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# NATIONAL HEALTH SERVICE CORPS

GOVERNMENT

## ACT OF 1970

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### HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON

LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

ON

### S. 4106

AND RELATED BILLS

TO AMEND THE PUBLIC HEALTH SERVICE ACT IN ORDER TO  
PROVIDE FOR THE ESTABLISHMENT OF A NATIONAL HEALTH  
SERVICE CORPS

AUGUST 28, 1970

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



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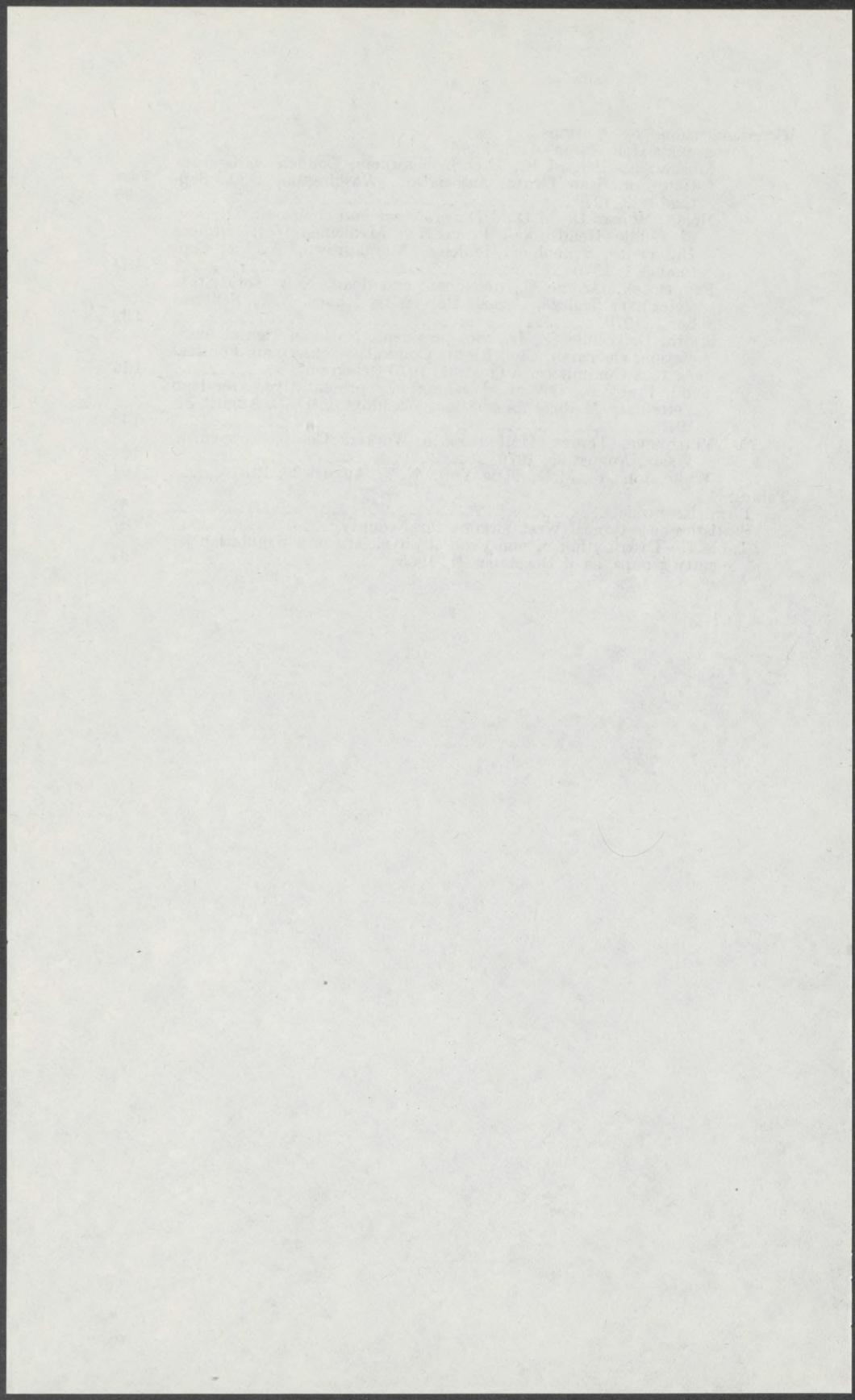
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# NATIONAL HEALTH SERVICE CORPS ACT OF 1970

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FRIDAY, AUGUST 28, 1970

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

The subcommittee met at 10 a.m., pursuant to call, in room 4232, New Senate Office Building, Senator Ralph W. Yarborough (chairman of the committee) presiding.

Present: Senators Yarborough and Javits.

Staff members present: Leroy Goldman, professional staff member to the subcommittee; and Jay B. Cutler, minority counsel to the subcommittee.

The CHAIRMAN. The Subcommittee on Health of the Labor and Public Welfare Committee will come to order and the hearings will proceed on S. 4106, a bill to amend title III of the Public Health Service Act for establishment of a National Health Service Corps and S. 4208 and S. 4296, related bills. The principal bill is called the National Health Service Corps Act of 1970.

(A copy of the bills follow:)

91<sup>ST</sup> CONGRESS  
2<sup>D</sup> SESSION

# S. 4106

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IN THE SENATE OF THE UNITED STATES

JULY 21, 1970

Mr. MAGNUSON (for himself, Mr. JACKSON, Mr. CRANSTON, Mr. HUGHES, Mr. KENNEDY, Mr. NELSON, Mr. RANDOLPH, and Mr. WILLIAMS of New Jersey) 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 in order to provide for the establishment of a National Health Service Corps.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*  
3       That this Act may be cited as the "National Health Service  
4       Corps Act of 1970".

5       SEC. 2. Title III of the Public Health Service Act is  
6       amended by adding at the end thereof a new part as follows:



1 the Corps for a period not to exceed an additional twenty-five  
2 months. An individual shall have the right to petition the  
3 Director (appointed pursuant to section 399j of this part)  
4 for early release from service in the Corps at the end of  
5 twenty-four months of service therein.

6 "DIRECTOR OF THE NATIONAL HEALTH SERVICE CORPS

7 "SEC. 399j. The Corps shall be headed by a Director  
8 who shall be appointed by the President, by and with the  
9 advice and consent of the Senate. It shall be the responsibility  
10 of the Director to direct the operations of the Corps, subject  
11 to the supervision and control of the Surgeon General.

12 "AUTHORITY OF SECRETARY TO UTILIZE CORPS  
13 PERSONNEL

14 "SEC. 399k. The Secretary is authorized, whenever he  
15 deems such action appropriate, to utilize commissioned  
16 officers of the Service and other personnel detailed to duty  
17 with the Corps to—

18 "(1) perform services in connection with direct  
19 health care programs carried out by the Service;

20 "(2) perform services in connection with any direct  
21 health care program carried out in whole or in part  
22 with the Department of Health, Education, and Welfare  
23 funds or the funds of any other department or agency of  
24 the Federal Government; or

25 "(3) perform services in connection with any other

1 health care activity, in furtherance of the purposes of this  
2 Act. Should services provided under this subsection  
3 require the establishment of health care programs not  
4 otherwise authorized by law, the Secretary is author-  
5 ized and directed to establish mechanisms whereby  
6 recipients of such services shall pay, to the extent  
7 practicable, for services received. Any funds collected  
8 in this manner shall be used to defray in part the oper-  
9 ating expenses of the Corps.

10 "NATIONAL HEALTH CORPS ADVISORY COUNCIL

11 "SEC. 3991. (a) There is established a council to be  
12 known as the National Health Corps Advisory Council  
13 (hereinafter in this section referred to as the 'Council'). The  
14 Council shall be composed of twelve members appointed as  
15 follows:

16 "(1) three members from the Department of  
17 Health, Education, and Welfare, serving outside the  
18 Corps, to be appointed by the Secretary;

19 "(2) three members appointed by the Secretary  
20 from private life;

21 "(3) three members detailed to duty with the  
22 Corps, at least two of whom shall be commissioned offi-  
23 cers of the Service, to be appointed by the Secretary;  
24 and

25 "(4) three persons who have received more than

1 minimal health care services from the Corps, to be ap-  
2 pointed by the Secretary after the Corps has been in  
3 operation for a period of at least one hundred and twenty  
4 days and to be appointed from geographically dispersed  
5 areas to the extent practicable.

6 “(b) Members of the Council shall be appointed for a  
7 term of three years and shall not be removed, except for  
8 cause. Members may be reappointed to the Council.

9 “(c) It shall be the function of the Council—

10 “(1) to establish guidelines with respect to how the  
11 Corps shall be utilized and to consult with and advise the  
12 Director generally regarding the operation of the Corps;

13 “(2) to assist the Surgeon General, at his request,  
14 in the selection of commissioned officers of the Service  
15 and other personnel for assignment to the Corps, and to  
16 approve all assignments of Corps members;

17 “(3) to establish criteria for determining which  
18 communities or areas will receive assistance from the  
19 Corps, taking into consideration—

20 “(A) the need of any community or area for  
21 health services provided under this part;

22 “(B) the willingness of the community or area  
23 and the appropriate governmental agencies therein  
24 to assist and cooperate with the Corps in providing

1 effective health services to residents of the com-  
2 munity or area;

3 “(C) the prospects of the community or area  
4 for utilizing Corps personnel after their tour of duty  
5 with the Corps;

6 “(D) the recommendations of any agency or  
7 organization which may be responsible for the de-  
8 velopment, under section 314 (b), of a comprehen-  
9 sive plan covering all or any part of the area or  
10 community involved; and

11 “(E) recommendations from the medical, den-  
12 tal, and other medical personnel of any community  
13 or area considered for assistance under this part.

14 “MANPOWER LIMITATIONS SUSPENSION

15 “SEC. 399m. (a) Commissioned officers of the Service  
16 detailed to service with the Corps and other personnel em-  
17 ployed in the Corps shall not be included in determining  
18 any limitation on the number of personnel which may be  
19 employed by the Department of Health, Education, and  
20 Welfare.

21 “(b) Notwithstanding any other provision of law,  
22 the Corps may, to the extent the Secretary determines  
23 such action to be feasible, utilize the facilities and personnel  
24 of hospitals and other health care facilities of the Service in  
25 providing health care to individuals as authorized under this

1 part, and to lease or purchase such other facilities as may  
2 be required to carry out the purposes of this Act.

3 "AUTHORIZATION FOR APPROPRIATIONS

4 "SEC. 399n. There is authorized to be appropriated  
5 the sum of \$5,000,000 annually to carry out the provisions  
6 of this part; for the fiscal years of 1971, 1972, and 1973."

91<sup>ST</sup> CONGRESS  
2<sup>D</sup> SESSION

# S. 4208

---

## IN THE SENATE OF THE UNITED STATES

AUGUST 10, 1970

Mr. MURPHY (for himself, Mr. DOMINICK, Mr. JAVITS, Mr. PROUTY, and Mr. SAXBE) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

---

## A BILL

To amend title VII of the Public Health Service Act by providing for the establishment of a family physician scholarship and fellowship program.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       That this Act may be cited as the "Family Physician  
4       Scholarship and Fellowship Program Act".

5       SEC. 2. Title VII of the Public Health Service Act is  
6       amended by adding at the end thereof the following new  
7       part:

1 "PART H—FAMILY PHYSICIAN SCHOLARSHIP AND  
2 FELLOWSHIP PROGRAM

3 "SCHOLARSHIP AND FELLOWSHIP GRANTS

4 "SEC. 799a. (a) In order to promote the more adequate  
5 provision of medical care for persons who—

6 "(A) reside in a physician shortage area (as de-  
7 termined pursuant to section 799c (b) ) ;

8 "(B) are migratory agricultural workers or mem-  
9 bers of the families of such workers ;

10 the Secretary is authorized, in accordance with the provi-  
11 sions of this part—

12 "(C) to make scholarship grants to individuals who  
13 are medical students and who agree, after completion of  
14 their professional training, to engage in the practice of  
15 family medicine (i) in a physician shortage area, or  
16 (ii) at such place or places, such facility or facilities,  
17 and in such manner, as may be necessary to assure that,  
18 of the patients receiving medical care in such practice, a  
19 substantial portion will consist of persons referred to in  
20 clause (B) ; and

21 "(D) to make fellowship grants to individuals who  
22 (while undergoing training, or receiving professional ex-  
23 perience, designed to prepare them to engage in the prac-  
24 tice of family medicine) are serving as interns or resi-  
25 dents in public or nonprofit private hospitals which (i)

1 are located in a physician shortage area, or (ii) a sub-  
2 stantial portion of the patients of which consists of per-  
3 sons referred to in clause (B).

4 For purposes of subparagraph (D) of the preceding sen-  
5 tence, training or experience in obstetrics, pediatrics, or in-  
6 ternal medicine shall be considered to be training or experi-  
7 ence preparing an individual to engage in the practice of  
8 family medicine.

9 “(b) (1) Scholarship grants under this part shall be  
10 made with respect to academic years, and fellowship grants  
11 under this part shall be made with respect to 12-month  
12 periods.

13 “(2) The amount of any medical student scholarship  
14 grant under this part to any individual for any full academic  
15 year shall not exceed \$5,000; the amount of any intern  
16 fellowship grant under this part to any individual for any  
17 twelve-month period shall not exceed \$9,000; and the  
18 amount of any resident fellowship grant under this part to  
19 any individual for any twelve-month period shall not exceed  
20 \$10,000 (in the case of an individual who, for a preceding  
21 twelve-month period, has not received a resident fellowship  
22 grant under this part), or \$12,000 (in any other case).

23 “(3) The Secretary shall, in awarding medical student  
24 scholarship grants under this part, accord priority to appli-  
25 cants as follows—

1           “(A) first, to any applicant who (i) is from a  
2           low-income family, (ii) resides in a physician shortage  
3           area, and (iii) agrees that, upon completion of his pro-  
4           fessional training, he will return to such area and will  
5           engage in such area in the practice of family medicine;

6           “(B) second, to any applicant who meets all the  
7           criteria set forth in subparagraph (A) except that  
8           prescribed in clause (i) ;

9           “(C) third, to any applicant who meets the criterion  
10          set forth in clause (i) ; and

11          “(D) fourth, to any other applicant.

12          “(c) (1) Any medical student scholarship grant  
13          awarded to any individual under this part shall be awarded  
14          upon the condition that such individual will, upon comple-  
15          tion of his professional training, engage in the practice of  
16          family medicine—

17               “(A) in the case of any individual who, in ap-  
18               plying for a medical student scholarship grant under  
19               this part, met the criteria set forth in subparagraph  
20               (A) or (B) of subsection (b) (3), in the physician  
21               shortage area in which he agreed (pursuant to such  
22               subparagraph) to engage in such practice; and

23               “(B) in the case of any individual who did not  
24               agree (pursuant to such subparagraph (A) or (B) ) to  
25               engage in such practice in any particular physician short-

1 age area or has been waived (pursuant to paragraph  
2 (4)) to engage in such practice in any particular phy-  
3 sician shortage area—

4 “(i) in any physician shortage area, or  
5 “(ii) at such place or places, in such facility  
6 or facilities, and in such manner, as may be neces-  
7 sary to assure that, of the patients receiving medical  
8 care provided by such individual, a substantial por-  
9 tion will consist of persons who are migratory agri-  
10 cultural workers or are members of the families  
11 of such workers;

12 for a twelve-month period for each full academic year with  
13 respect to which he receives such a scholarship grant. For  
14 purposes of the preceding sentence, any individual, who has  
15 received a medical student scholarship grant under this part  
16 for four full academic years and who has received fellow-  
17 ship grants under this part for three full twelve-month  
18 periods, shall be deemed to have received a medical student  
19 scholarship grant under this part for only three full academic  
20 years.

21 “(2) The condition imposed by paragraph (1) shall  
22 be complied with by any individual to whom it applies  
23 within such reasonable period of time, after the completion  
24 of such individual's professional training, as the Secretary  
25 shall by regulations prescribe.

1       “(3) If any individual to whom the condition referred  
2 to in paragraph (1) is applicable fails, within the period  
3 prescribed by paragraph (2), to comply with such condition  
4 for the full number of months with respect to which such  
5 condition is applicable, the United States shall be entitled  
6 to recover from such individual—

7               “(A) an amount which bears the same ratio to  
8 the aggregate of (i) the amounts of the medical student  
9 scholarship grant or grants (as the case may be) made  
10 to such individual under this part plus (ii) the amount  
11 of interest which would be payable on such amounts if  
12 such amounts had been loans bearing an interest  
13 rate of 7 per centum per annum and the interest thereon  
14 had been payable annually, as

15               “(B) (i) the number obtained by subtracting from  
16 the number of months to which such condition is applic-  
17 able a number equal to one-half of the number of months  
18 with respect to which compliance by such individual  
19 with such condition was made, bears to (ii) the number  
20 of months with respect to which such condition is  
21 applicable.

22       “(4) (A) Any obligation of any individual to comply  
23 with the condition applicable to him under the preceding  
24 provisions of this subsection shall be canceled upon the death  
25 of such individual.

1       “(B) The Secretary shall by regulations provide for the  
2 waiver of suspension of any such obligation applicable to  
3 any individual whenever compliance by such individual is  
4 impossible or would involve extreme hardship to such indi-  
5 vidual and if enforcement of such obligation with respect to  
6 any individual would be against equity and good conscience.

7       “(d) In awarding intern and resident fellowship grants  
8 under this part, priority shall be given to interns and resi-  
9 dents in hospitals a substantial portion of the patients of  
10 which are economically disadvantaged persons.

11       “ADMINISTRATION; CONTRACTUAL ARRANGEMENTS

12       “SEC. 799b. The Secretary may, in the administration  
13 of this part, enter into agreements with schools of medicine,  
14 hospitals, or other appropriate public or nonprofit private  
15 agencies under which such schools, hospitals, or other agen-  
16 cies will, as agents of the Secretary, perform such adminis-  
17 trative functions as the Secretary may specify. Any such  
18 agreement with any school, hospital, or other agency may  
19 provide for payment by the Secretary of amounts equal to  
20 the expenses actually and necessarily incurred by such  
21 school, hospital, or other agency in carrying out such  
22 agreement.

23       AUTHORIZATION OF APPROPRIATIONS

24       “SEC. 799c. (a) For the purpose of making medical  
25 student scholarship grants under this part, there is authorized

1 to be appropriated \$2,500,000 for the fiscal year ending  
2 June 30, 1971, \$3,000,000 for the fiscal year ending  
3 June 30, 1972, \$4,000,000 for the fiscal year ending  
4 June 30, 1973, \$5,000,000 for the fiscal year ending  
5 June 30, 1974, and for each succeeding fiscal year, such  
6 sums as may be necessary to continue to make such grants to  
7 students who (prior to July 1, 1974) have received such a  
8 grant and who are eligible for such a grant under this part  
9 during such succeeding fiscal year.

10 “(b) For the purpose of making intern and resident fel-  
11 lowship grants under this part, there is authorized to be ap-  
12 propriated \$2,000,000 for the fiscal year ending June 30,  
13 1971, \$3,000,000 for the fiscal year ending June 30, 1972,  
14 \$4,000,000 for the fiscal year ending June 30, 1973,  
15 \$5,000,000 for the fiscal year ending June 30, 1974, and for  
16 each succeeding fiscal year, such sums as may be necessary to  
17 continue to make such grants to interns and residents who  
18 (prior to July 1, 1973) have received such a grant or a  
19 medical student scholarship grant under this part, and who  
20 are eligible for such a grant under this part during such suc-  
21 ceeding fiscal year.

22 “DEFINITIONS

23 “SEC. 799d. (a) For purposes of this part—

24 “(1) the term ‘nonprofit’, as applied to any hos-  
25 pital, means a hospital which is owned and operated by

1       one or more nonprofit corporations or associations, no  
2       part of the net earnings of which inures, or may lawfully  
3       inure, to the benefits of any private shareholder or  
4       individual; and

5           “(2) the term ‘practice of family medicine’ means  
6       the practice of medicine by a physician (licensed to  
7       practice medicine and surgery by the State in which he  
8       practices his profession) who specializes in providing  
9       to families (and members thereof) comprehensive, con-  
10      tinuing, professional care and treatment of the type  
11      necessary or appropriate for their general health main-  
12      tenance.

13          “(b) (1) The term ‘physician shortage area’, when used  
14      in this part, refers to an area within a State which is  
15      determined, in accordance with this subsection—

16           “(A) to have an insufficient number of physicians  
17      practicing their profession therein so as adequately to  
18      meet the need for medical care of the population of  
19      such area; and

20           “(B) in which the ratio of physicians to population  
21      is lower than in other areas of the State.

22          “(2) The Secretary shall, in making determinations  
23      under this subsection, accept (in the case of any State) the  
24      determination, as to the number and location of physician  
25      shortage areas in such State, recommended to him by—

1           “(A) the State planning agency for such State (as  
2           designated pursuant to section 314 (a) (2) (A) ), or

3           “(B) if in such State there is no such agency, or  
4           if such agency fails or refuses to make a recommended  
5           determination to the Secretary within such reasonable  
6           time as he shall prescribe, by such other agency of such  
7           State as the Secretary finds to be qualified to make such  
8           a recommended determination and as the Governor of  
9           such State shall have designated to make such a recom-  
10          mended determination;

11 but only if—

12           “(C) such agency, in making such recommended  
13           determination, has sought and obtained the advice and  
14           assistance of the State medical society for such State;

15           “(D) such agency, in making such recommended  
16           determination, classifies each area which it determines  
17           to be a physician shortage area as to the degree of the  
18           physician shortage therein as compared with other areas  
19           which such agency determines to be physician shortage  
20           areas; and

21           “(E) the Secretary is satisfied with the adequacy  
22           of the criteria employed by such agency as the basis  
23           upon which such recommended determination was made.

24           “(3) If, in the case of any State, the Secretary does  
25          not receive (within such reasonable time as he shall pre-

1 scribe) a recommended determination with respect to such  
2 State which meets the requirements of paragraph (2), he  
3 shall (after seeking the advice and assistance of the State  
4 medical society for such State) determine the number and  
5 location of the physician shortage areas (if any) of such  
6 State on the basis of the most current and appropriate data  
7 available to him”.

91ST CONGRESS  
2D SESSION

# S. 4296

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## IN THE SENATE OF THE UNITED STATES

AUGUST 27, 1970

Mr. CRANSTON (for himself, Mr. YARBOROUGH, Mr. HUGHES, Mr. JAVITS, Mr. KENNEDY, Mr. NELSON, Mr. SCHWEIKER, and Mr. WILLIAMS of New Jersey) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

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## A BILL

To amend title VII of the Public Health Service Act to meet the need for additional personnel in the health professions by encouraging and assisting disadvantaged individuals to pursue training designed to prepare them to engage in the practice of such professions, and for other purposes.

1        *Be it enacted by the Senate and House of Representa-*  
2        *tives of the United States of America in Congress assembled,*  
3        That this Act may be cited as the "Health Professions As-  
4        sistance Amendments of 1970".

