these community college programs develop, the American Nurses Association worked with and encouraged its constituent State associations to secure changes in State nursing practice acts that would enable the programs to secure approval to operate from the responsible State agency. At the time experimentation with the associate degree program was initiated, many State laws stipulated the length of time for a nursing program, usually 3 years. Without a change in State law, graduates of the shorter associate degree programs could not be admitted to the licensing examination.

But any action now that would result in a proliferation of nursing programs of any type must be a matter of concern. There continues to be, in spite of the great assistance given through the graduate nurse traineeship program, a critical shortage of well-qualified teachers and administrators.

At the present time, already existing schools are having great difficulty filling vacancies with fully qualified faculty. New schools are having greater difficulty in attracting well-prepared teachers, not only because there is a serious shortage, but also because the qualified teacher is more likely to seek and accept a position in a nationally accredited school. The problems of nursing, in terms of quality and quantity of practitioners, will not be solved through multiplication of schools with inadequately prepared faculty. To prepare competent nurses, there must be qualified faculty.

We thank the committee for this opportunity to appear before you, Senator Hill, in support of S. 595. We urge you to reject the amendment in H.R. 3141 which, if accepted, would have serious consequences for nursing education in this country and for the quality of nursing care available to the public.

The CHAIRMAN. Mrs. Dolan, you heard Secretary Cohen's testimony, of course, in which he suggested a thorough study of this whole matter of accreditation.

I take it that you and the Commission would cooperate with him in any study that he might make. Is that right?

Mrs. DOLAN. In every way possible.

The CHAIRMAN. You would cooperate in every way possible in any study he might make?

Mrs. DOLAN. We certainly would.

The CHAIRMAN. May I ask you, how long have you been in North Carolina?

Mrs. DOLAN. I was born and raised in North Carolina. I worked in your State for a few years. In fact, while I was there, I had the great privilege of knowing your father very well and having many Sunday night suppers in your home with your parents.

The CHAIRMAN. I remember that. That is the reason I asked the question.

We hope you will be coming back soon again.

Mrs. DOLAN. It is nice to see you again, Senator.

The CHAIRMAN. It is very fine to see you again, and we certainly appreciate this splendid testimony that you brought us. We appreciate it very much. Thank you so much.

Mrs. DOLAN. Thank you.

The CHAIRMAN. Now, the American Association of Junior Colleges. Dr. James Hall, Dr. Wattenbarger, and Dr. Newman. Gentlemen.

Senator JAVITS. Mr. Chairman, we in New York are very proud of the Dutchess Community College of Poughkeepsie. I take the greatest pride in introducing Dr. James Hall, president of Dutchess, to this committee, of which I am a member. I consider his testimony personally to be of very great importance and commend it to you.

STATEMENT OF DR. JAMES HALL, PRESIDENT, DUTCHESS COMMUNITY COLLEGE, POUGHKEEPSIE, N.Y.; ACCOMPANIED BY DR. JAMES L. WATTENBARGER, DIRECTOR, DIVISION OF COMMUNITY JUNIOR COLLEGES, STATE DEPARTMENT OF EDUCATION, TALLAHASSEE, FLA.; AND DR. RANDOLPH NEWMAN, PRESIDENT, SANTA ROSA JUNIOR COLLEGE, SANTA ROSA, CALIF.

Dr. HALL. Thank you very much, Senator Javits.

Dr. WATTENBARGER. How are you today, sir?

The CHAIRMAN. All right, gentlemen. We are glad to have you here and will be pleased to have you proceed in your own way.

Dr. WATTENBARGER. Senator Hill, I am James Wattenbarger, director of the Division of Community Junior Colleges of the State Department of Education, Tallahassee, Fla. I am also speaking for the American Association of Junior Colleges. With your permission, I would like to request that a statement which I will not read be included in the record, if that is permissible.

The CHAIRMAN. All right. We would be glad to have you do so.

Dr. WATTENBARGER. I appreciate very much this opportunity to present a statement to this committee regarding the interest Florida has in the amendment to the Nurse Training Act (H.R. 3141) as passed by the House last week.

The State of Florida, as well as other States, greatly needs this amendment. During the past 5 or 6 years, Florida junior colleges have developed 10 associate degree nursing programs and are in the process of establishing 3 more at the present time. These programs already are providing an annual increase of more than 20 percent in new nurse graduates each year in Florida. Last year, for example, 167 associate degree graduates took the State board of nursing examinations as compared with 150 B.A. graduates and 242 diploma graduates. These associate degree graduates demonstrated a record on these examinations which was equal to or better than graduates from the other types of schools. If examination grades are used as a general indication of quality of programs, there can be no question of the quality of these programs in Florida community junior colleges.

In 1964, the standard mean scores of junior college graduates in nursing on the State board test pool examination were higher than baccalaureate graduates in all five parts of the examination.

The employers of these graduates rate them high. In fact, the final report of the W. K. Kellogg project (1964) reports that employers consistently gave associate degree graduates higher ratings than other graduates in a number of areas of standard nursing behaviors.

From June 1960 through June 1964, 426 students have graduated from Florida associate degree nursing programs. These ranged in age from 19 to 58, 20 percent were over 30 years of age, and there was approximately a 1:30 ratio between men and women. Seventy percent of the students enrolled in these programs signified an intent to work upon graduation in their home vicinity. These community junior colleges are truly serving their local communities.

Over 70 percent of the associate degree faculties hold a master's degree or higher. None has less than a B.A. degree.

Florida has had a great amount of experience during the past 10 years in expanding the programs of the community junior colleges. This State has followed carefully developed procedures in planning, in evaluating, and in providing for quality. The communityjunior colleges are dedicated to the development of programs which are needed by the people of the state in industry and in business, as well as in health services. Over 90 different occupationally oriented programs are now in operation in our Florida junior colleges.

These junior colleges are accredited by the State under the State board of education regulations. They also move into regional accreditation by the Southern Association of Colleges & Schools as soon as they are eligible under the association's rules. In addition, the Florida State Board of Nursing must approve any nursing education program which is established and operated. All graduates of these colleges must pass the State board test pool examinations in order to practice as nurses in Florida. There is ample assurance of quality and competence built into these programs.

Florida has developed community junior colleges very rapidly from 4 areas in 1957 to 20 areas in 1965; from 4,000 students to 75,000 students; from 1 nursing curriculum in 1957 to 12 in 1965. The increase is at present limited only by facilities and time available to develop sound programs.

We need and can use effectively funds made available by the Nurse Training Act. Such funds will make nursing education in Florida available to more people. They will provide an opportunity

to share equally with other institutions the benefits of funds appropriated by Congress. However, under the present interpretation of the act, Florida junior colleges cannot participate in these Federal funds. One of our junior colleges already has had to withdraw a request for funds.

The Florida State Junior College Board has stated a policy which limits these institutions from applying for accreditation from agencies other than the regular regional and State agencies which are established to examine the total program of the junior colleges. This policy has very sound reasoning behind it. The board is concerned with:

(1) The development of sound programs in many different areas and wants the total institution to develop, not a collection of separate schools. There should not be fragmentation of an educational institution such as is often encouraged and supported by specialized accreditation.

(2) The community junior colleges simply cannot afford the cost of specialized accreditation processes. Imagine a college with 10 or 12 or 20, or even 40 different occupational programs, each accredited by a different agency. Faculty do not have time for all the reports which would be required; the college budget could not stand the cost. For example, in nursing alone, under the costs of accreditation which have been outlined, a $1,500 basic accreditation fee with a $600 annual dues, the Florida community junior colleges would be required to pay over a period of 10 years almost $100,000 in fees.

(3) The Florida board is convinced that specialized program accreditation not only is unnecessary but in reality is undesirable.

(4) The Florida board believes that no single national agency is prepared to serve adequately even in an advisory capacity all parts of this country. The regional accrediting agencies can perform a much better job of accreditation; legally responsible State agencies can assure that public welfare and safety are protected.

There is another reason for passing the bill including the present amendment: Florida community junior colleges cannot believe that Congress intended for one single nongovernmental agency to have complete control over which institution may receive Federal funds and which may not. There is no alternative under the present legal interpretation. There are other and better ways to assure that funds are used appropriately, effectively, and efficiently. In this instance, however, there is only one road, and this road is closed for all of our Florida junior colleges as well as for many other community junior colleges in the country.

The amendment to H.R. 3141 as passed by the House will not in any way affect the quality of nursing education. It will, however, permit the community junior colleges of Florida, as well as associate degree programs in other States, to use funds as Congress undoubtedly intended when the act was passed in 1964: "to increase the supply of well-prepared nurses in the United States." Florida respectfully requests your support for this bill as amended.

The CHAIRMAN. Doctor, when we passed the Nurse Training Act of 1964 about a year ago, did you raise this question of accreditation?

Dr. WATTENBARGER. We had no opportunity even to comment on the bill when it was passed, sir.

The CHAIRMAN. Why do you say you had no opportunity?

Dr. WATTENBARGER. We were not consulted, is what I mean.

The CHAIRMAN. Well, did you ask to appear?

Dr. WATTENBARGER. No, sir. I didn't realize that this was passed in that form until after it was already passed.

The CHAIRMAN. I see.

Dr. WATTENBARGER. We did not envision at that time that this would be a stumbling block because it does not specifically say in the bill that you must use one accrediting agency.

The CHAIRMAN. Well, Dr. Newman?

Dr. NEWMAN. Thank you. I certainly appreciate the opportunity to present this testimony, Senator Hill. I represent the Santa Rosa Junior College, which was founded in 1958 and also the Association of Junior Colleges, which consists of over 70 junior colleges, comprising more than half of all the students enrolled in the freshman and sophomore years in the State of California.

Santa Rosa Junior College has offered a program in nursing education since 1945 and we have graduated 391 students. The quality of the program is indicated by the fact that during all of these years only 4 of the 391 graduates have failed to pass the licensing examination which would permit them to follow the profession in California.

Both the past history and present development of associate degree nursing programs in California strongly warrant designating State or regional agencies as approved accrediting bodies. During the 5-year pilot project authorized by the California Legislature for the conversion from 3 to 2 years, massive efforts were mounted in behalf of the associate degree nursing program. Community resources were mobilized including hospital cooperation, advice, and assistance from the medical professions, and strong support from boards of trustees and administrators.

At the State level, quality standards and effective procedures were developed and maintained by the State board of nurse education and registration. State board consultants assisted local districts in the development of programs and visited periodically to review procedures and standards. The Kellogg Foundation furnished invaluable support for nursing education in this State as well as others. The Western Council on Higher Education for Nursing, a segment of the Western Interstate Commission on Higher Education, sponsored and continues to sponsor conferences and workshops devoted to nursing education.

The net effect of all this effort is that California now maintains 30 associate degree programs with two more added this September, representing one-fourth of the programs in the United States; that associate degree programs have been given permanent status in nursing education in California by the legislature in 1963; and that the programs have been established and are being maintained as quality programs under the California State Board of Nurse Education and Registration.

Consider the significance of these figures for California:

Year	Number of associate degree nursing programs	Associate degree nursing program enrollment
1959	15	720
1964	30	2,312

In 5 years the number of programs doubled and enrollments tripled, and these are quality programs developed and strengthened under institutional accreditation by the California State Board of Nurse Education and Registration. Since 1962 a nurse educator has been assigned to visitation teams of the Western Association of Schools and Colleges for those junior colleges maintaining associate degree nursing programs and has submitted a special report on the nursing program as part of the accreditation report. The possibility of some combination of State board visitations with regional accreditation has been under discussion for several months and may provide an additional means of coordinating specialized and regional accreditation.

California, along with other States, needs more associate degree nursing programs, enlargement of existing programs, and increased enrollments. The Nurse Training Act of 1964 creates possibilities for attainment of these goals, but requiring accreditation by one named agency to establish eligibility for participation can stringently curtail those possibilities.

S. 595 and H.R. 3141 will permit approval or accreditation by either a regional accrediting agency or a State approval agency. Progress in nursing education in California, its quality programs and quality graduates underscore the logic and the reliability of the approaches provided by the bill before the committee.

May I add one comment, Senator?

THE CHAIRMAN. We would be glad to hear it, Doctor.

Dr. NEWMAN. I would say that we do not disagree with the principle of accreditation; we strongly support it. We believe that this can lend definite assistance to improvement of programs in the institution. We think there is more than one route to accreditation, and therefore we are in the process of exploring some of these routes now with the Western Association of Schools and Colleges.

We also believe that the California picture which shows the increase in growth of the quality programs is a convincing one, and that if we are to use the Nurse Training Act effectively, then the proposed amendment in S. 595 deserves support.

We also believe that the educational community has a responsibility for accreditation, and it has shown this as well.

Other national legislation, other Federal legislation, has not set up these roadblocks, in the case of the National Defense Act or in the case of the Higher Educational Assistance Act, and we cannot see the logic or appropriateness of establishing this kind of roadblock in connection with nurse training.

Thank you very much.

The CHAIRMAN. Thank you very much, Doctor. Dr. Hall.

Dr. HALL. Senator, I, too, would like to express appreciation for being here today, and for your courtesy. I would like to express the appreciation of my colleagues in the State of New York for your committee's work in behalf of higher education, education generally, and particularly for this bill S. 595.

I would like to indicate before reading this particular report that I have here today that our State, our group of colleges, and particularly my own college that I represent, have no quarrel but only fine relationships with the NLN. I have been at their office many times, in fact, their national offices are located in the borders of our own State in the city of New York.

I do believe, however, that the association does find itself in a position at this point of being in a rather unhappy situation, both on a

professional basis and on the basis of good human relations that are going to be necessary in the implementation of this education law.

With these brief introductory remarks, let me read to you the report from New York State representing the office of the executive dean for 2-year colleges in the State University of New York and the Council of Presidents of Community Colleges in New York State.

In New York State there are thirty-four 2-year colleges which operate within the program of the State University of New York; 28 local public community colleges and 6 State agricultural and technical colleges. All of these, controlled by law in New York State and by policies of the board of trustees and administration of the State university, are committed to provide education and training to help meet the State's need for technicians and semiprofessional workers including those relating to health sciences.

One of the most critical shortages of trained personnel in New York State is that of nursing. A special study, "Education for the Health Professions," sponsored by the New York State Board of Regents and the Governor of the State, recently recommended a ratio of 500 nurses to each 100,000 people. According to the Nurse Board Office, Division of Professional Education, New York State Education Department, it was in the biennium 1961–63, in the State at large, there were only 375 registered nurses in active practice for each 100,000 people, a ratio only a little better than one-half as large as was recommended by the study to meet the needs of the people of the State.

As one step toward solving this serious manpower problem, the public 2-year colleges in New York State have been rapidly expanding their programs to train registered nurses. These instructional programs lead to the associate degree after 2 years of college education, augmented by training in affiliated hospitals.

Although these associate degree training programs are relatively new within the college offerings, they have proved to be successful and a definitely effective way to help provide more registered nurses. The original experimentation which started the development of the associate degree program in nursing began in New York State with the registration by the board of regents of a program at Orange County Community College in 1952. In New York State, registration by the board of regents is a legal requirment for the establishment of a college degree program, and constitutes official and general accreditation of the program concerned. However, since the idea of a 2-year associate degree program in nursing was considered to be an experimental venture for the first 5 years, the number of programs and enrollees in them was necessarily closely controlled. Only during the past 5 to 6 years, therefore, has the real productivity of the associate degree program in nursing become evident in our State.

Over 1,100 licensed registered nurses have been added in New York State as a result of the associate degree program. The rate of expansion of the program is evident from the fact that in 1959 there were only 74 graduates from these programs in New York State, but in 1965 there were 539 graduates, a sevenfold increase in 6 years of operation.

Graduates from the program have been quite successful in meeting the rigid license examinations administered in New York State by the State education department for the board of regents, the same agency that is responsible for accrediting the program.

Since the start of the associate degree program in New York State in 1952, the successful rate of associate degree graduates in passing State licensing examinations for registered nurses has been over 83 percent.

It is on the basis of this strong and general record of success and service to the State that the associate degree nursing program has been steadily endorsed and supported by both educational and civic leaders. The study already referred to above made as one of its final recommendations, "the initiation of the baccalaureate programs of nursing to both the upstate and downstate medical centers; and the establishment of the associate degree program in each new community college of the State university system which can provide clinical training."

Comparable strong endorsement for associate degree programs has come from the State education department and from the nursing board units within the department. Indeed, in his letter of transmittal of a report to the W. K. Kellogg Foundation on July 1, 1964, Commissioner James E. Allen, Jr., refers to the associate degree nursing program as one of experimentation, development, and service as a prototype total effort that has "* * * stimulated the department to overtake the study and further development of health related programs in the community colleges."

A number of difficulties, however, confront the further development and strengthening of the associate degree program. Among these are shortages of fully trained instructors with advanced degrees in nursing, limitations of instructional equipment, laboratories, and related apparatus, and the lack of understanding of the purposes and characteristics of the associate degree program on the part of the general public.

A free and full participation in the Federal Nurse Training Act would help the associate degree program significantly to overcome these obstacles. But this complete degree of participation is not now possible, because of the required approach to accreditation of the program.

In New York State there are now 18 associate degree programs in nursing registered by the State education department, with 3 more to start this fall. Of the total of 21 programs to be in operation in the fall of 1965, 16 will be in public 2-year colleges.

Despite the fact that all of these public 2-year college programs have been approved by the State University of New York and the New York State Department of Education, only eight have thus far been accredited or given a formal statement of "reasonable assurance" of accreditation by the National League for Nursing. The need for the proposed Rogers amendment to the Nurse Training Act is, therefore, very clear.

It is further indicated in New York State by the fact that, as Commissioner Allen reported by letter to U.S. Commissioner of Education Keppel over a year ago, the New York State Board of Regents is a national, recognized, accredited group with a long record of successful performances of this important educational function.

Finally, let me report that some critics of the associate degree program claim that the number of "dropouts," or attrition, is excessively high. This has not proved to be the general course in New York State. Taking as an example the class that entered the associate degree program in 1963 and comparing with other classes in the same

year that entered the hospital degree diploma schools of the State, the State education department figures show an attrition rate of approximately 30 percent in associate degree programs and a higher one of about 39 percent in diploma programs.

In considering the matter of attrition, moreover, the fact must be remembered that community colleges seek to allow more students to "try" in a college program. It is to be expected, therefore, that the attrition rate in associate degree programs of community colleges would be high; but as already demonstrated, this does not mean that the products of the program are any the less respected.

In short, the interests of the State of New York are being well served by the associate degree program in nursing. They will be even better served if the proposed Rogers amendment is made a part of the Nurse Training Act. Senator Murphy?

Senator MURPHY. I have no questions.

The CHAIRMAN. Gentlemen, we certainly appreciate your appearance here this morning, appreciate your testimony.

Dr. WATTENBARGER. May I make one more statement, sir.

The CHAIRMAN. Yes, go ahead, Doctor.

Dr. WATTENBARGER. We have no quarrel with the National League of Nursing. In fact, I have been a member of that organization for the last 8 or 9 years—unless they refuse to accept my dues this year.

The CHAIRMAN. But as of now, you are a member?

Dr. WATTENBARGER. I have been a member for about 8 years. We appreciate their program, but we do object to their being the sole road to obtaining Federal funds.

The CHAIRMAN. Did you want to add something, Doctor?

Dr. HALL. May I say something, Mr. Chairman?

I would agree with Dr. Wattenbarger and would add one other point: That I do not think that the Federal Government, in the passing of Federal legislation, should place itself in the position of forcing a shotgun wedding. It is just that simple. I think that we all appreciate the NLN for its work in accreditation. We are not against some specialized accreditation, but we want it to be a voluntary wedding, not a shotgun wedding.

The CHAIRMAN. I want to thank you gentlemen very much for having appeared here. Dr. Hall, your prepared statement will be inserted in the record.

(For the statement referred to above see p. 179.)

Now, the National League for Nursing. Dr. Lois Austin.

STATEMENT OF MISS LOIS M. AUSTIN, PRESIDENT, NATIONAL LEAGUE FOR NURSING; ACCOMPANIED BY ELEANOR TOUR TILLOT, COORDINATOR OF EDUCATION FOR NURSING, HENRY FORD COMMUNITY COLLEGE, DEARBORN, MICH.; RENA BOYLE, AND MARY LISTON, NATIONAL LEAGUE FOR NURSING STAFF

Miss AUSTIN. Mr. Chairman, I am bringing up two other members who will give testimony, as well as two experts on the accreditation of our programs.

The CHAIRMAN. We are glad to have you. You may proceed now.

Miss AUSTIN. Thank you. I am Lois M. Austin, chairman, Division of Nursing Education of the School of Nursing, University of

Pittsburgh. I am president of the National League for Nursing, the national organization that is charged with the responsibility of accrediting educational programs in nursing.

I welcome the opportunity to appear here today to speak in support of the act entitled "Health Professions Educational Assistance Amendments of 1965" and to set forth the objections to technical amendment (b) as proposed by the House Subcommittee on Public Health and Safety in H.R. 3141, which amends section 843 of the Nurse Training Act of 1964, or Public Law 88–581.

Mr. Chairman, it was essential to include in my statement for the record complete documentation, to set forth the reasons for our objections to the amendment proposed by the House Subcommittee on Public Health and Safety in H.R. 3141. Since you have received this material and much of the information contained in my statement is in the record, I will only summarize and highlight the content of the testimony.

The CHAIRMAN. Well, we have the full material. It will appear in the record in full.

Miss AUSTIN. Yes. Though H.R. 3141 makes provision for schools of medicine, dentistry, osteopathy, and optometry, seeking Federal funds, to be accredited by the appropriate professional accrediting agency, this amendment singles out the nursing programs in colleges and universities and exempts them from national professional accreditation, and makes all programs, both accredited and nonaccredited, eligible to seek Federal funds.

The amendment of H.R. 3141 that would replace professional accreditation of baccalaureate and associate degree programs in nursing with regional or State approval of the educational institution would constitute a precedent for making nursing an exception to the accrediting policies governing the health professions, to those adopted by the National Commission on Accrediting and by the Federation of Regional Accrediting Commissions of Higher Education.

Mr. Chairman, I am not certain that even now nurses, educators, or the public are fully aware of the differences in accrediting practices among the six regional associations, or of what these differences could mean with respect to maintaining nationwide standards of professional education that safeguard the quality of education and the nursing services rendered by the graduates of these programs.

Both the educational institutions and the professions are increasingly concerned that, first, there are marked variations in the standards of the six regional accrediting agencies, in the type of information elicited from the institutions by their different questionnaires, in the influence these questionnaires exert on the self-studies expected of the institutions, in the composition and size of the visiting committees, and in the use of generalists in their plan for coordination with the many professional accrediting agencies, and in their policies and procedures for the reaccreditation of institutions previously accredited.

Second, 24 of the 131 institutions offering an associate degree in nursing are not accredited by a regional association.

Third, 55 of the 110 institutions that were so accredited had not been reevaluated by the regional agencies since the establishment of the nursing program.

Fourth, the number of States included in the 6 accrediting regions ranges from 2 to 19.

Fifth, the accreditation by one regional association has been merely the equivalent of statewide recognition of institutions offering associate degree programs in nursing.

Today, neither regional nor State accrediting agencies provide assurance of comparable overall quality of educational institutions because of the marked variation in their practices. The nursing profession cannot give assurance of nationwide quality of professional programs or their products unless the accrediting is done by the professional accrediting agency.

Since other testimony that you have received today has stressed the characteristics that differentiate between accredited and nonaccredited programs, I will not restate them, but refer you instead to pages 8 through 15 of the testimony of the National League for Nursing.

Rather, may I call your attention to a crucial factor that has had relatively little attention paid it:

The supply of adequately prepared nurse faculty members is not only limited, it is practically nonexistent.

The number of qualified nurse faculty members is limited, despite an increase in the number of graduations from master's programs in nursing. It is increasingly difficult to obtain well-qualified nurse faculty members.

Graduation from these programs increased from 1,149 in the year 1962–63 to 1,282 in 1963–64, an overall gain of 133.

These 1,282 graduates, supplemented by 21 who completed doctoral programs, constituted the sole source of supply for teachers, administrators, consultants, and supervisors for both nursing education and nursing service.

As of January 1, 1964, there were an estimated 1,560 budgeted faculty vacancies. Hence, there was a deficit of faculty for existing positions, and there was no reserve for attrition, for replacement of poorly prepared faculty, or for filling the positions created by the establishment of new programs.

To continue to spread the one commodity that is most scarce—that is, well-prepared teachers of nursing—among the nonaccredited programs will jeopardize the quality of all programs, without affecting a noticeable increase in the number of graduates who will be licensed to practice as registered nurses.

The strength of the National League for Nursing as a medium for improving nursing education lies in its membership, individuals and agencies, nurses and nonnurses.

Today, more than 1,050 institutions, offering educational programs in nursing, are members of the National League for Nursing.

Agency membership permits and promotes the direct involvement of the schools in formulating, using, and benefiting from the application of criteria, and within the league are mechanisms for assuring that it is the representatives of accredited programs who engaged in accrediting.

It is also the councils of member agencies that provide the vehicle for discussion, exchange of opinion, and group action, while individual membership facilitates the utilization of the competencies of professional educators in determinations of the goals, methods, and evaluation of outcomes of nursing education programs.

Speaking of the flexibility and adequacy of NLN's accrediting programs:

It was just 1 year ago, August 6, 1964, that members of this same subcommittee questioned Dr. Rena Boyle, who sits to my left, of the NLN staff, regarding the league's ability to process and take action if applications were submitted by all programs not nationally accredited. At that time, Dr. Boyle assured the committee that the league could process the applications if the faculties submitted the applications.

Today I am happy to say that Dr. Boyle's confidence in the league's accrediting processes was well placed. Between September 1964 and June 1965, 167 programs sought reasonable assurance of accreditation from the National League for Nursing. All visits were made, all materials were processed within the time schedules sent to the schools, and all lists were sent to the Commissioner of Education at the time promised.

The breakdown by type of program is of particular interest: 49 associate degree programs applied; 32 received "Reasonable Assurance."

Twenty-seven baccalaureate programs applied; 15 received "Reasonable Assurance," and four of these are now accredited.

Ninety-one diploma programs applied; 66 received "Reasonable Assurance"; and five of these are now accredited.

A total of 167 programs made application, and 113 were granted reasonable assurance of accreditation.

An additional 49 programs have submitted materials for reasonable assurance of accreditation and are scheduled for review at the September 1965 meetings of the review panels. Of those scheduled for this fall, 23 are associate degree programs, 14 are bachelor's programs, and 12 are diploma programs.

Sixty-five of the 113 programs that received reasonable assurance have requested and been scheduled for accrediting visits and consideration by the boards of review prior to 1967. Fifteen are scheduled for evaluation in the spring of 1967.

The departments scheduled the visits to new programs, and the meetings of the review panels prior to the dates set by the Public Health Service for receipt of applications for funds in order to accommodate the needs of the schools and have adhered closely to these schedules.

We are well aware of the criticisms that have been leveled at the NLN with respect to the associate degree programs. Consequently, it seems essential that the legislators and their public have sufficient information to view and evaluate the program of NLN in its proper perspective.

The National League for Nursing has supported, does support, and will continue to support associate degree programs in nursing. When the League was formed in 1952, its bylaws made provision for NLN agency membership for junior and community colleges that might establish this new type of nursing program. In the beginning, the numbers were too small—there were but five even the following year—to create a separate department and a council of member agencies of the league.

Since these programs were specifically designed to provide technical rather than professional education, they were placed with the diploma programs in a department of diploma and associate degree programs

in nursing rather than with the bachelor's and master's programs in a department of baccalaureate and higher degree programs.

In May 1965, the bylaws were amended to create the department of associate degree programs in nursing.

Because the league believed in these programs, it made its resources available to them: Consultation, conferences, channels for planning and holding programs of special interest, avenues for developing and using criteria appropriate to their needs, and placed at their disposal the services of its units for test construction, data gathering, statistics, and research, as well as those of business, personnel, and general administration. The NLN also sought outside sources of funds to provide additional services to these programs, and to date has been granted approximately $265,000 for these services.

The vision, the confidence, and the assistance of NLN's membership were well placed. Both the early programs and those more recently established that have been equally well planned and staffed in good educational settings have demonstrated their excellence.

The league has recognized the legitimacy of the requests of the junior and community colleges to be organized as a separate department. It has employed staff to service this new department; it has made changes in this accrediting procedures that will accommodate both new and established nonaccredited programs; and it has made agency membership available to the associate degree programs at reduced fees.

All this has been to enable them to continue to benefit from NLN services while they initiated a school improvement program that would upgrade the national picture and the performance of the mushrooming associate degree programs.

The league will continue to fulfill its commitments to support the associate degree programs in nursing, but it must also fulfill its commitments to the public, to students, and to the profession. And at a time when the educational standards of the junior colleges vary markedly from one State and region to another, when the minimal standards for nursing education of the 50 States do not assure adequate safeguards for professional education, and when the public must be assured of an ever-increasing supply of well-prepared nurses, I believe you will agree that the league is demonstrating responsible accountability for the quality of educational programs in nursing.

We wish to express our gratitude to you, Mr. Chairman, for the privilege of appearing before this subcommittee and presenting in this testimony information that indicates some of the far reaching and adverse effects that the amendment of H.R. 3141 would have on the health professions, on education in general, and on your constituents, the public.

I am certain that you, as the members of the committee, will have questions that you wish to ask, and I hope that there will be sufficient time provided to supply any additional information that you may desire.

Thank you.

The CHAIRMAN. Thank you, Miss Austin. Your complete statement will appear in the record at this point.

(The prepared statement of Miss Austin follows:)

PREPARED STATEMENT OF LOIS M. AUSTIN, R.N., Ph. D., PRESIDENT, NATIONAL LEAGUE FOR NURSING

I am Lois M. Austin, chairman, Division of Nursing Education of the School of Nursing, University of Pittsburgh. I am president of the National League for Nursing, the national organization that is charged with the responsibility of accrediting educational programs in nursing.

I welcome the opportunity to appear here today to speak in support of the act entitled "Health Professions Educational Assistance Amendments of 1965" and to set forth the objections to technical amendment (b) as proposed by the House Subcommittee on Public Health and Safety in H.R. 3141.

The provisions of the act relating to educational improvement and scholarship grants to schools of medicine, dentistry, osteopathy, and optometry, including the provisions concerning the accreditation of these schools (sec. 773b), are well conceived.