5        SEC. 2. Title VII of the Public Health Service Act is  
6        amended by adding at the end thereof the following new  
7        part:

1 "PART H—GRANTS AND CONTRACTS TO ENCOURAGE FULL  
2 UTILIZATION OF EDUCATIONAL TALENT FOR THE  
3 HEALTH PROFESSIONS

4 "SEC. 799a. (a) To assist in meeting the need for addi-  
5 tional professional personnel in the health professions (as  
6 defined in subsection (b)), the Secretary is authorized to  
7 make grants to State or local educational agencies or other  
8 public or nonprofit private agencies, institutions, and orga-  
9 nizations, or enter into contracts (without regard to section  
10 3709 of the Revised Statutes (41 U.S.C. (5))) for the pur-  
11 pose of—

12 " (1) identifying individuals with a potential for  
13 education or training in the health professions (includ-  
14 ing veterans of the Armed Forces of the United States  
15 with training or experience in the health field) who due  
16 to socioeconomic factors are financially or educationally  
17 disadvantaged, and encouraging and assisting them (A)  
18 to enroll in a school of medicine, dentistry, osteopathy,  
19 pharmacy, optometry, podiatry, veterinary medicine, or  
20 public health which is accredited as provided in section  
21 721 (b) (1) (B); or (B) if they are not qualified to  
22 enroll in such a school, to undertake such postsecondary  
23 education or training as may be required to qualify them  
24 to enroll in such a school;

25 " (2) publicizing existing sources of financial aid

1 available to persons enrolled in any such school or who  
2 are undertaking training necessary to qualify them to  
3 enroll in any such school; or

4 “(3) establishing such programs as the Secretary  
5 determines will enhance and facilitate the enrollment,  
6 pursuit, and completion of study by individuals referred  
7 to in clause (1) in schools referred to in clause (1) (A).

8 “(b) For purposes of this part, the term ‘professional  
9 personnel in the health professions’ refers to any of the  
10 following—

11 “(1) doctors of medicine;

12 “(2) doctors of dentistry or persons holding an  
13 equivalent degree;

14 “(3) doctors of osteopathy;

15 “(4) doctors of pharmacy or bachelors of science  
16 in pharmacy;

17 “(5) doctors of optometry or persons holding an  
18 equivalent degree;

19 “(6) doctors of podiatry or doctors of surgical  
20 chiropody;

21 “(7) doctors of veterinary medicine or persons  
22 holding an equivalent degree; or

23 “(8) graduates of schools of public health.

24 “(c) For the purpose of carrying out the provisions of  
25 this part, there is authorized to be appropriated \$5,000,000

1 for the fiscal year ending June 30, 1971; \$7,000,000 for the  
2 fiscal year ending June 30, 1972; \$9,000,000 for the fiscal  
3 year ending June 30, 1973; \$11,000,000 for the fiscal year  
4 ending June 30, 1974; and \$13,000,000 for the fiscal year  
5 ending June 30, 1975.”

6 SEC. 3. (a) Section 741 (a) of the Public Health Serv-  
7 ice Act is amended—

8 (1) in the first sentence thereof, by striking out  
9 “Loans” and inserting in lieu thereof “except as other-  
10 wise provided in the succeeding sentence, loans”;

11 (2) in the first sentence thereof, by striking out  
12 “\$2,500” and inserting in lieu thereof “\$3,500”; and

13 (3) by inserting after the first sentence thereof the  
14 following new sentence: “In the case of any student  
15 who is an individual referred to in section 799a (a) (1)  
16 such loans may not exceed \$7,000 for any such student  
17 for any such year.”

18 (b) The second sentence of section 741 (f) of such Act  
19 is amended—

20 (1) by striking out “15 per centum” and inserting  
21 in lieu thereof “33 $\frac{1}{3}$  per centum”;

22 (2) by striking out “a rural area” and inserting in  
23 lieu thereof “an urban or rural area”; and

24 (3) by striking out “an amount equal to an addi-  
25 tional 50 per centum of the total amount of such loans

1 plus interest may be canceled” and inserting in lieu  
2 thereof “an amount equal to the total amount of such  
3 loans plus interest may be canceled”.

4 (c) (1) Effective in the case of fiscal years ending after  
5 June 30, 1970, the first sentence of section 742 (a) of such  
6 Act is amended to read as follows: “There is authorized to  
7 be appropriated to the Secretary of Health, Education, and  
8 Welfare to carry out this part (other than section 744)  
9 \$45,000,000 for the fiscal year ending June 30, 1971, \$55,-  
10 000,000 for the fiscal year ending June 30, 1972, \$60,-  
11 000,000 for the fiscal year ending June 30, 1973, \$65,000,-  
12 000 for the fiscal year ending June 30, 1974, \$70,000,000  
13 for the fiscal year ending June 30, 1975, and \$75,000,000  
14 for the fiscal year ending June 30, 1976.”.

15 (2) The third sentence of such section 742 (a) of such  
16 Act is amended—

17 (A) by striking out “1972” and inserting in lieu  
18 thereof “1977”; and

19 (B) by striking out “1971” and inserting in lieu  
20 thereof “1976”.

21 SEC. 4. (a) Effective with respect to fiscal years ending  
22 after June 30, 1970, the first sentence of section 780 (b)  
23 of the Public Health Service Act is amended to read as  
24 follows: “For the fiscal year ending June 30, 1971 and for  
25 each of the next five fiscal years, the amount of the grant

1 under subsection (a) to each such school shall be equal to  
2 (1) \$2,000 multiplied by one-tenth of the number of full-  
3 time students of such school, plus (2) \$2,500 multiplied by  
4 the number of full-time students of such school who are in-  
5 dividuals referred to in section 799a (a) (1).”

6 (b) The second sentence of such section 780 (b) is  
7 amended—

8 (1) by striking out “1972” and inserting in lieu  
9 thereof “1977”; and

10 (2) by striking out “1971” and inserting in lieu  
11 thereof “1976”.

12 (c) (1) Section 780 (c) (1) (D) of such Act is  
13 amended by striking out “two” and inserting in lieu thereof  
14 “seven”.

15 (2) Section 780 (c) (1) (E) of such Act is amended—

16 (A) by striking out “1971” and inserting in lieu  
17 thereof “1976”; and

18 (B) by striking out “1972” and inserting in lieu  
19 thereof “1977”.

20 (3) The second sentence of section 780 (c) (2) of such  
21 Act is amended by striking out “\$2,500” and inserting in  
22 lieu thereof \$5,000 (in the case of any student who is an  
23 individual referred to in section 799a (a) (1) ), or \$2,500  
24 (in the case of any other student),”.

The CHAIRMAN. A bipartisan group of 22 Senators now are cosponsoring this bill, and that includes myself and eight other members of the Health Subcommittee.

The need for this legislation lies in the problem of maldistribution of health professionals in the United States. Isolated communities, and areas of urban and rural poverty, are notoriously deficient in health manpower and facilities. There is great imbalance in the distribution of medical care in the United States. The standards of care out in the many poor farming areas; many ghetto areas are shockingly poor; and there is tendency for health professionals, just as there is for professionals in all categories, to gravitate away from such areas and toward communities with greater economic, social, and other advantages for the professional practicing there. The result is that in health, as in many other matters, the rich get richer and the poor get poorer.

Inadequate health care and poverty feed upon one another in a vicious circle. The "diseases of poverty"—anemia, malnutrition, dental disease, high infant and maternal mortality, short life expectancies, and so on—make economic productivity and advancement very, very difficult, if not impossible, for the impoverished. This vicious circle can be found in any ghetto or in any sparsely populated rural area.

The physician maldistribution problem has occupied much of our time and attention here in the Health Subcommittee. My bill to promote the training of family practitioners is directed specifically at this question, and it is for this reason that we have scheduled today's hearing for a bill that also has much support, a bill offered primarily by the two distinguished Senators from the State of Washington, Senators Magnuson and Jackson, but with the help of most of us here on the Health Subcommittee.

The distinguished Senator, the principal author, is entering the room and, Senator Magnuson, if you will have a chair I will make my opening statement and you will be the first witness.

Unless health care can be distributed more equitably in America, today's social, racial, and economic gaps will widen at an ever-accelerating rate.

The bill we are considering today is no panacea for the problem of medical manpower maldistribution. It is a frankly experimental approach, but an approach that we feel may lead toward a resolution of this seemingly intractable maldistribution problem.

The essential feature of this bill is the creation of National Health Service Corps. Through the National Health Service Corps, the authority of the Public Health Service will be broadened to include the provision of health services to citizens in areas of isolation or urban and rural poverty.

The Corps is to be composed primarily of commissioned officers of the Public Health Service. Health Service Corps personnel will be used primarily to supplement manpower in ongoing health care programs. Authority is also provided for experimentation in utilization of the Corps.

We have a full schedule of expert witnesses waiting to appear before the committee. Unfortunately, the administration has declined this committee's invitation to present testimony on this important health bill. They have been invited and we sought to provide them

with a bill that would be satisfactory to them today. They didn't see fit to come. The Congress in general, this committee, and the author of this bill, who is here with us, grow increasingly weary of an administration which, after almost 2 years in office, still finds itself unable to take forthright positions on vital domestic health issues.

Unquestionably, the vexing crisis which besets the Nation worsens while the administration continues to "study the problem," conducts various studies and vetoes hospital bills and health appropriations. Bookshelves are full of studies. We now need effective action. In the future, this committee would hope to have the benefit of the administration's views with regard to health legislation. It is now time for this administration to put aside its studies and its rhetoric and to begin to deal with real problems. Anything less than that amounts to an abdication of the trust which was temporarily placed in the administration in November of 1968.

With that, we can proceed to our first witness, the distinguished Senator from Washington, Mr. Magnuson, chairman of the Appropriations Subcommittee dealing with health. He has also served with distinction for many years as chairman of the Commerce Committee. It was my privilege to serve on that committee under his chairmanship for 7 years, and I saw there his interest in the health of the people by the care that he gave to bills to consumer protection laws, including the protection of children from flammable materials, and in many other measures.

He has sponsored great bills before that committee, so it has been a great benefit to the country that he has become chairman of the Appropriations Subcommittee dealing with questions of health.

Senator, it has been a great privilege to work with you here for more than 13 years, and especially for the 7 years I served on your committee under your chairmanship.

#### STATEMENT OF HON. WARREN G. MAGNUSON, A U.S. SENATOR FROM THE STATE OF WASHINGTON

Senator MAGNUSON. I thank you, Mr. Chairman, very much.

I might say your contribution to these matters has been great. I often think with all of the activity that goes on now in the consumer field, many years ago we had to make a beginning, and although now so many people have joined us, we were voices in the wilderness in those days.

The CHAIRMAN. I recall that very well.

Senator MAGNUSON. The Senator from New York, too, remembers that. We are glad we got these things accomplished, and that now we have such great support.

Senator JAVITS. May I explain to Senator Magnuson, that I came to our hearings this morning out of deference and affection for him, but I am imminently awaited in the Foreign Relations Committee, and therefore must ask him to excuse me.

I would like to say I know of no witness I would welcome more before our committee and the subject of his testimony, S. 4106, of which I am cosponsor. This legislation is a marked contribution by him and Senator Yarborough to the totality of what we can do in

the health field. He is always with me, cooperating with me most closely, and it is with great pleasure I anticipate his testimony today.

Mr. Chairman, I ask unanimous consent to insert at an appropriate place in the record a statement by Senator George Murphy in support of S. 4208, Family Physician Scholarship and Fellowship Program Act, of a measure related to the same general subject, and ask it may be made part of the hearing record.

The CHAIRMAN. It is so ordered.

Senator MAGNUSON. Mr. Chairman, you have a number of distinguished witnesses this morning and I don't wish to take the time of the committee on a lengthy statement.

The CHAIRMAN. Will the Senator yield before he starts his statement. I want to say that despite my criticism of the administration for not making its contribution to this bill, that criticism does not include the Members of the Senate, of the minority party. With the aid of the able and distinguished Senator from New York, we have passed a great volume of health legislation for years, particularly in the past 2 years, and certainly, without his contributing to every bill, we wouldn't have succeeded. He is very helpful in pushing for beneficial legislation. So my remarks explicitly exclude him, his colleagues and those who worked with him. They made great contributions to the health bills that have been passed.

Senator MAGNUSON. In order to expedite these proceedings, I will submit for the hearing record a statement for myself and a statement for my colleague, Senator Jackson.

I do want to thank you, Mr. Chairman, for making these hearings possible and for joining as a cosponsor of this important legislation. I know that the committee has a very full schedule for the coming weeks, and we deeply appreciate your taking the time to consider the National Health Service Corps Act. Since you and eight other members of this subcommittee have cosponsored this legislation, and since the subcommittee has had such a distinguished record under your leadership in health matters of all kinds, I don't think I need to try to convince the chairman and others on the subcommittee of the bill's merits.

With your permission, Mr. Chairman, I will simply submit my statement and the statement of Senator Jackson, both of which are essentially the same as the statements we made at the time we introduced the bill on July 21. I will also submit some relevant materials that I am sure you would want in the hearing record.

Once again, my deep and sincere thanks for taking action on this very important bill. I know your hearing will be a fruitful one.

The CHAIRMAN. Thank you, Senator Magnuson. The request of course is granted, and this material will all be printed at this point in the record, and I order printed also copies of these statements of the Senators.

(The prepared statement of Senator Magnuson follows:)

PREPARED STATEMENT OF SENATOR WARREN G. MAGNUSON ON S. 4106, THE  
NATIONAL HEALTH SERVICE CORPS ACT OF 1970

Mr. Chairman, I want to begin by expressing my deep gratitude for your support of the National Health Service Corps Act, and for taking time from the Subcommittee's busy schedule to hold this morning's hearings. With this prompt action on your part, the chances for passage of this legislation have increased dramatically.

My remarks on the bill (S. 4106) today will be substantially the same as my remarks at the time Senator Jackson and I introduced the National Health Service Corps Act on July 21st of this year.

This legislation will establish a National Health Service Corps within the Public Health Service, in order to improve the delivery of health services to areas of urban and rural poverty where health services are now inadequate. The Corps will be comprised of selected commissioned officers of the Public Health Service and of other health professionals under civil service. Supervision of the Corps' activity will come from a Director, to be nominated by the President subject to the approval of the Senate. Assisting the Director will be a National Advisory Council of twelve members. Council members will include Federal health officials, private citizens, members of the Corps itself, and recipients of health services provided by the Corps. A complete analysis of the structure and functions of the Corps will appear later on in my remarks.

Mr. Chairman, the National Health Service Corps Act is an important piece of legislation for many reasons. In offering it, Senator Jackson and I have three basic purposes in mind. First, we want to increase the quantity and quality of health services in those areas of the country, and among those segments of the population, that need such services the most. Second, we want to revitalize the Public Health Service generally and the commissioned corps specifically by providing them with a mission to match their proud tradition. Finally, we hope in offering the National Health Service Corps Act to provide a framework within which the idealism and social commitment of our young health professionals and medical school students can be put to work, serving the most disadvantaged people in the nation.

I will comment individually on these three purposes, and then proceed to an analysis of the legislation itself.

#### I. THE DISTRIBUTION OF MEDICAL MANPOWER IN THE UNITED STATES

Mr. Chairman, anyone who is even remotely familiar with health care programs and services here in the United States recognizes that we are in the midst of a severe manpower shortage in the health professions. The first aspect of this manpower shortage is an absolute shortage in the number of trained doctors, dentist, nurses, and other health professionals. The Appropriations Subcommittee on the Departments of Labor and Health, Education and Welfare, of which I am Chairman, has listened to the staggering statistics of this absolute shortage during our hearings over the past month. The Subcommittee, the full Appropriations Committee, and the Senate as a whole will act, I hope, to provide a level of funding for the current fiscal year that will help to alleviate this shortage.

But the manpower shortage among health professionals has another facet, one that cannot be solved simply by increasing our appropriations for existing programs. This second facet involves the maldistribution of the health professionals that we do have. Physicians, dentists, and all other forms of medical personnel simply are not distributed in relation to the health needs of the United States. And so, while the nation as a whole faces a doctor shortage, the shortages in areas of urban and rural poverty are particularly acute.

It is virtually impossible for poor communities to attract and retain sufficient health professionals to meet even their most basic health needs. Senator Jackson and I have seen this over and over again in our home State of Washington, where isolated rural communities and the core areas of our larger cities simply do not receive a level of health care that most middle-class individuals would consider adequate. The causes of this maldistribution are no mystery—poorer communities have few attractive features for a young doctor or dentist with a family to raise—yet the consequences of inadequate health care in these communities are physically, socially, and economically crippling to our poorer citizens, and shameful for our nation as a whole.

Many health problems that would appear routine or even trivial in more affluent communities become serious or near-fatal in those areas where access to health care is severely restricted. The "diseases of poverty"—high infant mortality, short life expectancies, malnutrition, anemia, and so on—are exacerbated greatly when they go untreated, and contribute substantially to the vicious circle of poverty and low economic productivity.

The National Health Service Corps will not eliminate these diseases, nor will it solve completely the massive problem of maldistribution in the health professions. At the level of funding provided in this act—about \$5 million—about a

dozen communities across the nation will receive care from Corps members. But this pilot project phase, if it proves successful in more adequately meeting the health needs of the poor, can be expanded easily simply by increasing the authorization provided in this act and the appropriations to match.

What the Corps will do is provide substantial infusions of medical manpower in areas with ongoing Federally-funded health care programs. In some instances, the Secretary of HEW may choose to deploy Corps personnel in areas without existing health care programs, and authority is provided in the act to meet this eventuality. At this stage, however, and at this level of funding, the purpose of the act will be to demonstrate that the health care needs of the poor can be substantially met through a redistribution of health manpower.

A long range solution to the maldistribution of health professionals will require more than a Federal program of this type, of course, and it is our hope in offering this legislation that doctors, dentists, nurses, and other health professionals who serve in the Corps will wish to continue practicing in poverty areas after their tour of duty with the Corps has been completed. One of the factors to be taken into account in assigning Corps members, in fact, will be the prospects for continued service to the community after completion of the 25-50 month term of service in the Corps.

The National Health Service Corps thus will help meet the problem of maldistribution of health professionals in two ways: first, it will provide an infusion of health personnel into Federal health care programs in physician-deficient areas, and second, it will provide a program whereby health professionals can serve for a time in poverty areas and determine whether or not continued service in such areas would be worthwhile as a career.

## II. REVITALIZING THE PUBLIC HEALTH SERVICE AND THE COMMISSIONED OFFICER CORPS

The National Health Service Corps established in this Act is to be set up within the Public Health Service. The health professionals in the Corps will be drawn primarily from the commissioned officer corps of the Public Health Service. These two facts make the Corps, even at this pilot project level of funding, an extremely significant development for both the Public Health Service and the commissioned corps.

The Public Health Service and the commissioned corps have a long and proud tradition. Founded in 1873—for the purpose of protecting our seaports from importation of communicable disease—they have undergone many protean changes during their century of existence. The Public Health Service and the commissioned corps currently do not provide direct health services except to special population groups—American Indians, merchant seamen and the Coast Guard, and Federal prisoners. These programs are worthy ones, but being limited to such programs makes the direct health care services of the Public Health Service relatively minor in comparison with the other health care programs in which the Federal government has become involved.

Technically, of course, the Public Health Service and the Surgeon General are charged with the responsibility for administering the National Institutes of Health (NIH), the Food and Drug Administration (FDA), and the Environmental Health Service (EHS). I use the word "technically" because the *de facto* control of these organizations, insofar as there is centralized control and direction of their activities, lies with the Assistant Secretary of HEW for Health and Scientific Affairs. As a result, there is a great deal of confusion about the what the Public Health Service is, what it is doing, what it could be doing, and why it continues in existence at all.

These doubts surrounding the role and functions of the Public Health Service have contributed substantially to a lowering of morale within the commissioned corps. Proposals have been made, from time to time, to abolish the commissioned corps entirely or to transfer its functions to other, more logical, agencies. At the present time, most commissioned corps members who do not work in the direct health services programs for Indians, Seamen or prisoners spend their tour of duty in the Corps performing research or administrative tasks. This conflicts with the desire of many commissioned officers to be active in providing health care commensurate with their training and interests.

The sponsors of this legislation do not believe that the commissioned corps and the Public Health Service should be allowed to wither on the vine. Neither do we feel that we can afford to wait until one study after another is undertaken to determine the future of the commissioned corps and the PHS. We feel, rather,

that the commissioned corps and the PHS should be rejuvenated by assuming new responsibilities in keeping with their abilities and their proud traditions.

There is a unique camaraderie and feeling of mission among the commissioned corps that sets it aside from regular civil service. Even if this spirit is currently at a low ebb, there is ample reason—and more than ample need—to energize the commissioned corps that sets it aside from regular civil service. Even if this spirit is currently at a low ebb, there is ample reason—and more than ample need—to energize the commissioned corps and the PHS once again and to take advantage of these unique characteristics. This spirit should be redirected toward meeting the most challenging health problems of this nation, not dissipated during this period of great social need.

The National Health Service Corps will not displace the other functions of the PHS, nor will it absorb an inordinate number of PHS personnel, at least during this experimental phase. But it will provide an additional mission, that of providing health care directly to those segments of the population who need it most and who are being inadequately served today. This challenging new mission can raise the morale of the commissioned corps and the PHS at the same time it benefits the people of this nation.

### III. THE NATIONAL HEALTH SERVICE CORPS AND THE "NEW" GENERATION OF HEALTH PROFESSIONALS

The National Health Service Corps has a third purpose, and that is the utilization of the idealism and social commitment that characterize so many of our young health professionals and medical school students. I have met and talked with literally dozens of these fine young men, and women, as I know the other sponsors of this legislation have. Like so many other young adults with fine minds and excellent training, they are less than enthusiastic about the opportunities for social service within the "established" institutions of their profession. They desire instead to serve the poor, the hungry, and the needy who simply are not receiving adequate health care today, and they are willing to sacrifice more lucrative opportunities in order to perform this service.

The National Health Service Corps will provide a framework within which these men and women can achieve the service to society that they seek. It is upon the social commitment of these young men and women, in fact, that we will be relying to produce the personnel the Corps will need. Knowing that service in the Corps is an opportunity available to them should raise the morale of these health professionals during the time they are in their professional schools as well.

Ultimately, if the Corps proves to be a successful concept in improving the delivery of health care, it is not too much to anticipate that the experiences of the Corps will be drawn upon in the evaluation and planning of both governmental and non-governmental health care programs. In this sense, the young men and women who enter the Corps will know that their performance is important for the future of health care in the United States. The knowledge that they may be aiding in the redirection of the Federal and private health efforts, combined with the satisfaction of actually serving those in greatest need, will be the prime reward for Corps members and the prime incentive for those who wish to serve in the Corps.

### IV. ANALYSIS OF SECTIONS OF THE NATIONAL HEALTH SERVICE CORPS ACT

In drafting the National Health Service Corps Act, an attempt has been made to allow the Department of HEW some discretion and flexibility in administering the Corps. Passage of the Act should provide the Department with an opportunity as well as a directive, and its experimental nature necessitates a somewhat broad piece of legislation. The reasoning behind some of the sections of the Act may not be clear on first reading, so I would like to take this opportunity to clarify exactly what we had in mind in drafting the Act.

Section 399h establishes the Corps within the Public Health Service (for reasons outlined in Part II of my remarks), and defines the mission of the Corps, "to improve the delivery of health services to persons living in communities or areas of the United States where health personnel, facilities, and services are inadequate to meet the health needs of the residents of such communities and areas." The same Section further states that priority shall be given to those urban and rural areas where poverty conditions exist. As I explained above, poverty and physician-deficiency tend to go hand in hand in such areas.

Section 399i deals with the staffing of the Corps. As I noted earlier, the Corps will be composed of both commissioned officers of the Public Health Service and other civil service personnel. All Corps members will serve for a period of 25 months, with the option of extending their tours of duty for a period not to exceed another 25 months. The purpose of having a 25 month tour of duty is to allow a one month transition period within which incoming personnel can work with outgoing personnel in order to facilitate a continuity in patient care and other duties. For those members of the Corps who wish to follow their tour of duty with more schooling, this Section provides the right to petition for release from the Corps at the end of 24 months. The purpose of not allowing Corps members to serve more than 50 months is to provide an incentive to Corps personnel and to the agencies or communities within which they serve to find positions outside the Corps that will allow them to continue serving the poor.

Part of the purpose for the Corps itself, after all, is to encourage health professionals to locate permanently in areas with inadequate health care. We assume that a Corps member may serve in more than one community during a 50 month tour of duty, but that by the end of that period both the Corps member and a community within which he has served should be in a position to determine whether or not the individual is willing and able to undertake a long range commitment to a needy community.

Section 399j provides that the Director of the Corps shall be appointed by the President, subject to the advice and consent of the Senate. Establishing the Corps under a Director will give the Corps a stature similar to other Federal health agencies, and will serve to emphasize the importance that Congress attaches to this program even in its pilot project phase.

Section 399k establishes the manner in which Corps personnel may be utilized. Under Part 1 of this Section, Corps members may be used to supplement manpower in ongoing direct health care programs of the Public Health Service, meaning all programs within the Department of HEW. Part 2 specifies that Corps personnel may also be used in any direct health care program of other government agencies, such as the Office of Economic Opportunity's programs or those of the Department of Housing and Urban Development, or direct health care programs whose costs are underwritten by Federal funds. The practical effect of these two parts is to allow the Secretary to deploy corps personnel to any direct health care program that is ongoing and funded, in whole or in part, from the Federal Treasury.

Part 3 of Section 399k authorizes the Secretary to utilize Corps personnel "in any other health care activity, in furtherance of the purposes of this act." The purpose of this Part is to allow the establishment of health care programs where none presently exist, should this be something that the Director of the Corps and the Council feel to be of value. The applicability of this section would undoubtedly arise in rural areas where no Federally-funded program currently provides health services, yet where the Director and Council feel a pilot project would be useful. This Part provides that the Secretary will establish some fee-for-service mechanism in the event a project is established under this Part, such revenues as may be collected being used to partially defray the cost of the Corps operations. Under the other two Parts of this Section, no fees will be collected by the Corps, as Corps members will be serving in programs with fee mechanisms of their own. Insofar as the activities of Corps members under these two parts may contribute to more fees being paid into the program within which they are serving, such fees will continue to be paid into the general revenue of those programs. The purpose of the Corps is to provide health services, not to collect fees, but under each of these Parts a built-in precaution exists against the diversion of fees that might otherwise go to private practitioners.

Section 399l establishes the National Health Corps Advisory Council. The composition of this twelve-member Council is, in my opinion, one of the most exciting features of this legislation. Not only will the Council have three HEW officials and three private citizens, but it will also include three members of the Corps itself and three recipients of health care services provided by the Corps. This will insure the representation, at the highest level of decisionmaking, of both those individuals who serve in the Corps and those individuals who will be served by it. In addition, the Secretary conceivably might choose to appoint some or all of the private citizens from the ranks of the poor. As I will mention in a moment, this mechanism insures a double representation of the poor, both on the Council and on the 314(b) planning agency whose recommendations will be taken into account in assigning Corps personnel.

Subsection (b) of Section 399l provides that members of the Council shall serve for three years, shall be eligible for reappointment, and shall not be removed except for cause.

Subsection (c) outlines the functions of the Council. These include the establishment of guidelines with respect to utilization of the Corps, and the directive to advise and consult with the Director generally concerning the operation of the Corps. The Council may also assist the Surgeon General in the selection of Corps personnel, and will be responsible for approving all assignments of Corps personnel.

Under this same Subsection, the Council is assigned the responsibility of establishing criteria to determine which areas or communities are to receive assistance from Corps. In establishing such criteria, the Act directs the Council to take into account at least five factors. The first of these factors is the community's need for health services. The second is the willingness of the community—including the program within which the Corps will serve—to assist and cooperate with the Corps and its mission; this provision will insure that administrative restrictions—such as hospital visiting privileges—from various sources in the community will not impede the Corps' operations. A third factor to be taken into account in establishing criteria for utilization of the Corps is the prospect for utilizing Corps personnel within a community after their tours of duty are complete. This is necessary to provide an incentive for the community, and the program within which the Corps member may serve, to facilitate the retention in the community of those Corps personnel who may desire to continue serving the community following completion of their tour of duty. The knowledge that assignment of Corps personnel to the program and the community in the future may hinge in part on the post-service opportunities provided for Corps personnel who have served the community in the past should encourage communities who desire Corps assistance to take positive steps toward finding permanent positions for Corps members.

A fourth factor in establishing these guidelines will be the recommendations of the 314 (b) comprehensive health planning agency responsible for the area or community under consideration. These agencies not only have responsibility for the planning of health programs within their areas of jurisdiction, but through their heavy representation of poor people, insure that all health programs are consistent with the needs of those who are to receive services from them.

Finally, the recommendations of all medical personnel in the community or area under consideration for assignment of Corps personnel will also be taken into account. This insures that private practitioners, state medical societies, and other relevant organizations and individuals will not be ignored in the making of decisions affecting utilization of the Corps.

Section 399m (a) waives the manpower ceilings on both the commissioned corps and the Department of HEW, to the extent that the number of individuals in the Corps exceeds either of these ceilings. Section 399m (b) waives the restriction on the utilization of Public Health Service facilities and personnel for the provision of direct health care, provided the waiver is exercised only for Corps activities. This provision will allow the use of Public Health Service hospital facilities for pilot projects, if the Director and Council wish to do so. The Subsection also provides that the Corps may lease or purchase facilities in order to provide health care; this is to allow some flexibility in the event that the Council approves assignment of Corps personnel to a program or community whose facilities would be unable to accommodate the personnel assigned.

Finally, Section 399n authorizes the appropriation of \$5,000,000 annually to carry out the purposes of this Act. This sum might be spent to provide, for example, for 75 commissioned officers and 150 civil service personnel within the Corps (at a cost of \$3.8 to \$4 million), and for some minor leasing arrangements with respect to facilities and supplies. This sum is hardly sufficient to effect any sweeping changes in the health of our nation's poor, but if spent judiciously, could provide sufficient care in selected pilot project areas to allow some determination as to the feasibility and desirability of the National Health Service Corps concept.

#### V. CONCLUSION

The purposes of the National Health Service Corps, and the manner in which it will function, have now been described in some detail. Further explanations will be forthcoming from other sponsors of this legislation here and in the House of Representatives.

In closing, I wish to make an appeal for the objective and open-minded consideration of this legislation both within Congress and beyond. At first reading, some individuals or groups may perceive in this legislation a threat to established institutions or a barrier to future innovations. Closer inspection of the bill and its provisions will reveal that nothing of the sort is intended or contained within it.

The National Health Service Corps is frankly an experimental concept, and one that may lead to many different conclusions about the nature of health care in the future. In and of itself, however, the National Health Service Corps is compatible with current or potential national policies on the delivery of health care; it is not a threat to the manpower needs of the Department of Defense; it will not hamper, nor be hampered by, abolition of the doctor draft or the introduction of National Health Insurance. The National Health Service Corps is not an attempt to structure the health policies of the United States government, nor need it be subjected to a "public-*vs.*-private" debate that inevitably occurs whenever innovations in health care are suggested. Its only purpose is to serve the health needs of the poor, and to provide us with a body of knowledge from which we may find more effective ways to serve those needs on a major scale in the future.

Let us not judge the Corps in advance. Let us create it, fund it, and observe its performance. Then let us draw our independent conclusions about its value and what it tells us about the future. By creating the Corps and setting it in operation, we will at least have provided some health care to those who need it most, and we will have demonstrated to the poor that we truly are concerned about improving their condition. And if the Corps should fare better than this—as I hope and believe it will—its creation will have been a major step in meeting the crisis in health care that we face as a Nation today.

EXCERPT FROM THE HEARINGS BEFORE THE SENATE APPROPRIATIONS COMMITTEE, SUBCOMMITTEE ON DEPARTMENTS OF LABOR, HEALTH, EDUCATION, AND WELFARE, AND RELATED AGENCIES, 1970, ON FISCAL YEAR 1971 BUDGET

Senator MAGNUSON. Because of the lack of physicians and the problem of distribution of physicians we introduced a bill the other day, Senator Jackson and I, to see if we couldn't use commissioned officers in the Public Health Service in direct medical services to the urban poor and rural areas. Dr. Steinfeld, do you think this is a good idea?

Dr. STEINFELD. I think it is excellent.

Senator MAGNUSON. Thank you.

The CHAIRMAN. Senator, we all know serving here that very often when we have a beneficial measure in the closing days of Congress, we try to get hearings on it and set it up as a prelude to succeeding Congresses, but that it not my object in calling these hearings. I intend to get this bill out of subcommittee and the full committee and on the floor of the Senate, and I am sure the leadership of the Senate would cooperate. I would like to see it passed this year. We can't speak for the House. We hope to have the same cooperation.

It is my objective in calling these hearings, not just to set up something for next year, but to try to pass the bill this year. It would be too bad if it is deferred another year.

Senator MAGNUSON. I might say to the chairman that in the past few weeks I have been holding the hearings on the HEW education bill that has now become in overriding the veto. But the Surgeon General and Dr. Egeberg, Assistant Secretary for Health, in the hearings, particularly the Surgeon General, endorsed this bill. I will see that you get a copy of those hearings to put in your record.

The CHAIRMAN. Yes. Senator Magnuson, please, before you leave, there is an important matter pending before us for this next year. Last year, when I became chairman of the Appropriations Subcom-

mittee that deals with the Bureau of the Budget, I inquired into this. They had 178 hearing examiners at the bureau, and we gave them more. They said they needed more hearing examiners. These are the top people who pass on the budgets for different departments. We found that they did not have a single health professional or educational professional among all of those hearing examiners, who are constantly cutting back on these health and education bills.

Now we had in this country at the end of World War II 23 Public Health Service hospitals, and they have cut them back to eight. I have been digging into where the cutbacks came from, whether or not it is the Bureau of the Budget urging to cut off the money. They are trying to cut off the last hospital at the Great Lakes, and these Public Health Service hospitals have more latitude for research than any other system of hospitals in the country. It is very vital they be protected so as to stop this movement to absolutely disestablish and destroy them.

This ought to be stopped, and reversed. Your bill is a reversal; it is an important bill, for its internal content and for its thrust. I hope it will blunt and turn back this effort. We have had these hospitals from 1790. One of the first laws was the Maritime Seaman's Hospital from which came the Public Health Service hospitals, and this gives us some instrumentality so the Bureau of the Budget cannot destroy the PHS. Your bill is a landmark bill in helping to bring back, revitalize, and extend the PHS system.

Senator MAGNUSON. I might say, too, I have been disturbed during all of these hearings, as have the members of this committee, in what I like to call the delivery of health care.

The research has been good; there have been good things in research, but the delivery of health care has lagged, and this bill would put a new sense of urgency there. We have also been disturbed about the morale of the Public Health Service; there is a feeling that maybe the Service is not making contributions it ought to, and this bill would allow it to do so once again.

As a matter of fact, they tell me the introduction of the bill itself built up morale in the Public Health Service.

The CHAIRMAN. I think the morale is going down because the administration is closing the Public Health Service hospitals and trying to destroy this Service. I want to assure the Senator—and I seldom make this statement publicly—but I intend to push this bill with every resource I have.

At this point we will receive for the record the statements of the senior Senator from Massachusetts, Mr. Kennedy; the junior Senator from Wisconsin, Mr. Nelson; the junior Senator from Washington, Mr. Jackson; and the senior Senator from California, Mr. Murphy.

(The statements referred to follow:)

**STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM  
THE STATE OF MASSACHUSETTS**

Mr. KENNEDY. Mr. President, I am pleased to cosponsor the National Health Service Corps Act of 1970, introduced today by the distinguished Senator from Washington (Mr. MAGNUSON). As chairman of the Appropriations Subcommittee on the Departments of

Labor and Health, Education, and Welfare, Senator Magnuson has been one of the foremost advocates of better and more adequately funded health programs in the Nation, especially in the area of health manpower. The legislation introduced today is a tribute to his leadership in the field of health, and I hope that it will receive early action by Congress.

A National Health Service Corps will be an important step forward toward alleviating what is perhaps the most serious aspect of our overall health crisis—the worsening shortage of health manpower. Indeed, at bottom, our crisis in health is essentially a crisis in manpower. The need is urgent for more physicians, more dentists, more nurses, and more allied health professional and technical workers. We must develop new types of health professionals and para-professionals. We must make far more efficient utilization of our existing health manpower. Only if we succeed in these efforts will we be able to free our physicians and other highly trained health experts to carry out the skills for which they have been trained. In far too many cases, highly trained physicians spend the overwhelming majority of their working day in tasks that do not require their specialized medical skills.

One of the most promising methods of easing the shortage of doctors is to train new types of health workers to perform nonspecialized tasks, thereby freeing physicians for other, more urgent needs. We must develop a broad new range of allied health professionals, such as paramedical aides, pediatric assistants, community service health officers, and family health workers.

At a number of our universities, imaginative new programs are underway to train medical corpsmen from Vietnam as physicians' assistants. In Senator Magnuson's own State of Washington, for example, hospital corpsmen are being trained for 3 months in the medical school and then sent into the field for 9 months further training in the offices of private physicians. A similar program now exists at Duke University. These programs are unique in their emphasis on combined training in the classroom and in the field. They are programs that must be greatly expanded if we are to meet the urgent demand for more and better trained health manpower.

The need is especially clear in the case of the shortage of doctors. Our low physician-population ratio means that unsatisfactory medical care is a way of life for large numbers of our people in many parts of our Nation. The family doctor—the general practitioner—is fast disappearing, and is on the verge of becoming an extinct species. At the present time, only one out of four of the Nation's physicians is engaged in the general practice of medicine. Three out of four are specialists, most of whom accept patients only on a referral basis. Simply to meet the demand that exists today, it is widely known that we need 50,000 more doctors, and 150,000 more nurses.

To make matters worse, the geographic and social distribution of our doctors is highly uneven. This is the area where the National Health Service Corps will make its greatest contribution. Two-thirds of the physicians in America serve the more affluent half of our population. In some States, to be sure, the physician-population ratio is higher than the national average of 130 doctors per 100,000 population. In Washington, D.C., for example, the ratio is 318. In New York it is 199; in Massachusetts, 181.

In 16 States, however, the physician-population ratio is far below the national average. In Alaska and Mississippi, the ratio is an abysmal 69, or about one-half the national average. In Alabama, it is 75. Even in Texas, it is only 106. Clearly, therefore, extremely large groups of our population are receiving seriously inadequate medical care because of the shortage of physicians.

The problem is especially critical with respect to the health needs of our urban and rural poor. For too many of the poor, the only doctor they know is the cold and impersonal emergency ward of the municipal or county hospital. For too many of our citizens, the family physician has disappeared, to be replaced by the endless and depressing waiting rooms of hospitals built at the turn of the century.

Nowhere are the inequalities of our society more obvious than in the sickness of our poor. We know that our affluent few can buy the world's best medical care. But all too often it is care provided in modern medical towers looking out on urban landscapes condemning thousands of citizens to a lifetime of disease, under some of the worst medical care anywhere in the world.

In the United States today—the wealthiest Nation in the history of man—millions of our citizens are sick. And they are sick because they are poor. Their sickness is the shame of America. Of all the faces of poverty, the sickness of the poor is the ugliest. Of all the effects of poverty, it is the sickness of the poor that we could attack most easily, had we the will.

In areas of urban and rural poverty in the United States, medical care is available but only if one travels far enough, waits long enough, and endures the crowds, the inconvenient hours, the understaffed facilities.

The National Health Service Corps will help to solve these serious problems. I believe it is one of the most important steps we can take if we are to meet the critical need for health manpower in depressed areas. Once young Corps physicians are exposed to the problems of health care in poverty areas, I believe that a significant number of them will be encouraged to remain and dedicate their careers to this service, to the lasting benefit of the health of America.

#### **STATEMENT OF HON. GAYLORD NELSON, A U.S. SENATOR FROM THE STATE OF WISCONSIN**

Mr. NELSON. Mr. President, I am very pleased to sponsor this legislation establishing a National Health Service Corps with my distinguished colleagues.

Under this plan, teams of medical professionals and paraprofessionals would be sent into city and rural poverty areas to upgrade the medical care now available there.

It is loosely patterned after the National Teacher Corps program, which Senator Kennedy and I originally proposed in 1965. It is my firm belief that this health care program is destined to meet with the same overall acceptance by professionals in the medical field as well as the people to be served as the Teacher Corps has enjoyed over the past 5 years of its operation.

Despite dramatic medical advances and the investment of billions of Federal dollars, we are on the brink of a national health crisis with

thousands of families in urban ghettos and residents in poverty stricken rural areas unable to obtain adequate health and medical care.

The health resources of the Nation have been badly misallotted. Highly trained personnel and highly specialized medical equipment have been clustered in shiny new medical centers, isolated from the needs of many citizens in the inner city and rural towns.

The National Health Service Corps could substantially correct the present maldistribution of medical manpower by using local volunteers, paraprofessionals, and professionals in community clinics and other facilities serving the citizens of urban and rural regions.

Physicians serving in the program would become members of the U.S. Public Health Service as commissioned officers and would fulfill their military obligation. Nurses and other health care personnel would be recruited by the Public Health Service for assignment by the U.S. Surgeon General to serve in various areas of the country.

A National Health Corps Advisory Council, comprised of Government representatives, private citizens, and recipients of service by the Health Corps, would develop the policy governing the selection of personnel and their assignment to areas inhabited by medically needy.

In addition to projects in city ghettos, the Corps personnel could be used in health care programs serving Indians, migrant workers, Head-start children, people in model cities neighborhoods and expanded programs based in Public Health Service hospitals, neighborhood health clinics, and community mental health clinics.

Our young doctors, nurses, and other medical personnel should be given the opportunity to share in the satisfaction of public service through participation in a National Health Corps. Their counterparts in the educational and legal professions have already displayed their social consciousness by flocking to work in the National Teacher Corps and neighborhood legal services program.

Implicit with this manpower plan is the need for expansion of neighborhood health clinics and hospital satellite centers, the development of improved means to transfer patients to facilities with better medical resources, and a reassessment of priorities in Government health programs.

Local community residents, trained by medical personnel in local hospitals, could be mobilized as health workers to inform their neighbors about family health practices, preventive medicine, and the accessibility of health care while others could prepare for new career positions in the health field.

Without a comprehensive revision of the organization and delivery of health and medical care, millions of citizens will continue to receive no care at all or very marginal care at best.

As medicine becomes more and more specialized, there are fewer and fewer general practitioners available to serve the routine medical needs of the public. Less than 2 percent of today's medical graduates enter general practice.

When confronted with a relatively minor ailment, such as a cold or sprained ankle which could be normally treated at a doctor's office, many city residents must travel to the emergency room of a city hospital to receive medical attention.

These noncritical cases clog the emergency facilities and become a wasteful burden on the efficiency of the hospital's operation.

While this program will improve the allocation of the medical manpower we have available in our Nation, we cannot avoid confronting the overall physical shortage problem in the United States. It seems to me that Congress should consider the establishment of a National Public Health Academy as a source of trained personnel to serve the medical and health needs of our Nation.

Such an institution could aim its efforts at recruiting promising students from low-income families, who would be mostly likely to return and serve the medically needy after their training. Students at the academy would receive a full Government-financed medical education in exchange for an established term of service in regions faced with acute medical needs.

#### **STATEMENT OF HON. HENRY M. JACKSON, A U.S. SENATOR FROM THE STATE OF WASHINGTON**

Senator JACKSON. Senator Magnuson and I have worked closely on this National Health Service Corps concept for months. We have discussed our ideas with officials from the Department of HEW, members of the commissioned corps of the Public Health Service, senior officers of the Service, doctors, and medical school students. We know from these discussions that there is support for our proposals.

More importantly, we know that there is a great need for our proposal—a need that is not being met today and a need that will not be met in the future unless action is taken. Senator Magnuson and I have seen this need, not merely in a mass of statistics, but face to face in our own State of Washington. From the small logging towns and the tiny Indian fishing communities to the crowded neighborhoods of our inner cities, we have seen the need for this legislation. Even in our relatively affluent State, we have seen vast areas with little or no health services available, and we have seen hundreds of our constituents wracked by malnutrition and the diseases of poverty.

The poor and the isolated in our State are not unique in their need for health care; similar and even worse conditions exist in nearly every county in this Nation. In every corner of the land, poverty breeds ill health and ill health perpetuates poverty. Most Americans never see the diseases of poverty—malnutrition, anemia, high infant mortality, and low life expectancies—in their immediate communities, but this low visibility cannot obscure the statistical facts.

Fifty percent of the poor children in America have never had a polio shot or any other form of vaccination to protect them against this dreaded disease.

Two-thirds of our poor children have never seen a dentist during their lifetime.

At least half of the mothers who give birth in poor or isolated areas receive no prenatal care whatsoever.

The statistics go on and on; so does the subculture of poverty in America and the ill health that attends it. Those who speak of the need to make the poor productive, of taking them off the welfare rolls and getting them on the payrolls, must realize that little or no progress can be made in this respect until the poor and the isolated are provided a decent standard of medical care.

If a child's growth is stunted, if he cannot stay awake in class or if he is constantly ill, he cannot be expected to get ahead in life, or even to keep up. If a grown man is crippled unnecessarily by a disease that could easily have been cured, he cannot earn an adequate living for his family. If a mother is overly susceptible to illness, she cannot meet the demands of raising a family. To those with an inadequate standard of health care, the promise of equal opportunity is a hollow one indeed. As President Nixon has said :

Many of the problems of the poor are the product of ill health and many have serious medical consequences. We have already begun to develop new mechanisms for helping the poor pay medical costs, but now we must further improve our methods for delivering health services (to them) . . .

The National Health Service Corps is an experimental attempt to deliver those health services to the segment of our population that need health care most desperately. The Corps will not be operating on a huge scale, nor will it solve this health care distribution problem by itself. What the Corps will do is to provide us with greater practical experience in meeting the health care needs of the poor. It is on this experience that we will have to draw in the years ahead, whether the ultimate answer lies in the governmental or private sector, or somewhere in between.

THE NATIONAL HEALTH SERVICE CORPS AND THE MEDICAL MANPOWER  
NEEDS OF THE DEPARTMENT OF DEFENSE

Senator Magnuson has described, in his statement, the purpose and functions of the National Health Service Corps. He has stated that the Corps will not conflict with the medical manpower needs of the Department of Defense, and it is to this point that I will address the next portion of my remarks.

The Department of Defense needs a substantial number of health professionals. At the present time, for example, approximately 16,000 physicians are serving this Nation in the military. About 6,000 of the 9,000 doctors graduating from medical school each year are absorbed by the Defense Department, and most doctors are certain to serve in the military at some stage in their careers.

Even with these great needs, however, the Department of Defense has assented to, and Congress has authorized, alternative service for a limited number of health professionals. More than 700 doctors, dentists, and other health professionals satisfy their military obligation each through service in the commissioned corps of the Public Health Service. Commissioned officers of the Service serve for at least 2 years and are part of, not exempt from, the doctor draft. The functions these commissioned officers normally perform have been detailed in Senator Magnuson's statement.

During the middle 1960's, the medical manpower needs of the Defense Department grew considerably on account of the war in Vietnam. Many doctors were wrenched from private practice and their growing families in order to meet this need. As one method of minimizing the disruption to the medical community caused by the war, Congress in 1967 amended the Selective Service Act to limit the assignments of commissioned officers of the Public Health Service. This amendment, section 6(a)(2) of the Selective Service Act of 1967,

insured that commissioned officers would serve only in the areas of greatest need; in previous times they had been assigned a variety of posts that clearly rated less priority than service in the military or in those areas specifically designated by Congress.