On the other hand, the provisions of the amendment attached to this act, which would replace national professional accreditation of baccalaureate and associate degree nursing programs with regional or State approval of the colleges or universities of which they are part, are not well conceived and should not be adopted. This technical amendment, though attached to the Health Professions Educational Assistance Amendments of 1965, amends the Nurse Training Act of 1964 (Public Law 88–581). It pertains only to those nursing programs offered by colleges and universities; the largest number of programs, the 835 hospital schools, are unaffected.

Since intent of the Nurse Training Act of 1964 (Public Law 88–581) was to provide not only for an increased number of graduates but also for the improvement of nursing education, it restricted the allocation of public funds to those programs in nursing education that had received national professional accreditation or reasonable assurance of such accreditation. Though H.R. 3141 makes provision for schools of medicine, dentistry, osteopathy, and optometry seeking Federal funds to be accredited by the appropriate professional accrediting agency, this amendment singles out the nursing programs in colleges and universities, exempts them from national professional accreditation, and makes all programs, both accredited and nonaccredited, eligible to seek Federal funds.

The amendment of H.R. 3141 that would replace professional accreditation of baccalaureate and associate degree progrms in nursing with regional or State approval of the educational institution would constitute a precedent for making nursing an exception to the accrediting policies governing the health professions, to those adopted by the National Commission on Accrediting and by the Federation of Regional Accrediting Commissions of Higher Education.

The National Commission on Accrediting represents and speaks for more than 1,300 member colleges and universities with respect to accreditation. The Federation of Regional Accrediting Commissions of Higher Education speaks for the six regional agencies that accredit colleges and universities. The National Commission has recognized the Department of Baccalaureate and Higher Degree Programs of the National League for Nursing as the professional agency granting accreditation to bachelors and higher degree programs in nursing since 1952. Since that time, the same department of the NLN has worked in an appropriate manner with each of the six regional agencies.

The following policy statements of the Federation of Regional Accrediting Commissions of Higher Education and the National Commission on Accrediting are cited as reference.

The Federation of Regional Accrediting Commissions of Higher Education adopted the following policy statement at its meeting on October 14, 1964.

"* * * A general (regional) accrediting agency in granting accreditation accredits an institution as a whole, and therefore cannot omit from its evaluation any area of the program of the institution. However, the general accreditation of the institution as a whole is not and should not be interpreted as being equivalent to specialized accreditation of each of the several parts or programs of the institution."[1]

The board of commissioners of the National Commission on Accrediting declared at its annual meeting April 2–3, 1965:

"In accordance with its criteria for recognition of accrediting agencies, it has been and continues to be the policy of the National Commission on Accrediting to recognize regional associations of colleges and schools for general accreditation of educational institutions, and to recognize national professional or specialized

[1] National Commission on Accrediting. Reports. No. XV–3, pp. 3–4, April 1965.

agencies for accreditation of particular or specialized fields of study only when the commission considers that a social need exists for such accreditation." [2]

At this same meeting the commissioners stated:

"Following consideration of the request from the National League for Nursing for recognition of its accreditation of associate degree programs in nursing, the National Commission on Accrediting has concluded that there is a social need for national accreditation of this field of study and that the NLN is the agency to conduct such accreditation." [3]

Final action on the request for recognition was postponed pending further implementation of the proposal submitted by the NLN and of the recommendations of the commission.

With respect to the State accrediting agencies, the National Commission on Accrediting is equally explicit:

"* * * it is the considered judgment of the National Commission on Accrediting that agencies of the States should not be listed as nationally recognized agencies for general, specialized, or professional accreditation.

"On the immediately practical level, the recognition of State bodies for the accreditation of professional programs of study would lead to the real possibility of 50 or more agencies in each of the numerous professions applying differing standards of specialized accreditation to professional programs offered by colleges and universities. The consequences of such an eventuality are palpably undesirable and have, in fact, been a stimulus for the creation of national professional accrediting agencies.

"For these reasons the National Commission on Accrediting endorses the policy that State agencies should not be included on the lists of officially recognized accrediting agencies for general, specialized, or professional programs of higher education. In adopting this policy, the commission does not intend to question the responsibility of the appropriate State agency to protect the citizens of that State by exercising an approval function for general, professional, or specialized programs of higher education within the State." [4]

In November 1964, when the Commissioner of Education designated the National League for Nursing as the accrediting body for the purposes of the Nurse Training Act (Public Law 88–581), he commented in regard to State agencies:

"* * * that the procedures and standards for licensure of nurses and approval of programs of nurse education in the several States vary so widely that it does not seem feasible at this time to identify State accrediting or approval agencies for the purpose of this act. Though it may become necessary eventually to name one or more State bodies, I prefer at present to defer this aspect of the matter for further consideration." [5]

Regarding the regional associations, the Commissioner quoted the policy statement adopted on October 14, 1964, by the Federation of Regional Accrediting Commissions of Higher Education cited above.

Mr. Chairman, I am not certain that even now nurses, educators, or the public are fully aware of the differences in accrediting practices among the six regional associations or of what these differences could mean with respect to maintaining nationwide standards of professional education that would safeguard the quality of education and the nursing services rendered by the graduates of these programs. Both the educational institutions and the professions are increasingly concerned that:

1. There are marked variations in the standards of the six regional accrediting agencies, in the type of information elicited from institutions by their different questionnaires, in the influence these questionnaires exert on the self-studies expected of the institutions, in the composition and size of the visiting committees and in the use of generalists, in their plans for coordination with the many professional accrediting agencies, and in their policies and procedures for the reaccreditation of institutions previously accredited.[6]

2. Twenty-four of the one hundred and thirty-one institutions offering associate degree programs in nursing are not accredited by a regional association. (Twenty of the junior colleges offering associate degree programs in nursing were not accredited by a regional agency, while 4 of the 29 senior institutions were not so accredited as of 1964–65.)

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[2] Ibid., p.4.
[3] Ibid., p. 5.
[4] Ibid., pp. 6–7.
[5] National Commission on Accrediting. Reports. No. XV–2, p. 3, January 1965.
[6] W. K. Selden. "Nationwide Standards and Accreditation" (paper prepared for distribution at a panel session on "Developing Nationwide Standards" at the annual meeting of the American Council on Education, Oct. 1–2, 1964, San Francisco, Calif.), p. 5.

3. Fifty-five of the one hundred and ten institutions that were so accredited had not been reevaluated by the regional agency since the establishment of the nursing program. Of these:

Twenty had not been reevaluated since 1954–58.

Two had not been reevaluated since the early fifties.

Six had not been reevaluated since the forties.

Four had not been reevaluated since the thirties.

4. The number of States included in the 6 accrediting regions ranges from 2 to 19.

5. The accreditation by one regional association has been merely the equivalent of "statewide" recognition of institutions offering associate degree programs in nursing. (The western region includes California, Hawaii, and Guam, and only California offered associate degree programs in nursing until the fall of 1964, when the University of Hawaii admitted its first students to an associate degree program.)

In a paper prepared for a recent meeting of the American Council on Education, Selden said, "As a society places greater value on the attainment of academic degrees, the degrees from colleges and universities whose academic programs are superficial and shoddy will undermine the value of similar degrees from institutions whose educational offerings are excellent." [7] Today, neither regional nor State accrediting agencies provide assurance of comparable overall quality of educational institutions because of the marked variation in their practices. The nursing profession cannot give assurance of nationwide quality of professional programs or their products unless the accrediting is done by the professional accrediting agency.

I trust that this committee will safeguard the Nurse Training Act of 1964, and that it will not permit an amendment of the Health Professions Assistance Amendments of 1965 that would be in conflict with the best thinking of the health professions, with the National Commission on Accrediting, and with the decision of the Commissioner of Education.

We urge that Public Law 88–581 be retained in its original form. That the members of this committee, as well as other legislators of the Senate and House, were convinced of the value of accreditation was evidenced by the provision written into the act that stipulated that funds were to be awarded only to those nursing programs already accredited and to those having reasonable assurance of accreditation by a recognized body or bodies to be designated by the Commissioner of Education.

The strength of the National League for Nursing as a medium for improving nursing education lies in its membership—individuals and agencies, nurses and nonnurses. Agency membership permits and promotes the direct involvement of the schools in formulating, using, and benefiting from the application of criteria, and it is the councils of member agencies that provide the vehicle for discussion, exchange of opinion, and group action. Individual membership facilitates the utilization of the competencies of professional educators in determining the goals, methods, and evaluation of outcomes of nursing education programs. Within the league are mechanisms for assuring that it is the representatives of accredited nursing programs who engage in accrediting.

When the National League for Nursing was designated as the accrediting body by the Commissioner of Education, it recognized both its responsibility and its accountability to the public. We wish now to present to this committee evidence that will document the continuing record of achievement of programs accredited by the NLN, other evidence that will demonstrate both the adequacy and the Flexibility of the league's accrediting procedures; and additional evidence that will manifest the league's commitment to support associate degree programs that are educationally and professionally sound and to assist with the improvement of these programs that are unable to satisfy the educational standards of the nursing profession.

THE CONTINUING RECORD OF ACHIEVEMENT OF PROGRAMS ACCREDITED BY NLN

When we, at the request of this committee, presented testimony to it a year ago (Aug. 6, 1964), we emphasized that professional accreditation per se is recognition of overall excellence of the educational program and that the following characteristics served to differentiate programs accredited by the NLN from programs not accredited by the NLN:

1. Accredited programs have the largest enrollments.

[7] Ibid., p. 3.

2. Three-fourths of all professional nursing students graduate from NLN-accredited programs.

3. Accredited diploma programs are less costly to the institution offering the program than are nonaccredited diploma programs.

4. Accredited programs have better-prepared faculty.

5. A higher proportion of graduates from accredited programs enter nursing practice.

Now, 1 year later, the record of the nationally accredited programs continues. Enrollments in NLN-accredited programs increased by 4,966 students, whereas enrollments in nonaccredited programs decreased by 540.

The average enrollment in NLN-accredited programs increased by 5 this past year; the average enrollment in NLN-accredited programs was 137.5, and that in the nonaccredited programs was 69.9.

ENROLLMENTS—1964

Enrollments on Oct. 15, 1963 and NLN-accreditation status of programs of professional nursing on Jan. 1, 1964

Accreditation status	Number of programs	Number of students enrolled	Average enrollment
Accredited	707	93,587	132.4
Not accredited	441	31,157	70.7
Total	1,148	124,744	

ENROLLMENTS—1965

Enrollments on Oct. 15, 1964 and NLN-accreditation status of programs of professional nursing on June 30, 1965

Accreditation status	Number of programs	Number of students enrolled	Average enrollment
Accredited	717	98,553	137.5
Not accredited	438	30,617	69.9
Total	1,155	129,170	

Graduations, too, followed the same pattern as that previously presented to you, with the graduations from accredited programs increasing and those from nonaccredited programs decreasing.

GRADUATIONS—1962–63

Graduations by type of program and NLN-accreditation status, Sept. 1, 1962, to Aug. 31, 1963

Type of program	Number of graduates from accredited programs	Number of graduates from non-accredited programs
Baccalaureate	3,878	599
Associate degree	154	1,308
Diploma	20,366	5,872
Total	24,398	7,779

GRADUATIONS—*1963–64*

Graduations by type of program and NLN-accreditation status, Sept. 1, 1963, to Aug. 31, 1964

Type of program	Number of graduates from accredited programs	Number of graduates from non-accredited programs
Baccalaureate	4,445	544
Associate degree	114	1,331
Diploma	22,471	3,989
Total	27,030	5,864

Hence, to summarize the status of enrollments and graduations as of October 15, 1964:

1. Programs accredited by the NLN had the largest enrollments, with 98,533 students (76.2 percent) enrolled in 717 programs (62.3 percent); and if the numbers of students enrolled in programs that have received reasonable assurance of accreditation from the NLN are added to those in the accredited programs, these 106,363 students (82.3 percent) are enrolled in 828 programs (72.0 percent).

2. Three-fourths of the graduates were from two-thirds of the programs (of the graduates, 27,030 (76.7 percent) were from the 717 (62.3 percent) NLN-accredited programs); and if the graduates from programs that have received reasonable assurance of accreditation are added to those from accredited programs, these 28,883 graduates (82 percent) are from 828 programs (72 percent).

Enrollments and graduations as of Oct. 15, 1964, by type of program and accreditation status of program a of June 30, 1965

Type of program	Number of programs	Number of students enrolled	Number of graduates
Accredited:			
Baccalaureate	138	24,105	4,445
Associate degree	3	313	114
Diploma	576	74,135	22,471
Subtotal	717	98,553	27,030
Reasonable assurance: [1]			
Baccalaureate	13	626	32
Associate degree	32	2,276	477
Diploma	66	4,908	1,344
Subtotal	111	7,810	1,853
Not accredited:			
Baccalaureate	38	2,936	544
Associate degree	96	5,872	1,331
Diploma	193	13,999	3,989
Subtotal	327	22,807	5,864
Closed	8	99	512
Grand total	1,163	129,269	35,259

[1] 10 of these programs were not established or not reported by State boards of nursing as of Oct. 15, 1964; 14 were so newly established that the first class of students had not graduated as of Oct. 15, 1964.

Although no additional data were collected on cost of programs and preparation of faculty in 1965, we wish to re-present (for purposes of completeness) the data that were included in the testimony provided to this committee in August 1964.

3. Accredited diploma programs were less costly (to the institution) than non-accredited diploma programs: The cost of nursing education programs varies inversely with the size of student enrollment. A study of costs of nursing education conducted by the National League for Nursing's research and studies service and published in 1964 provided dramatic evidence relating to cost, size of enrollment, and accreditation status of the 126 diploma schools that participated in the study.

The larger the program, the lower the annual cost per student to the institution and the greater the likelihood that the program is accredited.

Cost, enrollment, and accreditation status of 126 diploma [1] programs included in National League for Nursing cost study

Size of student enrollment	Annual educational cost per student to the institution	Percent of programs by size of enrollment	
		Accredited	Non-accredited
Under 70	$1,425	0	50
70 to 120	997	38	31
More than 120	908	62	19

[1] The numbers of associate and baccalaureate degree programs that participated in the cost study were too small to provide comparable data.

4. The educational preparation of faculty teaching in accredited programs is better (as evidenced by the highest earned degrees) than that of faculty teaching in nonaccredited programs.

A. Highest earned credential of full-time nurse faculty employed in 195 accredited and nonaccredited baccalaureate and higher degree programs, as of Jan. 1, 1964

Highest earned credential	Total		Accredited		Nonaccredited	
	Number	Percent	Number	Percent	Number	Percent
Doctoral	145	4.6	130	4.8	15	4.0
Master's	2,502	80.0	2,242	81.3	260	69.9
Baccalaureate	475	15.2	381	13.8	94	25.3
Associate degree						
Diploma	6	.2	3	.1	3	.8
Total	3,128	100.0	2,756	100.0	372	100.0

B. Highest earned credential of full-time nurse faculty employed in 82 accredited and nonaccredited associate degree programs, as of Jan. 1, 1964

Highest earned credential	Total		Accredited		Nonaccredited	
	Number	Percent	Number	Percent	Number	Percent
Doctoral	8	1.6	2	3.5	6	1.4
Master's	336	67.8	47	81.0	289	66.0
Baccalaureate	132	26.6	9	15.5	123	28.1
Associate degree	16	3.2			16	3.6
Diploma	4	.8			4	.9
Total	496	100.0	58	100.0	438	100.0

C. Highest earned credential of full-time nurse faculty employed in 801 accredited and nonaccredited diploma programs as of Jan. 1, 1964

Highest earned credential	Total		Accredited		Nonaccredited	
	Number	Percent	Number	Percent	Number	Percent
Doctoral	11	0.1	11	0.2		
Masters	1,924	21.5	1,577	23.0	347	16.6
Baccalaureate	4,629	51.8	3,601	52.6	1,028	49.1
Associate degree	121	1.4	73	1.1	48	2.3
Diploma	2,254	25.2	1,584	23.1	670	32.0
Total	8,939	100.0	6,846	100.0	2,093	100.0

Source: National League for Nursing, Aug. 6, 1964.

The number of qualified nurse faculty members is limited. Despite an increase in the number of graduations from masters programs in nursing, it is increasingly difficult to obtain well-qualified nurse faculty members. Graduation from these programs increased from 1,149 in 1962–63 to 1,282 in 1963–64—an overall gain of 133. These 1,282 graduates, supplemented by 21 who completed doctoral programs, constituted the sole source of supply for teachers, administrators, consultants, and supervisors for both nursing education and nursing service. As of January 1, 1964, there were an estimated 1,560 budgeted faculty vacancies.[8] Hence, there was a deficit of faculty for existing positions and there was no reserve for attrition, for replacement of poorly prepared faculty, or for filling the positions created by the establishment of new programs. To continue to spread the one commodity that is most scarce—well-prepared teachers of nursing—among the nonaccredited programs will jeopardize the quality of all programs without effecting a noticeable increase in the number of graduates who will be licensed to practice nursing as registered nurses.

5. A higher proportion of graduates from accredited programs enter nursing practice: Evidence regarding the proportion of graduates from accredited and nonaccredited programs entering nursing practice reconfirmed the earlier testimony. "A higher proportion of the graduates from accredited programs than from nonaccredited programs pass State board examinations and are licensed to practice as registered nurses. It is only the graduates who are licensed and practice as registered nurses who swell the ranks of nurses to provide nursing service."

Evidence presented in testimony of Aug. 6, 1964—Number of candidates and percent failing State board examinations 1961–62

Type of program	Accredited		Nonaccredited	
	Number of candidates	Percent of failures	Number of candidates	Percent of failures
Baccalaureate	3,127	4	664	7
Associate degree	121	6	772	21
Diploma	17,875	12	5,313	22

Evidence presented in testimony of September 1965—Number of candidates and percent failing State board examinations 1963–64

Type of program	Accredited		Nonaccredited	
	Number of candidates	Percent of failures	Number of candidates	Percent of failures
Baccalaureate	3,696	6	744	19
Associate Degree	144	10	1,133	25
Diploma	20,118	13	5,950	24

For a first time in 1963–64, the graduates of nonaccredited associate degree programs had the highest proportion of failure on State board examinations. To be specific, 283, or 25 percent, of the 1,133 candidates from nonaccredited associate degree programs failed State board licensure examinations in 1963–64; in contrast, 14, or 10 percent, of the 144 candidates from accredited associate degree programs failed to achieve licensure.

The situation presented by the associate degree programs in nursing is in direct contrast with the picture presented by the diploma and baccalaureate nursing programs. In these two types of programs, the number of students enrolled and graduated from accredited programs continues to rise, the number in the nonaccredited steadily declines, and the graduates of the accredited programs contribute a minor proportion of the total failures on State board examinations.

On the basis of this continuing record of performance, we believe that NLN's accreditation program is helping to assure the excellence of education in nursing that is ultimately reflected in better patient care. That this belief is shared by

[8] Faculty Study, 1964. New York, National League for Nursing, Research and Studies Service, 1964, p. 8.

the American Nurses' Association and by the American Hospital Association is reflected in the attached statements of these two organizations.

Mr. Chairman, I wish to have these two statements entered as a part of this testimony.

THE FLEXIBILITY AND ADEQUACY OF NLN'S ACCREDITING PROCEDURES

It was just 1 year ago (Aug. 6, 1964) that members of this same subcommittee questioned Dr. Rena Boyle regarding the league's ability to process and take action if applications were submitted by all programs not nationally accredited. At that time, Dr. Boyle assured the committee that the league could process the applications if the faculties believed the programs met accrediting standards and submitted the applications. Today, I am happy to say that Dr. Boyle's confidence in the league's accrediting processes was well placed.

Following the enactment of the Nurse Training Act of 1964, the NLN worked closely with the schools, the Office of Education, and the Public Health Service in order to accommodate the needs of the schools by facilitating the rapid processing of accrediting materials. Both membership and staff watched anxiously the initiation of the newly developed procedures for granting reasonable assurance of accreditation and sought answers to the following questions:

1. Would the procedures prove adequate for screening both new and well-established programs in nursing?
2. Could the visitors, the review panels, and the staff of the department carry the additional load in addition to the work of the usual accrediting program?
3. Would it be possible to make the visits, process the materials, and meet the deadlines for notifying the Commissioner of Education of the status of the programs evaluated by the review panels convened for each type of nursing program?
4. Would the junior and community colleges use the league's accrediting service when so few had previously sought accreditation?

Now, 1 year later, we know that the answer to each of the four questions is "Yes."

Between September 1964 and June 30, 1965, 167 programs sought reasonable assurance of accreditation from the National League for Nursing. All visits were made; all materials were processed within the time schedules sent to the schools; and all lists were sent to the Commissioner of Education at the time promised. The breakdown by type of program is of particular interest with respect to question 4 above:

Of 49 associate degree programs applied, 32 received reasonalbe assurance.

Of 27 baccalaureate programs applied, 15 received reasonable assurance (4 of these are now accredited).

Of 91 diploma programs applied, 66 received reasonable assurance (5 of these are now accredited).

A total of 167 programs made application, and 113 were granted reasonable assurance of accreditation.

An additional 49 programs have submitted materials for reasonable assuranc of accreditation and are scheduled for review at the September 1965 meetings of the review panels. (Of those scheduled for this fall, 23 are associate degree programs, 14 are bachelor's programs, and 12 are diploma programs.)

Of the 113 programs that received reasonable assurance, 65 have requested and have been scheduled for accrediting visits and consideration by the boards of review prior to 1967. Fifteen are scheduled for evaluation in the spring of 1967.

The departments scheduled the visits to new programs and the meetings of the review panels prior to the dates set by the Public Health Service for receipt of applications for funds in order to accommodate the needs of the schools and have adhered closely to these schedules.

The review panels for reasonable assurance met at the following times: baccalaureate, September 1964 and February 1965; associate degree, December 1964 and February 1965; diploma, December 1964 and February 1965.

By the end of each meeting of the review panels, all reports and materials submitted for accreditation had been acted upon.

The dates were scheduled and publicized in the spring of 1965 for the review panels that will meet in September 1965, December 1965, and January 1966.

Yet, at the same time the new procedures, described above, were being used by the schools seeking reasonable assurance of accreditation, the ongoing accrediting program made its demands for visitors, processing of reports, boards of review, and correspondence with schools. By June 30, another 134 diploma, baccalaureate, and master's programs had been reviewed for continuing ac-

creditation and 34 programs had been awarded initial accreditation and been added to the lists of accredited programs.

Only associate degree programs lagged behind in this phase of NLN's accrediting activities. Since only one sought and received initial accreditation in the past year and two, formerly accredited, have closed, only three associate degree programs in nursing remained on the accredited lists as of June 1965.

I believe that the foregoing statements demonstrate that the NLN was able to adapt its accrediting procedures to emergent situations, to meet the needs of the schools, and to facilitate the operations of the groups with which it works.

NLN'S COMMITMENT TO THE IMPROVEMENT OF NURSING EDUCATION

The criticisms leveled at NLN in the accreditation of associate degree programs have been directed at three main targets: structure, costs, and procedures. The league recognizes that both structural limitations and certain of its practices have interfered in its relationships with and its services to the junior colleges.

Understandably, the administrative and teaching personnel in the junior colleges disliked having their accrediting services placed in an NLN department that is primarily concerned with the interests of diploma programs.

The league knows that it is these seeming inequities that have been brought to public attention. Consequently, it is essential that the legislators and their publics have sufficient information to view and evaluate the accrediting program of the NLN in its proper perspective. For this reason I introduce this section of my testimony.

The National League for Nursing has supported, does support, and will continue to support associate degree programs in nursing. When the league was formed in 1952, its bylaws made provision for NLN agency membership for junior and community colleges that might establish this new type of nursing program. In the beginning, the numbers were too small (there were but five even the following year) to create a separate department and a council of member agencies of the league. Since these programs were specifically designed to provide technical rather than professional education, they were placed with the diploma programs in a department of diploma and associate degree programs in nursing rather than than with the bachelor's and master's programs in a department of baccalaureate and higher degree programs. In May 1965, the bylaws were amended to create the department of associate degree programs in nursing.

The league has always believed in these programs. It saw in them the potential for tapping the resources of the junior college, for recruiting faculty who would be stimulated by the challenges of designing nursing programs within the settings of the junior colleges, and for attracting students who were interested in college-based programs of shorter length. And because the league believed in these programs, it made its resources available to them—consultation, conferences, channels for planning and holding programs of special interest, avenues for developing and using criteria appropriate to their needs—and placed at their disposal the services of its units for test construction, data gathering, statistics, and research, as well as those of business, personnel, and general administration. The NLN has also sought outside sources of funds to provide additional services to these programs.

The vision, the confidence, and the assistance of NLN's membership were well placed. Both the early programs and those more recently established that have been equally well planned and staffed in good educational settings have demonstrated their excellence. The league is proud of these programs and pays tribute to the leadership taken in curriculum development, in the experimental use of new methods and media for teaching, and in the interpretation of nursing education to the community. But the rapid increase in the number of programs associated with changes that are less than desirable makes it apparent that these programs are not unlike their predecessors and that they, too, would benefit by the self-imposed discipline of accrediting and by the opportunities for educational improvement offered through the Council of Member Agencies.

The league has recognized the legitimacy of the requests of the junior and community colleges to be organized as a separate department; it has employed staff to service this new department; it has made changes in its accrediting procedures that will accommodate both new and established nonaccredited programs, and it has made agency membership available to the associate degree programs at reduced fees. All this to enable them to continue to benefit from NLN services while they initiate a school improvement program that will upgrade the national picture and the performance of the mushrooming associate degree programs.

The league will continue to fulfill its commitments to support the associate degree programs in nursing, but it must also fulfill its commitments to the public, to students, and to the profession. And at a time when the educational standards of the junior colleges vary markedly from one State and region to another, when the minimal standards for nursing education of the 50 States do not assure adequate safeguards for professional education, and when the public must be assured of an ever-increasing supply of well-prepared nurses, I believe you will agree that the league is demonstrating responsible accountability for the quality of educational programs in nursing.

I should like to emphasize in conclusion that only if Public Law 88–581 is left as it was originally conceived by the Congress, without the amendment attached to H.R. 3141, can the nursing profession meet its obligation to insure quality programs of nursing education and quality nursing care. Professional accreditation, though complex, is essential if the schools are to attract the numbers of well-qualified students and well-prepared faculty who together work toward the betterment of nursing education. We know that professional accreditation is a major force in achieving maximal educational effectiveness and in meriting public confidence. We know, too, that the other health professions, prospective students, and the general public believe in and insist upon accreditation as an essential concomitant of American education.

We wish to express our gratitude to you, Mr. Chairman, for the privilege of appearing before this subcommittee and presenting in this testimony information that indicates the far-reaching and adverse effects that the amendment of H.R. 3141 would have on the health professions, on education in general, and on your constituents, the public.

If I can answer any questions or supply additional information, I shall be glad to do so.

Thank you.

[Attachments]

STATEMENT BY AMERICAN NURSES' ASSOCIATION TO FRANCES KEPPEL, COMMISSIONER OF EDUCATION, HEW, MAY 6, 1965

The American Nurses' Association recognizes and supports the National League for Nursing as the national accrediting agency for all basic nursing education programs. NLN accreditation is directed toward strengthening and maintaining quality of nursing education for the protection of both the student and the public. Such accreditation, we believe, is most essential at the present time for the effective development of associate degree programs which are providing rapidly increasing numbers of candidates for licensure as registered nurses.

We support your designation of the National League for Nursing as the accrediting agency for the purposes of awarding Federal funds for nursing education, and urge that NLN accreditation be maintained as a requirement for Federal assistance to associate degree programs as well as for diploma and baccalaureate programs.

EXCERPTS FROM THE 1963 ANNUAL REPORTS OF THE AMERICAN HOSPITAL ASSOCIATION

EXCERPT FROM REPORT OF COUNCIL ON PROFESSIONAL PRACTICE

"The council believes that, in order to survive, hospital schools of nursing must keep constantly improving their educational programs, and it therefore believes that support of the National League for Nursing accreditation program is in the best interests of hospital schools and their future. The board of trustees, holding a similar opinion and wishing to strengthen the association's statement concerning hospital schools of nursing, voted: 'To approve the statement of the American Hospital Association with respect to hospital schools of nursing.'" [9]

EXCERPT FROM STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION WITH RESPECT TO NURSING

"The American Hospital Association endorses the principle of accreditation of hospital schools of nursing as a method of assuring the community that high standards of education are being observed by hospital schools of nursing receiving such approval." [10]

[9] American Hospital Association. Annual Reports 1963: "Chicago, the Association, 1963," p. 122.
[10] Ibid., p. 127.

INFORMATION CONCERNING NLN REDUCED FEES FOR ASSOCIATE DEGREE NURSING PROGRAMS AS MENTIONED ON PAGE 20 OF THE TESTIMONY

Schedule of basic dues for agency membership in the National League for Nursing effective February 1965

Type of program(s) offered by institution	1965	1966	1967	1968	1969	1970
Associate degree	285	285	285	575	575	575
Diploma	500–600	500–600	500–600	575	575	575
Baccalaureate and masters	500–700	500–700	500–700	575	575	575

NOTE.—Agency member institutions will be charged the travel and daily expenses of the accrediting visitors at the time of an accreditation visit. Expenses will be prorated for all institutions in order to equalize charges regardless of geographic location. This practice becomes effective in the year 1965 for associate degree programs and in 1968 for diploma, baccalaureate, and masters programs. The charge for the per diem costs per person per visit at the present time is $30 per day. Exception: Those institutions offering associate degree nursing programs that have held agency membership prior to and as of Jan. 1, 1965, will not be charged for the travel and daily expenses of visitors for 1 accreditation visit made in 1965 or 1966.

The CHAIRMAN. Now, who is your next witness, Miss Austin?

Miss AUSTIN. Miss Tourtillott.

Miss TOURTILLOTT. In view of the time factor, and with your permission, Mr. Chairman, I would like to submit this statement for the record.

I am Eleanor Tourtillott, coordinator of education for nursing at the Henry Ford Community College in Dearborn, Mich. I am chairman of the Steering Committee of the Department of Associate Degree Programs of the National League for Nursing.

Miss Lois Austin has introduced testimony concerning the Health Professions Educational Assistance Amendments of 1965 (S. 595), with particular reference to technical amendment (b) as proposed by the House Subcommittee on Public Health and Safety in H.R. 3141. I strongly concur with Miss Austin in her testimony.