The National Health Service Corps Act is consistent with both the letter and the spirit of section 6(a)(2). It is also consistent with the criteria for selective service satisfaction laid down by the Acting Surgeon General in October of 1967, which stated in part that assignments satisfying military obligation in the Service must be:

a. (...) located organizationally within an office or bureau of the Public Health Service ... under its supervision, and ... paid from Public Health Service operating funds.

b. (...) those requiring) the performance of functions which carry out a responsibility vested in the Public Health Service by law.

The National Health Service Corps meets these criteria, although the responsibility to be vested in the Public Health Service will come from this law itself.

Legally, then, the Corps is consistent with the military manpower requirements of the Department of Defense. Even more importantly, the number of health professionals within the Corps will not detract from the military's needs. Even if we ignore the fact that the military's medical manpower needs are declining and may decline more precipitously in the near future, the absolute number of commissioned officers who could be detailed to the Corps at the \$5 million level of funding is approximately one-half of 1 percent of the total number of physicians in the military at the present time. Moreover, some of these officers would be ineligible for service in the military—women and those who had previously satisfied their military commitment—and others would come from a reshuffling of officers already in other service assignments. The number of health professionals serving in the Corps who might otherwise serve directly in the Department of Defense would not be more than 80 or 100 at any one time, and probably not more than 30 or 40.

Since service in the Corps is for a minimum period of 25 months, the annual diversion from the military might thus be as low as 15 to 20 doctors and dentists. At a time when abolition of the doctor draft and a volunteer army are under consideration, and when proposals have been made to transfer care of military dependents to private health service facilities, these few doctors seem a small price to pay for creation of the National Health Service Corps.

#### CONCLUSION

The National Health Service Corps is thus consistent with, and no threat to, the medical manpower needs of the Department of Defense. As Senator Magnuson has pointed out, it need not be a threat to any other institution, policy, or program.

The Corps can and should be described in more positive terms, however, and this can be done quite simply. The Corps will provide health services to those in greatest need. It will represent a challenging new mission for the Public Health Service. It will offer an opportunity to those upcoming health professionals who truly desire to serve their country. If for these reasons alone, the Corps is more than worthy of

congressional approval. The prospect that the Corps may teach us how to redirect our health efforts, both public and private, is an even more exciting and compelling reason for acting swiftly on this proposal.

The CHAIRMAN. We will receive for the record the statement of Senator Cranston on S. 4296, the proposed Health Professions Assistance Amendments of 1970.

**STATEMENT OF HON. ALAN CRANSTON, A U.S. SENATOR FROM THE STATE OF CALIFORNIA**

Senator CRANSTON. Mr. Chairman, it is a great pleasure to have the opportunity to make this statement regarding S. 4296, the proposed Health Professions Assistance Amendments of 1970. I am particularly delighted that you, as chairman of the full Labor and Public Welfare Committee, as well as chairman of the Health Subcommittee, are a cosponsor of this measure to encourage and assist disadvantaged individuals to pursue training in the health professions. The bipartisan support of the other cosponsors, Senators Hughes, Javits, Kennedy, Nelson, Schweiker, and William of New Jersey, is also most welcome and encouraging.

The importance of S. 4296 is indicated by the fact that a majority of the members of the Health Subcommittee have joined in its cosponsorship. The bill's purpose is to make important improvements in the health professions student loan and scholarship programs, to encourage greater representation of the educationally and economically disadvantaged in the health professions, and to provide incentives for health professionals assisted through Federal student loans to practice in urban and rural poverty areas.

As you have pointed out on numerous occasions, Mr. Chairman, we face a critical shortage of health professionals in the United States today, including an estimated 50,000 physicians and 9,000 dentists. Adequate health care is simply not available to millions of Americans. And this inadequacy is the result not only of a poorly functioning delivery system but also of shortages in various critical categories of health manpower.

In December 1968, the report of the Carnegie Commission on the future of higher education recommended "a substantial program of Federal aid for medical education" in order to increase the supply of medical school graduates in response to the Nation's rapidly growing need for medical services. Unfortunately, since that time, Federal support for medical education has not expanded at a pace adequate to meet the need.

An important facet of the overall shortage of health professionals is the disproportionately low representation of minority groups in such professions; their representation falls far short of the proportions which such groups represent in the population as a whole. For example, although blacks make up 11 percent of our population, only 2 percent of the medical profession is black. There are only 6,000 black physicians in the entire Nation; one out of every 560 whites is a physician while the rate for blacks is one out of every 3,800. Although comparable nationwide data is not available, the representation of Chicanos, Indians and those of oriental descent is estimated to be even lower proportionately. For example, although Chicanos comprised as

of 1960 approximately 11 percent of the total population in the Southwestern States, Chicanos comprise only 1 percent of the medical student bodies in those States. And in his July 8 message to the Congress transmitting his recommendations for Indian policy, the President said: "... almost unbelievably—we are presently able to identify in this country only 30 physicians ... of Indian descent."

This unequal representation is due in large part to two things: First, the lack of effective counseling to encourage and assist minority students to enter the health professions; and, second, the inadequacy of existing financial aid programs to provide assistance at levels which would enable the disadvantaged to meet the enormous, exploding costs of undergraduate and graduate education in the health professions.

The shortage of health professionals is most apparent and most unfair among the poor, for whom the lack of decent medical care is a serious and growing problem. It is estimated that 10 million persons in this country receive no medical care and for another 20 million the care is substandard and minimal. One reason for the appalling lack of adequate health care among the poor—both rural and urban—is the shortage of health professionals in general. Another is the severe economic disadvantages for any health professional choosing to serve in a low-income community. Poverty areas offer neither the prestige nor the economic rewards attainable in suburban or mid-city areas. Thus, not only are the disadvantaged deterred from following careers in the health professions by the prohibitive cost of the many years of schooling required, but those who do manage to become doctors, dentists or other health professionals are prevented from practicing in a poverty area by the necessity of repaying educational debts.

Many young health professionals—black, white, or brown, disadvantaged or not—who would otherwise find a worthy outlet for their idealism, energy and social commitment working in a poverty area find it is simply economically impossible to do so. So these professionals go into practice elsewhere, or they go into research, and the health needs of the poor go unmet.

An important new initiative in this area—which the bill I have introduced would complement and enlarge upon—is the health manpower development program of the National Urban Coalition. This new program is aimed at increasing the supply of doctors, dentists, and other health providers in poverty areas, under a \$2 million grant just made by the Office of Economic Opportunity. In announcing the new program, John W. Gardner, chairman of the coalition and former Secretary of Health, Education, and Welfare, said:

There is a particular need to recruit more minority groups into the health professions. In the United States today, only 2 percent of our physicians are black. Many more members of the minority communities, not only black but Mexican American and Puerto Rican, would like to pursue careers in health. Such opportunities are almost wholly dependent on the provision of adequate financial support. I cannot emphasize that point too strongly.

In order to assist disadvantaged students to enter the health professions, and to make other improvements in health professions student assistance programs, S. 4296 proposes a number of important changes in the health professions loan and scholarship programs. These changes would benefit all students in need of financial assistance. The loan program, which expires in fiscal year 1971, would be

extended through fiscal year 1976. The fiscal year 1971 authorization would be increased from \$35 million to \$45 million. The authorization for fiscal year 1972 would be \$55 million with increases of \$5 million for each of the next 4 fiscal years. The student loan maximum would be increased from \$2,500 to \$3,500 per year for all students. Estimates given to me by medical schools in California are that present student costs average about \$6,000 per year and are expected to increase substantially over the next several years. The combination of a loan—the maximum for which the bill would increase to \$3,500—and a scholarship—up to \$2,500 authorized under present law—would, therefore, just about cover average costs at these schools right now. However, there are many schools where costs are higher than \$6,000 per year, and that figure does not include the added expenses for married students with dependents.

For those who are educationally or economically disadvantaged due to socioeconomic factors, S. 4296 would increase the maximum loan to \$7,000 per year. A recent report to the Inter-Association Committee on Expanding Educational Opportunities in Medicine for Black and Other Minority Students, by a task force of the American Association of Medical Colleges, concluded that “the main barrier today for minority students is the inadequacy of financial aid. Coincident with increasing enrollment of minority students in medical schools, Federal Government and other sources of funds have been decreasing. The need is urgent for reversing this trend and establishing a better mechanism for utilizing available funds.”

Another feature of the bill is a broadening of present loan forgiveness provisions. Under existing law, indebtedness on health professions loans is forgiven at the rate of only 15 percent for each year of practice in a rural poverty area. S. 4296 recognizes the need to provide greater encouragement for health professionals to practice in areas where the need is greatest, including both urban and rural poverty areas. Under the bill, loans would be forgiven, up to the full amount of the loan plus accrued interest, at the rate of 33 $\frac{1}{3}$  percent for each year in which a physician, dentist, or optometrist practices in either an urban or rural poverty area. This provision for total loan obligation cancellation over 3 years would make cancellation for the first time an attractive alternative to private practice as a means of paying off a student loan. It would also dovetail nicely with Senator Magnuson’s proposed pilot project National Health Service Corps, contained in S. 4106, which I am privileged to cosponsor, and which is the principal subject of these hearings today.

In addition, in order to provide a greater inducement for medical and other health professions schools to admit larger numbers of disadvantaged students, S. 4296 would revise the scholarship formula to provide substantial additional assistance to such schools based on the number of such students they enroll. Under present law, this formula is \$2,000 times 10 percent of the full-time student population; that is, the school’s scholarship fund receives \$200 for each student enrolled. The bill would authorize an additional \$2,500 to the scholarship fund based on each full-time student who is disadvantaged—as defined in the outreach program which I will discuss next. The bill would also increase the maximum individual scholarship for such disadvantaged students from \$2,500 to \$5,000, and the scholarship program would be extended through fiscal year 1976.

Finally, S. 4296 would add a new part H to title VII of the Public Health Service Act to provide for grants and contracts to schools and other public or nonprofit organizations for the purpose of identifying, encouraging, and assisting disadvantaged individuals with a potential for education or training in the health professions. Specifically included would be those returning veterans with training or experience in the health field. Individuals would be assisted in enrolling, or in qualifying to enroll, in postsecondary education or training, including health professions schools. The outreach program would also provide for broad dissemination of information on sources of financial aid available for such postgraduate or postsecondary education and training.

To this extent, the bill's outreach provisions are similar to those contained in your bill, Mr. Chairman, S. 3586, the Health Training Improvement Act of 1970 already passed by the Senate (sec. 205), as well as the version passed by the House regarding allied health professionals. However, S. 4296 goes further and specifically would authorize the Secretary to fund such other programs as he determines would enhance the enrollment, pursuit, and completion of study by such disadvantaged persons once they are enrolled in medical and other health professions schools.

The bill would authorize appropriations of \$5 million for fiscal year 1971, and \$40 million over the next 4 fiscal years for this outreach and special assistance program.

This outreach concept was recommended in the AAMC report on expanding minority student opportunities in the health professions, which I referred to earlier. The report called for a network of regional centers to provide information about career opportunities for disadvantaged students in the health professions. Such a program, the report stated, would serve a vital motivational purpose in encouraging and assisting qualified disadvantaged students who were pursuing or considering education and training in the health professions. The fact is that many, many disadvantaged persons who could be effectively educated and trained for vital health professional roles never consider this as a viable possibility. This program would seek to change that and make clear the great possibilities which exist for them in this highly critical skill-shortage area.

This new outreach initiative would respond to two of the three major needs identified in the AAMC report: (1) recruitment of students into health professions education; and (2) retention of students already in the "educational pathway" leading to such professions.

Mr. Chairman, I wish to point out that physicians' assistants would be assisted under the allied health professions programs contained in S. 3586 now pending in conference committee. Physicians' assistants are specifically recognized in the Senate report on that bill as being one of several new and promising categories of health manpower. Thus, they would not be included under this bill which deals only with the more traditional categories of health professionals. However, I strongly believe that the physicians' assistant is a very important new category in the health manpower area, and must be assisted to the maximum possible extent.

As a member of the Labor and Public Welfare Committee's Health Subcommittee, and as chairman of its Veterans' Affairs Subcommittee, I have attempted to involve myself deeply in the committee's efforts to improve our health care delivery system and to expand our supply of health professionals. Meeting these goals requires increasing our commitment to, and our financing of, student assistance programs, institutional and special project grants to medical and health professions schools, construction funds, and research. However, in expanding and improving these programs I believe we must give special attention to ways in which they can be utilized to improve educational opportunities for the disadvantaged and to improve health care in our poverty areas.

Although I have emphasized the benefits of S. 4296 to disadvantaged health professions students, I would like to make very clear that this bill is also intended to provide general assistance to health professions schools and students by improving and enlarging the loan and scholarship funds available for all students at all medical and health professions schools. We took a major step in this direction by authorizing the appropriation of \$100 million in emergency relief for medical and dental schools in financial distress in passing S. 3586. Under the Senate version of that bill the Secretary would be authorized to make grants to medical and dental schools in dire financial straits as a result of their affirmative response to one or more of the following aspects of national health policy: (1) Increasing enrollment of students for the purpose of augmenting the supply of trained health professions personnel; (2) improving the quality or delivery of health care and services to disadvantaged persons in urban or rural areas; (3) providing care to substantial numbers of patients under medicare or medicaid; or (4) maintaining enrollments and quality in the face of rapidly rising costs.

An example of efforts to meet the health professions crisis is the action being taken by the University of California School of Medicine at Davis, where the first-year enrollment of medical students is to be increased from 52 to 100 next year. This 3-year-old school will apply for a 5-year, \$5 million grant under the physician augmentation program, which provides grants to medical schools willing to make major increases in their first-year enrollments. According to C. J. Tupper, dean of the school, "The plan reflects the concern on the part of administrative and faculty members as to the school's responsibility in meeting the physician manpower shortage crisis."

The Davis Medical School proposal is an ambitious one. In light of the very pressing needs and the long period of years before an entering medical student actually becomes an M.D., the timing is important and highly commendable. However, much of the success of the expansion will rest on the adequacy of Federal support in such areas as student assistance, institutional support and health facilities construction grants. It is important, therefore, that these vital programs of support for health professions education be maintained and expanded this year and in the coming years, as proposed in S. 4296, if initiatives like those proposed by University of California at Davis are to succeed in helping to solve the health manpower crisis.

Mr. Chairman, I request that there be included in the hearing record, following my statement, an analysis of the bill. I thank you for including S. 4296 for consideration at this hearing and for your courtesy in

permitting me to submit this statement. I especially want to thank you for the leadership and inspiration you have provided to me and the other members of the Labor and Public Welfare Committee in dealing with the critical health problems confronting the Nation.

ANALYSIS OF S. 4296, THE PROPOSED "HEALTH PROFESSIONS ASSISTANCE AMENDMENTS OF 1970."

I. GENERAL DESCRIPTION

The bill is designed to encourage and assist persons who are financially or educationally disadvantaged because of socio-economic factors to pursue training in the health professions. It would accomplish this by establishing a special outreach program to identify, encourage, and prepare disadvantaged persons to enroll in health profession schools and making grants to those schools once they enroll significant numbers of disadvantaged students. In addition, the present law concerning loans and scholarships for students in the health professions schools would be amended (1) to extend these two programs through fiscal year 1976; (2) to raise the maximum limits on loans for all students and on scholarships for disadvantaged persons; (3) to increase the authorizations of appropriations for the loan program; (4) to provide for substantial increases in the allocation of scholarship funds to schools in direct proportion to the number of disadvantaged students enrolled; and (5) to provide increased incentives for practice in urban or rural poverty areas by providing for full cancellation of student loans in return for three years of practice in those areas.

II. SHORT TITLE

*Section 1* gives the Act the short title "Health Professions Assistance Amendments of 1970."

III. HEALTH PROFESSIONS OUTREACH PROGRAM

*Section 2* of the bill would add a new Part H to Title VII of the Public Health Service Act. Title VII now includes provisions concerning training of professional health personnel. Part H would establish a new program to identify, encourage, and assist disadvantaged persons to prepare for, enter and complete training in the health professions. Part H consists of one section, 799a. It is analyzed by its three subsections. With the exception of clause (3), which is new, it is similar to the outreach provision contained in section 205 of S. 3586, the proposed "Health Training Improvement Act of 1970," passed by the Senate on July 13, 1970.

*Subsection (a) of Sec. 799a. Clause (1)* gives grant and contract authority to the Secretary of H.E.W. to establish, through public and private educational or other agencies, programs to identify potential health professions students who, due to socio-economic factors, are financially or educationally disadvantaged (Veterans with training or experience in the health field are specifically included.) Such individuals would be encouraged and assisted to enroll if qualified, or to undertake such post-secondary work as is necessary to become qualified to enroll, in a health professions school.

*Clause (2)* specifies that a school's or organization's encouragement and assistance efforts would include publicizing existing sources of financial aid available to persons who are enrolled in health professions schools or are undertaking training necessary to qualify for enrollment in any such school.

*Clause (3)* of this subsection would provide for grants to or contracts with schools to establish programs which the Secretary determines will enhance and facilitate enrollment, pursuit, and completion of study by disadvantaged persons who are potential health professionals.

*Subsection (b) of Sec. 799a.* Defines "professional personnel in the health professions" as doctors of medicine, dentistry, osteopathy, pharmacy, (or bachelor of science in pharmacy), optometry, podiatry or surgical chiropody, veterinary medicine or graduates of schools of public health. This definition is consistent with other parts of Title VII concerning types of health professions schools to which grants are made for construction, student loans and scholarships.

*Subsection (c) of Sec. 799a.* Would authorize appropriations for Part H from fiscal years 1971 through 1975. The initial authorization is \$5,000,000 for FY 1971, and the authorization for each subsequent year is increased by \$2,000,000 a year.

## IV. STUDENT LOANS

*Section 3* of the bill would amend the health professions student loan provisions of Title VII of the Public Health Service Act, 42 U.S.C. 294 a-b.

*Loan Levels. Clauses (1) and (2) of subsection 3(a)* would increase the present maximum loan level for all students from \$2,500 to \$3,500 per academic year.

*Clause (3)* would establish a maximum loan level of \$7,000 for disadvantaged students described in the Outreach Provision (Part H of section 799a).

*Cancellation of Loans. Subsection 3(b)* of the bill would amend present law which cancels student loan indebtedness incurred by physicians, dentists, and optometrists at the rate of 15 percent for each year of practice in a rural poverty area. The annual rate of cancellation would be raised to 33 $\frac{1}{3}$  percent, and the qualifying geographical areas would be expanded to include urban as well as rural poverty areas. The present provision permitting an additional 50 percent cancellation of the debt for work in a rural area is rephrased for clarity.

*Student Loan Authorization. Clause (1) of Subsection 3(c)* would amend the present student loan authorization section which now expires with an authorization of \$35,000,000 in fiscal year 1971. The new schedule would begin with a fiscal year 1971 authorization of \$45,000,000, rising to \$55,000,000 for 1972, and increasing by \$5,000,000 each fiscal year thereafter through fiscal 1976.

*Clause (2) of subsection 2(c)* would advance the dates but retain the present scheme for phasing out the student loan authorizations. For the three fiscal years following the last specific year's authorization, such sums would be authorized to be appropriated as are necessary to continue to provide loans to students who began their health profession training with a loan under this program.

## V. SCHOLARSHIP GRANTS

*Section 4* of the bill would (1) amend the present formula for scholarship grants, (2) extend the scholarship grant program through fiscal year 1976, and (3) raise from \$2,500 to \$5,000 the maximum limit on scholarship in the case of disadvantaged students described in the Outstretch Program (Part H of section 799a).

*Scholarship Grant Formula. Subsection 4(a)* of the bill would change the formula for scholarship grants to schools. The present formula provides a sum equal to \$2,000 multiplied by one-tenth of the enrollment, that is, \$200 for the scholarship fund based on each student enrolled. This provision would add to the scholarship fund \$2,500 based on each disadvantaged student enrolled. It also would extend the scholarship program beyond fiscal year 1971, the last year authorized in present law, to fiscal year 1976.

*Scholarship Grant Authorization. Subsection 4(b) and clauses (1) and (2) of Subsection 4(c)* provide, comparably to the provisions in section 3(c)(2) of the bill regarding the loan program, for extension of the dates of the scholarship program and for a gradual phasing out of the grants to ensure that a student who began his training with a scholarship may be assisted through to completion.

*Scholarship Limit Raised. Clause (3) of Subsection 4(c)* would increase the maximum scholarship which can be awarded during a school year from \$2,500 to \$5,000 in the case of disadvantaged students.

The CHAIRMAN. Senator Murphy has introduced S. 4208, the Family Physician Scholarship and Fellowship Act. We will receive his statement for the record.

#### STATEMENT OF HON. GEORGE MURPHY, U.S. SENATOR FROM THE STATE OF CALIFORNIA

Senator MURPHY. Mr. Chairman, on August 10, I introduced S. 4208, the Family Physician Scholarship and Fellowship Program Act. Nineteen Senators have cosponsored this measure with me. They are Senators Allen, Allott, Bennett, Boggs, Cooper, Cotton, Dole, Dominick, Eastland, Fong, Griffin, Hatfield, Javits, Pearson, Prouty, Saxbe, Smith of Illinois, Thurmond, and Tower.

I urge the Health Subcommittee and the full Labor and Public Welfare Committee to take early and favorable action on this much-needed measure.

Today, we need approximately 50,000 additional physicians to adequately meet the health needs of this country. Citing the national picture reveals the total problem, but one has to focus on certain communities to really appreciate the critical urgency of the problem and to understand why action by this subcommittee and the Congress in response to the physician shortage problem is called for now.

There are many communities in this country that are one-physician towns, and, even worse, there are communities that right now are no-physician towns. Furthermore, the evidence suggests that tomorrow, many of today's one-physician towns are in danger of becoming no-physician towns. S. 4208, I believe, is a workable and needed response to this problem.

The physician-shortage problem is more than just numbers, although additional numbers of physicians are needed; to solve the problem, we must also deal with the distribution-of-doctors problem so that doctors will go and practice in the areas that need them the most. For example, Los Angeles County has a physician-patient ratio of 1 to 600. On the other hand, in Watts and East Los Angeles, the physician-patient ratio is 1 to 3,000. S. 4208 will attempt to direct doctors into the areas where they are needed the most, whether this area is a poverty area of a large city, a migrant community, or an isolated rural community.

Under S. 4208, scholarships would be provided to young men and women who agree to practice medicine in areas designated as physician-shortage areas, or who agree to serve migrant agricultural workers and their families. For each year of the scholarship, 1 year of service would be required by the student in physician-shortage areas. Intern and residency fellowships would also be granted.

Mr. Chairman, surveys have indicated that over 25 percent of doctors practice in areas in which they were reared. In addition, we know that once a doctor establishes his practice, he is unlikely to move.

Based on this information, I have provided for priorities in awarding the scholarships. These priorities are (1) students from lower income families who reside in physician-shortage areas and who agree to return to those areas to practice; (2) other individuals from physician-shortage areas who agree to return to those areas to practice; (3) persons from lower income families who reside in non-physician-shortage areas who agree to practice in physician-shortage areas; and (4) other individuals who agree to practice in physician-shortage areas.

An added advantage, but not the primary purpose of this measure, would be, since lower income students are given priority, the attraction of more minority youngsters into medical schools. I am convinced that if we can attract youngsters from the physician-shortage areas, and provide them with scholarships in return for service in such areas that we will have a big step in solving the the manpower distribution problem.

This measure has the support of the California Medical Association as well as many deans of the medical schools in my State.

There are many health problems in the Nation. One thing, however, is certain. Unless we solve the medical manpower problem, we have

little chance of solving the other health problems of the Nation. That is why action is needed now to lay the groundwork for providing the medical manpower needed to meet the rising health demands of the country.

Mr. Chairman, I have spent a great deal of time and research in this area, and I know time does not permit me to go into all the facts and rationale for S. 4208. I would, therefore, urge that the committee carefully study the complete text of my introductory floor statement of August 10. I would like to ask, Mr. Chairman, that my remarks on that date be printed in the record.

Thank you.

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[From the Congressional Record, Washington, Aug. 10, 1970]

S. 4208—INTRODUCTION OF THE "FAMILY PHYSICIAN SCHOLARSHIP AND FELLOWSHIP PROGRAM ACT"

Mr. MURPHY. Mr. President, I introduce today the "Family Physician Scholarship and Fellowship Program Act." The bill is cosponsored by my colleagues, Senators Prouty, Dominick, Javits, and Saxbe.

Under this measure, family physician scholarships and fellowships would be offered to young men and women who agree to practice in areas designated as physician-shortage areas or to serve migratory agricultural workers and their families. For the first year, approximately 500 scholarships and 200 fellowships would be offered at a total cost of \$4.5 million. The number of scholarships and fellowships would be increased until by the 4th year 1,000 scholarships and 500 fellowships would be authorized. In addition to migrant areas, these areas may also be an isolated rural community, an Indian reservation, or a poverty area of a central city. The basic purposes of the bill are:

First, to help with the physician-shortage problem in general;

Second, to encourage and increase the number of individuals entering the family physician specialty in particular;

Third, to attack the problem of the maldistribution of physicians by encouraging the location of doctors in physician-shortage areas;

Fourth, to increase the number of lower income and minority individuals in the medical profession; and

Fifth, to tap the idealism, social commitment, and energies of youth to serve where the medical needs of the country are the greatest.

Scholarships not to exceed \$5,000 would be available to individuals agreeing to serve in physician-shortage or migrant areas. For each year of the scholarship, 1 year of service is required in a physician-shortage or migrant area.

Two types of postgraduate fellowships, intern and residency, are also provided. Since attracting medical school graduates into physician-shortage areas for their graduate work is a desirable goal in itself, no additional service requirement is demanded under the fellowship program. The fellowship program, then, will assist in providing needed medical assistance to physician-shortage areas or to the migrant population. Since there is a correlation between practice location and the location of internship and residency programs, this fellowship program should be a positive influence in attracting and hopefully attaching the doctors to physician-shortage and migrant areas.

As an inducement to encourage those who have been in the scholarship program to continue in the fellowship program, a year of their service obligation under the scholarship program is eliminated for those who complete their postgraduate work in this manner.

In keeping with the purposes of the measure, the following priorities for selecting individuals for the scholarships—and fellowships—are provided:

First, individuals from lower income families who reside in physician-shortage areas and who agree to return to those areas to practice;

Second, other individuals from physician-shortage areas who agree to return to those areas to practice;

Third, individuals from lower-income families who reside in nonphysician-shortage areas who agree to practice in a physician-shortage area; and

Fourth, other individuals from nonphysician-shortage areas who agree to practice in a physician-shortage area.

## PHYSICIAN SHORTAGE PROBLEM IN GENERAL

Mr. President, today it is estimated that the need exists for 50,000 additional physicians. According to the Public Health Service, approximately 297,000 physicians were actively engaged in practice in 1966 and 50,000 were needed to meet increasing demands for health care. This survey estimated that 400,000 physicians would be required by 1975 to meet demands for personal health care, for teaching, research, medical administration, and public health and military service. Yet, the U.S. Public Health Service warned:

"The output of U.S. medical schools at presently planned levels, even with the continued immigration of foreign physicians, will provide no more than 360,000 physicians by 1975, a figure far short of meeting estimated needs."

Mr. President, I ask unanimous consent that a Library of Congress chart illustrating physician needs be printed in the RECORD at this point in my remarks.

There being no objection, the chart was ordered to be printed in the RECORD, as follows:

## PHYSICIAN NEEDS

	Physicians	
	1968	1975
Estimated need.....	363,000	400,000
Estimated supply.....	311,600	358,000
Estimated shortage.....	52,000	42,000

Mr. MURPHY. Mr. President, the National Advisory Commission on Health Manpower in its November 1967 report said this about the physician shortage:

"The Commission believes that there is currently a shortage of physicians, and this shortage will worsen in relation to the growing demand, despite the expected shortage in the supply of physicians in the years ahead.

This Commission cited a number of factors responsible for the physician shortage, one of which was the continuing trend toward specialization. As the Commission stated:

"Specialization has decreased the number of physicians available to provide care for the entire family, and has resulted in a reduction of the number of persons seen per family."

## FAMILY PHYSICIAN SHORTAGE IN PARTICULAR

Mr. President, my bill responds to these developments. It does not yet respond to the physician shortage problem in general; its focus and thrust is aimed at the family physician shortage in particular. One of the measure's primary purposes is to reverse the alarming decline in the percentage of physicians in family practice. In 1931, 75 percent, or three out of four, of the doctors in the Nation were family practitioners; only 15 percent specialized. By 1949, or nearly two decades later, only 50 percent of the doctors were in general practice with 29 percent specializing. By 1967, again approximately two more decades later, only 21.3 percent, or approximately one out of five of the physicians were in general or family practice. According to figures in the report of the Citizens Commission on Graduate Medical Education, known as the Millis Report:

"In recent classes of medical school graduates, only 15 per cent have planned to enter general practice."

The trend is obvious; in my judgment, it must be reversed, if our health care system is to enjoy optimum health.

Recent testimony before the Senate Health Subcommittee indicated that the family physician "is capable of treating 85 percent of the illnesses that beset mankind." Yet, indications are that only 15 percent of our medical students will become family practitioners. Thus, it seems clear to me that we need more family physicians, capable of treating the "85 percent of the illnesses besetting mankind." Even in this age of specialization, the family doctor is a critical and central figure. I believe these statistics should make that self-evident.

My bill, Mr. President, then would recognize the primary role of the family physician. It seeks to reverse the trend away from family practice by providing scholarships for young people who want to become family physicians. Recent developments, including the following, convince me that we can attract more medical students into family practice:

First. The AMA approved the essentials for graduate training programs in family practice, December 1968;

Second. The American Board of Family Practice was established and approved in 1969 making family practice a specialty;

Third. The American Board of Family Practice offered examinations for certification of practice to eligible candidates in March 1970;

Fourth. A Residency Review Committee for Family Practice has been established and has members from the AMA Council on Medical Education, the American Council of General Practice, and the American Board of Family Practice; and

Fifth. Legislation, S. 3418, which has been introduced by Senator Yarborough and cosponsored by me and which will provide grants to medical schools to establish programs in the family practice, was recently reported to the full Senate by the Labor and Public Welfare Committee.

My bill recognizes that there will not be enough graduate programs in the family physician specialty immediately, and therefore properly makes other primary-care physicians—pediatricians, obstetricians, and internists—eligible for the fellowship programs.

#### MALDISTRIBUTION OF DOCTORS

Mr. President, my measure has a sharper focus than merely providing more doctors, although more doctors are needed. My bill specifically focuses on the family-physician shortage and also addresses itself to the critical problem of the distribution of doctors. Some suburban communities have adequate numbers of doctors, while many rural areas or poverty areas of our cities may not have a single physician. My research reveals that in some areas of Los Angeles near the U.S.C. medical school, the ratio of physicians is one to 3,000 patients whereas the county average is one to 600. This means that in the East Los Angeles area and the Watts area, it is five times as difficult to find a doctor as it is in Los Angeles County. My proposal is an attempt to move doctors into the Watts and East Los Angeles areas and other areas of the country where they are needed the most.

Dr. B. L. Bible, who is on the staff of the Department of Community Health, Division of Health Services, American Medical Association, in a January 1970 article stated:

"Because of the tendency of physicians, like other professionals, to settle in urban areas, and because of the problems in communities and transportation experienced by rural dwellers, rural people, particularly those in isolated areas, have only one-half the access to physicians and other health resources that the rest of the nation has."

The Library of Congress, which has been so helpful to me in gathering background information on this proposal, attempted research on the number of communities across the country without a physician. It reported that:

"Little research has been published on physician-shortage in small communities, and definitive statistics indicating the number of communities across the country without physicians could not be located."

My attention, however, was directed to a 1965 survey of more than 1,600 towns and cities in Minnesota, North Dakota, South Dakota, and Montana. The survey's investigators found that more than a thousand of the towns studied had no physician and 224 towns had only one physician. The physicians were usually older in relation to the rest of the physicians in the State. A median age of physicians in one-physician towns was 55 in Minnesota; whereas the median age of the total physicians in the State was 46.5. In North Dakota the median age of physicians in one-physician towns was 54; the median age of the total number of active physicians in the rest of the State was 41. In South Dakota the median ages were the same. In Montana the median age was slightly younger.

The size of the town and the physician's age were also related. The smaller the town, the older the physician for the most part. In towns of less than 500 in population, the median age of the physician was 58; in towns with population of between 501 and 1,000, the median age was 47; the median age was 44.5 in towns of 1,001 to 1,250 population. This survey not only identified the 1,000 towns without a physician—towns which would soon become no-physician towns as the older physicians die or retire. These communities, unless we provide the incentive, are not likely to attract replacements for their older doctors.

My proposal, as I have indicated, has built-in various inducements to deal with the distribution problem. First, the scholarships are only available to students who agree to serve in physician-shortage and migrant areas. Years of ex-

pensive education are thus provided in return for a commitment by the student to serve in these areas. Students are also encouraged to continue their post-graduate service in physician-shortage areas by the offering of competitive intern and residency fellowships.

A recent report published in the Public Health Reports in January 1970 discusses the question, how does the physicians select a location for his practice? It is based on a research project sponsored by the American Medical Association's Council on Rural Health. A random sample was taken of "all physicians in private practice who reside in nonmetropolitan counties of the United States" as available in AMA records. The random sample totaled 2,468 such physicians. Significantly, over 25 percent of the physicians surveyed in response to the question of how they decide upon their present practice location indicated that they were practicing in the area in which they were reared. That is why in designing my priorities, I have given first and second priority to students from physician-shortage areas. The study's results also indicated that "once a physician establishes a practice, he is unlikely to move." The study went on to say:

"At least 63 per cent of the physicians had not moved from their original practice location. This percentage was consistent regardless of community size. A more detailed breakdown of the area showed that about one-fourth of the physicians in non-metropolitan areas had practiced twenty years or more in the same place."

This same report indicated that:

"Physicians who practice in small towns are more likely to have rural rather than urban backgrounds . . . rural physicians have predominantly rural backgrounds and metropolitan physicians generally had urban locations during their youth."

The following hypothesis was offered:

"Physicians who practice in small towns are likely to have rural backgrounds."

Statistics from the report indicated that 49 percent of the physicians surveyed who were practicing in communities of less than 2,500 were raised in a small town. Therefore, the study concluded:

"Physician recruitment for rural areas would be enhanced if more young men with rural backgrounds were encouraged to enter the medical profession."

Based on this information, and I believe what commonsense would tell us, I have designed the priorities for the scholarship and fellowship program so that first choices would come to individuals from physician-shortage areas. I believe if we can offer them a scholarship and in turn secure from them a commitment to spend 4 years in an area, they will be more likely to continue to practice in that area after their obligation ends.

Furthermore, we also learned from this information that the longer we can attach a physician to an area, the more likely he is to stay there. Who could be greater motivated than a man or woman from an area to serve the people from the vicinity in which he was reared?

#### ATTRACTING LOWER INCOME AND MINORITY STUDENTS

Mr. President, there is a need in the country to attract more lower-income and minority youngsters into the medical profession. An additional and attractive feature of my bill is that it would have the effect of attracting more of these young adults into the medical profession.

In its 1968-69 survey of medical education, the American Medical Association asked the medical schools to report the racial origin of its medical students. Ninety-six out of 99 schools replied. Although the results may not be completely valid because most schools do not require their students to report their race, the survey said:

"Of the total medical school enrollment of the 96 reporting schools, 2.2% are Afro-American. Excluding the two predominantly Negro schools, only 0.8% of the total enrollment is Afro-American. Three regions, East North Central, South Atlantic, and Pacific, show a 1% Afro-American enrollment. The Pacific region also has a 6% Oriental enrollment. The Mountain region, which has 0.1% Afro-American enrollment, shows a 2% Oriental enrollment. The East North Central region has a 1% Oriental enrollment. Only the West South Central region has as much as 1% Mexican-American student enrollment in its medical schools."

President Nixon in his outstanding Indian message of July 8 to the Congress said:

"Almost unbelievable—we are presently able to identify in this country only thirty physicians and fewer than four hundred nurses of Indian descent."

Medical education is expensive making it difficult for lower income and minority individuals to enter the medical profession. Great efforts are being made. For example, in my State of California, the University of California has five medical schools in its system. Only eight minority students were enrolled on the five medical school campuses of the University of California system in 1968, and they were all at the San Francisco campus. By 1969, 54 minority students were enrolled, with each of the five campuses showing minority enrollment. By 1970, the number had increased to 93. The percentage of the minority enrollment varied from 13 to 25 percent, which shows that great efforts are being made in this direction.

#### TAPPING THE IDEALISM AND ENERGIES OF YOUTH

Mr. President, we know that many young people today are filled with idealism and have a strong commitment to help make this country a better place in which to live. I have talked to some of the medical students and found that there is a great interest and desire among them to serve the disadvantaged to meet the medical needs of the citizens of this country. Their commitment to service is great indeed, and they seem willing to forgo some of the more lucrative locations in order to have an opportunity to serve. My measure would provide a means to channel their talents, energies and idealism into the communities of the country which are crying for medical attention.

My measure is designed to train more doctors and to direct these doctors into the right places.

#### CONCLUSIONS

Mr. President, the Scripps-Howard newspapers recently concluded a month-long survey of doctors, both in private practice and working in government. Mr. Donald Kirkman writing in the July 7, 1970, Washington Daily News said:

"With surprising unanimity, those interviewed agreed that: The U.S. needs an immediate crash program to increase the number of health workers, with primary emphasis on doctors;

"Doctors in the U.S. are over-concentrated in suburbia and most have little desire to practice in ghetto and rural areas;

"Many of the nation's medical colleges and other health education institutions are on the verge of bankruptcy;

"Medical education is so costly that Negroes, the children of other minority groups, and poor whites are prevented from becoming doctors and dentists;

"The number of Negro and minority doctors is not keeping pace with the increase in the nation's Negro and minority population."

I believe, Mr. President, that my measure responds to most of the needs which the survey indicates are recognized by the doctors themselves.

As a member of the Senate Labor and Public Welfare Subcommittee on Health, I have supported and helped to shape the various programs that have been enacted to advance medical research, to provide the medical manpower necessary to do the job. Only recently I supported the Health Training and Improvement Act, a bill to extend and improve the allied health professions program which was initially enacted in 1966.

Recent years have seen a quantum leap in the demand for health services. This is as it should be as the nation moves to provide quality medical care and treatment for all its citizens. Although the medical care in this country is the finest in the world, our medical system does have serious problems. One of the most serious problems, which has already reached the crisis stage in many areas of the Nation, is the medical manpower shortage. The demand for more and better medical care and services is likely to continue to accelerate. A serious obstacle to meeting that growing demand is, and will be, unless steps are taken, this medical manpower shortage.

Dr. Egeberg emphasized this point when he said:

"I don't care what Congress does with medicare, medicaid and all the other programs. Nothing is going to improve the country's medical system until we get more doctors.

Mr. President, no one can say for certain that a new proposal, such as I advance today, will prove one hundred percent successful. Based on the evidence and surveys available, as well as common sense, I believe the program will work. It will help with the family physician shortage problem: it will help to redirect physicians to serious physician-shortage areas; and it will provide greater

opportunity for lower income and minority students to enter the medical profession. I discussed this proposal with the California Medical Association, and I am very encouraged with their reaction, encouragement and support.

Mr. President, I am also delighted with the encouragement I have received from deans of medical schools in California. I sincerely hope that the medical community, the administration and my congressional colleagues study this measure and join me in working for its enactment.

The CHAIRMAN. Now we come to the professional witnesses, and the first witness is Dr. Abraham Bergman, director of outpatient services of the Children's Orthopedic Hospital, Seattle, Wash., representing the Washington/Alaska regional medical program, and the Washington State Society of Pediatrics.

**STATEMENT OF DR. ABRAHAM B. BERGMAN, DIRECTOR OF OUTPATIENT SERVICES, CHILDREN'S ORTHOPEDIC HOSPITAL, SEATTLE, WASH., REPRESENTING WASHINGTON/ALASKA REGIONAL MEDICAL PROGRAM, WASHINGTON STATE SOCIETY OF PEDIATRICS**

Dr. BERGMAN. Mr. Chairman, I am Abraham B. Bergman, a physician specializing in the care of children. I am director of outpatient services at Children's Orthopedic Hospital and Medical Center in Seattle and associate professor of pediatrics and health services at the University of Washington in Seattle. I am legislative chairman of the Washington State Society of Pediatrics, and am also representing the Washington/Alaska regional medical program, serving the largest geographic area of any RMP program in the country.

I first wish to pay tribute to the distinguished chairman of this committee, Senator Yarborough, whose name is firmly linked with virtually all programs in the past decade launched to improve the health of the American people. It is a record of which you can be justly proud, and for which all health organizations in the country owe you a deep debt of gratitude.

**COMMUNITIES THAT NEED PHYSICIANS**

Wrangel is an isolated village in southwestern Alaska with a population of just under 3,000 persons. A year ago its only physician left, and the community has since been without any medical services.

Darrington is a town of 1,000 persons nestled in the North Cascade Mountains of Washington that has been attempting for 5 years to recruit a physician, to no avail.

Connell is in eastern Washington and is a trade center serving a farming area of over 3,500 people with a fine federally funded hospital nearby. Its one physician is now disabled, and can see no more patients.

In the large city of Seattle there are many physicians, but they are concentrated in the more affluent areas. On the other hand, there are several large publicly financed housing projects with completely inadequate health services, where residents have only an emergency room of the county hospital to turn to for medical care.

I could cite many more examples, but they would be repetitious and glaringly familiar to all Members of Congress. I am sure that a significant amount of mail to your offices concerns in some way the distribution of health services, describing examples of the type I have

just cited. They exist in every single State of the Union. I would like to submit, for the record, a letter outlining statistically the dimensions of the maldistribution problem in a typical State, Washington.

The National Health Service Corps will not solve the physician distribution problem. It is but a small step in meeting a few of the most extreme cases of hardship among our rural and urban poor. More important than the number of Health Corps personnel that would be deployed in this pilot program would be the commitment to take some action toward solving this vexing national problem. One can't pick up a magazine these days without seeing an article about the health manpower crisis. Bold innovative action is required; rhetoric and handwringing will not do the job.

#### ADVANTAGES OF HEALTH CORPS

I would like to comment on several features of S. 4106 that I find particularly attractive:

##### LOCAL INITIATIVE

Health Corps members will be assigned only upon application from, and certification of need by, local communities. Competition with local health resources is not an issue in this bill. We are addressing ourselves to communities where local physicians and dentists, if they exist at all, are pleading for help.

##### REJUVENATION OF THE COMMISSIONED CORPS OF THE U.S. PUBLIC HEALTH SERVICE

Rather than starting yet another Federal agency with its own bureaucracy, this bill proposes to provide the Commissioned Corps with a new mission befitting its long and proud tradition. The fate of the corps has been held in limbo by procrastination and indecision on the part of the present and previous administrations for too long. The corps should not be allowed to wither on the vine.

##### INCREASED UTILIZATION OF PUBLIC FUNDED FACILITIES

A variety of publicly funded health programs in rural and urban poverty areas are operating at reduced and inefficient capacity because of difficulties in recruiting and paying personnel. Examples are neighborhood health centers, large municipal hospitals, institutions for the mentally ill and retarded, migrant and Indian health programs, and many others.

Under this bill, National Health Service Corps personnel could be assigned to such programs, to help to get them off the ground and to operate more effectively in performing the missions already assigned them.

##### CHANNELING IDEALISM OF YOUNG HEALTH PROFESSIONALS

Our current crop of health science students appears to profess a great deal more concern about improving community health than previous generations. Personally, I am reserving judgment on the ex-

tent to which this idealistic talk will be translated into deeds. Nevertheless, appropriate opportunities for helping the underprivileged should be made available. The fact that health professionals can only join the corps through volunteering, and that their assignment will be to "nonplush" living areas, provides an ideal channel for service to the Nation, and an opportunity to serve in areas where such service is now impossible.

In conclusion, I can't conceive of any justified opposition to this bill. I am delighted that Surgeon General Steinfeld endorsed it as "excellent" during testimony several weeks ago on the HEW appropriations bill. I applaud you Senator Yarborough, on your leadership on this legislation, and urge you to take rapid and favorable action.

(The information referred to follows:)

*The Washington State*

MEDICAL EDUCATION and RESEARCH FOUNDATION

444 N. E. Ravenna Boulevard

Seattle, Washington 98115

Telephone (206) LA 3-9110

August 25, 1970

Abraham B. Bergman, M.D.  
4800 Sand Point Way N.E.  
Seattle, Washington 98105

Dear Doctor Bergman:

The State of Washington presently has 5,390 physicians licensed to practice and who have addresses in this State. Thus, the State of Washington has one physician for every 619 persons, or 161 physicians per 100,000 population. This ratio is rather meaningless, though, because neither the population nor the physicians are spread evenly over the State and only about 4,700 physicians are actually engaged in patient care; most of them are in the heavily populated counties.

Nearly two-thirds (62.4%) of the State's population live in the four most populous counties--King, Pierce, Snohomish, and Spokane--which comprise only 11% of the land area but have 78% of the physicians. King County alone has one-third (34%) of the population, 3% of the land area, and 52% of the physicians. Furthermore, there is a shift in the population from the rural to the suburban and urban areas. From 1960 to 1970, 40% of the population increase was in King County and 80% in the four most populous counties mentioned above. Two western rural counties and twelve eastern rural counties have shown a decrease in population from 1960 to 1970.

My latest count is that there are 76 locations within the State looking for physicians; nearly all of these are seeking GPs. I would say that the real shortage of physicians in the State is within what I call the first-contact physicians, i.e. GPs, internists, pediatricians, and general surgeons (I realize that general surgeons wouldn't like my categorizing them in this way, however in the rural areas they act much the same as a GP). I figure that there is a shortage of around 936 of these first-contact physicians. This is on the supposition that to provide a reasonable degree of medical care, we should allow one first-contact physician per 100,000 population.

You didn't give me much time to work at it, but the following are five cities--and there are many more--which are in very desperate need of physicians:

1. Forks, Clallam County; population (1960) 1,156, (1970) 1,314. One GP (54 yrs.) is contemplating retirement and wants to move to Clallam Bay and maintain his office in Forks for 2 or 3 days per week. A hospital with 17 acute care beds and 4 long-term care beds. Citizens will build a clinic if desired. 56 miles from Port Angeles (pop. 16,169). Needs 2 GPs.
2. North Bonneville, Skamania County; pop. (1960) 494, (1970) 452. No physician but doctor's office with equipment available for reasonable rent from former doctor's widow. No hospital but there is one 29 miles east in White Salmon which also has 2 GPs and a Medex.