I would like to speak to the technical amendment in view of my experience in associated degree nursing education. The past 12 years of my professional experience have been devoted to establishing and directing the associate degree program at Henry Ford Community College. During that time, 313 students have graduated from the program and are giving direct nursing care to patients. As an individual, I have been involved in the accrediting program of the National League for Nursing for the past 10 years. Thus, I am thoroughly familiar with the policies, procedures, criteria, and practices employed in accrediting diploma and associate degree nursing programs. It has been erroneously stated that junior colleges have been training nurses or giving nursing education for more than 35 years. The fact is that prior to 1953 when the first five associate degree programs in nursing were instituted, the chief contribution of junior colleges to the preparation of nurses was through the provision of general education courses to students in a number of hospital schools of nursing.

(Report on Associate Degree Programs in Nursing. New York, National League for Nursing, 1961, p. 1.)

Such courses were purchased by the hospital school. Eighty such arrangements were reported in nursing school at the midcentury, which study also indicated that three junior colleges were conducting diploma programs in nursing, but it made no reference to an associate degree program in nursing as a distinct type of program for the

preparation of nursing personnel. (Margaret West and Christy Hawkins. "Nursing Schools at the Mid-Century." New York, National Committee for the Improvement of Nursing Services, 1950, p. 71.)

The Henry Ford Community College achieved regional accreditation in 1949. Our nursing program was one of the first five associate degree nursing programs to be introduced in the Nation in 1953, and it was fully accredited by the National League for Nursing in 1959. We sought accreditation from the NLN because it was the only agency qualified to attest to the excellence of the nursing program.

The opportunity for associate degree programs in nursing to apply for NLN accreditation has been available ever since the establishment of the first such program in 1953. However, not many junior colleges have sought accreditation. One of the factors influencing the decision of nursing educators in this regard has been the concern of the junior-community colleges with generalized versus specialized accreditation.

It is my sincere belief that if the technical amendment is passed, the quality of associate degree nursing programs will be endangered. This amendment provides for regional accreditation or State approval of the educational institution. Regional accreditation is voluntary and implies meeting more than minimal standards; these vary greatly from region to region. State approval implies the meeting of minimal standards, and educational institutions must have State approval in order to open. Therefore, if the amendment passes, in essence any college will be eligible to apply for Federal funds for nursing programs.

This is a particularly crucial time in the development of associate degree nursing programs. Such programs are mushrooming throughout the country, and there is an acute shortage of qualified administrators and faculty. If the quality of nursing care given by the graduates of these programs is to be maintained and enhanced, there is need for nationwide standards of nursing education that will safeguard the quality of nursing education and nursing services.

The creation of the NLN Department of Associate Degree Programs provides the opportunity for the junior-community colleges to take an active role in the continuing development, strengthening, and evaluation of the associate degree nursing programs. The peer group, through its membership in NLN, has the opportunity to participate in the accreditation program, to study and evaluate its effectiveness, and to make its own recommendations for future directions. This opportunity to participate is provided through membership in the NLN Council of Member Agencies of the Department of Associate Degree Programs. Annual dues for such membership have been set at $285 for 1965, 1966, and 1967. This fee, introduced by the NLN in January 1965, was established in order to make it financially possible for junior-community colleges to become agency members and to actively participate in departmental activities. Accreditation charges for agency members are $30 per day per visitor regardless of geographic location. This fee structure is comparable to that of other voluntary accrediting agencies.

I believe that only if Public Law 88–851 is left as it was originally conceived by the Congress can the nursing profession meet its obligation to insure quality programs of nursing education and quality nursing care.

I am most appreciative, Mr. Chairman, for this opportunity and privilege of appearing before this subcommittee and presenting this information.

If you have any questions, I shall be happy to answer them.

STATEMENT OF MRS. LULU W. HASSENPLUG, DEAN, SCHOOL OF NURSING, UNIVERSITY OF CALIFORNIA, LOS ANGELES

Mrs. HASSENPLUG. Mr. Chairman, I have prepared a statement, and I would like to read it into the record.

The CHAIRMAN. That may be done.

Mrs. HASSENPLUG. Thank you.

I am Lulu W. Hassenplug, professor and dean of the School of Nursing, University of California, Los Angeles. I am chairman of the Council of Member Agencies of the Department of Baccalaureate and Higher Degree Programs of the National League for Nursing.

This council is composed of representatives of 191 university and college programs in nursing, three-fourths of which are accredited by the National League for Nursing.

As chairman of the council, I wish to make it clear that we support the intent of S. 595 but that we oppose and urge you to reject the technical amendment (b) as proposed by the House Committee on Public Health and Safety in H.R. 3141.

The council is opposed to this technical amendment since it would alter markedly the intent of the Nurse Training Act of 1964 to build quality into the professional education of all nurses. This amendment, if passed, would enable junior colleges to escape the discipline that the colleges themselves have imposed through the National Commission on Accrediting which has declared that there is a social need for national accreditation of nursing as a field of study and that the National League for Nursing is the appropriate agency to conduct such accreditation.

Since this technical amendment would replace national professional nursing accreditation of baccalaureate and associate degree programs with regional or State approval of the colleges and universities of which they are a part, I would like to emphasize the fact that general accreditation by regional associations is not identical to specialized accreditation by professional accrediting agencies and cannot be interpreted as equivalent. Professional accreditation of nursing programs like professional accreditation of medical and dental programs is a means of protecting the public against professional incompetence. Accreditation conducted by professional organizations represents the interest of both the practitioners and the educators of these professions by assuring that the quality of the professional education meets the needs of society and of the profession. Thus accreditation in professional fields has a dual purpose. It is a means of protecting the public interest so far as professional competence is concerned, and it is a guarantee to students that the college or university offers the kind of educational program that will equip them to be effective professional persons.

It has been stated repeatedly by representatives of the junior colleges that the accrediting program of the National League for Nursing has not been effective since only three of the junior college programs have been accredited. Let me emphasize again that this accrediting

program is voluntary and that each faculty group decides when it is ready to seek accreditation. The request for accreditation must come from the school.

The council of member agencies of the department of baccalaureate and higher degree programs of the league recognizes and supports the league as the national accrediting agency for all baccalaureate programs and opposes this technical amendment. And while I have no documentation available at this time, it is my understanding that every dean and director of the baccalaureate programs represented in the council of member agencies has gone on record as opposing the technical amendment attached to H.R. 3141 which we are considering here.

The fact that only three associate degree programs had attained accreditation as of June 1965 is of great concern to those of us in baccalaureate programs. We know how much help and consultation we need and how much we receive through the process of league accreditation when we are developing new programs or revising old ones, and we are certain that the faculties in the associate degree programs could profit from this same kind of help from their peer groups.

A number of directors and faculty in associate degree nursing programs are opposed to this amendment because they know the value of professional accreditation and they feel the need for it. The 32 programs that have been granted reasonable assurance of accreditation since September 1964 attest to this statement.

Nursing education standards can be maintained and improved only if all types of nursing education programs particpate in the professional nursing accreditation process. The structure and procedures are now developed within the league framework for all programs to seek accreditation. The accrediting service is ready and willing to help.

Since this amendment affects baccalaureate and associate degree programs and since the deans and directors of the baccalaureate programs in the Council of Member Agencies strongly oppose it, I urge you to reject this amendment. I also remind you that the American Nurses Association and the American Hospital Association are on record as opposing this amendment.

I thank the committee for this opportunity to appear before you to urge you to reject this amendment which if accepted will have serious consequences for nursing education and nursing service in the country.

The CHAIRMAN. Is there anything you would like to add, Dr. Austin?

Miss AUSTIN. No. This is the testimony we wished to present. We should be glad to answer any questions you might have.

The CHAIRMAN. I notice, I might say, that you are a Ph. D.

Miss AUSTIN. Yes.

The CHAIRMAN. In what branch did you get your doctorate?

Miss AUSTIN. My doctoral studies are in the area of curriculum and instruction from the University of Chicago.

I have my master's degree in education, master of arts, from Ohio State University, and my bachelor's degree with a major in nursing in one of the early programs from the State University of Iowa.

The CHAIRMAN. That is all very interesting.

Miss AUSTIN. I studied at Teachers' College for a degree in nursing education.

The CHAIRMAN. Then, you have been a student as well as a teacher, have you not?

Miss AUSTIN. I consider myself still a student, because I am teaching students.

The CHAIRMAN. You are still studying.

Miss AUSTIN. Yes, sir.

The CHAIRMAN. We thank you all for your appearance and your testimony here this morning.

The American Optometric Association. Dr. Hofstetter.

STATEMENT OF DR. HENRY W. HOFSTETTER, DIRECTOR, DIVISION OF OPTOMETRY, UNIVERSITY OF INDIANA, ACCOMPANIED BY WILLIAM P. MacCRACKEN, COUNSEL, AMERICAN OPTOMETRIC ASSOCIATION

Dr. HOFSTETTER. Senator Hill, I would like to bring with me a special admirer of yours.

The CHAIRMAN. Yes, indeed. Mr. MacCracken is an old friend of mine. We are happy to have him here.

Mr. MACCRACKEN. Thank you, Mr. Chairman. I always feel at home in your presence, but a little more so this morning, when I looked up there on the wall and saw that this was the President's Committee for the Employment of the Handicapped. So I think that lets me in.

The CHAIRMAN. All right. You are certainly welcome, most welcome.

Mr. MACCRACKEN. Thank you, sir.

Dr. HOFSTETTER. Mr. Chairman, my name is Henry W. Hofstetter and I reside at 936 South Hawthorne Lane, Bloomington, Ind. Since 1952 I have been professor of optometry and director of the division of optometry at Indiana University. I appear before you today to speak for the American Optometric Association and the Association of Schools and Colleges of Optometry, which represents the 10 optometry schools and colleges of the United States accredited by the Council on Optometric Education, the accrediting agency officially recognized by the National Commission on Accreditation.

The optometric profession extends its grateful appreciation to this committee for passage of the Health Professions Educational Assistance Act of 1963. The information presented during hearings on that legislation was sufficient to establish the need for more optometrists without restating it now. It was demonstrated then, and it can be again, that the present proportion of optometrists to population is grossly inadequate.

We have talked about a minimum ratio of 1 optometrist to 7,000 population, but while we are far from that goal, a more proper ratio should be 1 optometrist to 4,000 population. All branches of the military services need more optometrists. Only last week, one of your colleagues, Senator McIntyre, introduced a bill to encourage optometrists who are now in the Armed Forces to make it a career. Passage of that bill, however, will not increase education facilities, faculties, or enrollment capacity in optometry schools.

There once was a time when optometry had a relatively short training program which qualified students with the comparatively limited professional skills then known. The optometrist of that day could make a substantially rewarding career. Today the optometrist maintains a similar socioeconomic position as in the past, but the expenses involved in the extended preparation now required for an optometric education have increased drastically. The increased costs today make entrance into an optometric career prohibitive for a large share of the population.

Today's standard optometry curriculum extends 2 years longer than the one required when I graduated in 1939; and I graduated from the school at Ohio State University which had the longest curriculum at that time. I believe we have now reached a plateau in length of curriculum. We must now direct our primary design toward new, improved teaching techniques, careful screening of curriculum content, and a sounder scientific foundation to enable the student and graduate to grasp new developments more quickly. These are costly investments for both the optometric institutions and the students of optometry. The best way to implement future services in this aspect of health care is passage of the bill this committee now has under consideration.

Each of you recently received a letter from me which contained what I think is an unusual statistic. It was derived from Indiana University enrollment records over the last 12 years. This statistic, I am confident, can be supported by the other nine schools and colleges of optometry. It clearly points out the discouraging costs of optometric education for students from the 41 States which do not have optometric education facilities.

In my letter I neglected to point out that enrollment figures indicate that the great bulk of optometry students now come from the suburban and metropolitan centers where our schools and colleges are currently located.

As a result, a disproportionately small share of the graduates elect to practice in small towns and rural areas. It is for this reason that I respectfully request that, when the committee votes on this legislation, it favorably includes the three amendments proposed for page 15 of the bill, which will make available to optometrists practicing in rural areas the same forgiveness provisions as for the practices of physicians, dentists, and osteopaths.

The CHAIRMAN. The House passed those amendments, did they not, the ones you are now asking?

Dr. HOFSTETTER. No, the House did not.

The CHAIRMAN. They did not?

Dr. HOFSTETTER. No. Those were not submitted to the House?

The CHAIRMAN. They were not submitted to the House?

Mr. MACCRACKEN. I don't think they were, Senator.

The CHAIRMAN. Why did they not submit them in the House?

Mr. MACCRACKEN. I do not think the particular amendments came out in the committee.

The CHAIRMAN. It was a bill that we had previously passed in the Senate.

Mr. MACCRACKEN. That is right. They were inserted on the floor of the House.

The CHAIRMAN. This was a bill we had previously passed in the Senate, that was put up as an amendment to this bill on the floor of the House; is that correct?

Dr. HOFSTETTER. On the floor of the House, yes.

The CHAIRMAN. I just wanted to get that straight for the record.

Mr. MACCRACKEN. We were not expecting it.

Dr. HOFSTETTER. The shortage of optometrists is much more serious in some States than in others, but is acute in all States. There are 45 rural counties in Kentucky, according to a report by that State's Governor, which are without a single full-time optometrist.

Even in States where the ratio is more favorable, patients must schedule their appointments far in advance, and often wait inordinate lengths of time for examinations. This problem, common to medicine, dentistry, and osteopathy, is equally prevalent in optometry.

States with the highest percentage of rural population are generally those States with the highest Negro or Spanish-American population. They are also States with the lowest per capita income. Applicants desiring to enter the study of optometry from such States are those most in need of financial assistance to pay the costs of their education.

Attached to this statement is a tabulation which appeared in the December 1963 issue of the Optometric World, based upon the counties of 10 States in the Mississippi Valley area. The ratio of optometrists to population varies from 1 to 10,000 to 1 per 38,000. In over 50 counties not a single optometrist was reported, and some of those counties had populations in excess of 20,000. These optometric shortages appear in a region where States are generally believed to be the most self-sufficient. As a matter of fact, I am reminded of the difficulties we have had lining up optrometric services to assist the Federal Government in the war on poverty. We were startled to learn of vast regions, especially in the South, in which there were no optometrists to serve programs under Project Head Start.

Dr. Donald Springer, an Alabama optometrist, last year before the House Interstate and Foreign Commerce Committee, in testimony supporting Federal loans to optometry students, stressed that a number of optometrists in his State, because of indebtedness incurred, securing their educations and establishing practices in rural areas where they are badly needed, do not have sufficient financial backing to remain in rural areas. Because of insufficient backing, these optometrists return to the larger cities where they can enter practice with older, established optometrists and thus be relieved of some of the financial burdens they assumed in obtaining their educations and establishing their practices. Therefore any debt forgiveness feature which may be provided in this bill for optometry graduates who will set up practices in the smaller and rural communities can be expected to have a positive, long-range effect on the accessibility of vision care services.

A recent amendment to H.R. 3141 stipulates that to qualify for basic improvement grants, a school must enroll a number of students in excess of the largest single year's enrollment during the last 5 years. We agree with the purpose of this amendment, but we are fearful of this formula.

To cite an example, I am personally aware of at least one optometry school, not the one with which I am associated, which admitted an

oversized class several years ago in a bold attempt to institute a two-classes-per-year program—one entering in September and one in February. The school's administration discovered that the program created more problems that it solved. Enrollment had to be cut quite drastically the following year to enable the facilities to accommodate the previous year's high enrollment. The application of the proposed formula would quite automatically eliminate this school from eligibility.

Last year, in the fall of 1964, the 10 optometry schools and colleges collectively admitted a few more students than their total rated capacity—an event that can occur from slightly overestimating the number of "no shows."

It seems evident, therefore, that the present formula is likely to cause an undeserved hardship on the very schools which probably need basic improvement grants most.

It would seem that this section of the bill runs counter to the objective of health education aid. Schools in the broad field of health education now experiencing the greatest financial difficulty, and in greatest need of improving their quality, have an enrollment which cannot be substantially increased without impairing quality.

Certainly, there would be pressure on these schools to add even more students to their already overcrowded facilities. This will diminish rather than enhance the education their students receive. Under the construction grants program, increased enrollment is an appropriate requirement, but without regard to the availability of adequate physical facilities, it is dangerous.

Several optometry schools recently increased the length of the professional portion of their curriculums from 3 to 4 years. This resulted in an increase in total enrollment without reducing the size of the entering class to compensate. The addition of even the minimum of 5 more students per entering class, required by this provision of H.R. 3141, would mean a total enrollment increase of 20 students for the upper 4 years of the curriculum on top of the already increased burden brought about by the lengthening of the curriculum.

For a small school, such compliance to become eligible for the basic improvement grant would, in fact, lower the per student quality rating of the institution. It might also induce some college administrators to hold down admission numbers as a device to assure subsequent elibibility for grants intended to increase admissions.

On behalf of the Nation's optometrists and their schools and colleges, I thank you for this opportunity to express our views on this legislation, and urge its favorable consideration together with the amendments I have proposed.

If you have any questions regarding this statement, I will be happy to try to answer them.

The CHAIRMAN. I think you have made a very clear presentation of your feelings and your position with reference to that amendment; in fact, as to both amendments.

Is there anything you would like to add, Mr. MacCracken?

Mr. MACCRACKEN. No, thank you, Senator, unless you have a question.

The CHAIRMAN. It is always nice to have you here.

Mr. MACCRACKEN. Thank you, sir. It is always a pleasure for me.

The CHAIRMAN. And we appreciate your testimony.

Dr. HOFSTETTER. Thank you.

(The following material was submitted for the record:)

SUGGESTED AMENDMENTS FOR H.R. 3141

Page 15, line 3, after the word "dentistry" insert the word "optometry".

Page 15, line 6, after the word "physicians" insert a comma and the word "optometry".

Page 15, line 11, after the word "physicians" insert a comma and the word "optometry".

[From Optometric World, December 1963]

Population per optometrist

ARKANSAS

County	1960 population	Optometrists	Population per optometrist
Lonoke	24,551	(1)	
Crawford	21,318	1	21,318
Desha	20,770	1	20,770
Poinsett	30,834	2	15,417
Saline	28,956	2	14,478
Lincoln	14,447	1	14,447
Mississippi	70,174	5	14,035
Bradley	14,029	1	14,029
Jefferson	81,373	6	13,562
Pulaski	242,980	18	13,499
Columbia	26,400	2	13,200
Randolph	12,520	1	12,520
Ashley	24,220	2	12,110
Yell	11,940	(1)	
Jackson	22,843	2	11,421
Clay	21,258	2	10,629
Ouachita	31,641	3	10,547
Dallas	10,522	1	10,522
Prairie	10,515	(1)	
Franklin	10,213	(1)	
Independence	20,048	2	10,024
Cleburne	9,059	(1)	
Grant	8,249	(1)	
Searcy	8,124	(1)	

IOWA

Buena Vista	21,189	1	21,189
Pottawatomie	83,102	4	20,775
Dubuque	80,048	4	20,012
Cedar	17,791	1	17,791
Jasper	35,282	2	17,641
Butler	17,467	(1)	
Muscatine	33,840	2	16,920
Iowa	16,396	1	16,396
Chickasaw	15,034	1	15,034
Hancock	14,604	1	14,604
Lyon	14,468	1	14,468
Grundy	14,132	(1)	
Mitchell	14,043	1	14,043
Mills	13,050	1	13,050
Story	49,327	4	12,332
Audubon	10,919	(1)	
Adair	10,893	1	10,893
Decatur	10,539	1	10,539
Monroe	10,463	1	10,463
Warren	20,829	2	10,414
Louisa	10,290	(1)	
Fremont	10,282	(1)	
Worth	10,259	1	10,259
Osceola	10,064	1	10,064
Wayne	9,800	(1)	
Van Buren	9,788	(1)	

KANSAS

Johnson	143,792	5	28,758
Wyandotte	185,495	10	18,549
Leavenworth	48,524	3	16,175
Rice	13,909	1	13,909
Harvey	25,865	2	12,932

[1] None.

Population per optometrist—Continued

KANSAS—Continued

County	1960 population	Optometrists	Population per optometrist
Nemaha	12,897	1	12,897
Osage	12,886	1	12,886
Sedgwick	343,231	30	11,441
Greenwood	11,253	1	11,253
Jefferson	11,252	(1)	
Cherokee	22,279	2	11,139
Washington	10,739	1	10,739
Jackson	10,309	1	10,309
Pawnee	10,254	1	10,254
Doniphan	9,574	(1)	
Barton	32,368	4	8,062

LOUISIANA

Vermilion	38,555	1	38,555
Iberville	29,939	1	29,939
St. Martin	29,063	1	29,063
Bossier	57,622	2	28,811
LaFourche	55,381	2	27,690
Livingston	26,974	1	26,974
Jefferson	208,769	8	26,096
Richland	23,824	(1)	
Plaquemines	22,545	1	22,545
Pointe Coupee	22,488	1	22,488
St. Charles	21,219	1	21,219
East Feliciana	20,198	(1)	
Sabine	18,564	(1)	
St. John the Baptist	18,439	(1)	
St. James	18,369	(1)	
Vernon	18,301	1	18,301
Assumption	17,991	(1)	
Natchitoches	36,653	2	17,826
Union	17,624	1	17,624
Morehouse	33,709	2	16,854
Bienville	16,726	1	16,726
St. Mary	48,833	3	16,277
St. Bernard	32,186	2	16,093
Rapides	111,351	7	15,907
Terrebonne	60,771	4	15,193
West Baton Rouge	14,796	(1)	
Lincoln	28,535	2	14,267
West Carroll	14,177	1	14,177
Lafayette	84,656	6	14,109
Ascension	27,927	2	13,963
Grant	13,330	(1)	
Iberia	51,697	4	12,914
Avoyelles	37,606	3	12,535
Acadia	49,931	4	12,483
West Feliciana	12,395	(1)	
Tangipahoa	59,434	5	11,887
St. Landry	81,493	8	11,642
East Baton Rouge	230,058	20	11,503
Catahoula	11,421	(1)	
Ouachita	101,663	9	11,296
Caddo	223,859	20	11,192
Washington	44,015	4	11,004
Red River	9,978	(1)	
St. Helena	9,163	(1)	

MINNESOTA

Anoka	85,916	3	28,638
Nicollet	23,196	1	23,196
Scott	21,909	1	21,909
Washington	54,432	3	17,477
Benton	17,287	(1)	
Cass	16,720	1	16,720
Goodhue	33,035	2	16,512
Sibley	16,288	1	17,288
Dakota	78,303	5	15,661
Yellow Medicine	15,523	1	15,523
Wright	29,935	2	14,967
Murray	14,743	1	14,743
Watonwan	14,460	1	14,460
Marshall	14,262	1	14,262

[1] None.

Population per optometrist—Continued

MINNESOTA—Continued

County	1960 population	Optometrists	Population per optometrist
Chisago	13,419	1	13,419
Lac Qui Parle	13,330	1	13,330
Morrison	26,641	2	13,320
Dodge	13,259	(1)	
Sherburne	12,861	(1)	
Aitken	12,162	1	12,162
Roseau	12,154	1	12,154
Renville	23,249	2	11,624
Stevens	11,262	1	11,262
Wilkin	10,650	1	10,650
Lincoln	9,651	(1)	

MISSOURI

Pulaski	46,567	1	46,567
Pemiscott	38,095	1	38,095
New Madrid	31,350	(1)	
Platte	23,350	(1)	
Lawrence	23,260	1	23,260
Texas	17,758	1	17,758
St. Charles	52,970	3	17,657
Pike	16,706	1	16,706
Monroe	15,507	1	15,507
Newton	30,093	2	15,047
Cass	29,702	2	14,851
Clay	87,474	6	14,579
Washington	14,346	1	14,346
Wright	14,183	1	14,183
Carroll	13,847	1	13,847
Webster	13,753	1	13,753
Chariton	12,720	(1)	
Christian	12,359	1	12,359
Grundy	12,220	1	12,220
Ste. Genevieve	12,116	1	12,116
Callaway	23,858	2	11,929
McDonald	11,798	1	11,798
Montgomery	11,097	1	11,097
Andrew	11,062	1	11,062
Osage	10,867	(1)	
Howard	10,859	1	10,859
Monroe	10,688	(1)	
Moniteau	10,500	1	10,500
Mississippi	20,695	2	10,347
Taney	10,238	1	10,238
Bollinger	9,167	(1)	
Sullivan	8,783	(1)	
Clark	8,725	(1)	
Wayne	8,638	(1)	
Caldwell	8,330	(1)	
Ralls	8,078	(1)	
Iron	8,041		

NEBRASKA

Sarpy	31,281	(1)	
Cass	17,821	1	17,821
Saunders	17,270	1	17,270
Cedar	13,368	1	13,368
Red Willow	12,940	1	12,940
Dakota	12,168	1	12,168
Burt	10,192	1	10,192
Butler	10,312	1	10,312
Fillmore	9,425	(1)	
Clay	8,717	(1)	
Dixon	8,106	(1)	

[1] None.

Population per optometrist—Continued

NORTH DAKOTA

County	1960 population	Optometrists	Population per optometrist
Steele	25,137	1	25,137
McLean	14,030	(1)	----------
Polk	36,182	3	12,060
Norman	11,253	1	11,253
Rolette	10,641	1	10,641
McHenry	11,099	(1)	----------
Trail	10,583	(1)	----------
Morton	20,992	2	10,496
Cavalier	10,064	1	10,064
Mountrail	10,007	1	10,007
Benson	9,435	(1)	----------
La Mourc	8,705	(1)	----------

OKLAHOMA

Washita	18,121	1	18,121
Sequoyah	18,001	1	18,001
Cherokee	17,762	1	17,762
Craig	16,303	1	16,303
Osage	32,441	2	16,220
Wagoner	15,673	1	15,673
Comanche	90,803	6	15,134
Le Flore	29,106	2	14,553
Ottawa	28,301	2	14,150
Delaware	13,198	1	13,198
Adair	13,112	1	13,112
McIntosh	12,371	(1)	----------
Canadian	24,727	2	12,363
Blaine	12,077	1	12,077
Okfuskee	11,706	(1)	----------
Payne	44,231	4	11,058
Nowata	10,848	1	10,848
Kingfisher	10,635	1	10,635
Murray	10,622	1	10,622
Noble	10,376	1	10,376
Atoka	10,352	1	10,352
Rogers	20,641	2	10,320
Creek	40,495	4	10,124
Mayes	20,073	2	10,036
Jefferson	8,192	(1)	----------
Grant	8,140	(1)	----------

SOUTH DAKOTA

Roberts	13,190	1	13,190
Meade	12,044	1	12,044
Spink	11,706	1	11,706
Turner	11,159	1	11,159
Hutchinson	11,085	(1)	----------
Union	10,197	(1)	----------
Bon Homme	9,229	(1)	----------
Kingsbury	9,227	(1)	----------

[1] None.

HENRY W. HOFSTETTER, O.D., PH. D.

Residence: 936 South Hawthorne Lane, Bloomington, Ind.

Occupation: Professor of optometry and director, Division of Optometry, Indiana University.

Education, Ohio State University: B.S. in optometry, 1939; M.S. in physiological optics, 1940; Ph. D. in physiological optics, 1942.

ORGANIZATIONAL APPOINTMENTS AND OFFICES

Past president, Association of Schools and Colleges of Optometry.
Trustee, American Optometric Association.
Member, Optical Society of America Committee on Training in Optics.
Member, American School Health Association Committee on School Health Education.

Member, American Academy of Optometry.
Member, Association for Higher Education.
Member, Armed Forces-National Research Council Vision Committee.
Member, National Research Council, Highway Research Board Committee on Night Visibility.
Member, National Advisory Council on Education for Health Professions (created by Public Law 88-129).

OTHER ACTIVITIES

Extensive travel in Europe and Africa to study professional educational systems outside the United States.
Author, "Industrial Vision," Chilton Co., Philadelphia, 1956.
Author, "A Keratoscopic Survey of 13,395 Eyes," American Journal of Optometry and Archives of American Academy of Optometry, volume 36, No. 1, January 1959.
Author, "Dictionary of Visual Science," Chilton Co., Philadelphia, 1960 (with Max Schapero and David Cline).
Author, "Vision of the Aging Patient," edited by M. J. Hirsch and Ralph Wick, Chapter 1: General Introduction, Chilton Co., Philadelphia, 1960.

The CHAIRMAN. Now the American Association of Colleges of Pharmacy. Mr. Bliven.

STATEMENT OF CHARLES W. BLIVEN, EXECUTIVE SECRETARY, AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY

The CHAIRMAN. We are happy to have you proceed now in your own way.

Mr. BLIVEN. Thank you, Mr. Chairman.

I appreciate the opportunity to appear before the subcommittee, and I want to express our appreciation for your consideration of pharmacy in the past. We know that you and your committee will continue to give this same thoughtful consideration in the future to our needs, with respect to the health needs of the people.

I have a statement here which I request permission to read into the record.

The CHAIRMAN. You may do that.

Mr. BLIVEN. My name is Charles W. Bliven. I am executive secretary of the American Association of Colleges of Pharmacy, and I present the statement in this capacity. Before assuming this office I served for 14 years as dean of the School of Pharmacy of George Washington University, Washington, D.C.

I appear before you in support of S. 595 and H.R. 3141 in behalf of the membership of the American Association of Colleges of Pharmacy, which consists of 74 schools and colleges of pharmacy. All of them are nationally accredited. Seventy-three of our member schools are located in 44 States and the District of Columbia; the remaining school is located in Puerto Rico. Approximately 1,100 teachers are engaged in the instruction of some 12,000 undergraduate and 1,400 graduate students enrolled in our schools.

The curriculum leading to the undergraduate professional degree has required a minimum of 5 years since September 1960. Two of our member schools offer a required 6-year curriculum, and two others offer this longer program on an optional basis in addition to the minimum program. In the 5-year program at least 3 years of work in the professional subjects are required in addition to a 2-year basic science program. In the 6-year curriculum at least 4 years are mandatory beyond the 2 years of science.

The objective of the American Association of Colleges of Pharmacy is the promotion of education and research within the member institutions. Our association is a nonprofit organization.

I appear before you in support of S. 595 and H.R. 3141, the "Health Professions' Educational Assistance Amendments of 1965." S. 595 would extend the program for the construction of teaching facilities for students in schools of pharmacy and in other health professions. It would extend the student loan provision of the Public Health Service Act for students of medicine, dentistry, and osteopathy; provide for scholarships to needy students in these professions; and authorize grants to improve the quality of the schools of this group.

We appreciate the inclusion of schools of pharmacy in the construction portion of the legislation. H.R. 3141, as passed by the House, would make schools of pharmacy eligible for student loans, and it is asked that S. 595 be similarly amended. We ask, in addition, that students of pharmacy enrolled in the last 3 years of our schools and colleges of pharmacy be included in the scholarship grant portion of the bill.

MANPOWER

Our member colleges have the responsibility of graduating an adequate number of pharmacists at both the undergraduate and graduate levels to meet not only the replacement needs of the profession—currently 4,300 undergraduates annually on a replacement rate of 3.5 percent per year—but also the demands of our rapidly expanding area of the health sciences.

A rather constant pharmacist-to-population ratio of 67 per 100,000 has existed from at least 1920 until recently. If this ratio is used in the projection of manpower needs, schools of pharmacy will need to produce an average of 6,600 graduates annually during the period 1965–70, almost twice as many as are currently being graduated. During 1970–75, the average annual number of graduates must be increased to 7,200, and to 8,000 during 1975–80 if the 67 to 100,000 is to be maintained. (See table 4.)

The 67 per 100,000 ratio is based on the 1960 population of 180 million and 120,000 pharmacists. Information compiled by the U.S. Public Health Service shows that as of 1962 there were 123,057 licensed pharmacists residing in the State of registry. (Peterson, P. Q. and Pennel, M. Y.: Health Manpower Source Book 15, "Pharmacists," PHS Publication No. 263, sec. 15, p. 3, U.S. Government Printing Office, Washington, D.C.)

On the basis of this figure and a population of 188 million, the current pharmacist-to-population ratio is 65.9 to 100,000.

The CHAIRMAN. Your tables may appear in the record at the end of your statement.

Mr. BLIVEN. That will be fine.

Approximately 90 percent of our professional personnel are practicing in the community pharmacies throughout the country. The remaining 10 percent are engaged in the many other areas of the profession: in the pharmacies of our hospitals; in the control, research, or product development laboratories of the manufacturing plants; as medical service representatives to the physicians, in our educational programs; in government; and in the Armed Forces. The schools of pharmacy are making every effort to respond to the demands for personnel from all of these public health areas.

The educational program in pharmacy provides our graduates with an excellent background in the basic sciences as well as in the professional courses. For this reason allied health fields are utilizing an increasing number of our graduates. To provide an adequate number of pharmacists for the profession and the allied health fields, our schools and colleges of pharmacy will continue to need financial assistance through the provisions of this legislation.

In the important areas of hospital pharmacy, where about 10,000 pharmacists are employed, the demand is greater than the supply. Of the 7,000 hospitals only 2,339, less than one-half, have the services of a full-time pharmacist, and only 2,644 or 38 percent, have the services of a pharmacist on either a full-time or part-time basis. The annual replacement factor for full-time hospital pharmacists is estimated to be 12.8 percent, or 621, about 18 percent of the 1965 graduating class.

The continually greater demand for pharmaceutical services by our increasing population necessitates an increased output of pharmacists. The annual increase in the number of prescriptions filled in the community and the hospital pharmacies is one factor in this increasing demand for the professional services of pharmacists.

In 1964, nearly 900 million prescriptions were filled, almost 53 million more than in 1963. This increased number of prescriptions alone, on the average, requires the yearly services of about 3,600 pharmacists, the number graduated during 1964–65. Thus, the annual increase in the number of prescriptions and the failure to graduate a sufficient number of pharmacists to meet our annual manpower replacement needs clearly indicate that all pharmacists, in our hospitals and in our community pharmacies, are having greater and greater demands made of them for professional services. And I believe that it follows that if we are going to increase the number of physicians and other health personnel, we are going to have an even greater increase in the number of prescriptions in the future.

Still another factor to which the attention of all of us should be directed is the increased manpower demands for pharmacists which will result from health legislation recently passed and now before Congress. I refer, of course, to medicare, health research centers, and other similar legislation.

And I refer not only to pharmaceutical services as we currently think of them, but also the other areas of health service where our graduates can and will be expected to serve.

I might mention, in passing, that Dr. Berson this morning mentioned the need to meet the rising demand for health personnel.

FACILITIES

Since 1957, about 20 schools have been housed in new buildings, either separate or shared, and about 40 have acquired additional space. Since 1947, about 35 schools, approximately one-half of our total number, have acquired new facilities. In spite of this substantial building program during the past several years, a recent survey—with 59 of the 74 schools responding—shows that 35 schools are planning a total of 39 construction projects during the10-year period ending June 1974. The total cost of the projects is estimated at $53 million with approximately one-half of this amount, $27.4

million, being required for projects devoted to teaching facilities for the last three classes of the undergraduate curriculum.

Of course, it is not possible to state at this time if all the projects involving undergraduate teaching facilities will be eligible for consideration for funds under the legislation. But, as stated before this committee in 1963, the needs of schools of pharmacy appear to be the replacement or rehabilitation of existing structures and the expansion of some of them to meet area needs. There does not appear to be a need for the establishment of new schools within the next few years.

We realize, however, that physical facilities alone will not enable schools of pharmacy to meet their public health responsiblities; qualified students in sufficient number and properly trained staff members are equally essential to the education of tomorrow's pharmacists. All of these needs have been given priority in the thinking and planning of our college administrators.

STUDENT AID

There continues to be a need for financial aid to students of pharmacy in order that our schools can supply the essential number of well-qualified graduates. The inclusion of our student under the student loan and scholarship grant provisions of the bill would aid in this responsibility as the increased possibility of financial aid offered through these provisions would have a salutary effect on the number of students undertaking the study of pharmacy.

Schools of pharmacy need the scholarship program for the same reasons as do other members of the health professions. For medicine, dentistry, osteopathy, and optometry, the Committee on Interstate and Foreign Commerce listed the following:

(1) To increase the number of applicants.

(2) To increase the quality of students.

(3) To enable students of less affluent families to plan at an early date to undertake the study of medicine, dentistry, osteopathy, and optometry.

(4) To enable these schools to compete more adequately with other disciplines, such as the life sciences, where 81 percent are currently obtaining scholarship support in substantial amount.

The effect of the GI bill of rights of World War II on the number and, thereby, the quality of students is believed to have been as great for pharmacy as it was for medicine and the other health professions. It is believed that the availability of scholarships to students, particularly those from families in the low-income group, would have a similar salutary effect.

Two sources of funds through pharmacy foundations are now available to our students. The American Foundation for Pharmaceutical Education makes available $600 annually to each school for scholarship purposes. Since 1942, $594,202 has been awarded to 2,647 students. Since 1952 the John W. Dargavel Foundation, founded by the National Association of Retail Druggists, has made loans totaling $401,830 to 628 pharmacy students. During the 1963–64 academic year, 169 loans averaging $305 were made. Currently loans are limited to $350 a semester, but qualified students may receive two such loans during the year. In addition the Dargavel

Foundation provides annually each school with $200 of scholarship funds. This program was initiated at the beginning of the 1964–65 academic year.

Our students are eligible for loans under the National Defense Education Act but the statistics relative to their participation in this program are not available.

While these sources are most helpful, they do not meet the full need for funds. In 1963 almost half the deans of our schools reported an unmet need for additional financial assistance among their students.

I might say—and this is not in the statement—that a survey that we are running at the present time, requesting information of our schools as to how many schools would probably use the loan fund program if it were made available to them, has been progressing. I have heard from approximately one-half of the schools. Of this number, 25 have said that they would probably use it, and the indication is that they would request something in the neighborhood of $805,000; 10 have said "no."

If this was projected for all of our schools, this would mean that there was a possibility of loan funds being requested to the extent of about $1,700,000.

An increased number of well-qualified students is essential not only in the undergraduate curriculum but also in the graduate program where our future teachers and research personnel are trained. The excellent graduate programs developed by many of our schools is a vital part of the educational program for pharmacy, and the facilities for such advanced training must be expanded in the years ahead.

In a survey conducted in September 1963, 43 schools, with 72 reporting, indicated a shortage of 83 teachers. For the academic year 1965–66, 65 of our 74 member schools report a need for approximately 135 teachers as replacements or to fill new positions as compared to 120 for 1964–65. Of this number, about 100 must have a Ph. D. degree. With 108 graduates receiving this degree during the past academic year and with about one-half of this number taking positions in industry, a shortage of teachers will prevail again next year.

CURRENT FEDERAL ASSISTANCE FOR RESEARCH

Federal assistance in the form of health research facility grants and research grants from the National Institutes of Health has had a pronounced beneficial effect on our graduate programs and hence on the number of teachers for our schools and research personnel for the pharmaceutical industry. In fiscal year 1964 grants totaling $820,000 were awarded to five schools of pharmacy. A recent survey (with 59 of our schools reporting) showed that for the 10-year period ending June 1974, funds in excess of $20 million, based on the total cost of construction, will be required for new research facilities.

During the academic year 1963–64, schools of pharmacy received in research grants $6,619,000, representing an increase of about 18 percent over the amount received during the previous year. It is estimated that about one-half of the funds were utilized for research in the important areas of cancer, mental health, and cardiovascular diseases.

During fiscal year 1964, Public Service-supported research projects in schools of pharmacy totaled 182 with a dollar value of $2,834,000.

Since 1961 the annual growth rate of the amount of support has been 44 percent; during the past 10 years the dollar value has increased a hundredfold.

The figures on research facility needs and research funds are given to indicate the continuing increased interest and activity of schools of pharmacy in fundamental and applied research. We are grateful for the support for research available through the Federal programs, but we seek greater support for our undergraduate programs, both for teaching facilities and for student aid. We deem this support to be essential to the continued supply of well-qualified graduates in pharmacy, not only for the distribution of medicine, but also for the ancillary areas of the health profession as well as for teaching and research.

This concludes my statement, Mr. Chairman. I would like to express appreciation to you for permission to present it.

The CHAIRMAN. Well, the bill included schools of pharmacy in the construction portion of the legislation.

Mr. BLIVEN. That is right, the original bill.

The CHAIRMAN. The bill as passed would make schools of pharmacy eligible for certain loans, and you wish that amendment made?

Mr. BLIVEN. Yes, sir.

The CHAIRMAN. And then, you ask that in addition, students of pharmacy enrolled in the last 3 years of your schools and colleges of pharmacy be included in the scholarship grant portion of the bill. Three years out of how many years?

Mr. BLIVEN. Three years out of a total of five in most of our schools. Two schools in California require 6 years.

The CHAIRMAN. That is what I thought.

Mr. BLIVEN. And there are some optional programs.

The CHAIRMAN. But most of the schools have a 5-year course.

Mr. BLIVEN. Yes; they are 5-year schools. The minimum program for the professional part of the program—and I do not mean to imply that the other two are nonprofessional——

The CHAIRMAN. I understand that.

Mr. BLIVEN. But the 3 years is the minimum program or time that must be spent in a school of pharmacy.

The CHAIRMAN. We want to thank you very much for your presentation.

Mr. BLIVEN. Thank you, sir.

The CHAIRMAN. The three tables attached to your paper will be made a part of the record at this point.

(The tables referred to follow:)

TABLE 3.—*Undergraduate enrollment in continental U.S. schools of pharmacy, 1958–64*

Year	Last year	2d from last year	3d from last year	Total
1958–59	3,901	3,880	4,492	12,273
1959–60	3,645	3,872	4,982	12,499
1960–61	3,691	4,075	5,823	13,589
1961–62	3,906	4,784	[1] 2,137	10,827
1962–63	4,484	[1] 2,004	4,145	10,608
1963–64	[1] 2,145	3,756	4,390	10,291
1964–65	3,557	3,977	4,427	11,961

[1] The small enrollment in this class is the result of the transition from the 4- to 5-year program in 1960 by those schools not already on the longer program.

TABLE 4.—*Graduates from undergraduate curriculums of continental U.S. schools of pharmacy, 1958–65*

Year	Graduates	Year—Continued	Graduates
1958	3,683	1962	3,699
1959	3,686	1963	4,163
1960	3,497	1964	2,195
1961	3,438	1965	[1] 3,378

[1] Estimated.

TABLE 5.—*Average annual number of pharmacists, and requirements for replacements, new entrants, and total need for pharmacists in the United States for 5-year periods, 1960–80* [1] [2]

Period	Average annual number of pharmacists [3]	Requirements		Total
		Replacements [4]	New entrants	
1960–65	122,000	4,300	2,000	6,300
1965–70	132,000	4,600	2,000	6,600
1970–75	142,200	5,000	2,200	7,200
1975–80	153,600	5,400	2,600	8,000

[1] Puerto Rico is not included.
[2] Based on Bureau of Census population projection of February 1964, series B, and on the population increase as being linear.
[3] Based on 1960 pharmacist-to-population ratio of 67 to 100,000.
[4] Calculated at 3.5 percent of number of pharmacists.

The CHAIRMAN. Now, the American Podiatry Association; Dr. Theodore B. Eden.

Doctor, we are glad to have you and the other gentlemen with us.

Senator JAVITS. Mr. Chairman, I would like to introduce Dr. Theodore Eden, of Bay Shore, Long Island, N.Y., who appears here as chairman of the Council on Education of the American Podiatry Association. He is a very distinguished doctor with a fine reputation in our State. I take great pride in having this New Yorker of such distinction testify before the subcommittee.

The CHAIRMAN. Very well, Doctor. You may proceed.

STATEMENT OF DR. THEODORE B. EDEN, CHAIRMAN, COUNCIL ON EDUCATION; SEWARD P. NYMAN, EXECUTIVE DIRECTOR; LLOYD E. BLAUCH, DIRECTOR OF SPECIAL STUDIES DIVISION; AND ABE RUBIN, EXECUTIVE SECRETARY OF THE AMERICAN PODIATRY ASSOCIATION

Dr. EDEN. Mr. Chairman, I am Theodore B. Eden, Pod. D., a practicing podiatrist in Bay Shore, Long Island, N.Y. I am here as the chairman of the Council on Education of the American Podiatry Association. I appear before you today to explain the interest and concern of the podiatry profession and its colleges in the Health Professions Educational Assistance Amendments of 1965.

With me are Seward P. Nyman, executive director of the American Podiatry Association; Lloyd E. Blauch, director of our special studies division; and Abe Rubin, executive secretary of our council on education, and editor of the Journal of the American Podiatry Association.

Drs. Nyman and Rubin are two nationally eminent podiatry educators, and Dr. Blauch was the former Assistant Commissioner

for Higher Education of the Department of Health, Education, and Welfare, and a special consultant to the National Commission on Accreditation, a subject of great interest here today.

May I request at this time that my prepared statement and the attached exhibits be made a part of the record of this hearing, so that I may confine my remarks to a summation of the statement?

The CHAIRMAN. All right. We shall be happy to have your statement, and it, together with the supporting exhibits that you have with you, will be printed in full in the record.

Dr. EDEN. In summarizing my statement, I quote President Johnson in his health message to Congress, when he stated:

> In all sectors of health care, the need for trained personnel continues to outstrip the supply.

We submit that in the podiatry sector the need and demand is increasing at a much more rapid rate than podiatry institutions can cope with. We are confident that your committee in its deliberations will find it advisable to provide podiatry institutions the same opportunity that is being provided for medical, dental, osteopathic, and optometric schools.

The five schools of podiatry in the United States have a total enrollment of 625 students. For the past 2 years, they have been enrolling near-capacity classes. To provide the number of podiatrists needed by 1980, podiatry colleges will have to graduate about 600 students annually beginning with 1968. This is approximately three times their present capacity. The incidence of foot problems in the rapidly expanding older population makes real demands on the podiatrists. Two-thirds of all patients requiring podiatry care are over 45.

The 1961 White House Conference on Aging in one recent report stated:

> The institutionalized or home-care patient once moving about with pain-free feet is more easily motivated for total rehabilitation. Eighty-five percent of these older people have foot problems.

Over 40 percent of the practicing podiatrists serve the elderly in nursing homes, and one out of three serves homes for the aged.

A special commission examined podiatry education in 1960. A significant recommendation was:

> * * * that the American Podiatry Association represent to the appropriate legislative and executive officials of the Government the need and social advisability of making financial provisions for podiatry education, in ways similar to those made for the other health sciences.

The colleges were also advised to strengthen their faculties with considerably more full-time teachers and administrative officers, and to provide salaries commensurate with their responsibilities. The commission also noted a need to markedly increase scholarships and loan funds for students.

The report generated much interest in our professional education. The funds for podiatry education and research was organized, and it stimulated the giving by alumni and friends of more than a quarter of a million dollars, or $250,000 in the first 3 years. The association has been providing matching grants to each of our schools.

The dues of our members were recently increased by more than 50 percent. Out of this new dues structure, over 40 percent will be de-

voted to assistance to our educational institutions, including funds for scholarships, fellowships, and faculty improvement grants.

This is but scratching the surface, and is a long way from meeting the need. Indeed, the profession has concluded that the colleges of podiatry will never be adequately supported until they can obtain the help of public funds.

The five podiatry colleges serve the entire Nation. They are all private nonprofit institutions and receive no public funds in support of their operations. In order for podiatry colleges to train sufficient numbers of podiatrists and to train them well enough to serve the needs of our increasing population, Federal support will be necessary. As in the other health professions, scholarship grants are needed in schools of podiatry so that less affluent, highly capable young people may enter the profession. Scholarships are available to fewer than 2 percent of the podiatry students. The rising cost of attending health professions schools without financial aid projects the danger that they will be manned by individuals who are financially able but not necessarily the most capable of our young people.

Another reason for including colleges of podiatry in the provisions for scholarship grants is to provide freedom of choice for young people who wish to prepare for professional health service. Obviously, freedom of choice is narrowed when one field of study offers financial inducements while a competing field does not. It is sound policy to encourage young people to enter those fields of service in which their major interests lie and for which they have aptitude.

We believe it is apparent that podiatry institutions and students should have the opportunity to participate not only in the extension of the construction grants and the student loan provisions of the Health Professions Educational Assistance Amendments of 1965 but also in the other amendments which would provide grants to improve the quality of training provided by health professions schools and scholarship grants.

We believe that the Senate will wish to correct what seems to be an oversight in not including podiatry in all facets of the Health Professions Educational Assistance Amendments of 1965.

If the Health Professions Educational Assistance Amendments of 1965 are enacted in their present form without providing podiatry institutions the opportunity to participate in all facets, there will be serious obstacles in maintaining a high quality of training in podiatry colleges as well as in attracting sufficient numbers of capable young people to study podiatry and serve the needs of our increasing population. All parts of the legislation should provide opportunity for participation by podiatry institutions as now do the sections on the extension of the construction program and student loans.

Mr. Chairman, thank you for the opportunity to present this information. It will be a privilege to answer any questions you may have.

The CHAIRMAN. Well, you are asking to come under the scholarship provisions of the bill——

Dr. EDEN. Yes, sir.

The CHAIRMAN (continuing). As you now come under the construction program and the student loan program. Is that right, sir?

Dr. EDEN. Right. We also request to be included in the improvement grants.

The CHAIRMAN. The improvement grants, yes.

Dr. EDEN. The basic ones.

The CHAIRMAN. Is there anything else any of you would like to add?

Dr. EDEN. Not unless you have some questions, sir.

The CHAIRMAN. I think you have made your case, and your statement will appear in full in this record. You gave us a mighty good summation of it. Thank you, sir.

Dr. EDEN. Thank you, Mr. Chairman.

The CHAIRMAN. We appreciate it, and I want to thank all of you very, very much.

(The prepared statement of Dr. Eden together with the attachments and various statements and correspondence follow:)

PREPARED STATEMENT OF DR. THEODORE B. EDEN, CHAIRMAN, COUNCIL ON EDUCATION, AMERICAN PODIATRY ASSOCIATION

Mr. Chairman and members of the subcommittee, I am Theodore B. Eden, Pod. D., a practicing podiatrist in Bay Shore, Long Island, N.Y. I am here as the chairman of the Council on Education of the American Podiatry Association. I appear before you today to explain the interest and concern of the podiatry profession and its colleges in the Health Professions Educational Assistance Amendments of 1965.

This legislation proposes, as President Johnson said in his health message this past January, to provide "support now to increase the quantity and assure the continuing high quality" of those "who serve our Nation's health." The amendments being considered would provide: (1) Educational improvement grants; (2) Scholarship grants; (3) Extension of the construction program for medical, dental, and other health professions schools; and (4) Extension and improvement of the program for student loans.

The Health Professions Educational Assistance Act of 1963 did provide an opportunity for podiatry colleges to participate in the construction grants, and we support the amendments under consideration. However, in order for podiatry institutions to increase the scope and quality of their teaching programs, as is anticipated for the health professions schools, the 1965 amendments should contain appropriate language to insure that podiatry institutions and students will have the opportunity to participate in all the programs designed to increase health manpower and maintain or improve the quality of their education. The amendments as passed by the House of Representatives did provide for establishment of student loan funds for podiatry students. Our reading of the House deliberation on the 1965 amendments leads us to believe that podiatry institutions were not included in the two other features of the 1965 amendments through an oversight. We shall present some information which we believe will enable you to make the necessary changes in the language of the amendments so as to include podiatry institutions in all facets of this legislation and so help the public by helping these institutions.

THE NEED FOR MORE PODIATRISTS

It is not common knowledge that foot health problems are of serious proportions. A 1951 Public Health Service Report [1] on the physical status of the men examined through selective service in World War II disclosed that twice as many registrants were rejected for foot problems (1.4 percent) as were for dental problems (0.7 percent). Of those examined registrants 90.1 per 1,000 had foot defects as compared with 116.1 per 1,000 for dental defects.

While these numbers are significant, the incidence of foot problems in the rapidly expanding older population makes real demands on the podiatrists.

The 1961 White House Conference on Aging in one report stated: "The institutionalized or home-care patient once moving about with pain-free feet is more easily motivated for total rehabilitation. Eighty-five percent of these older people have foot problems." Over 40 percent of the practicing podiatrists serve in nursing homes, and one out of three serves homes for the aged.[2]

[1] Goldstein, Marcus S., Physical Status of Men Examined Through Selective Service in World War II; Reprint No. 3080, Public Health News, vol. 66, No. 19, May 11, 1951, pp. 587–609.

[2] Blauch, Lloyd E., 1964 Survey of the Podiatry Profession, II. Podiatry Services and Practices, August 1965, pp. 602–611.

At our association's 53d annual meeting (Aug. 12–17, 1965, St. Louis, Mo.) a report [3] on a health interview survey conducted between July 1963 and June 1964 by the National Center for Health Statistics was presented. Analysis by the division of health interview statistics of the national center revealed that noninstitutionalized patients suffering from foot ailments visit podiatry offices more than 11 million times in an average year. The study also showed that two-thirds of all patients that required podiatry care are over 45.

Recognizing the need to develop some information about podiatry and its services, the American Podiatry Association established a special studies division in 1963. It was fortunate in obtaining the services of the former Assistant Commissioner for Higher Education, Lloyd E. Blauch, Ph. D., to direct these studies. One of the first projects was to make an inventory of the podiatrists in the United States and to assess manpower needs. Studies were also made of enrollments in podiatry schools. Reprints of these reports (exhibits A, B, C) are attached. The studies demonstrate that in 1978 if the present capacity of the colleges is unchanged, the deficit of podiatrists will be considerably more than 4,700. The situation cannot be changed materially until the facilities of the college are expanded. In order to care for the deficits in the number of podiatrists needed by 1980, and to provide the number needed to supply the profession in keeping with increases in population, the podiatry colleges will have to graduate about 600 students annually beginning with 1968. This is approximately three times their present capacity.

EDUCATIONAL IMPROVEMENT GRANTS

In 1960 the American Podiatry Association established a Special Commission on the Status of Podiatry Education "to examine from a broad point of view the profession's educational program and advise on steps necessary to improve this program." William K. Selden, LL.D., executive secretary of the National Commission on Accrediting, chaired the commission. Copies of the report, "Podiatry Education in the 1960's," were supplied Members of Congress in a previous session when hearings were bieng held on proposed legislation for assistance to health professions education. On the attached exhibit D we have quoted some pertinent recommendations from the report.

The report generated much interest in our professional education. A fund for podiatry education and research was organized and stimulated the giving by alumni and friends of more than $250,000 in the first 3 years. The association, through its dues structure, has been providing matching grants of $10,000 annually to each of our schools. The dues of our members were recently increased by more than 50 percent. Out of this new dues structure, over 40 percent will be devoted to assistance to our educational institutions including funds for scholarships, fellowships, and faculty improvement grants.

Exhibit E is a comparison of some data about our schools just prior to the commission's report, and now 5 years later. Enrollment is up over 40 percent; operating expenditures have risen 131 percent; the average cost of education per student has jumped from $980 to $1,680; the number of full-time instructors has increased 107 percent.

However, in 1964–65, the student-faculty ratio in podiatry colleges was 8.0—this in contrast with a 4.6 average ratio for the 10 poorest medical schools in 1962–63, and 6.4 ratio for all dental schools in 1960.

All podiatry schools experience a severe shortage of operating funds. Some may even be in jeopardy. In fact, in 1962 the accreditation of one podiatry school was removed which caused it to close its doors.

The five colleges are all private, nonprofit institutions. None receives public funds in support of its operation. Without Federal support, podiatry colleges will not be able to train sufficient numbers of podiatrists and to train them well enough to meet the needs of our increasing population.

SCHOLARSHIP GRANTS

Scholarship grants are needed in colleges of podiatry for the same reasons as in schools of medicine, osteopathy, or dentistry; that is, to make it possible for the less affluent but highly capable young people to enter the profession. Without such financial aid, and with the rising costs of attending professional schools, there is great danger that these professions in the future will be manned by

[3] From a report presented to the 1965 Annual Meeting of the American Podiatry Association by Robert R. Fuchsberg of the National Center for Health Statistics. The report is in preparation for publication the latter part of 1965 or early 1966.

persons who can surmount the financial barrier, but who are not necessarily the most capable of our people. At present, considerable aid is available for graduate study leading toward the Ph. D. degree. The same aid should be made available to the students of all health professions, including podiatry students.

Another reason for including colleges of podiatry in the provisions for scholarship grants is to provide freedom of choice for young people who wish to prepare for professional health service. Obviously, freedom of choice is narrowed when one field of study offers financial inducements while a competing field does not. It is sound policy to encourage young people to enter those fields of service in which their major interests lie and for which they have aptitude.

Furthermore, it should also be noted that many students, particularly the less affluent, will inevitably be attracted to professional fields which offer financial help, often regardless of their major interests. Thus, a lack of scholarships in podiatry, when other health fields have them, would seriously handicap the colleges of podiatry in their efforts to recruit a fair share of talent.

Only a few scholarships are available to podiatry students. Less than 1 percent of the podiatry students have been provided scholarship funds. The largest of these scholarships provides only for tuition fees.

EXTENSION OF CONSTRUCTION GRANTS

Every college of podiatry has indicated its intent to file an application for a construction grant, and one has already filed such an application. The expectation is that within a very few years all the colleges will apply for construction grants, provided the authorization for such grants is extended. Three of the colleges have to settle problems in connection with land acquisition associated with urban redevelopment projects. In a fourth, a change of administration due to retirement is imminent. In all of these colleges considerable development of physical facilities is contemplated for the near future.

The manpower studies that have been completed recently demonstrate a real need for many more podiatrists and facilities in which to train them. Therefore, the American Podiatry Association urges the extension of the construction grant program for medical, dental, and other health profession schools.

STUDENT LOANS

The House of Representatives did provide for participation by podiatry students in the student loan program in the Health Professions Educational Assistance Amendments of 1965.

At present, podiatry students participate in student loans authorized by the National Defense Education Act (Public Law 88–665). The colleges of podiatry now request that they be included in the student loan provisions of the Health Professions Educational Assistance Act of 1963 for the following reasons:

(1) Under the National Defense Education Act, a borrower is usually required to begin repayment of the principal 1 year after the date on which he ceases to pursue a full-time course of study. Under the Health Professions Educational Assistance Act, repayment of student loans need not begin until 3 years after the borrower ceases to pursue a full-time course of study. The 3-year period of grace granted before repayment is required would be highly advantageous for podiatry students for two reasons:

(*a*) A significant number continue on in specialized training in internships and residencies during which time they have little or no income and frequently have sizable expenses; and

(*b*) Graduates in podiatry, for the most part, enter independent practice and require time, often considerably more than 1 year, to develop financial ability to repay loans. Only rarely do graduates in podiatry assume salaried positions.

(2) Under the National Defense Education Act, Federal funds for student loans are allotted to States. An institution of higher education competes with other institutions in its State for a share of loan funds. Some colleges of podiatry report that they have not been able to obtain sufficient sums to meet all demands for loans to their students. Under the Health Professions Educational Assistance Act, an applicant institution competes with other institutions of its type on a nationwide basis. Since the five podiatry colleges serve the entire Nation, transfer to the Health Professions Educational Assistance Act is more appropriate. Furthermore, colleges of podiatry train professional health personnel, and they should be included with institutions for the health professions.

IN SUMMATION

President Johnson in his health message to Congress stated: "In all sectors of health care, the need for trained personnel continues to outstrip the supply." We submit that in the podiatry sector the need and demand is increasing at a much more rapid rate than podiatry institutions can cope with. We are confident that your committee in its deliberations will find it advisable to provide podiatry institutions the same opportunity that is being provided for medical, dental, osteopathic, and optometric schools.

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A special commission examined podiatry education in 1960. A significant recommendation was "* * * that the American Podiatry Association represent to the appropriate legislative and executive officials of the Government the need and social advisability of making financial provisions for podiatry education, in ways similar to those made for the other health sciences." The colleges were also advised to strengthen their faculties with considerably more full-time teachers and administrative officers, and to provide salaries commensurate with their responsibilities. The commission also noted a need to markedly increase scholarships and loan funds for students.

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We believe it is apparent that podiatry institutions and students should have the opportunity to participate not only in the extension of the construction grants and the student loan provisions of the Health Professions Educational Assistance Amendments of 1965 but also in the other amendments which would provide grants to improve the quality of training provided by health professions schools and scholarship grants.

We believe that the Senate will wish to correct what seems to be an oversight in not including podiatry in all facets of the Health Professions Educational Assistance Amendments of 1965.

If the Health Professions Educational Assistance Amendments of 1965 are enacted in their present form without providing podiatry institutions the opportunity to participate in all facets, there will be serious obstacles in maintaining a high quality of training in podiatry colleges as well as in attracting sufficient numbers of capable young people to study podiatry and serve the needs of our increasing population. All parts of the legislation should provide opportunity for participation by podiatry institutions as now do the sections on the extension of the construction program and student loans.