Skamania County (pop. 5,741); has only one physician who is 51 yrs. of age and partially deaf. He is located in Stevenson with a population of 907 and located 5 miles east of North Bonneville.

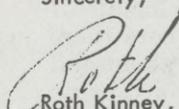
3. South Bend, Pacific County; pop. (1960) 1,671, (1970) 1,720. Now has one GP (57 yrs.) and a G.S. (58 yrs.), and a 39-bed general hospital. Needs 2 GPs capable of surgery and visiting specialists from a variety of specialties.

Pacific County has a population of 15,308 and the 2 physicians in South Bend are attempting to serve an area of around 10,000 population.

4. Sultan, Snohomish County; pop. (1960) 821, (1970) 1,110. No physician, no hospital. Monroe 7 miles west (pop. 2,694), has 2 physicians and a hospital with 33 acute care beds and 32 long-term care beds. There is no physician or medical facility to the east until far beyond the summit of the Cascade Pass. The area surrounding Sultan has a population of approx. 6,000. A GP is badly needed now.
5. Connell, Franklin County; pop. (1960) 906, (1970) 950. Connell is located 35 miles north of the tri-cities area (Pasco, Kennewick, and Richland) and 20 miles southeast of Othello, fine hospitals at both locations. The disability of the physician practicing in Connell left it doctorless. Connell is a trade center of over 3,500 people. Excellent clinic building available.

I hope this will be of some interest to you.

Sincerely,

  
Roth Kinney, Director  
Planning and Research

RK:sr

The CHAIRMAN. Dr. Bergman, I do not believe there should be justified opposition to this bill, but I couldn't be quite as optimistic as you are in saying "I can't conceive of any justified opposition to this bill."

Not justified opposition, no. You put in the word "justified," and that is the saving clause.

What about the practical matter of there being opposition to this by doctors and dentists who are opposed to the program?

Dr. BERGMAN. Well, Senator, I think that the tools of our profession have changed in the last several years. Doctors and dentists are busy these days and are crying for help. We have found particularly in our rural areas, and I am sure you have found certainly in the State of Texas, with doctors and dentists in rural areas, that competition is no longer a matter that is brought up. They are crying for help and if there are any doctors and dentists in these small communities at all, they are working 14, 15, and 16 hours a day and they don't know what to do; they have no time off, for example. That is what I mean, that the profession is in need of help—and your family practice bill is an example that has the support of the medical profession. The training of paramedical personnel, and another thing that you have been vitally interested in, the returning corpsmen, are needed, and here we find the attitude on the part of the practicing community is one of acceptance, wanting to get more and more people out into the field to help. That is why I made that statement. Plus the fact that the bill insures that corps personnel will be sent only where the medical community welcomes them.

Chairman YARBOROUGH. I hope that is true, that we will not have the opposition of medical people. Certainly, I can't see opposition from dentists, as scarce as they are.

Your reference to Connell in eastern Washington, which is a trade center serving a farming area of over 3,500 people, makes me recall that I grew up in a small town of about 500 people with a surrounding farming community, and our trade area had another 500 to 1,000 people. We had a few medical doctors; and we had one new one that moved in and there was great jealousy among the doctors in having three in a town of 500. Now, of course, they have no doctors there at all, and it would be impossible, practically, to get one to move in.

Dr. BERGMAN. I would like to say, Mr. Chairman, the principle in this bill was adopted by the board of trustees of the American Medical Association several months ago. It was not accepted by the house of delegates, I believe, for more technical reasons, but the principle of Public Health Service physicians giving care in areas where there were not physicians is something that is now freely talked about and I think the vast majority of the medical profession would accept it; certainly the physicians in my State are very interested in this sort of thing.

The CHAIRMAN. What would be the effect of ending the doctor draft on this program? Do you think the National Health Service Corps would be able to find enough volunteers?

Dr. BERGMAN. I believe so, sir. I don't think ending the doctor draft would in any way deter volunteers from coming into the corps. There is a generation of idealistic medical students and dental stu-

dents who would like the opportunity to serve their country and serve the underprivileged.

Currently, there is no organizational framework in which these people can go to work to help today. Just providing money does not do that much good. There is no realistic way now in which they can go in and serve in such communities, and I believe this bill would provide the opportunity to do so. I believe we would be well supplied with volunteers.

The CHAIRMAN. There is legislation now pending in Congress to assist in recruiting doctors for rural areas by financing their medical education. Do you think that it would have any relation to this bill?

Dr. BERGMAN. Well, I think that is a very interesting bill and Senator Javits referred to it in his statement, but I think we need a variety of programs to help in this problem of distribution of physicians; there is no one answer. This legislation, S. 4106, is but a small step and the legislation you just referred to is another step; however, that is a financing bill, to finance medical education for physicians who serve in rural areas. Personally, I don't know whether that will do the job. Indenture, I don't think, has worked out too well in other countries, but I think, as you stated in your opening statement, this is the time for action now. Certainly such bills are not inconsistent with S. 4106. The whole country is screaming for action in the area of health manpower and we have to try a lot of different things—we have to step out and do something. The administration has just stood still on this.

The CHAIRMAN. The other bill is to give additional people, disadvantaged and advantaged individuals, an opportunity to pursue medical training. The problem I see there, though, is the lack of places in the medical schools for students to attend.

In my own State 2 years ago in the fall I know there were 1,230 who applied for admission to the medical schools approved by the local medical societies. The authorities of the medical schools found the high educational training and character of those 1,230 sufficient to go to medical schools, yet the schools admitted only 400 students, and there were 900 that were prepared in that State—which has a great shortage of doctors. These students had no place to go to school. Some found spots in out-of-State medical schools and some in other nations. One country, in its entering class, had 600 students from the United States. We talk about how their medical education doesn't compare to ours, but when these people graduate they will be welcomed back home because we don't have enough doctors.

I sent out a letter of appeal last week to the deans of every medical school in the United States, begging them to get 10 percent more students this year than they had last year, or more than they planned to admit, and asked them, if they couldn't admit 10 percent, what additional percent they could admit. As of last night, we had not had one reply that admitted one more student. One school had sympathy with us, but had already agreed to increase their enrollment before this by four students; I tried to get them to admit just one more student and they wouldn't agree.

As long as this situation exists we won't admit one more medical student; we won't be able to have real health care for the American people, nor better distribution than that we have; we simply won't have adequate care.

I will ask the staff if we have received any more letters.

They say "No." I will have comments on the floor of the Senate next week about the state of the medical education; if we don't get a favorable response, well, we will be lucky with 100 medical schools letting in one more American this year.

Thank you very much for your attitude toward the necessity for this aid to the American people.

Dr. BERGMAN. Thank you, Senator Yarborough.

The CHAIRMAN. The next witness is Dr. Amos Johnson, Garland, N.C., the past president of the American Academy of General Practice.

Dr. Johnson, we welcome you back before the subcommittee. You have made great contributions to medical care in America, toward helping to solve this roadblock to our rapidly expanding population having the health care necessary to meet its needs.

We thank you for the leadership you have exercised. More than any other one person in America, I think you are responsible for the progress made to date on the Family Practice Act.

We welcome you back here and you may proceed in your own way, Doctor.

I might add that I think the people of the country know how much they owe you—or they ought to know—for your efforts to get medical care to the farming and rural areas of our land.

Thank you for your contribution.

**STATEMENT OF DR. AMOS N. JOHNSON, PAST PRESIDENT OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA; PAST PRESIDENT OF THE AMERICAN ACADEMY OF GENERAL PRACTICE, GARLAND, N.C.**

Dr. JOHNSON. Thank you, Senator Yarborough. It is good to be here.

Mr. Chairman, I am Dr. Amos Johnson. For 37 years I have been a family physician in a rural community of eastern North Carolina. Some 700 people live in our village. I provide primary health care for families which total some 5,000 people.

I am the past president of the Medical Society of the State of North Carolina, and past president of the American Academy of General Practice. For 9 years I was a commissioner on the Joint Commission on Accreditation of Hospitals and I am now serving on the Medical Assistance Advisory Council, which is the National Advisory Council to the medicaid program.

As an aside about that, I might state that those of you in the Senate mandated that there be this Council, advisory to the medicaid program, but it has been used but little over the year and it has had little opportunity to contribute much to the medicaid program during the last part of medicaid.

The CHAIRMAN. Dr. Johnson, how many people are there on that National Advisory Council?

Dr. JOHNSON. There are some 20 or thereabouts, and it was an Advisory Council mandated by legislation that set up title XIX, but for the last 2 years this Council has had very, very little opportunity to study or participate in any of the decisions that have been made.

The CHAIRMAN. I direct the committee staff to look into this and to have a report for me by Tuesday, September 1. From the problems that medicaid has now, we see how badly it needs advice from people with expertness in the administration of such programs. I regret to hear this has not prevented these problems and I hope to see it remedied within the coming years. The staff will take note to write this up and bring me a memorandum of this. Thank you for calling my attention to that; that is just one of the many contributions you made to better health care in America.

After all, we have *x* number of tax dollars and have to use them efficiently or all of the bills we pass won't help in medical care. Thank you.

Dr. JOHNSON. I am privileged to be here today to present testimony in support of Senate bill 4106, titled the "National Health Service Corps Act of 1970." This bill was introduced in the Senate on July 21 jointly by Senators Magnuson and Jackson of Washington and was then cosponsored by Secretaries Cranston, Hughes, Kennedy, Nelson, Randolph, and Williams of New Jersey. Now it has a bipartisan group of 22 cosponsors.

Initially, I want to be recorded as being in support of this bill in its entirety. The basic concepts which this act will implement, if approved by the Congress, are fundamental and essential to "shoring up" vital health care needs of a large segment of our country's population. Essential areas of need for health and medical care services and the potential for this "corps" to effect workable patterns for meeting these needs were ably spoken to on the floor of the Senate by the distinguished group of Senators who introduced and cosponsored S. 4106. It would be redundant to repeat these articulate statements of support for this bill.

In the few minutes of my testimony I plan to talk to two facets of potential of this bill which may be more obvious to me perhaps than to many others who read the bill. As a result of experience, observations and, hopefully, wisdom gained during 37 years of general or family practice in a remote, rural, poverty-stricken community such as described by those Senators supporting this bill, I lay claim to a unique body of knowledge related to the needs for this legislation.

The opportunity which S. 4106 offers for experimentation and development of knowledge and skills in innovative systems for the provision of health and medical care for the whole spectrum of our population, including the remote, the poor, and the underprivileged alone more than justifies the passage of this bill. Senator Magnuson was more than passingly aware of this potential when, in his introductory remarks, he said, "The National Health Service Corps is, frankly, an experimental concept, and one that may lead to many different conclusions about the nature of health care in the future."

That the distinguished Senator from Washington had high hopes that the implementation of this "Corps" could be of tremendous importance to our health care effort is also contained in his introductory remarks:

At the very worst, by creating the Corps and setting it in operation we will have provided some health care to those who need it most, and we will have demonstrated to the poor that we truly are concerned about improving their condition. And if the Corps should fare better than this—as I hope and believe it will—its creation will have been a major step in meeting the crisis in health care that we face as a Nation today.

As I ponder this crisis in health care to which Senator Magnuson referred, I firmly believe that medical education, itself, including the internship and residency training years, has without intent been productive of the untenable health care predicament in which we find ourselves today. During the desirable and healthy evolution of medical education, with its concomitant, miraculous scientific discoveries and breakthroughs resulting from the scientific discipline and scientific research, important integral components of the health care delivery system were overlooked or forgotten.

It follows as naturally as day follows night that this rapid increase of scientific knowledge and excellence of medical education should be productive of medical specialization and subspecialization. It also normally follows that specialization would be productive of departmentalization and fragmentation of medical education, which also carries over into internship and residency training years. As specialization and fragmentation of medical knowledge became the order of the day, "generalization" of broad-spectrum medical knowledge as it applies to the whole man was lost sight of. Perhaps it is a reasonable analogy to say that in 1900, medical education was productive of scientific medical morons, while today, 1970, 70 years later, medical education is productive of scientific medical spastics. There may be reason to take a hard look at the relative potential for health care productivity of each.

Could it be that current medical education systems have produced our present physician maldistribution problems? Has medical education been so refined and fragmented that its major product—medical specialists and subspecialists—can only function and service in large and sophisticated medical centers? When, if ever, has medical education in general or any medical school in particular evaluated its annual productivity, the various members and assortments of specialists which are produced, to see how this output meets the health manpower needs of our communities, our cities, our States, or our Nation? Actually, as yet, is there any substantive evidence that our present process of educating physicians and ancillary health personnel really understands the urgent need for large numbers of broadly-trained family physicians or general practitioners, physicians' assistants, nurse practitioners, and so forth? Are these educators aware of the need to provide for all the people of our country ready access to primary health care, and to have someone available with whom each family and community of families can identify as their own personal advocate for their health needs?

This bill originally will ask for funding up to \$5 million and, as Senator Magnuson says, "Fewer than a dozen communities across the Nation will receive care from Corps members." Yet, if this concept with its relatively insignificant funding is implemented, and carefully nurtured as it grows by the competent health professionals who even yet exist in our Public Health Service, it may well come to be our most productive health care delivery system experiment of recent times. This experiment could, in a practical manner, identify for our future benefit the proper mix of specialists, generalists, assistants, nurses, and other necessary personnel needed to provide adequate health maintenance and medical care for all patterns of communities throughout our Nation.

Knowledge and experience gained through excellent Public Health Service guidance of this Corps effort could reasonably be expected to provide new and more productive concepts for the education and assembling of health and medical care teams to move into and remain in any identifiable community of need.

It is largely by chance now that physicians decide to locate in this community or that city to do their lifetime of practice. I know of no meaningful nor effective effort at a regional, State, or national level to identify systematically at a community level, large or small, the relative number of health professionals of specifically identified skills required to provide adequate care for each community. The need for the proper mix of professionals and special skills to match the realistic needs of the community involved is of much too vital importance to be left to chance alone. With proper guidance, this Public Health Service project could begin to cut meaningful patterns leading to the implementation of this concept of efficient planning to meet the needs of identifiable communities. Conceivably, then, medical education, including the education of ancillary medical personnel, could be altered to develop know-how and ability to put together predetermined patterns of teams to meet specific area needs.

There is much of potential productivity to be identified with this bill.

The one other facet of S. 4106 upon which I want to dwell briefly deals with the involvement of the U.S. Public Health Service as the responsible Federal health related agency charged with implementation of this bill. Those who thought this bill through and structured it properly for introduction to both Houses of the Congress of the United States demonstrated keen insight and wisdom when they selected that this act be set up within the Public Health Service. That Senator Magnuson and those able Senators who, with him, support this bill specifically spoke at some length to their interest in revitalizing the Public Health Service and the Commissioned Officer Corps, I believe will prove to be the proper motivating impetus to start the return of the Public Health Service to its proper stature of leadership among health affiliated Federal agencies.

During my 37 years of medical practice at one time or another, I have served as a member or, or in an advisory capacity to, many of the councils and committees of essentially all of the Federal bureaus and departments which were or are concerned with the provision of health care for our American people. In my younger days, the U.S. Public Health Service, under the direction of one of several able and distinguished Americans privileged to become Surgeon General of the U.S. Public Health Service, was the able guardian of the health status of all Americans. Such distinguished Surgeons General as Dr. Leroy Burney and Dr. Luther Terry, along with innumerable subordinate officers and members of the Commissioned Corps, took pride in spending a major portion of their productive lives in continuity, working with and for the American people to maintain and retain a progressively higher level of health and physical fitness. No one questioned then, nor questions now, that these devoted professionals performed at the highest level of excellence.

However, a few years ago in the course of events, some of which were both normal and abnormal, the U.S. Public Health Service came upon

lean years. With the advent of bureaus and bureaucracies—with the advent of high-level, politically oriented advisory councils and task forces, those who were committed to a life work in continuity involved with health maintenance and care for Americans, regardless of the political perspective of the administration in power, came on hard days.

Health care and medical affairs became the concern of established bureaucracies. Top echelon bureaucrats at an appointive level became pawns of the whims of vested interests and powerful organizations. It followed logically that the high-visibility bureaucrats at a subappointive level must please and appease their appointed bosses if they were to retain their prestige and place in the sun. Somewhere in this "rat race," about 3 years ago, it was decided, at a high level of bureaucracy, that the U.S. Public Health Service was outdated and obsolete, and should be abolished—so systematically since then, the Public Health Service has been picked to pieces and emasculated. As a result of this unfavorable trend, those dedicated career officers, for whom it was personally and professionally rewarding, have left the service. Due to the Doctor Draft, little talent of any consequence has since come on board. Those, as an aside, that do come on board, are young students and many of them are very knowledgeable and very productive, but they come for only a 2-year stint and then pass on.

Meanwhile, much of health planning and management in the past few years has been done, to a considerable extent, by those who could hope for little continuity of service and who are or were both personality-oriented and politically expendable. The atmosphere has been nonconducive to long-term, efficient and effective leadership. Perhaps herein are to be found reasons for our somewhat-less-than-desirable or acceptable health care delivery system at the present time.

In conclusion, let me express my approval of, and appreciation for, the apparent sincere intent of those top level Members of the Congress who support this bill to start a revitalization program which can restore the U.S. Public Health Service to its proper place in health leadership—unlike those personality oriented bureaucrats who are here today and gone tomorrow and who have "no pride in past ancestry or hope for future posterity."

Members of the Commissioned Corps of Public Health Service are available and accountable for the results of their decisions and leadership. At all times, they take pride in their success and are humiliated by their failures. Of necessity, their motivations for excellence of productivity and effectiveness have to be of the highest magnitude. I salute with reassurance the revitalization of the U.S. Public Health Service.

Again may I say I support S. 4106 in its entirety.

Thank you, Senator, for allowing me to appear before your distinguished committee.

The CHAIRMAN. Dr. Johnson, just one moment. This is a very informative statement. Since I have been chairman of this committee for the past 2 years, I have been interested in why the Bureau of the Budget was trying to emasculate the PHS, close the PHS hospitals and destroy them as you described here.

I have had people tell me—I am not at liberty to use the names—but I have knowledge that it didn't start with the Bureau of the

Budget; they are being encouraged to do it by the bureaucrats in HEW.

What I am concerned with is saving the Service. You have given us a helpful and enlightening statement here. I find in you someone that knows the score, and I would like to receive a little more information from you to try to help me to save this great Service.

As you point out, in the past it has been a guardian against yellow fever because of the way they quarantine the ports. So the PHS has been the guardian of the American people for a long time. It provided us with inoculation against typhoid and against pellegra in the South, and against the hookworm of the South; all of these great things the PHS has done.

What we need is cumulative implementation of the best that has been developed. Here the PHS, one of the greatest things we have had in the country, is being cut to pieces. You described it better than I have seen it in my 2 years; you have told us "how" and "why." This is a great contribution in additional support of this bill on a much broader subject, and I thank you for what you have done to help the American people over the years.

Dr. JOHNSON. Senator, I sat by real closely watching this whole business develop just as you have said. The bureaucrats who came and went with the various administrations and with the various surges of different administrations who were in for a few months at a time. In high places, you see, the appointive bureaucrats have the power over those who are career people under them. I have seen this decision, I can almost stake it out as to who was on the fifth floor of HEW when this happened, and how it grew and how the word was passed down, that the Public Health Service is obsolete, that "it is a bit of a threat to our efforts as bureaucrats here representing certain administrations to handle the health problems of this country." These people were coming and going, and this reminds me of when I was a younger man, I played professional baseball—I belonged to the Pittsburgh organization, but I was on one of their farm clubs—and we used to say we had three teams. Somebody would ask, "How is that?" And we would say, "We got one coming, we have one here playing, and we have one going," and we were rotating all the time, you know.

And that is what has been happening for the past several years with our health care effort in this country, and it is no wonder that we find ourselves in this sad state of disrepair, because there is no continuity of responsibility for the productivity of our efforts.

The CHAIRMAN. Well, I think this is beyond this mere bill. What you just said may well be one of the greatest contributions made here. I would like to confer with you further about this. How long will you be in the city today, Doctor?

Dr. JOHNSON. As long as you would like me to, sir.

The CHAIRMAN. I will have one of the staff members talk to you immediately. However, due to the number of witnesses I will not go into it further, but we need to explore how to revitalize the PHS of the United States.

I have offered one bill this year and have been able to push it along to give them the same status in retirement that the officers in the health

field in the armed services get. Even in retirement PHS officers were not getting an equal break. We will push that bill. But it is miniscule compared to the broad problem of authority for the PHS.

Dr. JOHNSON. I have one other comment I would like to make. I think if this bill is passed and implemented, that administratively it must go through the same channels during its inception as do other health projects. I think that it would have to be under the direct responsibility of the Secretary of Health, Education, and Welfare and from there down to the United States Public Health Corps.

The CHAIRMAN. And in that progression downward our problem is that it not become "down and out."

Thank you, Doctor.

Dr. JOHNSON. Thank you, Senator Yarborough.

The CHAIRMAN. The next witness is Dr. James R. Kimmey, New York, executive director of The American Public Health Association.

Please proceed, Dr. Kimmey.

**STATEMENT OF DR. JAMES R. KIMMEY, EXECUTIVE DIRECTOR, THE  
AMERICAN PUBLIC HEALTH ASSOCIATION, NEW YORK**

Dr. KIMMEY. Thank you, Mr. Chairman.

I am Dr. James R. Kimmey, executive director of The American Public Health Association. I have a prepared statement which I would like to submit for the record, and summarize it for you. I know that time is moving along.

The CHAIRMAN. Yes, it is, and I know that the people here come from different States which are far away, people who have not yet been heard, and some of them may wish to catch a plane. I appreciate your thoughtfulness in this regard, Dr. Kimmey, and I will order your entire statement printed in full at this point in the record, and you may summarize it as you see fit.

(Dr. Kimmey's prepared statement follows:)

Statement by

James R. Kimmey, M.D.  
Executive Director

The American Public Health Association\*

Mr. Chairman and Members of the Committee,

The American Public Health Association appreciates the opportunity to appear and offer comments on the National Health Service Corps Act of 1970. We view this proposal as a potentially important interim step towards solving the problem posed by inadequate numbers of health service personnel and by their maldistribution. In addition to the knowledge that may be gained on the feasibility of assignment of scarce personnel to the areas of highest need, indirect advantages may accrue from a strengthening of the career professional service of the Federal government and from a mobilization of interest in medical practice in the poor communities both rural and urban.

Comment

There are at least forty million Americans today for whom the oft-cited health care crisis is a very real, personal, daily problem. These people cannot gain access, even to the crisis-oriented episodic treatment that characterizes so much of American medicine. They are exposed each day through the media to the technical triumphs of medical science and must wonder why they are unable to exercise their

\*Presented before the Public Health Subcommittee of the Senate Committee on Labor and Public Welfare, August 28, 1970.

basic right to adequate health. Those of us who spend our time analyzing health care in this country can measure the crisis and express its limits in graphs, charts, and ratios but by their very nature these analytical tools tend to depersonalize the problem of the individual who suffers or dies needlessly for lack of an immunization, because he cannot get to a clinic, or because his community has no physician. There is no question but what the problem is complex and the solution will be costly but somehow we must get on with the business of meeting the emergency while evaluating approaches to long-term solutions. In our view, S.4106 presents an opportunity to attack one of the root problems of health care delivery, the maldistribution of health personnel--particularly in the areas where the forty million poor live.