EXHIBIT A

[Reprint from Journal of the American Podiatry Association, May 1965]

NUMBER OF PODIATRISTS NEEDED

(By Lloyd E. Blauch, Ph. D.) [1]

[A study of the geographic location of the 8,008 registered podiatrists in the United States in 1963 revealed a shortage of 3,000 podiatrists. This deficit was based on the assumption that each city with a population of over 10,000 would provide a satisfactory practice for a podiatrist.

[If the number of podiatrists is to keep pace with the Nation's expanding population, it is estimated that 13,559 podiatrists will be needed by the year 1978.]

Elsewhere it has been shown that in December 1963 there were 8,008 (7,995 under 75 years of age) registered podiatrists in the Nation, and it was estimated that about 3,000 more were needed at that time.[2] This estimate was made through a careful study of the geographic location of the podiatrists. It was assumed that a city of 10,000 population was large enough to provide a satisfactory practice for a podiatrist. (This assumption appears to be justified by the fact that 582 podiatrists were found in 494 cities with populations under 10,000.) It was also assumed that in cities over 10,000 population every 10,000 population would provide a satisfactory practice for a podiatrist. On this basis there was a total deficit (or shortage) of 2,997 podiatrists in 1963.

And how about the future? The need and demand for podiatrists in the years ahead will depend on several factors, among them an expanding population, an increasing public understanding and appreciation of podiatry service, and an enlarging capacity of the people to pay for podiatry service. The expanding population is the only factor that is readily measurable, but the others are also very significant.

It should also be recognized that ways may be developed to increase the service productivity of individual podiatrists, such as, for example, the use of auxiliary personnel and greater use of hospitals and nursing homes for patients with foot conditions. Increased podiatry service for hospitalized patients may, of course, increase the need for more podiatrists. Prepayment plans and public provision for health services may also affect the need for podiatrists.

The U.S. Bureau of the Census provides estimates of population for future years, which are in four series; A, B, C, and D; based on different assumptions relating to fertility, mortality, and net immigration.[3] Series A consists of the highest estimates and series D the lowest estimates. Series B, which is used in this paper, is the series used by the U.S. Public Health Service in its computations. It suggests an increase of 25.4 percent in the 15 years from 1963 to 1978.

In 1963, the Nation's population was 189,278,000 which was served by 7,995 podiatrists;[4] that is, for every 100,000 population there were 4.22 podiatrists. If one assumes that the number of podiatrists should increase as rapidly as the population, and if the ratio of podiatrists to population would remain as in 1963, it appears from table I that in 1968 the Nation should have 8,449 podiatrists; in 1973, 9,090 podiatrists; in 1978, 9,849 podiatrists (assumption A). However, if one begins with the estimated number of podiatrists required in 1963 (7,995 plus 3,000, or a total of 10,995), the number for every 100,000 population should be 5.89 (assumption B). At this rate the number required in 1968 would be 11,632 podiatrists; in 1973, 12,515 podiatrists; in 1978, 13,559 podiatrists.

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[1] Director, Division of Special Studies, American Podiatry Association.

[2] Blauch, L. E.: "Present Manpower Deficit in Podiatry". J.A.P.A. 54: 551–553, 1964.

[3] U.S. Department of Commerce, Bureau of the Census. "Projections of the Population of the United States, by Age and Sex: 1964–85, with Extensions to 2010," p. 2, U.S. Government Printing Office, Washington, D.C., July 1964.

[4] Podiatrists retire from practice at various ages. However, for this study only podiatrists under the age of 75 years are considered. A number 75 years old and older continue in practice, but this number is probably no greater than the number who retire before reaching the age of 75 years.

TABLE I.—*Estimates of population and number of podiatrists needed using series B population figures*

Year (July 1)	Population (series B)	Podiatrists needed on basis of 4.2 podiatrists per 100,000 population (assumption A)	Podiatrists needed on basis of 5.9 podiatrists per 100,000 population (assumption B)
1963	189,278,000	[1] 7,995	10,995
1968	200,212,000	8,449	11,632
1973	215,409,000	9,090	12,515
1978	233,378,000	9,849	13,559

[1] The total number of podiatrists was 8,008. It is estimated that 7,995 were under 75 years of age.

PODIATRISTS IN FUTURE YEARS

Losses of the manpower in podiatry occur in two ways: (1) by death and (2) by retirement. Unfortunately, the records of the profession over the past years are not complete and therefore estimates of the numbers of podiatrists in the future are made on the basis of survival rates of podiatrists in 1963 and the recruits (graduates of podiatry colleges) who join the profession from time to time.

The additions to the profession (graduates of colleges of podiatry) for 1955 and the following years are shown in table II.

The estimates of numbers of podiatrists under 75 years of age at various times are shown in table III. They are explained as follows:

1. Survival rates are from mortality tables. Thus, of 100 persons 25 to 29 years old, 99.259 percent will survive into the next 5-year period (col. 2).

TABLE II.—*Enrollments in colleges of podiatry, 1951–52 to 1960–61 with projections to the future, and annual numbers of graduates*

Academic year	1st year enrollment	Year	Graduates [1]	Academic year	1st year enrollment	Year	Graduates [1]
1951–52	186	1955	161	1959–60	131	1963	111
1952–53	154	1956	140	1960–61	136	1964	102
1953–54	133	1957	106	1961–62	139	1965	126
1954–55	145	1958	119	1962–63	155	1966	134
1955–56	178	1959	170	1963–64	208	1967	175
1956–57	159	1960	138	1964–65	184	1968	156
1957–58	139	1961	119	1965–66	[2] 225	1969	[3] 191
1958–59	122	1962	101				

[1] From 1951–52 to 1960–61 the total of 1st year enrollments was 1,482. The corresponding graduates 4 years later came to the total of 1,267—about 85 percent of the corresponding 1st year enrollments. The numbers of graduates from 1955 to 1964 are actual; the numbers beginning with 1964 are estimates based on enrollments in 2d-year, 3d-year and 4th-year classes in 1964–65; the numbers beginning in 1968 are 85 percent of 1st-year enrollments 4 years earlier.

[2] Number that can be accommodated on the basis of present capacity and continuing indefinitely.

[3] Continuing indefinitely.

2. The age distribution of the podiatrists in 1963 has been computed from ages reported by 3,309 respondents to a questionnaire early in 1964 (col. 3).

3. Of the 553 podiatrists in the age group 25–29 years, 549 (99.259 percent of 553) will be found in the age group 30–34 years, in 1968 (col. 4).

4. Similarly, of the 929 podiatrists in the age group 30–34 years, 921 (99.133 percent of 929) will be found in the age group 35–39 years in 1968 (col. 4). Similar computations for all age groups in column 3 produce other numbers in column 4.

5. In each 5-year interval new podiatrists join the profession. They will be in the age group 25–29 years (693, 955, and 955, as shown in cols. 4, 5, and 6).

TABLE III.—*Numbers of podiatrists at various times based on (1) the total number in 1963, (2) the number of recruits (graduates of the colleges), and (3) the number of survivors through the passing years*

Age group (1)	Survival rates (2)	1963 supply (3)	Survivors in 1968 (4)	Survivors in 1973 (5)	Survivors in 1978 (6)
25–29	99.259	553	[1] 693	[1] 955	[1] 955
30–34	99.133	929	549	688	948
35–39	98.733	1,369	921	544	682
40–44	97.961	1,257	1,352	909	537
45–49	96.590	1,201	1,231	1,324	890
50–54	94.370	1,201	1,160	1,189	1,279
55–59	91.504	785	1,133	1,095	1,122
60–64	84.427	450	718	1,037	1,002
65–69	81.218	150	393	628	907
70–74	74.702	100	122	319	510
Total		7,995	8,272	8,688	8,832

[1] Podiatrists (graduates of colleges of podiatry) entering practice.

6. Additions of columns 3, 4, 5, and 6, respectively, show the numbers of podiatrists under 75 years of age to be 7,995 in 1963; 8,272 in 1968; 8,688 in 1973; and 8,832 in 1978.

DEFICITS OF PODIATRISTS IN FUTURE YEARS

In table IV data from tables I and III are combined to show the deficits in the numbers of podiatrists required in future years. The figures indicate that the supply of podiatrists will increase in the next 15 years but not as rapidly as the number needed in order to maintain the podiatrist-population ratio of 4.22 per 100,000 as in 1963 (assumption A) or 5.81 per 100,000 (assumption B). The result will be a mounting deficit due to the supply of podiatrists not keeping up with the population increases, which by 1978 will reach 4,017 (1,017 plus the 3,000 deficit in 1963) (assumption A) or 4,727 (assumption B).

TABLE IV.—*Deficits in the numbers of podiatrists needed at various times, 1963–78*

Year	Total population	Estimated number of podiatrists (table III)	Ratio of 4.22 podiatrists per 100,000 population (assumption A)		Ratio of 5.81 podiatrists per 100,000 population (assumption B)	
			Podiatrists needed (table I)	Expected deficit	Podiatrists needed (table I)	Expected deficit
1963	189,278,000	7,995	7,995		10,995	3,000
1968	200,212,000	8,272	8,449	177	11,632	3,360
1973	215,409,000	8,688	9,090	402	12,515	3,827
1978	233,378,000	8,832	9,849	1,017	13,559	4,727

TO SUM UP

It is now possible to obtain a general picture of the manpower situation in podiatry in the near future years. The summary runs as follows:

1. In 1963 there were 8,008 registered podiatrists in the Nation; 7,995 were under 75 years of age.

2. The deficit in the number of podiatrists needed in the Nation in 1963 on the basis of geographic distribution was about 3,000.

3. The deficit in numbers required in the future to keep up with the population increase, taking into account the supply in 1963 (7,995) and the deficit (3,000) in the same year, will be considerably more than 4,000 by 1978. In making this statement it is assumed that the present capacity of the colleges of podiatry will remain unchanged.

4. The situation cannot be changed materially until the facilities of the colleges of podiatry are expanded to accommodate and graduate greater numbers of students. In order (1) to care for the deficits in the number of podiatrists needed

by 1980 and (2) to provide the number needed to supply the profession in keeping with increases in population, the colleges would have to graduate about 600 students annually beginning with 1968. That number of graduates each year would require first year enrollments of about 700.

WHAT THIS MEANS

It appears rather obvious from the situation described above that public need for podiatry service will not be adequately cared for in the near years ahead unless (1) there is considerable improvement in recruiting; (2) expansion of facilities to train more persons to practice the profession occurs; and (3) steps are taken to effect a distribution of podiatrists, particularly newcomers to the profession, into geographic areas which are undersupplied. This presents a challenge to many persons and groups, but more especially to the podiatry profession which is dedicated to serving the foot health conditions of the public, and to those public-spirited individuals and groups outside the podiatry profession who are particularly concerned for the health and welfare of the men, women and children of the nation.

Acknowledgment.—The helpful assistance of Mrs. Maryland Y. Pennell, Chief, Health Manpower Statistics Branch, Center for Health Statistics, U.S. Public Health Service, is gratefully acknowledged. Mrs. Pennell suggested the way to compute the numbers of survivors in various age groups of podiatrists. She also read and criticized a draft of the article.

EXHIBIT B

[Reprint from Journal of the American Podiatry Association August 1964]

PRESENT MANPOWER DEFICIT IN PODIATRY

(By Lloyd E. Blauch, Ph. D.[1])

In a paper published [2] earlier this year, the first report of the manpower studies being conducted by the Division of Special Studies of the American Podiatry Association was presented. A summary table showed the number of registered podiatrists and the ratio of podiatrists per 100,000 population, by State.

From that table it can be seen that over half the podiatrists practice in States where the ratio is 7.6 or higher. With the Nation's population today (June 1964) being 192 million, there would need to be 14,692 podiatrists to provide every State with at least the aforementioned ratio of podiatrists to population. But there are only slightly over 8,000, which represents a deficit of more than 6,600 podiatrists. This is one rough estimate. To obtain more valid estimates, and on a State-by-State basis, the division of special studies has made a detailed manpower survey.

Lists of State-registered podiatrists as of the end of 1963, were obtained directly from State boards of podiatry examiners, or other appropriate State licensing bodies. Lists were cross checked to eliminate duplicate registrations (or license). A podiatrist who is licensed in more than one State is listed only by his principal office or address.

Detailed tables were then compiled for each State. In each State the podiatrists were tabulated by county, cities, and standard metropolitan statistical areas. From these State tables, a summary table (table I) for the Nation was prepared. It may be of interest to the reader to know that, in the Nation, there are 3,115 counties, 2,168 places with over 10,000 population and 215 standard metropolitan statistical areas.

In estimating the number of additional podiatrists that the country should have, one could use several procedures. In the light of our present state of knowledge, the best procedure seems to be to employ, as a basis, the size of communities that afford a satisfactory practice for a podiatrist. In following this procedure, three figures are used: (1) The number of registered podiatrists; (2) the number of podiatrists needed, based on the ratios of podiatrists to population; and (3) the deficits, or the number of podiatrists needed less the number registered. These deficits are taken as the estimates of additional podiatrists needed.

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[1] Director, Division of Special Studies, American Podiatry Association, Washington, D.C.

[2] Blauch, Lloyd E., Ph. D., "Numbers and the Podiatry Profession," J.A.P.A., 54: 4: 248-252 (April 1964).

The deficits (estimates) are obtained by using three types of geographical units, as follows:

(1) *Counties.*—It is assumed that a county with a population of 20,000 or more can provide a satisfactory practice for a podiatrist; a county with 40,000 people can provide practices for 2 podiatrists, and so on. This assumption appears to be justified by the fact that 69 counties with smaller populations have 1 or more podiatrists. In computing the deficits by counties, those counties with fewer than 20,000 people which had no podiatrists were not included.

TABLE I.—*Number of podiatrists registered in the United States and deficit in numbers based on ratios of numbers of podiatrists to population*

State	Registered poidatrists		Deficit in number of podiatrists to population on basis of—		
	In the State	In standard metropolitan statistical area of the State	1 to 20,000 in counties	1 to 10,000 in cities	1 to 10,000 in standard metropolitan statistical areas
Alabama	28	25	100	97	121
Alaska	1	(1)	5	4	(1)
Arizona	35	31	24	43	61
Arkansas	18	8	41	25	25
California	756	697	109	390	657
Colorado	70	57	15	32	60
Connecticut	196	166	2	33	31
Delaware	21	18	3	0	12
District of Columbia	64	96		12	104
Florida	170	137	58	78	184
Georgia	49	40	70	92	134
Hawaii	4	4	22	32	46
Idaho	20	(1)	2	4	(1)
Illinois	813	719	32	52	42
Indiana	166	69	40	60	82
Iowa	96	48	17	24	40
Kansas	49	22	28	42	58
Kentucky	65	45	36	26	57
Louisiana	34	31	93	113	120
Maine	29	12	15	13	7
Maryland	78	62	67	75	179
Massachusetts	552	498	13	43	16
Michigan	264	213	92	190	354
Minnesota	89	62	39	68	112
Mississippi	8	3	55	42	15
Missouri	102	74	63	106	163
Montana	13	7	2	7	7
Nebraska	37	20	5	22	32
Nevada	12	12	2	5	8
New Hampshire	29	7	2	2	2
New Jersey	421	301	16	95	89
New Mexico	21	10	13	22	16
New York	1,462	1,365	40	88	192
North Carolina	49	30	127	71	79
North Dakota	10	3	2	5	3
Ohio	524	430	45	84	224
Oklahoma	46	30	34	59	71
Oregon	40	26	33	23	62
Pennsylvania	921	780	14	76	165
Rhode Island	66	61	2	15	30
South Carolina	15	9	81	28	58
South Dakota	17	6	2	3	2
Tennessee	42	33	93	87	127
Texas	158	145	215	400	453
Utah	19	18	16	15	41
Vermont	10	(1)	5	3	(1)
Virginia	56	34	95	98	111
Washington	64	47	61	61	122
West Virginia	40	25	33	8	30
Wisconsin	153	99	29	49	82
Wyoming	6	(1)	5	7	(1)
Total	8,008	6,635	1,991	2,997	4,686

[1] No standard metropolitan statistical area in the State.

(2) *Cities.*—It is assumed that a city with a population of 10,000 or more can provide a satisfactory practice for a podiatrist. This assumption appears to be justified by the fact that 582 podiatrists are found in 494 cities with populations under 10,000.

(3) *Standard metropolitan statistical areas.*—Such an area consists of a large city (at least 50,000 population) and a surrounding county or counties. These areas, 250 of them, have been designated by the Bureau of the Budget. They are used in estimates made by Federal offices from time to time. A standard metropolitan statistical area (SMSA) is defined as an "integrated economic and social unit with a recognized large population nucleus." Each SMSA is treated in this study as a city (1 podiatrist to 10,000 population) in estimating the number of podiatrists needed.

From these data it can be assumed that there is a present deficit of podiatrists ranging from 2,000 to 6,600 depending upon the manner in which the estimate is obtained. A deficit of 3,000 is probably the most realistic estimate.

Future reports will consider manpower needs in podiatry for our rapidly expanding population and the greatly increasing utilization of and demand for podiatry services.

EXHIBIT C

[Reprint from Journal of the American Podiatry Association, October 1964]

ENROLLMENT, SPACES, MANPOWER SHORTAGES, AND PROJECTED PODIATRY CONSTRUCTION [1]

ENROLLMENT TRENDS AND FIRST YEAR SPACES

(Abe Rubin, D.S.C.,[2] *Washington, D.C.*)

Two tables (I and II) summarize the presently accumulated data on present and past enrollment, number of grade eligible applicants (including number of multiple applicants), number of graduates and number of spaces available for first year enrollment.

With the close of the 1962 school year, the accrediation of one podiatry college was removed, and the institution closed its doors. We could therefore complete a check of grade eligible applicants not enrolled, only for the years 1962–63 and 1963–64. However, it will be noted in table II, that enrollment for the several years preceding 1962–63 were quite low and would probably not yield additional significant data.

An examination of the first year enrollments as shown in tables I and II reveals a low point of first year enrollment in the years 1958–59, 1959–60, 1960–61, averaging 127. Beginning with 1961–62, the enrollment has constantly risen, an increase of 64.5 percent and average yearly gain of over 20 percent. Projecting this rate into 1964–65 suggests a first year enrollment of approximately 250 students if the spaces were available.

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[1] Adopted from a report submitted to, and at the request of the Division of Hospital and Medical Facilities, Bureau of States Services, Public Health Services, Department of Health, Education, and Welfare, Washington, D.C., in connection with Public Law 88–129, June 5, 1964.

[2] Executive secretary, Council on Education, American Podiatry Association.

TABLE I.—*1st year enrollment, spaces and grade eligible applicants not enrolled in podiatry colleges for the years 1962–63 and 1963–64*

School	1962–63					1963–64				
	Spaces	Enrollment	Grade eligible not enrolled [1]	Applied and enrolled elsewhere	Applied but did not enroll elsewhere	Spaces	Enrollment	Grade eligible not enrolled	Applied and enrolled elsewhere	Applied but did not enroll elsewhere
California [2]	30	31	20	0	2	35	34	12	0	3
Illinois	50	46	16	5	3	50	54	23	9	2
Lewi	50	20	13	1	1	40	38	12	0	3
Ohio	60	59	12	3	1	60	59	20	5	3
Pennsylvania	([3])	([3])	([3])	([3])	([3])	20	24	18	2	2
Totals	190	156	61	9	7	205	209	85	16	13

[1] "Grade Eligible Not Enrolled"—In 1962-63 the 61 grade eligible applications were submitted by 47 applicants. In 1963–64 the 85 grade eligible applications represented 47 applicants. For these 2 years the number of multiple applications was 52 and 25 of these did enroll at 1 of the institutions for a multiple application rate of 25.8 percent.
[2] California in 1963 opened its Lesoine Hall increasing its spaces to 35.
[3] Pennsylvania admitted its 1st class in September 1963.

The following table compares first year enrollment and first year spaces:

	1st year enrollment	1st year spaces
1958–61	[1] 127	240
1961–62	147	190
1962–63	156	190
1963–64	209	205
1964–65 [2]	250	215

[1] Average.
[2] Projected.

The drop in first year spaces in 1961 is due to the closing of one institution. In 1963–64, the Pennsylvania college admitted its first class (20 new spaces), the California college continued its rehabilitation and expansion program opening Lesoine Hall (5 additional spaces), but the M. J. Lewi College had to reduce its number of spaces by 10, providing a net gain of 15 spaces in all colleges. An additional 10 will be available in 1964–65 at the Pennsylvania college. The M. J. Lewi reduction arose from some drastically needed rehabilitation in the present structure.

It will be also noted the total occupancy in 1963–64 first-year classes is more than 100 percent. This is because two schools each accepted four students more than the spaces indicated, to cover first-year attrition.

In the year, 1963–64, in addition to the 209 students admitted to the first-year class, 31 additional grade eligible applicants (47 applicants minus 16 enrolled) failed to enroll. It seems to be self-evident that there is need to immediately increase the number of space available to accommodate grade eligible applicants.

Table II shows that number of annual graduates has almost reached bottom (just under 100 in June of 1964) but will be limited to approximately 200 per annum unless new schools are opened or the present ones enlarge their facilities.

House Report No. 109 and Senate Report No. 485 noted that we had stated that we had "anticipated a shortage of facilities by 1966." Obviously, we underestimated the rate of growth of our first-year enrollment. In fact, if the Pennsylvania college had not admitted its first class in September of 1963, the situation would have been considerably worse.

TABLE II.—*Podiatry College enrollment and graduates, 1958–62*

	1962–63 enrollment				1st year classes				June graduates		
	4	3	2	1st	61 to 62	60 to 61	59 to 60	58 to 59	62	61	60
California	27	14	25	31	24	23	31	30	19	19	17
Chicago					16	14	13	12	6	3	10
Illinois	25	25	32	46	23	22	21	28	25	25	34
Lewi	23	17	30	20	28	20	24	26	24	31	18
Ohio	39	41	42	59	51	48	42	28	22	38	33
Totals	114	97	129	156	147	127	131	124	96	116	112

NOTE.—1. In the past 4 years, there has been an increase of 20.5 percent in first-year enrollment, 13.6 percent of this in the last 2 years. 2. The average attrition rate in the past 3 years is 16 percent and the mean yearly rate 16.3 percent.

TRENDS IN THE QUALITY OF APPLICANTS

There is no real data on trends in the quality of applicants as there is no standardized national test for podiatry matriculants. However, each student must have satisfactorily completed at least 60 semester hours in an accredited institution of higher learning, with the usual prerequisites for the health professions. One school has advised us that as of late May 1964, they have accepted for September 1964, 17 applicants for 30 spaces, 15 of whom have baccalaureate degrees, and no applicant with less than a 2 average grade.

The question of standardized national tests for podiatry students has been inquired into. However, there were fairly strong indications that it was not too feasible for the small number of students involved, and that there is some doubt as to their usefulness as a basis for selecting students for a professional training. Our own fragmentary inquiries suggest that motivation (judged by interviews) is a much stronger factor in student success, provided that the student has minimal prerequisites. In fact, high motivation has overcome in a significant number of instances a relatively low entrance grade.

MANPOWER NEEDS IN PODIATRY

At the recent 24th Eastern States Health Conference, the theme was "The Expanding Role of Ambulatory Services in Hospitals and Health Departments." Norman R. Ingraham, M.D., Philadelphia commissioner of health, reported podiatry as "a service most highly demanded by the elderly." * * * This statement is representative of the rapidly increasing utilization of podiatry services.

In order to learn some data about the increasing utilization and the extent of podiatry manpower available, some studies have been undertaken by the special studies division of the American Podiatry Association. Two early reports have been published.[3] [4] These are the first reports of these studies. Reports are not yet available relating our numbers and distribution to the growth of the Nation's population.

The total registration of podiatrists (the earlier figure of 8,018 has been refined to 8,008) includes nonpracticing podiatrists and the retired. The data indicates that there is a present national deficit of podiatrists ranging to over 4,500 but not less than 2,000.

The distribution of podiatrists tends to concentrate in States in which podiatry colleges are located. But, even in these States: New York, Pennsylvania, Illinois, Ohio, and California, there is less than 1 podiatrist per 10,000 population. The deficit in these 5 States alone, based on 1 to 10,000 population in standard metropolitan statistical areas, is 1,285. This is six times the total number of first-year spaces presently available.

A complete report on these studies will be available this autumn.

[3] Blauch, Lloyd E., Ph. D., "Numbers and the Podiatry Profession," JAPA, 54: 4: 248–252 (April 1964).
[4] Blauch, Lloyd E., Ph. D., "Present Manpower Deficit in Podiatry," JAPA, 54: 8: 551–553 (August 1964).

PROJECTED CONSTRUCTION

There are no immediate plans for new schools. However, there have been some discussions regarding the establishment of new schools in southern California, Massachusetts, Texas, Georgia, and Florida. Three or more are likely to materialize within the next decade.

The construction plans of our present schools within the next few years are rehabilitative and will provide for major expansion of enrollment. It should be pointed out that the Council on Education, of the American Podiatry Association, has advised some of the schools that unless rehabilitation occurs, their present number of spaces will have to be reduced. One school, in fact, has stated that unless it can rehabilitate very shortly, the present number of spaces of 50 will have to be reduced to 36. Another school actually reduced its spaces this year by 10.

Here we should like to point out that, although at the moment relatively adequate, frequently dreary and "unmodern" appearance of podiatry college facilities is discouraging qualified desirable applicants from entering the podiatry profession.

The following table shows by school the amount of construction planned and the best available timing data.

School	Amount of construction	Will apply for grant
California Podiatry College	$327,995	Being filed.
Illinois College of Podiatry	1,950,000	As soon as possible.
M. L. Lewi College of Podiatry	1,250,000	January 1965.
Ohio College of Podiatry	318,000	1966 or 1967.
Pennsylvania College of Podiatry	400,000	April 1967.
Total	4,245,995	

California College is prepared to begin immediately. In 1963, it completed construction of Lesoine Hall to provide classrooms, laboratories, and related facilities for 45 to 50 students. But, it must however expand its teaching hospital before clinical material will be sufficient for classes of such size.

The Illinois College of Podiatry is in an area of the city that is being rehabilitated and may be forced to move the institution to a new site if it cannot get its present plans for construction approved by the local authorities. Finalization of plans is imminent awaiting decision as to site, the present one, or a new one.

The M. J. Lewi College is planning major expansion and expects to file an application for a Federal grant in January 1965.

The Ohio College of Podiatry is part of the university circle development plan in Cleveland, Ohio, and is being allocated grounds on which major expansion of the present facilities will occur in the next 2 to 3 years. If appropriate and adequate arrangements with a teaching hospital are not realized, it will be necessary for the school to build a small teaching hospital and correspondingly increase the amount of Federal participation that would be requested.

The Pennsylvania College of Podiatry entered its first class in rented quarters this fall and had anticipated qualifying as a new institution. They recently entered into an agreement to purchase an existing hospital and clinic which they will occupy, after rehabilitation, during the summer of 1966. They anticipate that by April 1967, they will be seeking Federal participation in a $400,000 expansion program.

The total projected construction suggests that Federal participation of more than $2 million can be justified in the next 5 to 6 years, approximately half of this in the initial period and the remainder in the early part of the second period.

INITIAL DEGREE OF FEDERAL PARTICIPATION

The increasing demand for podiatry services, the present large deficit of podiatry manpower and an anticipated greater shortage, the need for extensive rehabilitation to prevent lowering of the quality of the training and decrease in the number of first year training spaces, and the present greater than 100 percent occupancy of first year spaces requires major expansion of training facilities and justifies Federal participation in the amount of over $2 million in the next 6 years with approximately one-half of this in the next year or 2.

As anticipated by Assistant Surgeon General Harold Graning in his letter to the American Podiatry Association of April 29, 1964, we have not provided as much information as we would have preferred. However, we believe that what has been submitted justifies for podiatric institutions some Federal participation through the health professions education assistance program in its initial years of operation. The Council on Education of the American Podiatry Association offers any assistance it can render in these matters.

EXHIBIT D

PODIATRY EDUCATION—SOME RECOMMENDATIONS BY THE SPECIAL COMMISSION ON STATUS OF PODIATRY EDUCATION, 1961

FINANCIAL SUPPORT

"* * * that the American Podiatry Association represent to the appropriate legislative and executive officials of the Government the need and social advisability of making financial provisions for podiatry education, in ways similar to those made for the other health sciences."

FACULTIES

"* * * that each college of podiatry immediately initiate a program to strengthen its faculty and that practices, including the following, be adopted to effect improvement:

"(*a*) The appointment of full-time faculty members with graduate doctoral degrees in the basic sciences;

"(*b*) The appointment of faculty members in the clinical sciences who have pursued advanced study beyond their professional degrees;

"(*c*) The appointment of some faculty members with degrees in other professional fields, as medicine and pharmacy;

"(*d*) The appointment of faculty members who have training in and strong interest in research; and

"(*e*) The provision for salaries and working conditions adequate to attract faculty personnel of ability and competence.

"* * * that all deans, directors of foot clinics, and other similar administrative officers be appointed on a full-time basis, and that they be provided salaries commensurate with their responsibilities."

STUDENT AID

"* * * that scholarships and loan funds for students be markedly increased."

The commission consisted of: (1) three educators, nonpodiatrists, from the field of higher education; (2) one doctor of medicine, a medical educator; and (3) one practicing podiatrist, a member of a board of trustees of a podiatry college.

53-366—65——11

EXHIBIT E

Some comparative data—4-year podiatry colleges [1]

	1959–60		1963–64		1964–65	
	Average	Range	Average	Range	Average	Range
Enrollment	105	80 to 141	137	101 to 202	146	116 to 196.
Operating expenditures	$103,112	$65,000 to $135,000	$192,955	$109,000 to $274,000	$237,780	$129,000 to $428,000.
Average expenditure per student	$980	$750 to $1,399	$1,219	$1,038 to $2,709	$1,680	$1,015 to $3,265.
Income from tuition and fees	$67,357	$53,000 to $80,000	$111,690	$90,000 to $140,000	$131,647	$125,000 to $140,000.
Tuition and fees per student					$1,009	$897 to $1,200.
Income from patient services			$60,000	$16,000 to $89,000		
Gifts and grants for operations			$25,000	$20,000 to $30,000		

[1] These 4 schools have been in operation 49 or more years. A 5th school admitted its 1st class in September 1963. Data from 5th school is not included.

Operating expenditures, 1959–60 to 1964–65, increased 131 percent; enrollments, 1959–60 to 1964–65, increased 40.9 percent; full-time instructions, 1959–60 to 1964–65, increased 107.7 percent; (1959–60=13; 1961–62=17; 1964–65=27).

PREPARED STATEMENT OF HON. EDWARD V. LONG, U.S. SENATOR FROM THE STATE OF MISSOURI

Mr. Chairman, the House Interstate and Foreign Commerce Committee has reported out H.R. 3141, the 1965 amendments to the Health Professions Educational Assistance Act, which is S. 595 before this subcommittee. I have recently received a letter from the distinguished dean of the University of Missouri at Kansas City School of Dentistry, Hamilton B. G. Robinson, in which the dean expresses deep concern with one of the amendments approved by the House committee. This amendment provides that in order to receive improvement grants under the act, schools must increase their enrollment by 2½ percent or by a minimum of five students per year. Dean Robinson's letter indicates the unfortunate effect such a restriction would have on the University of Missouri at Kansas City School of Dentistry, the sixth largest such institution in the Nation. This school is certainly among the finest institutions of its kind in the country, and its continued expansion is of vital importance toward adequately serving the growing health needs of the Midwest. I therefore request, Mr. Chairman, that Dean Robinson's letter be included in the hearings record of the Subcommittee on Health on S. 595. I ask that the members of the subcommittee give this matter their most careful consideration when acting on this important measure.

UNIVERSITY OF MISSOURI AT KANSAS CITY,
Kansas City, Mo., August 18, 1965.

Hon. EDWARD V. LONG,
U.S. Senate,
Washington, D.C.

DEAR SENATOR LONG: I note that the House Commerce Committee has voted out the provisions for amendments to the Health Professions Educational Assistance Act (H.R. 3141). Under this bill, the Federal operating funds for medical, dental, and osteopathic schools are authorized under a new program of so-called basic improvement and special improvement grants. To get basic improvement grants under the present bill, schools must increase their enrollment by 2½ percent or a minimum of five students per year.

This seems to present a distinct advantage to those schools which have not been running at full capacity. The University of Missouri at Kansas City accepts 116 students per class which overtaxes our facilities to the maximum. We presently have an application in for a new facility under the Health Professions Educational Facilities Act which would increase our capacity by about 1970 to 150 students per class. In the meantime, we would certainly not be able to increase our enrollment by five students per year as every position in our classrooms and laboratories is filled. On the other hand, Harvard University accepts 14 students per class. As you can see, it would require very little effort on their part to increase their enrollment by 2½ percent. The great discrepancy in the size of classes in American dental schools are represented by the 6 largest schools, New York University, 171 per class; Ohio State University, 150 per class; University of Pennsylvania, 137 per class; Temple University, 129 per class; Marquette University, 122 per class; and the University of Missouri at Kansas City, 116 per class. At the other end, we have Harvard with 14 per class; Puerto Rico with 26 per class; University of California at Los Angeles (a new school) with 28 per class; Meharry with 31 per class; and Nebraska with 35 per class. I cannot see how schools capacity can be expected to increase their enrollment by 2½ percent or by a minimum of five students which is required for qualification.

Your consideration of this apparent discrepancy will be greatly appreciated as has your firm support of similar legislation in the past.

Sincerely,

HAMILTON B. G. ROBINSON, *Dean.*

PREPARED STATEMENT BY HON. GEORGE McGOVERN, A U.S. SENATOR FROM THE STATE OF SOUTH DAKOTA

Senator McGovern. It has come to my attention that the proposed Health Professions Educational Assistance Amendments of 1965, H.R. 3141, do not make provision for assistance to the health profession of chiropractic, even contingent upon their schools being accredited.

I have advocated expansion of legislation in the field of education—to include assistance to all institutions which play a significant role in this society. Efforts along this line have been successful in the Higher Education Act of 1965 and it is my feeling that expansion of H.R. 3141 to include this type of school is concurrent with those interests.

These schools have been built by the profession and when they reach the accredited status of similar institutions I feel they should be afforded similar rights. Therefore, I would like to submit a statement by Dr. A. A. Adams, president of the American Chiropractic Association, on this matter.

STATEMENT BY DR. A. A. ADAMS, PRESIDENT, AMERICAN CHIROPRACTIC ASSOCIATION

Mr. Chairman, I am Dr. A. A. Adams, president of the American Chiropractic Association, headquartered in Des Moines, Iowa. The American Chiropractic Association is the nationwide nonprofit professional association representing the large majority of chiropractic practitioners in the United States. The association which I represent has embarked on a definitive program to upgrade its institutions and facilities. This is the greatest effort ever expended by the profession in this area and a substantial burden on the individual practitioners who financially support this effort—we receive not one penny of Federal, State, or local tax funds.

My concern in submitting this statement today is that although we are recorded as strong advocates of this administration's efforts to assist education in our country, we are not specifically included in plans thus far presented, nor are we included in the plan before your committee, at this time.

As the second largest healing art in the United States today, I feel this forum presents the major opportunity to remedy this situation. For years our profession has been entirely free from any outside assistance in its development. In line with this "self-help" our members have built the schools, libraries, and facilities on their own. I am proud to announce that some of our schools are on the verge of full accreditation.

It is as simple as this—we are not covered by this legislation because our schools are not yet accredited; and we need this type coverage to continue to upgrade as soon as we are accredited.

Once accredited up to standards set by the Department of Health, Education, and Welfare we will have a recognized agency under law. However, we will still have no possibility of obtaining assistance when we are accredited if provision is not made now for coverage as soon as we are accredited.

My plea to you is that this legislation be amended to include chiropractic practitioners and institutions in the benefits of the Health Professions Educational Assistance Act, when we are finally accredited to meet the standards of such act. We are the only major health profession excluded from this legislation completely and I trust in your efforts to improve the quality of health practitioners in the United States; the profession of chiropractic will get an equal opportunity to better itself. The millions of patients who successfully use chiropractic care, and those who will in the future, are the ones who will benefit, and the ones for whom I am most concerned today.

Thank you for your attention.

CONGRESS OF THE UNITED STATES.
HOUSE OF REPRESENTATIVES,
Washington, D.C., September 3, 1965.

Hon. LISTER HILL,
Senate Office Building,
Washington, D.C.

MY DEAR SENATOR: I am writing about S. 595, the Health Professions Educational Assistance Amendments of 1965.

Section 771(b) prohibits operaional grants to medical schools unless they increase their first year enrollment by 2½ percent, or five students whichever is greater.

The University of Tennessee Medical School at Memphis turns out more M.D.'s than any other medical school in the country. The principle reason for this is that they have been expanding at the maximum possible rate for the past 30 years. At the present time, they have reached a condition where they simply cannot expand without a serious threat to their accreditation.

I am enclosing a memorandum that sets out the history and the present situation of the school better than I can do it.

Of course, we all applaud the objectives of this enlightened legislation. It is my feeling that the University of Tennessee Medical School is exactly the sort of institution that this legislation is designed to assist. To eliminate them from the program at the time when they need the funds the most will not gain this objective.

I would be grateful to you if you would give serious consideration to amending S. 595 in such a manner as to eliminate this difficult requirement. At the very least, the enforcement of such a provision ought to be postponed for a few years to enable these universities in the same condition as mine to catch their breath.

With all good wishes, I remain

Respectfully yours,

Enclosure. GEORGE GRIDER.

THE UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE—A STATEMENT OF THE EFFECTS OF CERTAIN FEDERAL REQUIREMENTS AND PROPOSED REQUIREMENTS ON ITS FUTURE DEVELOPMENT

The Federal Health Professions Educational Assistance Act of 1963, implemented in 1964, already has assisted a number of medical schools by providing matching funds for construction of new and/or expansion and improvement of existing physical facilities.

Additional assistance is on the horizon if the Congress enacts legislation proposed in H.R. 3141 and S. 595, both designed to provide, among other types of assistance, basic and special improvement grants to the medical and dental schools. The House Committee on Interstate and Foreign Commerce recently reported favorably on H.R. 3141. S. 595 is in committee.

Should legislation result from these bills, medical education throughout the United States will be strengthened appreciably. With few exceptions, it is to be expected that every medical school will be able to qualify to receive these much needed improvement grants.

In enacting the Health Professions Educational Assistance Act of 1963, the Federal Government sought to stimulate the production of a larger number of physicians and other health professions personnel. To guarantee this result, medical schools seeking construction grants are required to give assurance that the size of their freshman classes will be increased over the largest previous freshman class size.

Although a similar requirement was not originally a part of either H.R. 3141 or S. 595, the House committee, in reporting the bill, added such a requirement. Medical and dental schools applying for basic improvement grants would be required to increase their freshman enrollment by 2½ percent or five students, whichever is the larger figure.

The University of Tennessee College of Medicine, in a most unusual if not unique position of having critical needs for expanding its physical facilities and improving the financial aspects of its operations, will be unable to take advantage of Federal assistance because of the requirement for expanding its enrollment of students.

An examination of the past and current status and activities of the college of medicine can only lead to the conclusion that its unusual position will cause it to be penalized if, in attempting to qualify for Federal assistance, it attempts to increase its freshman enrollment.

It is contended that during the past 15 to 30 years, the college of medicine has accomplished what other medical schools are now being asked to; namely, to operate at an expanded level of production. Whereas this accomplishment has been made without Federal assistance, other schools will be benefited greatly by such assistance.

More than 30 years ago, the University of Tennessee College of Medicine inaugurated a bold new plan in an effort to overcome the physician deficit of Tennessee and to contribute to the physician resource of the United States generally. Without appreciable expansion of its facilities or strengthening of its faculty, but with more complete utilization of both, the plan entailed two changes from the regular operation of other medical schools. Instead of admitting a single freshman class each 12 months, a freshman class was admitted each 3 months. Instead of conducting the instructional program from September to June, followed by a 3-month holiday, the program was put on a year-round basis. By accepting 4 new classes in each 12-month period, 140 new students could be accommodate each year, and the college became one of, if not the largest medical school in the United States. Its system of year-round instruction was an accelerated one and permitted students to complete the curriculum in 39 calendar months rather than in 45 calendar months required in other schools.

The admission of multiple classes each year and the conduct of an accelerated curriculum was unique then and remains so today. No other medical school has adopted such a plan, nor does any of the dozen new medical schools to be established in the next few years plan to adopt this system.

Despite the size of its operations and the feature of year-round instruction, the college of medicine was required to increase the size of the incoming classes by 30 percent as a result of a legislative mandate in the late forties. Beginning in 1950, therefore, 200 new students were admitted annually in 4 classes of 50 students each. Unfortunately, the legislative action failed to provide more than minimal assistance for expanding facilities and faculty. In 1963, facing a critical need to improve its program, the college abandoned the system of the quarterly admission of 50 students in favor of the admission of 100 students each 6 months. The accelerated program of instruction still is followed, however, although it is becoming more evident that this program also must be changed.

From the standpoint of quantitative consideration, the college of medicine is making and has made through the years one of the largest numerical contributions of physicians of any U.S. school, averaging 160 graduates per year.

As is to be expected, the largest number of its students is drawn from Tennessee. However, about 25 percent of its students are taken from other States, and of these nonresidents, 91 percent locate in other States for practice. It must be noted also that 38 percent of the Tennessee resident students take up practice in States other than Tennessee.

The college has contributed to the physician resource of Tennessee as can be seen from the following. In the period of 13 years between 1950 and 1963, the population of the State increased 11 percent, while the physician population increased 30 percent. Whereas 36 percent of the total number of licensed physicians in Tennessee in 1950 were graduates of the college of medicine, this percentage had increased to 52 percent in 1963. There were 86 percent more college-of-medicine graduates in Tennessee in 1963 than in 1950.

This sustained production of physicians during the past 15 years has been accomplished with far less than optimal facilities and faculty. Faculty of the basic science departments not only have the responsibility for all the instruction of the large number of medical students, but all students in the college of pharmacy (100 per year) and in the college of dentistry (140 per year) receive their basic science instruction in the same departments. These departments also guide approximately 100 students annually in graduate programs leading to the M.S. and Ph. D. degrees. A comparison of the ratio of faculty to students in our college of medicine reveals that it is now and has been consistently lower than the national average.

The necessity to schedule the use of teaching laboratories and classrooms almost every hour of every day has prevented flexibility in the curriculum, and has prevented better students from undertaking special laboratory projects outside routine assignments. The heavy teaching responsibilities incumbent on the faculty have made it difficult to attract outstanding established teachers.

Through the years, the college has come under the searching survey of the national accrediting agencies several times. The reports of these agencies have been consistent in their criticism of the inadequacies of physical plant and teaching equipment; the low faculty-student ratio, and the large numbers of students

being accommodated. Two such surveys within the past 4 years have resulted in warnings that the college must somehow strengthen its programs.

With the enactment of the Health Professions Educational Assistance Act of 1963, it was hoped that funds might be available for improving the physical plant. The requirement that an increase in student enrollment must be made to qualify for such a grant, however, practically eliminates this source of assistance.

The amended H.R. 3141 with the requirement of expanded student enrollment also fails to recognize the already overextended operation of the University of Tennessee College of Medicine. If H.R. 3141 and S. 595 result in legislation including the requirement of increased enrollment, and if the college of medicine attempts to qualify for assistance by admitting a greater number of students, its position will be weakened rather than strengthened.

It is suggested the increased enrollment requirement be eliminated from H.R. 3141 as the bill now is amended; that it not be included in S. 595, or some formula be developed whereby recognition may be made of the past contributions of certain medical schools which have already overextended themselves in meeting physician needs.

UNIVERSITY OF PENNSYLVANIA,
Philadelphia, September 1, 1965.

Hon. LISTER HILL,
U.S. Senate,
Washington, D.C.

DEAR SENATOR HILL: I am greatly concerned about the amendment that the House has adopted relative to H.R. 3141 and S. 595.

As you are aware, all dental schools are desparately in need of additional operating budget. Many of us, including our own school, have already made provisions to increase our enrollment in order to qualify for construction and rehabilitation funds as provided by H.R. 12. It would be impossible for us to again increase our entering class enrollment by even the 2½ percent or five first year students stipulated in the current amendment to H.R. 3141. To do this would seriously jeopardize the quality of instruction to our first year students. Our physical plant is such that laboratory space could not be provided without extensive construction to qualify for the basic and special improvement grants provided in the bills now under consideration.

I would strongly suggest your consideration of this problem and urge that this amendment be deleted from H.R. 3141. I prefer the provisions of S. 595 as introduced by you.

Sincerely yours,

LESTER W. BURKET, D.D.S., M.D., *Dean.*

STATE OF OREGON,
OREGON STATE BOARD OF NURSING,
Portland, Oreg., August 27, 1965.

Hon. MAURINE NEUBERGER,
U.S. Senate,
Washington, D.C.

DEAR SENATOR NEUBERGER: We should like to enlist your support in defeating the technical amendment to H.R. 3141, the Health Professions Educational Assistance Amemendments of 1965.

It is our belief that all nursing programs receiving Federal funds under the Nurse Training Act of 1964 should be required to be accredited by the National League for Nursing Accrediting Service which is recognized by the nursing profession as the national accreditating agency for all nursing programs.

Programs or schools receiving Federal funds should all have a set of similar standards to meet if both students and the public are to be protected.

If regional college accreditation boards or State boards of nursing are set as the accrediting body, standards would vary from region to region and from State to State.

Accreditation from a regional college accreditation board would not necessarily insure that an adequate program in nursing education would be maintained. A college or university that receives regional accreditation could have both strong and weak programs within the institution. Having a program in an educational setting does not guarantee it being a sound educational program.

It is our belief that the taxpayer's money should be used only to support quality programs and that programs accredited by the National League for Nursing have demonstrated their ability to recruit and retain qualified faculty and maintain programs that produce qualified practitioners.

All five of the professional nurse schools in Oregon hold NLN accreditation. Our percentage of failures on the State board test pool licensing examinations are minimal in comparison to other States which do not have as many of their schools accredited. Oregon has been one of the 10 top States in achievement in the licensing examinations (all States belong to the test pool and administer the same licensing examinations). During the calendar year 1964, we had less than 4 percent failing the examination.

We solicit your support in maintaining quality standards for nursing education to insure properly prepared practitioners to care for the people of our State and Nation by defeat of the technical amendment to H.R. 3141.

Very truly yours,

DONNA M. MONKMAN, R.N.,
Executive Secretary.

PALO ALTO MEDICAL CLINIC,
Palo Alto, Calif., August 25, 1965.

Senator THOMAS H. KUCHEL,
Senate Office Building,
Washington, D.C.

DEAR SENATOR KUCHEL: With full realization of the many demands upon your time and energies, I nevertheless should like to bring to your attention a situation which has, in my opinion, become increasingly serious during the past 10 years. I should appreciate very much indeed your opinion on this matter.

For the past 7 years I have represented the Stanford University School of Medicine on the Medical Education Committee of the Tuberculosis and Health Association of California. This committee is charged with distributing approximately $45,000 annually among the existing six medical schools in California, for the express purpose of improving undergraduate medical education in chest diseases. These funds are derived from the annual Christmas Seal sale in the State of California.

During the years I have been privileged to be a member of this committee, I have gradually become aware of a problem which appears to be of increasing seriousness—namely, the enormous disparity between funds available for medical research in this country, including California, and the relatively inadequate funds available for medical education.

Unfortunately, it appears that the Federal Government is largely responsible for this serious imbalance. There is a great deal of evidence to support this assertion and I should like to quote just a few authorities in this field, whose opinions my own experience supports completely.

At the recent annual meeting of the American Thoracic Society in Chicago, in June, Dr. James Shannon, Director of the National Institutes of Health, in Bethesda, Md., stated that the NIH budget for 1964 was $1.8 billion, while the cost of operating all 89 medical schools in the United States during 1964 was approximately $600 million. Since the major part of the NIH budget is devoted to research grants of various kinds—mainly to universities and medical schools—it appears that funds from this source alone are vastly in excess of funds available for medical education, as distinct from medical research.

At the same meeting, Dr. Robert Ebert, the new dean of Harvard Medica School, stated that many faculty members are supported chiefly by Federal funds, and that this creates a divided loyalty, to the detriment of the university, its graduate schools, and its students.

In the recent Coggeshall Committee report, "Planning for Medical Progress through Education," it was stated that the Committee believes that the Federal Government has placed undue emphasis in the past on medical research, at the expense of medical instruction. Further, this situation has been aggravated by the fact that research funds have been provided without adequate allowance for overhead, leading to a diversion of resources from instruction to support research.

In 1963, Dr. Joseph C. Hinsey, director of the New York Hospital, Cornell Medical Center, and past president of the Association of the American Medical Colleges, made the following observations at a dinner commemorating the 10th anniversary of the Lederle medical faculty awards: "If a well-planned effort to improve the situation of the medical teacher is not undertaken forthwith, we

may bequeath to our children a serious deprivation in health care and a seriously impaired capacity to maintain our national defenses against disease and disability. This will be the case regardless of what system of medical care our Nation may see fit to adopt in the years to come. The Federal agencies neglect medical education in their overzealous support of research. I can appreciate the political bad odor of the word, 'teaching,' but we must not abdicate our responsibility to emphasize the fact that without adequate teaching, research will eventually die on the vine. I do want to set the record straight to the effect that I am an ardent supporter of research, but I also demand that this be conducted in the milieu where the interest of the student, at all levels, and of the patient are protected. With the emphasis on research, our young staff members are inclined to neglect their responsibilities in teaching and patient care, and to give more and more time to the research laboratory. At present, the individual who goes the research route is the one who is rewarded. Many gifted teachers have career awards, where they are supposed to give up not more than 15 percent of their time to teaching. Supposedly, the menial tasks of patient care and of teaching are to be cared for by the less gifted ones. One finds that many of the most able young people are not available for the teaching appointments that come up. But I do know that the future of medical education is going to require the reestablishment of a better balance between teaching, research and patient care. The quality of research and patient care will depend on whether we get enough of the best qualified teachers to develop the individuals necessary for the maintenance and the advancement of the Nation's health."

Finally, I should like to quote from an article in a recent issue of "Chemical & Engineering News" by Prof. W. T. Lippincott, professor of chemistry at Ohio State University—"The simple, verifiable fact is that the faculty has devoted a larger percentage of its time to research in the past 10 years than ever before. There can be no doubt that, supported by massive Government grants and intimately associated with every measure of success of a university, research has become king. Medical schools in recent years have been increasingly dominated by research scholars, to the inevitable detriment of teaching."

Prof. Julius H. Comroe, professor of physiology and director of the Cardiovascular Research Institute at the University of California Medical Center, in San Francisco, tells me that by law, the National Institutes of Health are prohibited from contributing any funds whatever for medical education in this country. If this is true, it seems to me that since the Congress framed this law the Congress can also modify it, if this seems in the best interests of the country's welfare.

May I apologize again for intruding upon your extremely busy life. I do so only because this matter seems to me to be of great importance for the future health of the citizens of this country.

Most sincerely,

FRANCIS S. NORTH, M.D.,
Chief, Section of Chest Diseases, Palo Alto Medical Clinic, Assistant Clinical Professor of Medicine, Stanford University School of Medicine.

THE UNIVERSITY OF NORTH DAKOTA,
Grand Forks, August 16, 1965.

Hon. QUENTIN N. BURDICK,
U.S. Senate,
Washington, D.C.

MY DEAR MR. BURDICK: It has come to my attention that a bill (S. 595) is under consideration in the Senate Labor and Public Welfare Committee, which would amend the Nurse Training Act of 1964 (Public Law 88–851, sec. 843F) by substituting State approval of the educational institution, or regional accreditation, for the present requirement of professional accreditation of basic baccalaureate and associate degree nursing programs. I surely hope that in the final form of the bill such an amendment will not appear.

All our evidence shows that nursing programs which have been accredited by the National League for Nursing (or given reasonable assurance of accreditation), are stronger, larger, have better prepared faculty and are more economical to operate than nonaccredited programs. Approximately 77 percent of all graduates are from National League for Nursing accredited programs. A higher percent of graduates from such programs are successful in passing State licensing examinations than are those from nonaccredited programs. Professional accreditation

would seem one of the best ways of insuring that Federal funds are spent where they will do the most good. It would seem that this proposed amendment might weaken the efforts of the nursing profession to improve and strengthen nursing programs of all types. Every effort is being made to provide the people of this country with the best nurses with the best possible preparation, in order to give high quality nursing care. The National League for Nursing has been designated by the Surgeon General, the nursing profession and the National Commission on Accreditation, as the official accrediting agency for the nursing profession. Its requirements for accreditation include both regional accreditation of the institution and also State approval of the nursing program. I surely hope that you will do all you can to interpret to your colleagues the need for professional accreditation as a means of insuring continuance of high standards as we attempt to increase the supply of nurses.

I will appreciate any assistance you can give.

Sincerely,

MARGARET F. HEYSE, *Dean.*

PREPARED STATEMENT OF JEAN E. BOYLE, DIRECTOR, UNIVERSITY OF OREGON SCHOOL OF NURSING, RE TECHNICAL AMENDMENT TO H.R. 3141

I believe this amendment has serious consequences for nursing education and must be opposed. Therefore I'm writing to solicit your support and influence in defeating this amendment.

If allowed to pass, it means that National League for Nursing accreditation of baccalaureate and associate degree programs in nursing will no longer be a requirement for receiving Federal funds under the Nurse Training Act of 1964. Such a change does not adequately safeguard the quality of program in nursing or give assurance to the public and the practitioners that the purpose and accomplishments of the professional programs meet the needs of society and the profession.

General accreditation of institutions is granted by six regional associations of schools and colleges which together cover the United States and its possessions. There are marked variations in the standards of these six regions and the type of information elicited from institutions by their different questionnaires. Accreditation of the entire institution doesn't imply same level of quality in each of the various programs offered by an institution nor can it be interpreted as implying the equivalent of specialized accreditation for each of its professional programs.

When several national nursing organizations united to form the National League for Nursing in 1952, it was agreed among them that accrediting in nursing would be the function of the National League for Nursing through its Division of Nursing Education. From its inception, therefore, the bylaws have carried the proviso that the National League for Nursing has the responsibility for accrediting educational programs in nursing. This responsibility is for accrediting all, not some, types of programs in nursing.

The characteristics of accredited and nonaccredited nursing programs substantiate the desirability of granting Federal funds to accredited programs and to newly established programs that have reasonable assurance of meeting national standards. The Commissioner of Education's designation of the National League for Nursing as the accrediting body was warranted, since the record of the National League for Nursing accredited programs has demonstrated their ability to attract, maintain, and graduate the largest numbers of students; to recruit and retain qualified faculty; and to provide educational programs of good quality at lesser cost. Since it can be shown also that program quality is associated with an increased number of qualified graduates, it is obvious that the public's money will reap the greatest dividends when it is invested in nationally accredited programs and in students enrolled in such programs.

Programs of school improvement and the accreditation of bachelor of science, master, and diploma programs has moved steadily forward under National League for Nursing auspices, the associate degree junior college programs in nursing have not.

The National League for Nursing took steps for an interorganizational committee of National League for Nursing and the American Association of Junior Colleges, and the 1964 conference for representatives of associates from associate degree programs in an attempt to encourage collaborative endeavor with institutions conducting this type of nursing program.

It is not National League for Nursing alone that places a high premium on its accrediting service. At its recent meeting June 1965, the American Nurses

Association board of directors shares with National League for Nursing board of directors the concern and growing awareness that neither the student of nursing nor the future recipients of nursing care are assured of the quality of associate degree programs in nursing that are mushrooming throughout the country. And, at the conclusion of the meeting, the board of directors of American Nurses Association took formal action to recognizing National League for Nursing for the accreditation of all programs in nursing leading to licensure.

We realize that shortage of qualified nurses and adequate nursing service is a major national problem. We supported the Health Professions Act of 1963 (Public Law 88–129) and the National Nurse Training Act of 1964 (Public Law 85–581). Legislators were convinced of the value of accreditation as evidenced by the provision written into the act.

National League for Nursing developed procedures whereby reasonable assurance to new programs could be established, enabling such programs to secure Federal aid, but including a provision that makes it mandatory for such programs to seek National League for Nursing accreditation prior to July 1, 1967, if institutions expect eligibility under Public Law 85–581 to be continued on the basis of National League for Nursing evaluation of programs.

Therefore, we believe under present law, adequate provision has been made to assist all types of nursing programs move toward improvement in quantity and quality of preparation for nurses. We believe it will not be to the best interest of nursing education or for nursing service of the public, to remove from the accreditation requirement the responsibility of the professional accrediting agency; namely, National League for Nursing as a requirement for seeking Federal aid.

I am requesting your consideration of the issues involved and invite your support to influence action that will defeat the passing of technical amendment, H.R. 3141, Health Professions Educational Assistance Act Amendments of 1965 which will come up for hearing at the Senate Committee on Labor and Public Welfare soon.

THE AMERICAN PUBLIC HEALTH ASSOCIATION, INC.,
Washington, D.C., September 8, 1965.

Hon. LISTER HILL,
Chairman, Senate Committee on Labor and Public Welfare,
New Senate Office Building, Washington, D.C.

MY DEAR MR. CHAIRMAN: This is to apprise you of the position of the American Public Health Association relative to S. 595, the bill which you have introduced to improve the educational quality of schools of medicine, dentistry, and osteopathy, to authorize scholarships for needy students and to continue the construction aid and student loan program for such schools. I am informed that your committee is considering this bill and consideration of the American Public Health Association's position would be appreciated.

We were pleased to support enactment of this original legislation 2 years ago. We shared your view that because of our deficit position a 3-year authorization could in no way be considered adequate to meet the need. You may recall that at the time of the hearings 2 years ago, we urged the longer authorization contained in your bill of that time rather than the shorter duration contained in H.R. 12.

The brief experience with Public Law 88–129 has exhibited the need and justification for continuation of this program. I am confident that your committee has at its disposal adequate statistical data relative to the use of appropriations for medical and dental school construction and the vast need which still exists. We are of the opinion that the student loan program has operated judiciously to assist students desiring an education in medicine or dentistry. The justifications which were cited in our statement of 2 years ago are nearly as valid today as they were then and we urge continuation of this program.

We do have some questions relative to the scholarship arrangement contained in S. 595. The language contained in the original legislative proposal appears to provide to schools of medicine, osteopathy, or dentistry simply another source of funds to be used as they deemed advisable. We believe the scholarship mechanism to be most useful when based upon excellence of performance, meritorious scholastic attainments and when based upon a nationwide merit competition. We are not sure whether or not this end has been attained in the amendment voted by the House to H.R. 3141, but we believe the concept merits careful study.

The American Public Health Association is mystified by the action of the House in attaching to this bill, which, we understood, relates solely to the Health Professions Educational Assistance Act, an amendment which pertains to the problems of accreditation of associate degree and collegiate schools of nursing. A diligent search of the hearings conducted by the House reveals that this latter matter was not dealt with affirmatively at all—in fact the sole reference that I can find is contained on page 160 of the hearings where Chairman Harris pointed out that Congress has authorized a separate program for nursing and that "it is not included in this program." The American Public Health Association is and has for decades been firmly committed to the policy of the highest possible standards of excellence of performance by health personnel. One of the essential means for attaining such excellence is through the constant improvement of the schools which train health personnel. We believe that one important method of obtaining high standards is an impartial procedure for accreditation of training facilities. This measurement of attainment can best be made by peers, persons skilled, experienced and competent in the appropriate health specialty. We question the merit of allowing for accreditation of associate degree or collegiate schools of nursing by State or regional educational agencies and must, therefore urge against the approval of this feature of H.R. 3141 which has been passed by the House.

We respectfully urge your committee to eliminate this provision from this legislative proposal. If, in fact, there appear to be reasons to question the present system of accreditation, we urge that this be made a matter of study by the Congress in connection with continuing programs of Federal aid for nursing.

Your consideration of these American Public Health Association views is respectfully urged.

Sincerely yours,

BERWYN F. MATTISON, M.D.
Executive Director.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., August 25, 1965.

Hon. LISTER HILL,
U.S. Senate, Washington, D.C.

DEAR SENATOR HILL: This association strongly supported the new and progressive amendments to the Public Health Service Act which pertained to teaching facilities and the training of professional health personnel. We expressed our detailed support of the proposals embodied in the legislation (H.R. 3141) as it was being considered by the House Committee on Interstate and Foreign Commerce.

We are greatly concerned, however, over an amendment which the House committee added to title VIII of the nurse training program. The committee, under section 843 pertaining to definitions, has amended the term "accredited" in a manner in which we feel will be detrimental to the purpose of the program.

The act, at present, provides that the Commissioner of Education is given authority to recognize any body or bodies for purposes of accrediting programs of nurse education. He is, thereby, given authority to determine that an accrediting body is desirable and competent for accrediting programs of nurse education in collegiate, in 2-year junior college and in the 3-year hospital schools of nurse education.