In the abstract, the physician-population ratio has been a convenient tool to use in describing a part of the manpower component of health care delivery. It is a deceptive measure, however, because many factors that affect both the physician side of the ratio and the population side are ignored in its construction. Viewed without consideration of these factors, we might say we are not doing badly, since the physician-patient ratio has remained relatively stable at 145-150 per 100,000 population for nearly two decades. While these gross figures have remained the same, the percentage of the 145 physicians that are retired, employed in industry, involved in administration or public health work, or conducting highly specialized types of practice has increased markedly. On the population side of the ratio, factors such as personal poverty, price discrimination, distance from services, and others are "washed out" when we deal with the population as a whole. Thus, although the ratio for the nation as a whole has remained stable and approximates a "desirable" figures set rather arbitrarily many years ago, more than half of the States are below

this "desirable" ratio and many of these States are also the lowest in per capita income. There are vast differences between the ratio in urban areas and rural areas, and striking--even shocking--variations in subunits of metropolitan areas. Thus the ratio of physicians to population for New York City is 278 per 100,000 population while in central Harlem the ratio is 73 physicians per 100,000 population.

Why do such severe disparities in the distribution of physicians exist? Studies, experience, and conventional wisdom suggest several reasons:

I. Professional Factors

- a. Specialization--The preponderance of new physicians today enter specialty training directly from internship or military service. Less than a fifth of graduating seniors are electing general practice, and less than a third of all physicians active in 1965 were in general practice. Specialty practice, by its nature, requires a larger patient population to provide an interesting and remunerative caseload. Specialists locate where referrals are brisk and where facilities are adequate.
  
- b. Facilities--The new physician--specialist or not--has been trained in an institution where the most sophisticated equipment, technical facilities and consultation are readily available. He learns to practice his art and his science in this milieu and gravitates naturally towards situations where the practice setting meets his high standards.

- c. Professional Stimulation--The rapid progress in the science of medicine necessitates a constant effort on the part of the conscientious practitioner to "keep up". This is easier where continuing education programs are readily available and where there are a sufficient number of colleagues to permit a ready exchange of ideas and concepts on an informal basis.

## 2. Personal Factors

- a. Cultural--The physician, by selection is above average in intelligence and education, and is likely to have certain expectations in relation to community life that he or his family find unfulfilled in the smaller isolated communities or in the poverty areas of larger cities. Despite growing efforts to redress the imbalance, the majority of American physicians are drawn from the white upper and middle classes and gravitate to the areas where their practice can be conducted in comfortable and familiar surroundings. In the case of the urban ghettos, culture and language differences breed a lack of communication that is frustrating to both the patient and the physician and detrimental to quality medical care.
- b. Workload--Medical practice can be physically and socially demanding at best, and in the under-supplied community, the practitioner is liable to see a threat of total immersion in

the need for services. This is a professional factor as well, since the conscientious physician may feel his ability to practice quality medicine is impaired by excessive patient loads.

- c. Economic--The significance of the economic factor is less than clear. If the physician were purely economically motivated, or economics were even a major motivation, it might well work toward providing services in these areas where competition is low, need is high, and substantial numbers of patients have their health care subsidized by governmental sources.

These factors--although oversimplified--indicate the caveat implicit in suggestions that expansion of the medical schools and production of more physicians will answer the need. Obviously, the bias against the under-supplied areas will continue because the communities which offer the most in professional and personal terms are largely unsaturated. In order to meet the needs of the 40 million poor, other solutions will have to be--and are being--explored. In the long run government and foundation supported efforts to improve facilities, efforts like the Regional Medical Programs to improve continuing professional education, and the elevation of family practice to specialty status may help alleviate the negative professional factors. Improved transportation and communication and the cultural levelling occurring in this country as a result may combat the cultural isolation factors and new practice arrangements may improve the workload factor. In the short run, however, the problem of maldistribution remains acute and for a significant portion of our population requires immediate solutions. The experimental program embodied in S.4106 would be an important initiative in this direction.

We would also offer comments on the bill's potential for strengthening the career professional service within the Department of Health, Education and Welfare. The constant organizational ferment in the health component of HEW for the past three years has been destructive of morale among career employees, has seriously affected recruitment and retention of high-quality personnel, and has seriously compromised the effectiveness of many Federally-supported health programs. The initial steps in the Spring of 1968 which moved the Assistant Secretary for Health and Scientific Affairs into a position of line authority and downgraded the status of the chief professional officer--the Surgeon General--to that of staff man and principal deputy was the first of a series of decisions that have led to erosion of professional leadership in the health programs of HEW. There appears little question but what the health effort of the Federal government can best be accomplished under the overall direction of an official who is a member of the Administration and is responsive to the Administration's policies and priorities. Many European countries have adopted this approach in the person of a Minister of Health. At the same time, other countries have recognized that the wisdom of maintaining a strong hierarchial professional career service with program responsibility for health matters vested in a Director-General of Health. Although this top career professional reports to the responsible member of the administration (the Minister) he retains direct line authority over the operation of health programs. This is not true in the model that has been adopted in the Public Health Service and in a relatively short time, the debilitating effects of a lack of continuity of professional leadership are manifest. Thus, to the extent that S.4106 would contribute to a revitalization of the concept of career leadership and responsibility, it would serve a valuable function.

ANALYSIS

We have several specific comments that relate to the various sections of S.4106, and which have bearing on both the direct and indirect benefits of the approach as discussed earlier. These are as follows:

1. Establishment and Functions The provisions of Section 399h place the proposed National Health Service Corps in the Public Health Service under the direction and supervision of the Surgeon General. If the intent is to vest the Surgeon General with authority over the NHSC as a personnel system, there is precedent in his role in relation to the Commissioned Corps of the Public Health Service. If it is intended, however, that he have operating responsibility for the program, the question might arise as to how this will be accomplished under the existing organizational pattern of the Department as established under Reorganization Plan No. 3 of April, 1968. The Assistant Secretary for Health and Scientific Affairs was thereby vested with line authority over the operating programs of the Public Health Service, and the Surgeon General relegated to the status of "Principal Deputy". The latter intent--reestablishment of a chief career professional officer with line authority for health programs--is desirable and has been urged by one Association in the past. The role of the Surgeon General might be clarified (See Director of Health Service Corps, below).
  
2. Staffing; Term of Service Section 399i allows the Surgeon General to assign commissioned officers and other personnel to the NHSC,

and allows for detailing of such personnel for 25 months, with an option for a 25 month extension. A small point, but in view of the clear intent that the NHSC be an operating program of the Public Health Service an important one, is the use of the word "detailed" rather than "assigned". As used elsewhere in the Public Health Service Act, "detailed" refers to use of commissioned officers and other personnel in programs of other executive departments or other levels of government, etc. "Assigned" would be more consistent with normal usage and expressed interest.

3. Director of the National Service Corps Section 399j establishes that the NHSC will be headed by a Director appointed by the President. Despite the visibility that a Presidential appointment would give the head of NHSC, this would appear to give Congressional approval to a further "politicization" of the professional program of the Public Health Service. In recent months, the Administration moved to transfer the directorship of the Health Services and Mental Health Administration, a major component of the Public Health Service, from career professional status to the White House appointment schedule, and the move met heavy resistance from concerned health organizations and was rescinded. Revitalization of the concept of a strong career professional component in HEW requires less, rather than more, partisan appointments. This is not intended to impugn the abilities of those who are proposed for such appointments, but rather to question the degree to which their professional values can be affected by their political values in program decision-making. The objective of strengthening the Service would seem to be

better served by vesting appointment authority in the Surgeon General.

4. Authority of Secretary to Utilize Corps Personnel Section 399k authorizes the Secretary to utilize personnel assigned to the NHSC in three ways--in existing direct care programs, in programs receiving Federal funds in part or in whole, or any other direct health care activity consistent with the Act's purposes. This desirable degree of flexibility is further strengthened by authorizing collection of fees from recipients. In view of the fact that a substantial portion of the poor who will be in the population served by the NHSC will be eligible for services under Title XVIII or Title XIX of the Social Security Act, and others will have private insurance, the Committee might wish to consider language permitting collection from third party payers as well as individual recipients of services.
  
5. National Health Corps Advisory Council Section 399l deals with the establishment, membership, and functions of a National Health Corps Advisory Council. The inclusion of recipients of services on the Council is an innovation worthy of special mention, as such councils are wont to exclude consumers, or to identify "consumer" only with community leadership. Under Subsection (3), one criterion to be considered in assignment is the "recommendation of any agency or organization responsible for the development, under Section 314 (b), of a comprehensive (health) plan" for the area in which a community seeking NHSC assignees is located. Since appropriations for support of such agencies fall far short of the need, and since the local planning input is important in this program, the Committee might

considered adding "or other agency, as determined by regulation, which performs a similar function" to provide for such input where there is no 314 (b) funded group.

6. Manpower Limitations Suspensions Section 399m exempts the NHSC from personnel ceilings, and authorizes use of Public Health Service facilities for care of individuals covered by the Act, as well as lease or purchase of such other facilities as required. This latter provision is also worthy of special attention, as it would allow experimentation with use of Federal facilities in areas where other facilities are lacking or inadequate. The experience gained might be a basis for extending the same type of provision for community use to the Veterans Administration Hospital system at some future date.

Appropriations The appropriations authorization requested is modest, but seems consistent with the experimental nature of the programs.

Dr. KIMMEY. Thank you, Mr. Chairman. I think that the statements made by the sponsors of this bill for the Congressional Record at the time of the introduction, as well as the other witnesses today, have highlighted necessarily the magnitude of the problem of the maldistribution of medical personnel in the United States.

The American Public Health Association, as an organization of 28,000 people, is interested in the problems of the health of the public of this country and supports the concept in S. 4106. We hope that this bill will be enacted.

I think that I would stress, however, as other witnesses have, that this is only the first step; it is a beginning of the solution to a very complex problem that we have in this country. Other witnesses this morning referred to the "health care crisis," and I think all of us refer to health care crises from time to time, yet maybe that is not the best possible term for what is wrong with health in the United States today.

In medicine, "crisis" implies that it is an appointive time which the patient will either get better or die, and this "health care crisis" seems to be going on for a much longer time than the definition would allow.

What we are really seeing around the country are these communities where people can't get medical care; they can't get a physician in what would be called a rural-urban community, and this is a health care tragedy of the first order. This is highly personal, and as we look at the physician-patient ratio and the charts and graphs and economic forecasts and so forth, we have a tendency to depersonalize the extent of the problem facing the country and the problem that this type of legislation, with its impact on the maldistribution of professional people, would be effective in solving or beginning to solve.

In relation to the indirect benefits of the bill, particularly strengthening of the carrier professional components of the Department of Health, Education, and Welfare and the attracting of more physicians into practice in the rural areas, we also see positive benefits that might accrue from the bill being enacted and this kind of program being established within the Public Health Service.

These comments in more detail, along with technical comments on the bill, are included in my formal statement.

I think that events of yesterday, Mr. Chairman, also enter into our considerations on this bill. My statement was prepared before S. 4296 was introduced by Mr. Cranston of California, the Health Professional Assistance Amendment of 1970, and I think that the proposal embodied in S. 4296 is also responsive to one of the problems highlighted in my prepared testimony, and that is the fact that of American physicians today, only 2 percent are black, and an even smaller percent represents other minority groups who are strongly represented among the poorer groups or the population. We need to look for ways to identify interested students in these fields to get these students together with the possible aid that is available to them, and do everything we can to increase the enrollment of students who might not otherwise be able to get into schools of medicine and schools of dentistry and other health professions and schools of public health.

Also, in view of yesterday's introduction of Senate bill 4297, concerning national health insurance, and other bills of the same type that have been previously introduced in both Houses, I think a bill of this type becomes of great significance.

The maldistribution problem, the fact there are 40 million poor Americans not getting access to medical care, will certainly become a greater problem if we don't have any national means for these Americans to come to the services. This is not to say we should delay for 1 minute the production of some type of supportive financial support for people that can't afford medical care, but rather that bills like this which begin to attack the maldistribution problem, and which begin to attack the shortage problem, which began to attack the shortage of allied health manpower as well as medical practitioners, are important bills that should be introduced and passed on an emergency basis to begin to tool up for the demands that will come on us with universal health insurance.

Mr. Chairman, those essentially are the remarks going to this and I would like to make a personal comment or two on this bill.

Starting in 1963 and going through 1968, I was a commissioned officer in the Public Health Service, the regular corps, and intended to make my career for the next 20 to 30 years in the U.S. public service. I was very personally involved in a way on the other side of the things that the previous witnesses have been making their observations about from the outside, and I was on the receiving end of some of these changes and was in the position of judging, in terms of my own career, what the changes that were going on in the administration of the Department of Health, Education, and Welfare meant in terms of career development in the future for someone who intended to remain as a commissioned officer for a full career and obviously made a decision in 1968, that the future for a commissioned corps officer, as far as an individual who wanted to make a career, was not as good as it was in 1963.

The CHAIRMAN. Just a moment, if I may interrupt.

Has anything happened in the past 2 years that would indicate to you that this was going to get better?

Dr. KIMMEY. No, sir; it has not. I think perhaps it got a little worse.

The CHAIRMAN. The public health has gotten worse?

Dr. KIMMEY. Well, the comment was made about what I call the politization of the health segment of the Health, Education, and Welfare Department, and the fact that in the reorganization plan in 1966 it put the Assistant Secretary of Health into a position, a policy position, and essentially relegated the Surgeon General to a position of assistance, but with no operating responsibility directly.

If we had created a line authority, a Secretary of Health, or an Under Secretary of Health in HEW, and had retained a career professional in charge of the operations of the health part of the Department, I think this would have been a step forward.

One could argue that the Public Health Service, as a professional corps, in the past has not been as responsive to some of the social currents in the country as it might have been. It had a professional job to do, to quarantine, and many other things that have been mentioned, and it did this job very well.

I don't think you could fault it for this. On the other hand, in the social climate of the early 1960's, medical care for a nonbeneficiary was not a part of the function of the Public Health Service, and we might have been deficient in those days in this issue.

So I think, as we saw, as these became political issues, a move was made to put a politically responsive individual into the line of authority—and incidentally, other countries have done this and this works quite well. But I think the mistake we made is removing the Surgeon General from line authority over our health programs and our professional programs of the service, and putting in essentially a staff function for him.

Europeans have a minister of health and a policy similar to what I have just described, and the Surgeon General has urged a reconsideration in our setup, and the consideration of this kind of model, and we see good reason for the administration to have somebody who is a member of the administration, directly a member of the Cabinet, a department member, an individual who can look at the priorities of the problems of the country and can help set policy, but to keep an ongoing continuity of a line professional authority within the health structure of the Government.

Mr. Chairman, these are mixed personal and association comments.

Thank you, sir.

The CHAIRMAN. I think they are very valuable. I wish you would write me a letter which I would ask to be printed in the record, a letter setting those comments out. I would like to get broader comments and then put those in the Congressional Record, and I might state that 45,000 copies are printed every day and they are not generally available in the streets as a tabloid, but they do go to the libraries of the Government and to the departments of the Government, so that everyone concerned can see if they desire, and so that everyone in the White House can see what the comments are, and the major libraries are able to put that material into relevant files so that people doing research in medical schools and different universities and different departments of medicine can see what is happening in medicine in America.

I think your contribution is very valuable, and I want to put it in the Record to give it a broader distribution than just this hearing.

Dr. KIMMEY. With your permission, I would like to submit a copy of the editorial of the New England Journal of Medicine, and a copy of an article by Dr. Albert Snoke appearing in a journal of the American Public Health Association which deals with the problem in detail.

The CHAIRMAN. What is the circulation of the journal of the APHA?

Dr. KIMMEY. Well, I took this job about 3 weeks ago, and I have not gotten acquainted enough yet to get to the circulation.

The CHAIRMAN. All right, what is the circulation of the medical journal you mentioned?

Dr. KIMMEY. The New England Journal of Medicine is one of the major medical journals, and very widely circulated. This editorial appeared a few months ago and has been well received and has not yet been circulated in all libraries or throughout the administration.

The CHAIRMAN. Well, I would like to review that, but the time here is getting short for this session, as you know.

Now you mentioned legislation on S. 4296 was introduced yesterday, and I concurred in the opinion of the author as far as an authorization of \$45 million ending next June 30, when it goes up to \$75 million.

Yet Senator Magnuson, in offering this bill, lends to it his great experience and great legislative expertise. I have watched him for 13 years. He was committee chairman when I came here, and, if you will note, this bill had a very modest beginning, only \$5 million, and he mentioned the fact it is a mere pilot project level, but the principle is established.

So here you have a \$5 million bill and in 3 years it is \$15 million. Well, this totals up, as I get it by rapid mental calculation, to about \$330 million in the other bill, and I am afraid that \$330 million would be so heavy it would pull the \$15 million under the surface with it.

Dr. KIMMEY. I mentioned that bill, possibly another approach to the broad problem, but certainly not as a kind of substitute for S. 4106, but I might add, in closing, that those of us who have been active in supporting health legislation, health administration, and so forth, have often referred to the 89th Congress as the "Health" Congress, there being a great volume of health legislation coming out of that Congress. I think the bills introduced in the last couple of months here in the 91st Congress would show that you are running for the title now.

The CHAIRMAN. Thank you very much for your excellent statement.

Dr. KIMMEY. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness is Mr. Bill Lucca, executive director of the Commissioned Officers Association of the U.S. Public Health Service.

Come around, please, Mr. Lucca.

**STATEMENT OF WILLIAM J. LUCCA, EXECUTIVE DIRECTOR, COMMISSIONED OFFICERS ASSOCIATION OF THE U.S. PUBLIC HEALTH SERVICE**

Mr. LUCCA. Thank you, Mr. Chairman.

My name is William J. Lucca, and I am executive director of the Commissioned Officers Association of the U.S. Public Health Service. I am, indeed, grateful to you, Mr. Chairman, and the members of this subcommittee, for giving the Commissioned Officers Association the opportunity to present their views on S. 4106, a bill which would establish a National Health Service Corps.

The Commissioned Officers Association of the U.S. Public Health Service represents approximately 4,600 members, which number includes 87 percent of the career active duty personnel of that Service. These members are physicians, dentists, scientists, engineers, pharmacists, nurses, veterinarians, dietitians, and others in the Commissioned Corps of the Public Health Service. The Corps is unique in that its entire personnel is derived exclusively from professions in which individuals are trained outside the service and qualified prior to commissioning.

The Commissioned Officers Association supports S. 4106 and recommends its enactment. We do, however, have some suggested changes which I will outline a little later in my statement.

The basic purposes of S. 4106, as we understand them, are:

1. To demonstrate how the quantity and quality of health care can be improved in areas deprived of that care at the present time;

2. To revitalize the Public Health Service and its Commissioned Corps by broadening its mission;

3. To satisfy the social motivation of young health professionals.

The funding of \$5 million annually for fiscal year 1971-72 and 1973 would necessarily limit the scope of the program and, in effect, make it a pilot or demonstration project.

Mr. Chairman, the present authorities under the Public Health Service Act now permit the use of employees—both Corps and civil service—in carrying out demonstration projects such as kidney dialysis projects. Public Health Service professional personnel, including draft obligated officers, may be used in these projects. The establishment of the National Health Service Corps, however, would give stature and visibility to the program and emphasize the importance it deserves.

The Commissioned Officers Association believes that the enactment of this legislation would accomplish the following objectives:

1. It would provide care to groups now being deprived of adequate health services;

2. It would utilize PHS facilities more broadly and make their activities an integral part of the health resources of the communities in which they exist;

3. It would enhance the potential of additional people in health careers;

4. It would provide a laboratory for health delivery research;

5. It would provide an opportunity to effectively utilize ancillary health personnel;

6. It would broaden the mission of PHS and meet motivation of many young professionals thereby making more attractive, service careers.

Mr. Chairman, we have several suggestions that we feel would strengthen the legislation and we recommend them for your, and your committee's, consideration:

1. The appointment of a Director by the President by and with the consent of the Senate appears unnecessary. This official, according to section 399j, is subject to the supervision and control of the Surgeon General. The appointment of the Director should, therefore, be the responsibility of the Surgeon General.

2. Provision should be made for coordinating this program with the Health Services and Mental Health Administration which has responsibility for direct care services and health service research.

3. Provision should be made for increased funding in fiscal year 1972 and 1973 for expansion of the program.

4. A substitute for the word "Corps" should be considered since this term could easily be confused with the present Commissioned Corps personnel system.

Mr. Chairman, there is a segment of the population that desperately needs direct health care and that is being inadequately served at the present time. The Commissioned Officers Association believes that the Public Health Service is the most logical agency to meet this need.

We further believe that the dedication, the enthusiasm, and the expertise of Public Health Service commissioned officers make them the ideal professionals to be utilized for the delivery of health care to our underserved areas. The Commissioned Corps has a long and

proud tradition. It has made outstanding contributions to the health of our Nation. It now has an opportunity, through this legislation, to make perhaps its most significant contribution.

Mr. Chairman, the Commissioned Corps has withstood attacks and attempts to phase it out or abolish it. Though the attacks have not been successful to date, the morale of the PHS is at a low ebb. This legislation would strengthen and revitalize the Commissioned Corps at a time when it sorely needs it. Many young commissioned officers are disenchanted with the Public Health Service because they cannot relate their own goals and objectives with any stated goals, objectives, or plans of the Public Health Service.

They are confused as to what the long-range policies are for the Federal health establishment. They recognize a number of national health needs, but are unsure whether the Federal Government plans to involve itself in these areas, and if there is Federal involvement, they are uncertain as to what their role is.

S. 4106 would enable these young officers to fulfill a deep social commitment and at the same time provide an incentive to retain these men as career officers.

Mr. Chairman, we hope that the committee will consider this legislation favorably, and I wish to express my thanks to the members of this subcommittee for the opportunity to present testimony.

The CHAIRMAN. I have instructed the staff, Mr. Lucca, while this hearing is going on, to put this bill as a crash program at the top of the legislative calendar for health; because time is so short for the session we must give it every possible thrust in trying to pass it.

I am directing the staff to make note of the four points on page 3, the recommendations made for changes in the bill. I know I agree with two of them, and the other two I just need more information on, but the two I am positive I am for, and one of those is provision 3, to increase funding in 1972 and 1973. We should raise the sum.

On this question of morale, Mr. Lucca, I want to direct your attention to Public Law 91-253, signed into law May 14, 1970. My bill, S. 2452, was to amend section 211 of the PHS Act to equalize the retirement benefits for the commissioned officers of the PHS with the retirement benefits provided for other officers in the uniformed services. We did pass that. That is so their retirement would not be less.

Mr. LUCCA. You did, and that did do a great deal for morale.

The CHAIRMAN. Retirement alone is not the main factor in life; what a man does during his working life is more important. But retirement is important, and he should not be discriminated against by being downgraded.

Mr. LUCCA. The Commissioned Corps greatly appreciates your efforts.

The CHAIRMAN. On the question of morale and what the Corps has done in the way of its great work, I can only think about when the Public Health Service first was set up in 1798, wasn't it?

Mr. LUCCA. Yes sir, in 1798.

The CHAIRMAN. 1798. Is that when the seaman's hospital first opened? This was under the Maritime Department.

Mr. LUCCA. Yes, I believe that is right.

The CHAIRMAN. Sometime in the 1790's, under our early Government, as contrasted with our present Government and this present

situation. Now, our Government was less than 10 years old when this PHS was set up, wasn't it?

Mr. LUCCA. Yes.

The CHAIRMAN. I hope this generation will have as much judgment about saving this Service as that generation did in creating it.

Thank you for your contribution.

Mr. LUCCA. Thank you.

The CHAIRMAN. Our next witness is Dr. Robert L. Nolan, division of preventive medicine, Medical School of West Virginia University, Morgantown, W. Va.