The Commissioner of Education has recognized the accrediting program of the National League for Nursing. We endorse this selection as the league is the only experienced national accrediting body recognized in the field of nurse education.

The amendment adopted by the House committee provides that collegiate or associate degree (2-year junior college program) programs of nurse education must be approved or accredited by either a regional accrediting agency or a State approval agency. This change, in effect, removes these two groups of schools from the accrediting program conducted by the National League for Nursing, and it provides only that the 3-year hospital programs of nurse education will be under the accrediting program of the National League for Nursing. A definite weakening of the nationwide efforts being made to strengthen schools of nursing would result. The optional selection of State approval authority, of course, removes the requirement for accreditation entirely.

This amendment removes from the authority of the Commissioner of Education the responsibility and decision as to the satisfactory accreditation of the

collegiate and 2-year schools; and in essence, breaks down the responsibility of the Federal Government for the conduct of the program.

I would be most unfortunate at this time for the Commissioner of Education to be forced to recognize multiple accrediting authorities. Such an approach would prove very detrimental to the development of one nationwide program of accreditation. It will likely result in different standards for schools and varying qualifications of their graduates. The products of these three schools of nursing all take the same qualifying examinations within the States. We believe, therefore, different basic accrediting of the schools makes no sense whatever and will prove to have an unfortunate effect upon the efforts being made to strengthen the 3-year hospital schools of nursing and to improve the programs of certain of those schools through the national accrediting efforts.

We have seen no evidence that the regional accrediting authorities which are responsible for accrediting institutions of higher learning in terms of their general educational quality are competent in the areas of professional nurse education. Their present programs and staff would have to be augmented extensively. The program developed by the National League for Nursing has fully demonstrated its competency.

There appears also to be a basic fallacy attached to the proposed amendment as it suggests that one accrediting authority has competency for all programs of education within a college or university including all the various highly specialized and professional schools. This basic policy suggests that one accrediting authority would be competent to cover not only the university in general but the school of law, the school of engineering, the school of medicine, the school of dentistry, the school of nursing, etc. The regional accrediting authorities responsible for overall accreditation of an institution of higher learning may rely upon the certification of accrediting authorities for various professional schools within the university. However, schools of medicine are accredited by a voluntary program which is the same for all medical schools and which is carried out by a liaison committee between the Association of American Medical Colleges and the American Medical Association. The accreditation of schools of dentistry is carried out by the American Dental Association.

There has been expressed some concern on the part of the 2-year junior college programs of nursing education that they were required to pay the accrediting fees established by the National League for Nursing. This is, of course, a fact. Since the National League for Nursing is a voluntary program it must be supported by charges assessed to cover the costs of the accrediting program. Thus, the 2-year junior colleges, as well as the collegiate schools and the hospital schools, would each be required to pay a fee. The apparent desire of the junior colleges to avoid this fee seems a small justification for removing them from the requirement presently provided in the law. As we see it, it seems a very small price to pay in return for the substantial Federal assistance that is offered. It is, of course, necessary that all programs of nurse education covered under the act must face the cost of providing for their special accreditation. This means that the 2-year junior college programs would be faced with the same essential costs which would be required by a national accrediting authority and cannot expect to avoid costs of accrediting programs by attempting to place themselves under the authority of the various regional educational accrediting bodies.

Finally, I believe it is quite appropriate to compare the situation that would result from the proposed amendment to what would happen if we returned to the days of having a variety of accrediting or approval authorities for schools of medicine. No one familiar with the whole situation would suggest that the future of medical education and the future health of the American people would be served by breaking down a single nationwide uniform approval program of such schools and substituting several possible approval authorities with the likelihood of widely differing standards and quality being the result.

We sincerely urge that the Senate committee not accept the amendment to section 843 and pertaining particularly to the term "accrediting," but that you retain the language presently in this section of the act. When the Congress passed the nurse education bill, it was quite specific in its intention to require the assurance which accreditation would provide to students in nursing education. There is every indication that a strong uniform accreditation program is needed and one which can exert its influence upon all schools of nurse education. It is important to realize that for the year 1963–64, of the graduates of baccalaureate programs which were not accredited, 19 percent failed to pass their State board examinations and 25 percent of the graduates of associate degree (2-year junior college) programs which were not accredited failed to pass their examinations.

This would certainly seem to indicate the desirability of refraining from any weakening of accreditation requirements which must be met by all schools of nursing in order to be eligible to receive Federal funds.

Sincerely yours,

KENNETH WILLIAMSON,
Associate Director, American Hospital Association.

PACIFIC UNIVERSITY,
COLLEGE OF OPTOMETRY,
Forest Grove, Oreg., August 18, 1965.

Re Inclusion of optomery in Senate bill 595.

To: Members of Senate Committee on Labor and Public Welfare.

From: Wm. R. Baldwin, O.D., Ph. D., dean, College of Optometry, Pacific University; and chairman, Educational Policy Committee, Association of Schools & Colleges of Optometry.

DEAR SENATOR: Optometric educators individually and collectively through the Association of Schools & Colleges of Optometry have been seeking knowledge of methods to improve optometric educational programs with accelerating vigor. Firm conclusions have been drawn from this quest concerning important improvements that need to be made in our educational programs. However, each optometric educational institution is involved in an impasse that detracts from our educational goals and from the public welfare. We have attempted to hold educational expense to the students to a minimum level so that the large number of students who enter optometry with limited financial resources will not be prevented from securing their own educational goals. We are, on the other hand, faced with the consistently increasing costs of developing consistently improving educational programs. The inclusion of optometry in the provisions for student scholarships or grants, and in the program to improve the quality of professional education provides a double-barreled solution to the two-headed dilemma. The following items are submitted as supporting evidence that the inclusion of optometry in the scholarship and institutional improvement sections of S. 595 is both important and necessary to the achievement of excellence in optometric education, and therefore, in the public interest.

SCHOLARSHIPS

(1) Tuition has increased in virtually all of the schools and colleges of optometry over the last few years. Other educational costs that must be borne by the students have also increased. The total amount of money required to secure an optometric education has, therefore, increased markedly while the funds from which students may draw have not shown such an increase. Some students who have been conscientiously interested in pursuing the 6-year professional program in optometry have changed to graduate studies in basic science areas because nonrefundable fellowships are readily available in these fields.

(2) A larger proportion of optometry students come from nonprofessional backgrounds than is the case in most other professions. A survey of college scholarship applications at one institution revealed that more than 60 percent of the students in the optometry program required significant financial assistance over and above that which could be provided from savings or by parents.

(3) Documented need for funds by students in schools of optometry is currently approximately two times the amount of funds available through existing programs.

(4) When a student in optometry must commit himself for a major portion of his financing through a loan program he is faced with an unusually difficult financial burden during the early years of practice when many other financial obligations must be taken on and when income is lowest.

INSTITUTIONAL IMPROVEMENT

(1) Surveys of current financial needs of optometric educational institutions have been made on an individual and a nationwide basis. The Council on Accreditation of the American Optometric Association has determined that approximately $23 million needs to be raised over the next 5-year period to bring optometric education up to rising minimum standards. The 5-year plan for our own school which is enclosed projects a needed operating budget of almost $400,000 per year compared to the current budget which is approximately $175,000 per year.

(2) In order to maintain high standards in optometric education it is necessary to attract to optometric faculties personnel who have advanced degrees in certain basic sciences. Competition for such personnel is keen and optometric colleges are generally having difficulty in meeting this demand. In the clinic portion of the educational program it is extremely important that sutdents have close and constant exposure to the clinical faculty. This requires a low student-faculty ratio. Every school and college of optometry is short of this standard.

(3) New techniques and new instrumentation require continuous need for new laboratory and clinical equipment. Much of this is needed in relatively large numbers and much of it is very expensive. Every school and college of optometry operates short of its minimum need with regard to such equipment.

The importance of substantially increasing the supply of optometrists has been convincingly documented to both the American Optometric Association and the National Congress. On the part of the American Optometric Association this has resulted in major emphasis being placed on attracting bright students into optometry, in providing outside support for optometric education, and in substantially increasing the number of optometry schools within noted universities. The National Congress has responded to this documentation by including optometry in bills providing financial support to be used for the construction of new or improved facilities for education in the health care professions and in the health professions student loan program. These programs have been helpful although several schools are experiencing difficulty in finding funds to commit to supply matching construction funds. It is my understanding that the House Interstate and Foreign Commerce Committee has included optometry in its version of the bill which you are considering.

Your continued support of the goal of excellence in optometric education and, therefore of excellent vision care of the American public, is urgently solicited.

Respectfully,

WM. R. BALDWIN, O.D., Ph. D.

COLLEGE OF OPTOMETRY, PACIFIC UNIVERSITY—RECOMMENDATIONS FOR IMPLEMENTATION OF THE NEW EDUCATIONAL PROGRAM OF THE COLLEGE OF OPTOMETRY

INTRODUCTION

The following plan outlines what are believed to be the essential elements in the development of a sound 4-year program in optometry. While the development of a curriculum is the core of the planning of a new educational program this cannot be considered separately from such other aspects as institutional objectives, composition of faculty, nature of the student body, and financial resources. If the educational program is to be effective, all of these elements must be woven into the learning experiences that we want the student to have. A different curriculum would be proposed if different conclusions had been reached concerning the propriety or realizability of the other links in the educational chain for which these recommendations are designed.

General purpose

It is recommended that the college of optometry adopt the following as a statement of its purpose: To produce a practitioner who has high competence to render professional care, to analyze new methods critically, to understand his professional role in society, to advance visual care through personal scientific inquiry, and to qualify for the increasing number of careers other than private practice which can best be served by an individual with an optometric education.

OBJECTIVES

It is recommended that the college of optometry specify the following as its educational objectives.

1. Sufficient liberal arts education to give ample opportunity to develop scholarly curiosity, to learn to grow culturally and intellectually, and to assimilate and communicate ideas well.

2. An understanding of the concepts, techniques, and information of the natural, physical, and behavioral sciences with special emphasis on respect for, and knowledge of, methods in research, both basic and applied.

3. Penetrating knowledge of visual science, i.e., the special application of the biological, physical, and behavioral sciences to vision, with thorough familiarity with the growth of visual science and the sources of current primary information.

4. Development of skill and procedures that are necessary to professional excellence as an optometrist, with ability to analyze and apply these skills critically.

5. Coordination of behavioral, physiological, social, and ethical aspects of patient care in the clinical training program.

6. Knowledge of proper procedures of managing a professional practice and adaptability to future modes of practice.

7. Development of insights into historical aspects of optometry, its role as a profession, and orientation in general prspectives of professionalism.

8. Knowledge of relationships between visual care and public health practices and socioeconomic trends.

9. The development of intellectual and ethical attitudes of integrity, compassion, and respect for the dignity of man.

10. The acquisition of attitudes and techniques that will insure that professional and cultural development be continuous throughout one's career.

SELECTION OF STUDENTS

These recommendations are based throughout on the conclusion that our new physical facility will adequately contain an undergraduate program of 4 years' duration, each class numbering approximately 64 students.

There is considerable evidence that students will be seeking to enter professional programs in optometry in increasing numbers. This will mean that greater selectivity will be permitted in the future. It is recommended that specific criteria for eligibility be developed within the following framework:

1. Scholarship: In addition to a minimum grade-point average, consideration should be given to academic performance in those courses that seem most closely related to later course work in the professional curriculum.

2. Aptitude: Judgements in this category should be made by the optometry admissions committee. Tests such as the Kuder preference test—Occupational should also be used but tested for validity.

3. Attitude: While perhaps impossible to quantify, this is at least equal in importance in the selection of students who can fulfill the educational objectives. Interview reports by selected optometrists or faculty counselors who have known the students represent one means of evaluating attitudes. Information on criteria for evaluation would be supplied to the interviewers. Once students are selected, every effort should be made to clearly inform them concerning what is expected of them and to develop a high level of aspiration.

4. Prerequisites: It is proposed that only those students who have completed a minimum of 2 years of college work be admitted to the college of optometry and that this work include a minimum of 30 hours of natural and physical science and 30 hours of liberal arts. Each of the following study areas must be included in the 30 semester hours of science: Biology, vertebrate anatomy including laboratory dissection; chemistry (introduction to analysis); mathematics (including calculus); physics (including electricity and light); psychology (general or introductory). The 30 hours of liberal arts must fulfill nonscience course requirements for a baccalaureate degree at Pacific University.

PROFESSIONAL CURRICULUM

The following curriculum outline is based upon the educational objectives already stated.

Other considerations are:

1. Approximately equal time is given to the combination of basic science and basic visual science courses as to clinic and professional courses.

2. An attempt is made to carry liberal arts, basic sciences, and clinical and professional courses from the first through the third year of the professional curriculum.

3. Topical areas are broad and are based on most likely combinations of individual competence in the basic visual sciences. In both the basic visual science courses and in the clinical courses, team teaching would be used to take full advantage of special competences of individual faculty members.

4. Courses requiring laboratory are limited to two in a given semester.

First year

VS-301	Biological chemistry	5	VS-302	General anatomy and physiology	5
VS-303	Physical and geometrical optics	5	VS-304	Ophthalmic optics	5
	Liberal arts elective	5		Liberal arts elective	4
OPT-319	Optometric orientation	2	VS-306	Statistical methods	3
	Total	17		Total	17

Second year

VS–405	Anatomy and physiology of the visual system	5
VS–407	Experimental psychology	5
VS–409	Pathology and epidemiology	5
	Liberal arts elective	2
	Total	17
VS–406	Cell biology and genetics	5
VS–408	Behavioral vision	5
OPT–420	Optometry I	5
	Liberal arts elective	2
	Total	17

Third year

OPT–521	Optometry II	5
VS–511	Physiological optics I	5
OPT–523	Visual testing and dispensing laboratory	4
	History and logic of science	3
	Total	17
OPT–522	Optometry III	5
VS–512	Physiological optics II	5
OPT–524	Clinic I	4
OPT–526	History of optometry	3
	Total	17

Fourth year

OPT–627	Optometry IV	5
OPT–629	Clinic II	5
OPT–631	Ocular pathology	5
OPT–633	Research and thesis	2
	Total	17
OPT–628	Practice management	5
OPT–630	Clinic III	5
OPT–632	Environmental vision	5
OPT–634	Research and thesis	2
	Total	17

COURSE OUTLINES

Specific course outlines would be developed by faculty members having responsibility for the areas involved. However, following are general descriptions of the expected content in the courses offered in visual science and in optometry.

VS–301. Biological chemistry. An introduction to organic chemistry and biochemistry. The course culminates in chemical processes that are involved in vision.

VS–302. General anatomy and physiology. Gross and microscopic anatomy of body systens and their functions with emphasis on the anatomy of the head, and on neurology.

VS–303. Physical and geometrical optics. A study of the fundamental principles and concepts of optics including light and shadows, reflection and refraction, study of mirrors, prisms, and lenses, compound lens systems, astigmatic lenses, lens aberrations, nature of light, interference, diffraction, polarization, and photometry.

VS–304. Ophthalmic optics. Principles of optics applied to the design and use of optical instruments, especially ophthalmic instruments. A study of ophthalmic lenses including methods of design and fabrication, and of other ophthalmic appliances.

VS–306. Statistical methods. The principles and applications of statistical methods used in psychometric and biological investigations.

VS–405. Anatomy and physiology of the visual system. The morphology of the eye and related neural pathways and the physiology of the neural systems that mitigate vision. The trophic physiology of the ocular structures and fluids.

VS–406. Cell biology and genetics. A coordinated presentation of cytology, genetics, and microbiology. Emphasis is placed on the relation of population genetics to vision.

VS–407. Experimental psychology. A study of the fields of psychology, experimental design, and primary information related to important studies of human behavior.

VS–408. Behavioral vision. Principles of behavioral science using experiments in vision with emphasis on the application of psychometrics to visual testing.

VS–409. Pathology and epidemiology. The study of the principles of general and systemic pathological changes, and of epidemiology, culminating in and emphasizing those conditions which affect the visual system.

VS–511. Physiological optics I. The study of the eye as an image-forming mechanism. Visual discrimination abilities, entoptic phenomena, and visual motor activities.

VS–512. Physiological optics II. Sensory and electrophysiological aspects of vision and the perception of spatial relationships.

OPT–319. Optometric orientation. Discussion of the objectives of optometric education, careers in optometry, optometric nomenclature, and organizations and institutions in optometry.

OPT–420. Optometry I. Lectures nad demonstrations explaining the theory and techniques of standard examination procedures. Introduction to symptomatology.

OPT–521. Optometry II. Systems and methods of visual analysis and problems relating to clinical practice. Statistical treatment of clinical data. Optometric aspects of reading problems.

OPT–522. Optometry III. Clinical apsects in binocular vision including visual training procedures, strabismus, and the development of visual functions.

OPT–523. Visual testing and dispensing. Laboratory. Demonstration and practice in routine and special clinical tests of vision. Practical experience in fabricating and dispensing eyewear.

OPT–524. Clinic I. Closely supervised experience in visual examination and patient care on selected patients of the clinic.

OPT–526. History of optometry. Lectures tracing the important discoveries in visual science, the antecedents of the profession, and the development of optometric institutions and organizations, as well as current trends in the profession

OPT–627. Optometry IV. Special optometric procedures including contact lenses, aniseikonia, subnormal vision; case studies of patients with unusual visual problems.

OPT–628. Practice management. Optometric ethics, economics and jurisprudence; procedures in establishing, managing, and developing a professional practice, including practical experience in these procedures through externship in the offices of selected optometrists.

OPT–629. Clinic II. Continued experience in examination, analysis, and prescription with attention to special optometric procedures employed in strabismus, low vision, pathology detection, aniseikonia, and contact lens fitting.

OPT–630. Clinic III. Continuation of OPT–629.

OPT–631. Ocular pathology. Lecture and demonstration in the etiology and course of primary and secondary ocular diseases and their differentiation. The nature of ocular involvement in systemic disease with special emphasis on diseases of high incidence which are subject to early detection by examination of the eye. Also lectures and laboratory in the use of instrumentation and techniques used to detect pathology in the eye and related structures.

OPT–632. Environmental vision. Analysis of the visual characteristics of vocational and avocational troups such as industrial workers, schoolchildren, and aging citizens, and of their special visual requirements including task design and lighting principles. Investigation into public health practices and methods and methods and health care trends.

OPT–633. Research and thesis. The student is required to select a research topic, design and conduct an experiment, and prepare a publishable report under the supervision of a faculty committee.

OPT–634. Research and thesis. Continuation of OPT6–33.

Total hours required in the professional program for the O.D. degree: Hours in visual science, 58; Hours in optometry, 62.

Special provisions: One year of foreign language (German, French, or Russian) is strongly recommended as a liberal arts elective. Other courses may be taken to acquire a major in a field other than visual science.

Requirements for B.A. or B.S. degree in visual science: The student must meet university requirements for a bachelor's degree with a minimum of 30 hours in visual science courses maintaining a grade of "C" or better.

Students in the College of Optometry must fulfill university requirements for a baccalaureate degree prior to entering the final year of the professional program.

Those entering the College of Optometry with a bachelor's degree need meet only the specific content requirements previously listed in biology, chemistry, mathematics, physics, and psychology. Such persons may complete the professional program in 3 calendar years by taking the following schedule of courses:

First year

VS–301	Biological chemistry	5	VS–302	General anatomy and physiology	5
VS–303	Physical and geometrical optics	5	VS–406	Cell biological and general	5
OPT–319	Optometric orientation	2	VS–408	Behavioral vision	5
VS–407	Experimental psychology	5	VS–306	Statistical methods	3
	Total	17		Total	18

Summer

VS–409	Pathology and epidemiology	5
OPT–420	Optometry I	5

Second year

VS–405	Anatomy and physiology of the visual system	5
OPT–521	Optometry II	5
OPT–523	Visual testing and dispensing laboratory	4
VS–511	Physiology optics I	5
	Total	19
VS–304	Ophthalmic optics	5
OPT–522	Optometry III	5
VS–512	Physiological optics II	5
OPT–526	History of optics	3
	Total	18

Summer

Elective		3
OPT–524	Clinic I	4
		7

Final year.—On schedule.

If the bachelor's degree holder has earned credit for courses in the professional curriculum other schedules may be designed.

GRADUATE AND POSTGRADUATE PROGRAMS

A master's degree program in physiological optics is considered an essential part of the educational program in optometry. It is recommended that the program be designed for 12 students. As part of their graduate training these students will, under supervision, serve various functions in the undergraduate program. These include: Laboratory supervision, assistance with discussion groups and with programed instruction. Courses offered in the master's program in physiological optics would be as follows:

PO–751. The eye and receptor system. Considerations of the eye, its optical and sensory components, its refractive status, and its imagery. Electrical and physiological considerations of the visual pathways.

PO–752. Motor activity in the visual system. Quantitative and qualitative studies of eye movements, accommodation, and pupillary mechanisms, with reference to their underlying musculature and neurology.

PO–753. Processes of vision I. The visual stimulus and the perception of brightness, color, form, detail, and motion. Related neurophysiological responses of the visual system.

PO–754. Processes of vision II. Additional consideration of the sensory visual system, and the perception of spatial relationships in monocular and binocular vision.

PO–757. Studies in behavioral vision. Visual experience influencing, affected by, and as a part of general behavior. The design and results of psychological and physiological experimentation in behavorial science, especially as they pertain to human and animal vision, are carefully analyzed.

PO–761. Special topics in physiological optics. Arranged topics for readings, experimentation, and report, in any of the aspects of visual science. This course may be repeated one or more times for credit with permission of the instructor and with different topics covered.

PO–765. Seminar in physiological optics. For progress reports and discussion of original or published research in physiological optics. To be taken for credit each semester the graduate student is in residence.

PO–775. Research. Experimental or theoretical research toward a thesis or major publication.

If the educational program has developed sufficiently by 1970 to warrant such consideration, a study should be made at that time to determine the feasibility of developing a Ph. D. program in physiological optics.

Under the supervision of a director of postgraduate education the self-sustaining program for certification of practicing optometrists in special areas should be expanded. Not only is this in keeping with the objectives of the educational program but it establishes a necessary rapport between the institution and the profession.

STEPS THAT NEED TO BE TAKEN TO PERMIT THE EDUCATIONAL PROGRAM OF THE COLLEGE OF OPTOMETRY TO ACHIEVE ITS OBJECTIVES

1. Increase in number of hours of culturally and socially based courses in humanities and social sciences; more freedom of choice in selection of these courses; greater stress in such courses on developing a framework of reference which not only permits the student to answer more questions but more importantly to continue to grow culturally and intellectually as a result of his education.

Specific proposals:

(*a*) Require a minimum of 40 semester hours in the above areas.

(*b*) Eliminate credit but maintain some requirements for activities-oriented subjects.

(*c*) Eliminate individual course requirements.

2. Restructuring of certain science courses to meet preoptometry requirements. Without exception the following recommendations are consistent with modern and tested programs of instruction.

Specific proposals:

(*a*) Biology—One year of zoology, first semester emphasis on prevertebrates, second semester on vertebrates.

(*b*) Chemistry—One semester general, one semester analysis.

(*c*) Mathematics—One-year course for which most high school graduates could qualify that would carry the students through calculus.

3. Basic visual science courses should be circumscribed according to the scientific fields involved in development of primary information. These are neurophysiology, anatomy, physiology, psychology, physics, and physiological optics.

Specific proposals:

(*a*) Establish a department of visual science within the college of optometry.

(*b*) Employ new faculty according to the following schedule:

Fall 1966—Physiologist with research experience in vision.

Fall 1967—Neurophysiologist with research experience in vision.

Fall 1968—Physiological opticist.

Fall 1969—Optometric consultants to practice; management course; additional optometric clinic instructors.

(*c*) Finance development of above department by:

1. Allocating $50,000 from Brombach bequest to be used only to insure development if following sources are not available.
2. Private foundation support.
3. Basic improvement grant from U.S. Public Health Service.
4. Special improvement grant from U.S. Public Health Service.
5. Research contracts.
6. Optometric fund for education.

(*d*) As teaching time is reduced because of research contracts additional appointments would be made.

4. All optometric courses would be taught by teaching personnel having the O.D. (or the M.D.) degree. These individuals would make up the department of optometry.

Specific proposals:

(*a*) Team teaching in some courses with emphasis on, and time allocated for, preparation and development of materials for program instruction.

(*b*) Increased emphasis on individual learning through development of learning resources center.

(*c*) More optometric faculty time allocated to individual supervision of clinic students and in laboratories.

(*d*) Development of a short-term extern program in selected optometric offices aimed primarily at practice management aspects of the students' training.

(*e*) Development of special clinics.

(*f*) Support of faculty development by provision of financial support for attendance at special courses and institutes.

(*g*) Finance development of above by:

1. A $50,000 allocation from Brombach bequest to be used only to extent following resources do not meet needs.
2. Private foundation support.
3. Increase in funds from tuition.
4. Basic improvement grant, U.S. Public Health Service.
5. Increased clinic income.
6. Optometric fund for education.

GENERAL FINANCIAL RECOMMENDATIONS

1. Beginning September 1966 set tuition at $1,200 per year.
2. Base the optometry budget on the following:
   (*a*) Seventy-five percent of tuition income from students in optometry (after deducting proportional amount for courses taken outside of optometry).
   (*b*) Eighty percent of clinic and ophthalmic laboratory income.
   (*c*) Funds from outside sources specified for optometry.
3. Establish an endowment fund from that portion of the Brombach bequest not assigned to carrying out the above recommendations. Income from this fund would be used to support a teaching chair in behavioral vision to be named in honor of Dr. Brombach.

FIVE-YEAR BUDGET

The following page represents estimated budgetary requirements for the college of optometry for the next 5 years.

Increase in budgetary requirements over the preceding year

	1966	1967	1968	1969	1970
Personnel administration	$4,000	$2,000	$3,000	$3,000	$3,000
Faculty	28,500	15,500	8,000	38,000	18,000
Teaching assistant	2,000	----------	2,000	5,000	5,000
Staff	4,600	----------	----------	5,600	1,200
Equipment and supplies	22,000	8,000	1,000	1,000	20,000
Travel	2,000	----------	----------	1,000	----------
Total increase above 1965	62,900	89,600	104,800	158,400	205,600
Total anticipated budget expenses	242,900	269,600	284,800	378,400	385,600

ANTICIPATED INCOME INCREASES OVER THE NEXT 5 YEARS

Total income increase:					
Tuition [1]	$12,000	$48,000	$20,000	----------	----------
Clinic	----------	10,000	5,000	----------	----------
Postgraduate	1,000	2,000	2,000	----------	----------
Optical laboratory	1,000	1,000	1,000	----------	----------
Research contracts	5,000	----------	20,000	$10,000	$10,000
Other sources	12,500	----------	20,000	20,000	20,000
Total increase above 1965	29,500	90,500	158,500	188,500	218,500

[1] Recommend fixing tuition throughout the 4-year professional curriculum for each student at the amount in effect at the time of his matriculation into the college of optometry.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

The National Association of Retail Druggists, representing 36,000 independent retail drugstore owners across the United States, wishes to record its support for the bill S. 595. We would like to go on record to request that the bill be amended to read:

"To amend the Public Health Service Act to improve the educational quality of schools of medicine, dentistry, osteopathy, *and pharmacy,* to authorize grants under that Act to such schools for the awarding of scholarships to needy students, and to extend expiring provisions of that Act for student loans and for aid in construction of teaching facilities for students in such schools and schools for other health professions, and for other purposes."

Because the pharmacy curriculum requires 5 years (6 years in two schools) beyond high school, the financial requirement is a factor deterring some qualified young men and women from undertaking the study of this health profession. It is estimated that an unmarried student will require $1,600 per year at a public school and $2,400 at a private school. Thus, for a 5-year period, including both prepharmacy and pharmacy studies, the amount required is $8,000 and $12,000, respectively.

The inclusion in the scholarship provisions of students of the last 3 years of the pharmacy program, the minimum period of enrollment in a school of pharmacy, would provide financial assistance to those students who may otherwise hesitate to begin the studies because of the financial burden. Particularly would this be true of students from low-income families who through family support and/or self-help and borrowing are able to complete their prepharmacy program.

As reported in testimony on H.R. 3141 before the House Committee on Interstate and Foreign Commerce, two sources of scholarship funds are available to pharmacy students: the American Foundation for Pharmaceutical Education and the Dargavel Foundation of the National Association of Retail Druggists. The former provides each school with $600 per year on a matching basis, and the latter provides $200 to each school on a nonmatching basis. In addition the National Association of Retail Druggists, through the Dargavel Foundation, makes loans to students who have completed at least 1 year of the 5-year program. In 1963–64, 169 loans averaging $305 were made.

In spite of these sources of financial aid and the loan program of the National Defense Educational Act, there is an additional need for funds as expressed by about a half of the deans of schools of pharmacy in a 1963 survey. While loan funds will be of considerable assistance, the availability of scholarship funds are believed to be an essential adjunct to a loan program in order to assist those who, because of the financial burden, might undertake the program only because of the availability of nonrefundable grants.

In its report on H.R. 3141 the House committee listed the reasons why a scholarship program is necessary for schools of medicine, dentistry, osteopathy, and optometry. These are—

1. To increase the number of students.
2. To increase the quality of students.
3. To enable interested and qualified students to plan at an early date to undertake these programs of study even though they come from less affluent families.
4. To enable these schools to compete more adequately with other disciplines such as the life sciences where 81 percent of the students are obtaining support in substantial amounts.

Schools of pharmacy also need scholarship programs for these reasons.

The committee noted the favorable effect of the World War II GI bill of rights on the number of applicants to medical schools. This same result was noted in schools of pharmacy when enrollments increased markedly, reaching their peak about 1948–49. While enrollments are increasing slowly from the low of the mid-fifties, they are about two-thirds of what they were in 1948–49.

There is a definite shortage of pharmacists at the present time and this shortage will increase in the future, as there are many young people who would like to study pharmacy but simply do not have the financial means to pursue a pharmacy education.

The enactment into law of medicare legislation definitely requires additional pharmacists. The operation of hospitals and nursing homes will further add to the shortage of pharmacists. There are hospitals and nursing homes at the present time unable to secure pharmacists. By reading the help-wanted columns in any of the newspapers of our Nation advertising for pharmacists, it is evident that a shortage truly exists.

In 1962 the U.S. Public Health Service showed that there were 123,057 pharmacists licensed in the United States with a total population of 188 million but today in 1965 the number of pharmacists have remained approximately the same while our Nation's population has soared to 195 million.

There is a shortage of pharmacists in our hospitals as only 2,339 out of 7,000 hospitals, less than one-half, have pharmacists on a full-time basis; 2,644 hospitals or 38 percent have a pharmacist on full-time or part-time basis; it is estimated that less than 5 percent of the nursing homes in the Nation have pharmacists on duty.

Of the approximately 123,000 pharmacists licensed in the United States, 90 percent are practicing in community retail pharmacies, 8 percent are carrying on their profession in hospitals, and 2 percent are engaged in research in development laboratories, in education programs, in the Armed Forces, and in other Government positions.

Prepared Statement of the American Medical Association

Mr. Chairman and members of the subcommittee, the American Medical Association is grateful for an opportunity to present its views to the subcommittee on a measure which the association deems to be of great significance to the health resources of our Nation.

Providing for the health needs of our citizens has been, and continues to be, a concern of the American Medical Association. As the national association representing in excess of 200,000 phvsicians of this country, we share with this

subcommittee and the Congress the goal of increasing the number of physicians necessary to meet the needs of our growing population. In addition, we recognize the need for facilities to accomplish this goal.

The quality of medical care available to our citizens today is a matter to which this country can point with pride, for we can state without equivocation that its excellence is not surpassed elsewhere. A principal factor in this achievement has been the excellence of medical education.

Since its inception in 1847, the American Medical Association has been seriously concerned with the quality of medical education in the United States and has worked constantly to improve the standard of medical education. In collaboration with the Association of American Medical Colleges, the AMA has been responsible for the survey and accreditation of existing medical schools and has provided consultation and advice for institutions developing new medical schools in order that they might eventually meet standards for accreditation. In addition, the American Medical Association has appeared before congressional committees on a number of occasions in support of measures which would provide assistance in the construction and rehabilitation of medical schools.

EXTENSION OF CONSTRUCTION PROGRAM

As we understand the pending bill, it would extend the expiring provisions of the Health Professions Educational Assistance Act of 1963, Public Law 88–129, which provides in part for matching grants for construction, replacement, or rehabilitation of medical schools. The bill would, in addition, extend the program of Federal loans to medical students and provide new programs authorizing Federal funds for grants to medical schools for education improvements and for scholarships.

In August of 1963, at the time H.R. 12 and S. 911, 88th Congress (Public Law 88–129), were being considered by this subcommittee, the AMA testified in support of the construction provisions, pointing to the priority of need at that time for an increase and improvement in the physical facilities available for medical education. We indicated our belief that there was need for assistance in the expansion, construction, and remodeling of the physical facilities of medical schools and that, therefore, a one-time expenditure of Federal funds on a matching basis was justified.

It was then apparent that new medical schools would be needed and that many existing schools would have to increase the size of their classes in order to produce the physicians required to provide medical care for our growing population. Accordingly, the American Medical Association and the Association of American Medical Colleges worked actively to encourage qualified educational institutions to initiate the development of new medical schools. The need for financial assistance in the construction of new medical schools and for the replacement and rehabilitation of obsolescent facilities led to the enactment of Public Law 88–129.

Partially as a result of that law, 12 institutions have made public announcement of commitment to the establishment of new medical schools and at least as many more institutions are seriously considering the establishment of new schools. In addition, many medical schools have made application for funds to assist in the replacement or rehabilitation of outmoded facilities, with the anticipation of expanding significantly the size of their present medical classes. It may, therefore, be concluded that the construction provisions of Public Law 88–129 have been successful in implementing the program to increase the number of medical graduates.

It is our understanding, however, that the total amount requested in construction applications currently on hand exceeds the funds available under Public Law 88–129, and that many more applications can be expected within the next few years, for which no funds can be provided unless additional appropriations are forthcoming. The American Medical Association believes that new and expanded medical schools will be vitally needed in the years ahead to provide for our growing population and that the provision of Federal matching funds for construction is important to the development of such facilities. The AMA, therefore, supports section 3 of S. 595 which calls for extension of the construction program for medical schools.

IMPROVEMENT GRANTS

Section 2 provides for a new program of grants to schools of medicine, dentistry, and osteopathy. Designated as "basic improvement" grants, they are apparently designed, in an unrestricted manner, to assist the schools in the operation and

maintenance of their educational programs. The American Medical Association has consistently opposed Federal operational support of medical schools because it is our conviction that it is likely to lead to Federal domination of medical education. We urge the subcommittee to delete this provision from the bill.

STUDENTS LOANS AND SCHOLARSHIPS

S. 595 also provides a new program for grants to medical schools for scholarships and extends the student loan program implemented pursuant to the enactment of Public Law 88–129.

With respect to scholarships, there does not appear to be any justification for the use of public funds to finance the education of students who will enter a profession in which they will earn above average incomes. Through a system of loans (repayable after entering the profession), such students are now enabled to complete their education.

Various arguments have been advanced to support the contention that scholarships are required for medical students, but we do not believe they can be sustained after close scrutiny. First, it is claimed that scholarships are necessary to attract a sufficient supply of superior applicants to medical schools. The fact is that the number of qualified applicants is more than adequate to fill the positions in medical school classes, and future projections indicate that the ratio of applicants to positions in the entering classes is likely to increase, even with the anticipated development of new medical schools and expansion of existing schools. From a low point of 1.7 to 1 in the late 1950's the applicant-to-accepted-student ratio has now risen to about 2 to 1 and is expected to reach 3 to 1 by 1975.

Furthermore, the quality of applicants appears to be improving—based on college records and medical college admission test scores. The proportion of "superior" medical school applicants compares favorably with that in other graduate fields, according to a recent study by the National Opinion Research Center. Surveys carried out among superior students at the high school level show also that the popularity of medicine as a career has been increasing among such students. This would indicate to us that unless other factors intervene, the quality of medical school applicants will be maintained in future years.

A second argument is that medicine is a career open only to the children of wealthy families and that Federal scholarships for needy students would permit large numbers of underprivileged students to enter the profession. This claim is based upon figures showing that only 15 percent of medical students are from families with incomes below $5,000 compared to 39 percent of the families in the general population who have incomes at this level, and that 49 percent of medical student families have incomes above $10,000 compared with 18 percent of families in the general population. It must be remembered, however, that medical schools may accept only students who have first completed 2 to 4 years of college, and when the family incomes of such college students or graduates are considered, they are found to be much closer to incomes of families of medical students than are those of the general population. Similarly, comparison of the incomes of the families of graduate students in the arts and sciences with those of the families of national merit scholarship finalists shows that they are practically identical with the incomes of families of medical students.

We note that the scholarship program under the bill would favor students from low-income families on the basis of need for financial assistance. However, it has never been demonstrated that there are significant numbers of needy students who are denied careers in medicine for lack of financial support. That the availability of Federal scholarships would not be likely to make a significant difference in the proportion of needy students studying medicine may be seen by the fact that, although Federal fellowships and scholarships have been available to graduate students in the arts and sciences for many years, the family incomes of students in these fields are approximately the same as those of families of medical students.

During the fiscal year 1964, a total of $3,900,905 in nonrefundable grants was awarded to medical students, as reported by the 87 medical schools. The amount of nonrefundable grants has increased steadily in recent years through increasing support from private and local government sources. Although the costs of medical education to the student have also increased during this period, the growth of nonrefundable grants has been at a faster rate.

We believe that the scholarship provisions in S. 595 should be deleted as they were in 1963 from H.R. 12. The adequacy of loans available to medical students and the increasing amounts of nonrefundable grants available to them make unnecessary the proposed scholarship program. We therefore urge that the scholarship provisions of S. 595 not be adopted.

With respect to the student loan provisions of the pending bill, in our testimony before the enactment of Public Law 88–129 we stated that a loan program was unnecessary since the financial needs of students were being adequately met by the non-Government, nonsubsidized guaranteed loan program of the AMA Education and Research Foundation. Two additional years of experience with the AMA–ERF loan program have strengthened the conviction that this program, together with existing private loan programs of medical schools, is capable of meeting the needs of medical students for financial assistance. We would like to briefly describe the AMA loan program at this time.

Designed to alleviate the financial difficulties of medical students and to encourage career decisions in favor of medicine, the American Medical Association Education and Research Foundation loan program utilizes the principle of a security fund functioning as a surety agency, to make available unsecured personal loans at a relatively low rate of interest to medical students, interns, and residents. Administration costs are paid by the foundation.

The growth and success of the AMA–ERF loan program have been outstanding. Initiated in March of 1962, it is now estimated that one in every six medical trainees in the country is an AMA–ERF borrower. In a little more than 3 years' time, the program has provided over 22,000 loans totaling more than $25 million in principal amount—of an average of nearly 600 loans per month. Of this total, 13,000 loans, or nearly 60 percent, have gone to medical students, the others to interns and residents. At no time during the history of this program has any qualified loan applicant been refused a loan because funds were lacking. The less than 6 percent rejections were applications which sought funds primarily for nonessential living expenses.

Under the AMA–ERF program, medical students who have completed the first term of their freshman year may apply for loans of up to $1,500 per year and for a total of up to $10,000 over their entire medical training period. The loans are made to students through normal banking channels and are countersigned by AMA's Education and Research Foundation which agrees to buy any defaulted note at face value plus accrued interest. To demonstrate its ability to perform under the contractual agreement, the foundation deposits funds equal to 8 percent of the credit extended to borrowers. In effect, this makes available $12.50 for every dollar contained in the guarantee fund.

The AMA–ERF fund has been developed through contributions from various sources including physicians, medical organizations, and private industry. An important incentive to contributors is the enterprising and self-reliant attitude developed in our young citizens who demonstrate their desire to be responsible for financing own education.

In view of the availability of private loans to medical students, including the AMA–ERF program, we submit that a need to continue the federally subsidized loan program has not been demonstrated. We urge that the loan provisions under the Health Professions Educational Assistance Act of 1963 not be extended.

NATIONAL ADVISORY COUNCIL ON MEDICAL AND DENTAL EDUCATION

The bill also provides for the establishment of a National Advisory Council on Medical and Dental Education to advise the Surgeon General in the preparation of general regulations and with respect to policy matters in the administration of the proposed educational improvement and scholarship grants to schools of medicine, dentistry, and osteopathy. The AMA does not believe that the new programs of educational improvement grants and scholarship grants should be adopted, in which case, of course, there would be ne need for this advisory council. Another National Advisory Council is already in existence, pursuant to Public Law 88–129, which should continue to function. In the event the provision for the new National Advisory Council is adopted, we believe that its members should include representatives of the practicing physicians of this country, selected from a panel of names submitted by the AMA.

We appreciate this opportunity of presenting the views of medicine to this subcommittee in its consideration of S. 595, 89th Congress.

PREPARED STATEMENT OF DR. JAMES F. HALL, PRESIDENT, DUTCHESS COMMUNITY COLLEGE, POUGHKEEPSIE, N.Y., REPRESENTING THE OFFICE OF THE EXECUTIVE DEAN FOR 2-YEAR COLLEGES IN THE STATE UNIVERSITY OF NEW YORK AND THE COUNCIL OF PRESIDENTS OF COMMUNITY COLLEGES IN NEW YORK STATE

Mr. Chairman and members of the committee, I appreciate very much this opportunity to present the following report for the information of the members of the committee.

In New York State there are 34 2-year colleges which operate within the program of the State University of New York; 28 local public community colleges, and 6 State agricultural and technical colleges. All of these controlled by law in New York State and by policies of the board of trustees and administration of the State university, are committed to provide education and training to help meet the State's need for technicians and semiprofessional workers including those relating to health sciences.

One of the most critical shortages of trained personnel in New York State is that of nursing. A special study, "Education for the Health Professions," sponsored by the New York State Board of Regents and the Governor of the State, recently recommended a ratio of 500 nurses to each 100,000 people. According to the Nurse Board Office, Division of Professional Education, New York State Education Department, it was in the biennium 1961–63, in the State at large, there were only 375 registered nurses in active practice for each 100,000 people. In the New York City area, where over one-half of the people of the State live, the ratio was only 276 active nurses for 100,000 people—a ratio only a little better than one-half as large as was recommended by the study to meet the needs of the people of the State.

As one step toward solving this serious manpower problem, the public 2-year colleges in New York State have been rapidly expanding their programs to train registered nurses. These instructional programs lead to the associate degree after 2 years of college education augmented by training in affiliated hospitals.

Although these associate degree training programs are relatively new within the college offerings, they have proved to be successful and a definitely effective way to help provide more registered nurses. The original experimentation which started the development of the associate degree program in nursing began in New York State with the registration by the board of regents of a program at Orange County Community College in 1952. (In New York State registration by the board of regents is a legal requirement for the establishment of a college degree program and constitutes official and general accreditation of the program concerned.) However, since the idea of a 2-year associate degree program in nursing was considered to be an experimental venture for the first 5 years, the mumber of programs and enrollees in them was necessarily closely controlled. Only during the past 5–6 years, therefore, has the real productivity of the associate degree program in nursing become evident in the State.

Over 1,100 licensed registered nurses have been added in New York State as a result of the associate degree program. The rate of expansion of the program is evident from the fact that in 1959 there were only 74 graduates from these programs in New York State, but in 1965 there were 539 graduates, a sevenfold increase in 6 years of operation. Graduates from the program have been quite successful in meeting the rigid licenser examination administered in New York State by the State education department for the board of regents, the same agency that is responsible for accrediting the program.

Since the start of the associate degree program in New York State in 1952, the successful rate of associate degree graduates in passing State licensing examinations for registered nurses has been over 83 percent.

It is on the basis of this strong and general record of success and service to the State that the associate degree nursing program has been steadily endorsed and supported by both educational and civic leaders. The study already referred to above made as one of its final recommendations, "the initiation of the baccalaureate programs of nursing to both the upstate and downstate medical centers; and the establishment of the associate degree program in each new community college of the State university system which can provide clinical training."

Comparable strong endorsement for associate degree programs has come from the State education department and from the nursing board units within the department. Indeed, in his letter of transmittal of a report to the W. K. Kellogg Foundation on July 1, 1964, Commissioner James E. Allen, Jr., refers to the associate degree nursing program as one of experimentation, development, and service as a prototype total effort that has "* * * stimulated the department to

overtake the study and further development of health related programs in the community colleges."

A number of difficulties, however, confront the further development and strengthening of the associate degree program. Among these are shortages of fully trained instructors with advanced degrees in nursing; limitations of instructional equipment, laboratories, and related apparatus; and the lack of understanding of the purposes and characteristics of the associate degree program on the part of the general public.

A free and full participation in the Federal Nurse Training Act would help the associate degree program significantly to overcome these obstacles. But this complete degree of participation is not now possible because of the required approach to accreditation of the program. In New York State there are now 18 associate degree programs in nursing registered by the State education department with 3 more to start this fall. Of the total of 21 programs to be in operation in the fall of 1965, 16 will be in public 2-year colleges. Despite the fact that all of these public 2-year college programs have been approved by the State University of New York and the New York State Department of Education, only eight have thus far been accredited or given a formal statement of "reasonable assurance" of accreditation by the National League for Nursing. The need for the proposed Rogers amendment to the Nurse Training Act is, therefore, very clear. It is further indicated in New York State by the fact that, as Commissioner Allen reported by letter to U.S. Commissioner of Education Keppel over a year ago, the New York State Board of Regents is a nationally recognized accrediting group with a long record of successful performances of this important educational function.

Finally, let me report that some critics of the associate degree program claim that the number of dropouts, or attrition, is excessively high. This has not proved to be the general course in New York State. Taking as an example the class that entered the associate degree program in 1963 and comparing with other classes in the same year that entered the hospital degree diploma schools of the State, the State education department figures show an attrition rate of approximately 30 percent in associate degree programs and a higher one of about 39 percent in diploma programs. In considering the matter of attrition, moreover, the fact must be remembered that community colleges seek to allow more students "to try" in a college program. It is to be expected, therefore, that the attrition rate in associate degree programs of community colleges would be high but, as already demonstrated, this does not mean that the products of the program are any the less respected.

In short, the interests of the State of New York are being well served by the associate degree program in nursing. They will be even better served if the proposed Rogers amendment is made a part of the Nurse Training Act.

PREPARED STATEMENT OF DR. RICHARD N. MACBAIN, PRESIDENT, AMERICAN OSTEOPATHIC ASSOCIATION

Mr. Chairman, members of the subcommittee, my name is Dr. Richard N. MacBain. I am president of the Chicago College of Osteopathy and have been delegated by the American Osteopathic Association and the American Association of Osteopathic Colleges to submit this statement on their behalf in support of S. 595, the Health Professions Educational Assistance Amendments of 1965.

There are five colleges of osteopathy and surgery. All are nonprofit, tax-exempt institutions. All are accredited by the American Osteopathic Association, and all are members of the American Association of Osteopathic Colleges.

The impact of the osteopathic colleges is national in scope. Their 1964–65 student body was derived from 46 States and the District of Columbia. Their graduates are engaged in the legalized practice of their profession in each of the 50 States and the District of Columbia.

A statistical study of the osteopathic profession compiled by the American Osteopathic Association shows that as of December 31, 1964, there were 11,654 active osteopathic physicians in the United States, 9,835 or 83.3 percent of whom held licenses conferring unlimited practice rights in their present location.

As indicated in Senate Report 485 on the Health Professions Educational Assistance Act of 1963, in most sections of the United States, doctors of osteopathy are licensed under the same conditions as doctors of medicine.

S. 595 amends and extends the construction and student loan features of the Health Professions Educational Assistance Act of 1963, Public Law 88–129, and

adds provisions for "grants to improve the educational quality of schools of medicine, dentistry, and osteopathy," and for grants to these schools for award of scholarships.

In advocating a program of extension and expansion such as that incorporated in S. 595, the President's Commission on Heart Disease, Cancer, and Stroke in its report to the President last December stated that the physician supply is beyond question the most critical single element in manpower for medical services, and said:

"About 7,700 physicians graduated from the Nation's 87 medical and 5 osteopathic schools in 1964. We must be able to graduate an additional 1,000 per year, starting now, to keep pace with population growth. Present trends, including the 12 to 15 new medical schools in various stages of development plus anticipated expansions of existing shools, will yield approximately 9,000 per year by 1975 and fewer than that in the intervening years."

The Commission's Subcommittee on Manpower as included in the report pointed out that:

"As of December 31, 1963, 13 States and the District of Columbia had at least 1 physician in private practice for every 1,000 in the civilian population. Assuming that this ratio is a reasonable measure of need for the remaining 37 States, it is estimated that there is a shortage of 20,000 physicians for private practice at the present time. Were we able to expand the output of the Nation's medical and osteopathic schools by 25 percent immediately, it would require 10 years to make up this deficit alone."

The bill extends the grants for construction program of the act from June 30, 1966, to June 30, 1971. The five osteopathic colleges and a sixth in the planning stage at Pontiac, Mich., filed letters of intent to apply for participation in this program involving a total estimated Federal share of $24,670,000. An application by the Chicago College of Osteopathy was filed during June 1965 and is currently pending. The others are engrossed in overall plans for meeting the necessary architectural and financial requirements, but since the deadline for application was July 1, 1965, none of them would be able to qualify unless the proposed extension of the program is adopted.

The bill extends the student loan provisions of the act for 5 years to June 30, 1971, raises the individual loan ceiling from $2,000 to $2,500, and removes the ceiling on appropriations.

The demand for these loans has far exceeded the funds available for allotment under this program. In the 1964–65 academic year, 498 out of an osteopathic student body of 1,661 received loans under Public Law 88–129. The schools requested $1,244,772 but were limited to $398,088 or 32 percent due to insufficient allocable funds. The proposed amendments should be helpful, providing adequate appropriations are made available.

In addition to the funds available under this program, the Student Loan Committee of the American Osteopathic Association makes loans to juniors and seniors. During the year 1964–65 the committee made 132 loans aggregating $97,875. These loans bear 3 percent interest and are repayable 3 years after graduation, unless extended. Average repayment period has been 5 years. Loans require a cosigner with bank reference.

S. 595 authorizes a new program of basic improvement grants and special improvement grants to medical, dental, and osteopathic schools to be used by the schools for the improvement of the quality of their educational programs. The basic improvement grants for fiscal year 1966 would amount to $12,500 to each school plus $250 per full-time student, and for each of the next 4 years the grant would amount to $25,000 for each school plus $500 per full-time student. Upon a showing that the applicant school needs additional financial assistance in order to strengthen its curriculum or to improve the quality of its education, the Surgeon General would be authorized to make special improvement grants within limits prescribed in the bill.

The only osteopathic college which receives State assistance for operation and maintenance is the Philadelphia College of Osteopathy. Pennsylvania has no State medical school and instead subsidizes the seven private nonprofit medical schools including the Philadelphia College of Osteopathy which are located in the State. For the year 1964–65, the allotment to the Philadelphia College of Osteopathy was $583,200, which was about 45 percent of the school budget of $1,300,000.

Two of our schools are located in Missouri; namely, the Kirksville College of Osteopathy and Surgery and the Kansas City College of Osteopathy and Surgery. The president of the Kirksville college states that constitutional provisions in that State prevent operational appropriations for non-State-owned institutions. He

says that efforts are being generated to change these provisions as they apply to schools and colleges in the health fields, but that it is anticipated that this will require many years of effort and cannot become available in time to meet present urgent problems. The president of the college of osteopathic medicine and surgery at Des Moines reports a similar situation in that State. There are no provisions for operational funds or student loans for privately operated schools of medicine in the State of Illinois. We have one State-owned medical school, the University of Illinois, and four privately operated medical schools and one osteopathic college. None of the latter five is eligible for any State help and it is questionable if any will be forthcoming in the forseeable future. The only possibility of this college getting such help would be if a concerted drive were made by the much more politically powerful schools of medicine.

Last year the Chicago College of Osteopathy spent $840,079.21 entirely for the training of doctors. This was made up from tuition, $256,192.57; professional fees, $154,489.25; Public Health Service grants for research and for training in heart, cancer, and mental health, and grants for work-study under the Economic Opportunity Act, $275,533; miscellaneous, $16,477.29; total, $702,692.11, leaving a deficit of $137,387.10. This deficit was covered from hospital operations and from gifts. The college hospital has 167 beds, and affiliated teaching hospitals in Detroit provide an additional 385 beds.

Out student faculty ratio is 4.6. We could use an additional 25 members, which when added to our 55 member faculty would permit necessary additional time for research. An important drawback to enticement of additional qualified faculty members is lack of space. We are already operating in very cramped quarters, as are all the other colleges.

In the 1964 Public Health Service brochure entitled "Medical Education Facilities, Planning Considerations, and Architectural Guide" occurs the following:

"One of the most important factors affecting medical school space needs is the size and character of the full-time faculty. Marked variation exists in the number of such faculty at schools now in operation, as well as in the kind of accommodations—particularly research laboratories—provided for them."

The above mentioned Commission's Subcommittee on Manpower put it this way:

"When considering ways in which medical schools can best be helped to increase the number and quality of the Nation's physicians, it is apparent that different schools have very different problems. Some of the newer and some of the impoverished schools badly need full-time faculty in larger numbers."

In connection with the provisions for improvement grants, we feel that requirement of student expansion in order to participate, as provided in the House-passed companion bill, H.R. 3141, would work at cross purposes to the program and should be rejected. I have already alluded to current overcrowding as well as the necessity for improvement of our student-faculty ratio.

S. 595 provides that the Surgeon General shall not approve or disapprove any application for improvement grant except after consultation with the National Advisory Council on Medical and Dental Education established under the bill.

The Advisory Council is to consist of the Surgeon General as Chairman and 12 members, at least 3 of whom would be selected from the general public and the remainder from among "leading authorities in the fields of medical and of dental education, respectively." Our understanding is that the field of medical education as so referred to is intended to include medical and osteopathic authorities, and that osteopathic representation on the Council would be constant

The words "and osteopaths", line 20, page 6, of the bill should be deleted as redundant. Throughout the Health Professions Educational Assistance Act the term "physician" includes doctors of medicine and doctors of osteopathy, and this format should not be altered.

The bill authorizes scholarship grants to schools of medicine, osteopathy, or dentistry for scholarships to be awarded annuallyby the schools for the fiscal year 1966 in the amount of $2,000 multiplied by one-tenth of the number of full-time first-year students, and continuing for succeeding fiscal years until as much as 10 percent of the entire student body is awarded scholarships, with a cutoff date of June 30, 1973, the awards to be made particularly to students from low-income families and applied to the student's tuition, fees, books, equipment, and living expenses at the school making the award.

In 1960 the State of Florida established a $1,000 a year scholarship for a resident who has been selected for admission by any approved osteopathic college.

In 1964 the State of New York established a $50,000 scholarship fund for New York students contemplating the study of osteopathic medicine.

In the spring of 1965, 13 scholarships of $1,500 each were awarded by the Auxiliary of the American Osteopathic Association to students entering osteopathic colleges in 1965. Several State associations award scholarships in small amounts, and a few memorial scholarships are made available. These are important, but their aggregate is not substantial.

The proposed scholarships will help prevent siphoning off of high quality students to other fields where Federal scholarships are available.

The road to becoming a physician is long, arduous, and expensive. More than 70 percent of the entering freshmen at osteopathic colleges hold baccalaureate or advanced degrees. A minimum of 3 years of preprofessional college work is required. The standard curriculum of an osteopathic college requires at least 5,000 hours of professional instruction distributed over 4 college years. The graduate then begins an internship in a hospital approved for intern training by the American Osteopathic Association. After internship, an increasing number of graduates enter on 3-year terms of residency training in approved hospitals, followed by 2 years of specialty practice preparatory to examination for certification by boards in such specialties as internal medicine, surgery, radiology, obstetrics, gynecology, pediatrics, and pathology.

We support the House amendment to H.R. 3141 which provides that loans under Public Law 88–129 to medical, osteopathic, and dental students may be forgiven at the rate of 10 percent a year up to a total of 50 percent for practice in State certified shortage areas.

AMERICAN PHARMACEUTICAL ASSOCIATION,
September 13, 1965.

Hon. LISTER HILL,
Chairman, Subcommittee on Health,
Committee on Labor and Public Welfare,
Washington, D.C.

MY DEAR SENATOR HILL: The American Pharmaceutical Association, the national professional society of pharmacists in the United States, fully supports the objectives of S. 595 and H.R. 3141.

We are, of course, pleased that the House-passed measure includes authorization for matching grants to aid in the construction, replacement, or rehabilitation of teaching facilities for the training of pharmacists. We are also pleased that the House-passed measure expanded the existing program which provides funds for the operation of student loan funds to include students at the schools of pharmacy.

The health profession of pharmacy plays an important role in comprehensive medical care. The citizens of every community depend upon complete health care service, and it is essential to the public health and welfare that an adequate supply of pharmacy manpower be continuously available to serve the public. We do expect that the need for pharmacists will become greater and the role that pharmacists fulfill in comprehensive health care will increase as we implement the recent programs designed to make better health care available to all citizens.

Quite naturally, pharmacy competes with medicine, dentistry, and the other health professions for students. The normal matriculation period for pharmacists is now 5 years plus an internship and even 6 years in some instances. The present exacting nature of the pharmaceutical sciences, which grows more complex and demanding daily, requires that the profession of pharmacy continue to attract young people of the highest academic caliber.

Thus, we are disappointed that the House-passed measure does not include schools of pharmacy in part F of title VII of the Public Health Service Act. We urge your committee to add schools of pharmacy in part F.

We believe that the availability of scholarship assistance is an important factor facing a student making a choice of a career, particularly when he is choosing between one or another of the health professions. We have formed recruitment programs to interest students studying pharmacy through the National Advisory Commission on Careers in Pharmacy. We have participated fully in the national science fairs programs to reach potential students. Thus, the omission of pharmacy from the scholarship provisions will place our recruitment programs at a disadvantage.

Scholarship support, the loan program, and adequate classroom facilities will help our schools of pharmacy attract and educate students capable of meeting the

rigorous requirements established by the profession to serve the public properly and faithfully.

We respectfully request that our comments be made a part of the hearing record on S. 595.

Sincerely yours,

WILLIAM S. APPLE, Ph. D.,
Executive Director.

PHARMACEUTICAL MANUFACTURERS ASSOCIATION,
Washington, D.C., September 10, 1965.

Re S. 595 and H.R. 3141, 89th Congress.

Hon. LISTER HILL,
Chairman, Senate Labor and Public Welfare Committee,
Washington, D.C.

DEAR MR. CHAIRMAN: This letter is submitted on behalf of the Pharmaceutical Manufacturers Association in support of S. 595 and H.R. 3141, bills amending title VII of the Public Health Service Act and entitled the "Health Professions Educational Assistance Amendments of 1965." This legislation, if enacted, would extend, for an additional 5 years, an existing program for the construction of teaching facilities for students in schools of medicine, pharmacy, and in other health professions. It would also, among other things, extend the student loan provision of the Public Health Service Act for students of medicine, dentistry, and osteopathy; and provide scholarship grants for needy students in such schools.

The Pharmaceutical Manufacturers Association is a trade association of 140 manufacturers of prescription drugs and related products who produce more than 90 percent of the Nation's total prescription drug output. We respectfully invite attention to the historical fact that there has been no important development in recent decades in drug therapy in which member firms of PMA have not played a significant role, either in the discovery of the agent or in defining its utility and making it readily available in useful and dependable form to the medical profession.

We observe with appreciation the recognition which Congress has accorded to pharmacy by including in the construction portion of this program the schools of pharamacy located throughout the United States. Since these schools serve the Nation's health interests, this recognition is truly merited. Their graduates must be trained to meet demands in many fields concerned with public health, as for example service in Federal and State Governments, in the Armed Forces, in research, in community pharmacies, and in industry.

We believe that the student loan and the scholarship grant portions of the bill should be expanded to include students in pharmacy, and we note with approval the action of the House of Representatitives in its recent passage of H.R. 3141, the eligibility inclusion of schools of pharmacy for loan programs for student aid. We would urge your committee to take like action. There is available ample documentation to show that many of these students need financial aid to enable them to continue their education and thus provide the Nation with an essential number of well-trained and well-qualified persons in the many fields in which pharmacy plays such a vital role. The increased availability of financial aid will encourage greater numbers of high-ranking students to follow careers in pharmacy.

It would be deeply appreciated if you would make this letter a part of the record of your committee's hearings on S. 595 and H.R. 3141.

Sincerely yours,

AUSTIN SMITH, M.D.,
President.

The CHAIRMAN. The subcommittee will now stand in recess.

(Whereupon, at 1:35 p.m. the subcommittee adjourned, to reconvene subject to the call of the Chair.)

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