Dr. Nolan, we welcome you here, and in my 13 years on this Health Subcommittee and 13 years on the Education Subcommittee I have marveled time and time again about the witnesses of West Virginia who have made such great contributions in the fields of both health and education.

Here is a State, not large in area and population, and not reputed to be one of the wealthiest in the Nation, yet time after time in health and education laws they have made one of the major contributions of the States. I recall my own long, hard fight to pass the GI bill, and even students in West Virginia gave us more aid than those of any other State in the Union.

So I welcome you from the great State which you represent, great in terms of input to better health and education legislation in the country.

Thank you, Doctor, and proceed in your own way.

**STATEMENT OF DR. ROBERT L. NOLAN, DIVISION OF PREVENTIVE MEDICINE, MEDICAL SCHOOL OF WEST VIRGINIA UNIVERSITY, MORGANTOWN, W. VA.**

Dr. NOLAN. Thank you very much, Senator.

I want to express my appreciation to you for the leadership you have personally given us who are struggling with others to help improve the health services that this subcommittee and full committee have provided.

I am Robert L. Nolan, M.D., of Morgantown, W. Va., where I am serving as professor and chairman of the division of public health and preventive medicine and professor of pediatrics at West Virginia University School of Medicine. It is a pleasure to have this opportunity to present my individual views on S. 4106, the proposed National Health Service Corps Act of 1970.

In connection with these views I have also submitted appendixes giving information concerning health conditions in the State of West Virginia, which, with the consent of the chairman, might be included in association with the testimony, if that is agreeable.

My reaction is based upon 17 years combined experience as a pediatrician—formerly with the Kaiser-Permanente program in Oakland, Calif.—local public official, and medical school professor in both urban and rural settings.

In West Virginia and other States S. 4106 could significantly contribute to the alleviation of current health needs.

This State is the only one situated entirely within the Appalachian mountains, with the variety of regional and economic problems well-

known to the subcommittee. Almost 60 percent of West Virginia population is dispersed in rural areas, many living in relatively isolated hollows, without access to health and medical services.

I would like to offer for the chairman's brief review these relief maps prepared by the Army Map Service, which illustrate the isolation of some of our mountain areas and which are factors in the health problems in those regions.

The CHAIRMAN. Let me say that in one year I flew to Texas and back 60 times. Generally, unless the weather is bad, the flights are practically always over your State. I doubt that anyone else has looked down on the West Virginia area as much in the past 15 years as I have, except professional airline pilots, machinists and hostesses, and people who live in West Virginia.

As I look down at the mountains and those hollows, I often wondered how people get back in the hollows. So you are talking to someone who has gazed down on your State many times.

Dr. NOLAN. Yes, thank you, Senator.

We are very appreciative that you are expressing your concern about our health problems through this legislation and the other bills you have supported.

I want to emphasize that the facilities that we take for granted in more affluent regions are simply nonexistent. There is a severe shortage of physicians and nurses in these rural areas; in some counties there are no practicing physicians or nursing personnel available.

The State's own health task force report in 1967 (see appendix A) noted:

(1) that there were only 96 medical doctors per 100,000 population, compared with a national average of 142 per 100,000. Furthermore, an undetermined number of these physicians, average age 53 years, were not in full-time practice.

In the last 10 years approximately 60 communities with populations of less than 10,000 have been left without physicians as rural practitioners retired and were not replaced. In 13 counties there was only one physician for four times the patient population recommended by the American Medical Association (one per 700), and in six counties the population load for physicians was six times the recommended ratio.

(2) Although it was estimated that the State needed 720 public health nurses, there were only 136 so identified, or one-sixteenth of the need, and even this data is incorrect because only a couple of dozen or less of those 136 were actually trained as public health nurses;

(3) 32.6 percent of West Virginia families had total incomes of less than \$3,000 per year. This represented 150,637 families. Only 44,193 families of this group were receiving welfare assistance. Assistance payments based on 52 percent of need determined in the early sixties. The rest had to fend for themselves and had no organized support for medical care;

(4) Local county health departments in the remote areas typically do not have a full-time health officer and have to rely upon an already overworked local physician for part-time service. Programs and services in such departments are very limited and rarely are able to make a significant impact upon unmet individual health needs;

(5) 120,000 homes were found to be without adequate water and sewage services essential for health;

(6) 375,000 homes (521,142 total in State) disposed of solid waste in such a manner as to create a nuisance and public health hazard;

(7) No adequate public transportation in rural areas for either ordinary or emergency medical care was observed.

These and related conditions have their expression in:

(a) Higher maternal death rates: one-third of the 1,343 maternal deaths in the United States per year occurred in rural areas and small towns.

(b) Higher rates of disability and death from accidents (30 to 40 percent).

(c) Higher infant mortality rates in rural areas, one-third higher.

(d) Longer periods of disability and hospitalization for specific illnesses.

On pages 2a and 2b of my statement there is some information about a typical West Virginia rural county which illustrates some of the problems.

(The information referred to follows:)

STATISTICS ON A TYPICAL WEST VIRGINIA RURAL COUNTY

Location in West Virginia—North Central.

Population: Preliminary 1970 census, 24,768; 1960 census, 27,233.

Age group	1950 population	1960 population	Increase or decrease	Percent increase or decrease
Under 5.....	3,929	3,085	-844	-21.5
5 to 19.....	9,284	8,537	-747	-8.0
20 to 44.....	10,336	7,554	-2,782	-26.9
45 to 64.....	5,232	5,290	+58	+1.1
65 and over.....	2,618	2,767	+149	+5.7
Total.....	31,399	27,233	-4,166	-13.3

Income:

Total personal income.....	33,773,000
Total wages and salaries.....	21,917,000
Total proprietors income.....	1,809,000
Transfer payments.....	5,277,000
Per capita personal income (1965).....	1,271
Median family income (1960).....	3,214
Percent of families more than \$3,000.....	46.4
Percent of families \$10,000 and over.....	3.6
Number of public assistance recipients (1964).....	1,169

Education:

Median school years completed.....	8.6
Percent completed less than 5 years.....	10.6
Percent completed high school or more.....	25.7

Health care:

Crude birth rate.....	16.6
Crude death rate.....	10.5
5-year average infant mortality rate 1961-65.....	27.9
Physician ratio <sup>1</sup> .....	*1/1,885
Dentist ratio.....	1/6,600
Health officer, part time.....	-----
Public health nurse ratio.....	1/26,400
Public health sanitarian ratio.....	1/26,400
Hospitals.....	1
Hospital beds.....	54

<sup>1</sup> Population base, 26,400.

\*Corrected; 1970: 1/3,500.

PER CAPITA GOVERNMENTAL EXPENDITURES FOR HEALTH CONTRASTING RURAL WEST VIRGINIA WITH URBAN WASHINGTON, D.C.

West Virginia—Combined expenditures of the Departments of Health, Welfare, and Mental Health, 1969-70 Fiscal Year

Statement health department.....	7, 823, 000
Welfare department.....	15, 500, 000
Mental health including psychiatric hospital.....	17, 400, 409
<b>Total</b> .....	<b>40, 723, 409</b>

41,000,000 over 1,700,000 equals \$24.12 West Virginia per capita.

District of Columbia Department of Public Health, 1969-70: 89,000,000 over 800,000 equals \$111.25 District of Columbia per capita.

Dr. NOLAN. I would perhaps call your special attention to the per capita personal income which in 1965 was only \$1,271 and the median family income only \$3,214 in 1960, and percent of families over \$3,000 income was in the minority, only 46.4 percent.

Note also, gentlemen, that the median school years completed in that county were only 8.6 and that only 25.7 completed high school or more educational training.

Our physician-patient ratio at the time of survey, approximately 68, was 1 to 1,885, and since that time we have lost additional physicians in that county and one physician serves approximately 3,500 people now.

Although there were 54 hospital beds in that county, many of them could not be used because there were no health personnel to take care of the individual needs.

Further, at the bottom of page 2b is summarized some of the comparisons between the State of West Virginia per capita expenditures for health, mental health, and welfare departments, which was approximately \$24 per person, and a comparison with similar services for the District of Columbia Department of Public Health, which was approximately \$111 per person, or 4½ times the ratio.

In surveys conducted locally by physicians in our division, for example, appendix C, there has been well-documented inadequate housing, absence of water, lack of preventive medical services, and a variety of untreated medical conditions ranging from parasitism to heart disease.

But none of this data, however impressive, tells how the coal in these mountains is generating the power for the light in this room and that in extracting that coal we have robbed a man and his family of his water supply, destroyed some of the most beautiful hills in the world, permanently polluted streams and rivers and left a trail of human misery as a heritage for young children.

In these areas we have made equal opportunity a cruel joke, have crowded children and their families into tiny shacks unfit for human habitation and condemned another generation to a way of life without hope, without adequate food, education, or basic health resources.

Despite the fact that these problems have been well-known and documented for decades, there is at present no Federal program that has a specific responsibility or authority to provide personnel for relief of such rural health problems. Local resources have not been and are not able to provide the needed services.

Although this fiscal year Federal health expenditures are expected to reach \$20.6 billion, depending upon the administration's willingness to spend the money Congress appropriated, I have been told without this proposed act, S. 4106, no funds can be expended for the needed services of the proposed statute.

In the past year I have gone from one Federal branch to another within the Department of Health, Education, and Welfare without being able to get any support for basic health services in our isolated mountain regions.

In March and April of this year I had the privilege of participating in a study of migrant health conditions which included my own visits to southwest Texas and southern Florida, supported by the Field Foundation. The testimony of my colleagues who worked with the Field Foundation, with which I completely agree, was presented before your Subcommittee on Migratory Labor on July 20, 1970.

I personally saw the adverse conditions for migrant families in these areas of Texas and Florida that were similar to those in the most depressed areas of Appalachia. This proposed act could also make a substantial contribution to alleviating the health problems of this severely disadvantaged group of migrant families.

Even in relatively affluent California where I practiced for 12 years, large numbers of urban families in segregated areas were functionally isolated from needed health and medical services.

In none of the areas involved, rural Appalachia, seasonal agricultural regions, or segregated urban areas has it been possible heretofore to influence sufficient physicians, dentists, nurses, and other health personnel to settle. S. 4106 is needed to help relieve this disparity of distribution.

In such areas innovative approaches including physician assistant programs, and new health delivery systems have been impaired in development by the absence of a nuclei of professionals with whom new methods could be developed.

I would like at this point to call attention of the subcommittee to the report of the President's National Advisory Commission on Rural Poverty issued in September 1967, entitled, "The People Left Behind," and draw specific attention to its recommendation No. 4, printed on page 69, which states: "The Commission recommends that a National Rural Health Corps of trained volunteer health personnel be established to work in rural areas with serious health needs."

I would hope that the fact that that report was issued under a preceding administration would not cause its work to be forgotten.

In summary, I am in support of this proposal, S. 4106, since its provisions offer an important step in the direction of—

1. Meeting serious current health needs of disadvantaged residents in both rural and urban areas;
2. Providing experience in the development of new health delivery techniques;
3. Permit the more efficient use of existing facilities;
4. Enhance the regionalization of health services;
5. Reducing hospitalizations and unnecessary costs by making prevention of illness and early treatment possible for isolated families;

6. Relieving the burdens of many dedicated overworked physicians still in practice in the understaffed areas; and

7. Demonstrate to our young people the commitment and relevance of a Government that does care about its citizens and their health.

If we really believe in a national goal of effective and dignified health care for every American, no matter what his station in life or where he lives, then S. 4106 could move us in that direction.

The only major qualification that I would offer is that the effectiveness of S. 4106 and the achievement of its goals will require more funds than the proposed \$5 million per year. I hope the committee will consider at least a \$20 million annual expenditure for this program no later than the second or third year of operation.

In addition, there is one technical question I would like to call to the chairman's attention in regard to section proposed 3991(c)(3)(b) with regard to the functions of the council that would be created by this proposed act. In (b) reference is made to taking into consideration the willingness of the community or area and the appropriate governmental agencies therein to assist and cooperate with the corps in providing effective health services throughout the community or area.

I would like to suggest that that be modified to add after the word "governmental" the words "and private" so that private groups and agencies that have interests and concerns including consumer groups as well as professional groups, could be taken into consideration in the same way as formal governmental agencies.

Thank you very much for this opportunity.

The CHAIRMAN. Well, thank you very much, Doctor, for your very knowledgeable contribution, being based not only on your experience in West Virginia, but California and Texas and other areas.

I raise a question about your proposed amendment to subparagraph (b) of subparagraph (3) of subparagraph (c) of section 3991, which is line 23, page 5, of the bill.

Do you have the bill before you?

Dr. NOLAN. I do.

The CHAIRMAN. "The appropriate governmental and private agencies."

Do you mean if there is a private hospital there, perhaps there is no doctor there? By urging of health care to the American people, some people got an idea I am opposed to the medical profession, and of course I am not. They are the people we rely on to get the health care to the people.

I just want to expand it. I want more people to be a part of this health profession and this great expert medical expertise, so we do not stint the people.

One time when I first returned from overseas service as a staff officer within a division in World War II, I was employed by the Medical Association of Texas to draft certain legislation and present it, and got it passed.

I had two different bills. While working on those, I learned that at that time, right after World War II, we had 254 counties in Texas and 26 counties without a single medical doctor.

Some of the cases that were mentioned in here by Dr. Bergman, and others, out in Alaska or in the hollows of West Virginia, some of these would not be considered rural communities in Texas, with an impediment to a doctor going there, because most of Texas—and my fellow Texans might not appreciate it—most of Texas is relatively flat. You get in your car and the difficulty is that it is so flat and you can see so far, you have difficulty in trying to hold your automobile down to some reasonably safe speed above the legal speed limit.

If you get up over 100 miles an hour on this one site, the policemen will stop you. You can roll out and roll 100 miles or 200 miles to a football game Saturday night, with little difficulty because the roads are so flat in the country, with a good road system.

I think the highway system is one of the best in the Union, though our public health pushes down to 40th, and education about 32d—we have done a lot more for the concrete than for the people. We have excellent highways.

So we do not have the isolation in Texas as you have it in many of the rural communities, yet we have difficulties of getting a doctor to go to a rural county or town.

The data you have are most interesting, and you present a typical county. The collective data would be about representative of a rural county in Texas.

We have two of the 10 biggest cities in the Nation, three of the 15 biggest cities, we have 20 percent of all of the 10 or 15 biggest cities in this Nation, whatever number you want to take. Yet our rural counties are losing population, and as is true of the whole Nation, over 60 percent of the counties lost population in 1940 to 1950, over 60 percent lost population from 1950 to 1960, and in the preliminary figures 1960 to 1970, we have about 80 counties gaining in population, with about 170 losing in population, so the number of counties losing population is increasing.

I think one of the amenities of real living itself is having medical care. I don't think the growing imbalance of the population, favoring a few great cities, presents any sociological or economic reason for optimism here. I think the worst imbalance comes in a concentration of population.

Thank you very much for this very informative paper. Thank you very much, and as for your recommendation for greater funding and other recommendations, I direct the staff that every recommendation for amendment is to be carefully considered.

The CHAIRMAN. The next witness is Dr. Robert Shannon, vice president, Student American Medical Association.

#### **STATEMENT OF DR. ROBERT M. SHANNON, VICE PRESIDENT, THE STUDENT AMERICAN MEDICAL ASSOCIATION**

Dr. SHANNON. Mr. Chairman, it is a great pleasure to be here before your committee.

I am Robert M. Shannon, a fourth-year medical student at the University of Maryland Medical School. I am appearing before you today in my capacity as vice president of the Student American Medical

Association, which represents more than 24,000 medical students, and 36,000 interns and residents.

For many years, the concept of the National Health Service Corps has received wide support from young professionals in medicine. Each year since 1965, the national conventions of the Student American Medical Association have seen the passage of major resolutions supporting the establishment of such a corps. The thrust of the discussion has centered on the need for direct intervention to improve the delivery of health care in the povertystricken areas of our country.

The health care crisis presently occurring in this country has many facets, among which are:

1. The quantity and quality of health care.
2. The deficit of physicians, other health professionals, and allied health personnel.
3. The present maldistribution of these groups.

At present, problems seen in the quantity and quality of delivered health care do not revolve around the patient's opportunity for heart transplant. Rather, at issue is the minimum level of health care available to all citizens.

Many geographic health crisis areas, areas of unacceptable minimum care levels, have been defined throughout our country. Estimates of the number of Americans affected vary from the Urban Coalition's figure of 42 million (proposal for a civilian assistance program, prepared by the Urban Coalition, August 12, 1969, p. 3) to the approximately 30 million noted by Under Secretary for Health and Scientific Affairs, Dr. Roger O. Egeberg.

The shortage of physicians and other health professionals has been well documented in the past. The Department of Health, Education, and Welfare in 1967 pointed out that by 1975 a minimum of 40,000 more physicians than the present output of U.S. medical schools and the immigration of foreign medical doctors could provide would be necessary to maintain a "minimum essential (ratio of physicians to population) to protect the health of the people of the United States."

This statement was followed by the inauguration of the physician augmentation program, which was created to assist medical and osteopathic schools to increase their total enrollments by some 4,000 students during the next 4 years. Although the response by medical schools has been vigorous, the expectations of this program have not yet been reached.

This shortage of physicians compounds the health care crisis, particularly in the economically deprived areas of the country. These areas lack many of the attractive features of our more affluent suburban areas, where good hospitals, diagnostic facilities, referral systems, and a highly-desirable social environment exist.

Congress has, in recent years, created dozens of Federal programs to support development of delivery, encourage training of health manpower, construct facilities, and stimulate health planning. Yet, not one of these Federal programs provides for essential staffing without which health services for the deprived millions is an expression not only of numbers, but also of distribution and deployment of health manpower.

A progressive decline in the number of physicians per 100,000 population is evident as one moves further away from our cities. (See appendix I.)

However, maldistribution exists also within our large urban centers, where the highest physician to population ratios in the country exist. Therefore, essential staffing becomes the sine qua non of health care delivery to the poor.

Today's medical students are well aware of the aforementioned. The recognition can be found in their writings, literature, programs, actions, and call for change in medical education.

I would offer the following as testimony of student support and commitment to the National Health Service Corps concept:

1. Massive overapplication has occurred for positions in SAMA projects in Appalachia, Indian health, migrant health, and other related areas.

2. Overapplication (in order of five to 10 per position) for the 700 presently available positions in the Commissioned Corps.

3. A recent survey conducted by SAMA which identified 1,500 U.S. medical students who desire to participate in a corps-type program in poverty areas.

4. At the 1970 SAMA convention, over 90 percent of the delegates, representing 92 U.S. medical schools, voiced their support by resolution supporting the concept of a National Health Service Corps.

As concerns the actual proposal, it is highly commendable that an overlap of service is provided between outgoing and incoming personnel. This in essence provides a very real continuity not previously found in Federal programs.

However, in light of:

1. So great a need;

2. The necessity for flexibility to establish facilities in areas not presently served by the Public Health Service; and

3. The fact that the needs of presently ongoing direct-care programs under other Government agencies are great enough to absorb several times the proposed membership of the new corps (see appendix II);

The Student American Medical Association strongly urges the initial funding level be \$10 million during the first year, with successive increases for each of the next 3 years of \$5 million per year.

Mr. Chairman, the enactment of the National Health Service Corps Act of 1970 will provide the opportunity for young health professionals to serve their country where its needs are greatest.

Thank you for the opportunity to testify before you today.

(Appendixes I and II referred to follow:)

APPENDIX I  
 TABLE I.—DISTRIBUTION OF NON-FEDERAL PHYSICIANS AND POPULATION BY COUNTY GROUPS, AS OF DEC. 31, 1965 (BASED ON DATA FROM AMA,  
 "DISTRIBUTION OF PHYSICIANS, HOSPITALS, AND HOSPITAL BEDS IN THE UNITED STATES, 1966")

	Total physicians		Total in private practice		General practitioners		General surgeons		Internal medicine		Obstetricians-gynecologists		Pediatricians		Psychiatry	
	Popu- lation (mil- lions)	Num- ber	Num- ber	per 100,000 popula- tion	Num- ber	per 100,000 popula- tion	Num- ber	per 100,000 popula- tion	Num- ber	per 100,000 popula- tion	Num- ber	per 100,000 popula- tion	Num- ber	per 100,000 popula- tion	Num- ber	per 100,000 popula- tion
Total United States	190	270,000	130,000	140.0	81,000	90.0	25,000	83.0	240,000	150.0	25,000	86.0	3,000	50.0	28,000	80.0
Greater metropolitan <sup>1</sup>	69	160,000	82,000	95.0	56,000	120.0	20,000	67.0	160,000	100.0	20,000	69.0	2,600	43.0	23,000	66.0
Lesser metropolitan <sup>2</sup>	59	130,000	24,000	34.0	17,000	35.0	11,000	37.0	52,000	33.0	10,000	34.0	2,300	38.0	12,000	34.0
Adjacent <sup>3</sup>	30	18,000	1,600	11.0	5,800	11.0	1,900	6.3	15,000	9.4	2,100	7.2	130	2.2	2,200	6.0
Total urban <sup>4</sup>	160	220,000	120,000	12.9	6,900	17.0	1,600	5.3	21,000	13.0	1,700	5.9	68	1.1	1,800	5.0
Isolated semirural <sup>5</sup>	29	12,000	5,200	9.0	4,300	9.0	1,000	3.3	11,000	6.9	970	3.3	26	.43	1,000	2.0
Isolated rural <sup>6</sup>	6	9,600	3,100	5.1	5,300	6.8	750	2.5	8,700	5.4	790	2.7	18	.30	810	2.0
Total rural <sup>7</sup>	35	8,100	5,500	4.3	2,000	8.0	310	1.0	7,800	4.9	280	.97	12	.20	290	.....

<sup>1</sup> 109 counties in SMSA's with 1,000,000 or more inhabitants.

<sup>2</sup> 301 counties in SMSA's with 50,000 to 1,000,000 inhabitants.

<sup>3</sup> 889 counties contiguous to metropolitan areas. Population in such counties ranges from 500 to 508,500 inhabitants.

<sup>4</sup> Sum of first three groups.

<sup>5</sup> 1,024 counties containing at least 1 incorporated place with 2,500 or more inhabitants.

<sup>6</sup> 758 counties not included in the above 4 groups.

<sup>7</sup> Total of isolated semirural and rural.

## APPENDIX 2

This bill provides for far fewer personnel than could adequately meet the needs of even a few federally-funded health programs. A preliminary survey of manpower requirements that could be met with National Health Service Corps personnel made recently in the Department of Health, Education, and Welfare yielded a figure of two hundred and seventy doctors, and two hundred and eighty other health professionals. These figures apply only to section 314E, Migrant Health, Community Mental Health Centers, and OEO projects. The personnel that could be provided by a National Health Service Corps and utilized by the Office of Child Development (children and youth, and maternity and infant care), model cities projects, public health service hospitals, and the Indian health service have not been calculated.

The CHAIRMAN. In your statement, you say :

For many years the concept of the National Health Service Corps has received wide support from young professional in medicine.

I am wondering why I never heard that before. I have been on the subcommittee nearly 13 years.

Dr. SHANNON. Unfortunately, Senator, the young medical students are just beginning to understand power in Washington, and the places and methods to get particular ideas out front. I think our presentation today is an indication of that, and it is only in the last 2 years that we have testified before committees.

The CHAIRMAN. You also state :

The National Convention of the Student American Medical Association have seen the passage of major resolutions supporting the establishment of such a Corps.

Dr. SHANNON, Yes, sir.

The CHAIRMAN. Now you might have sent to members of the health subcommittee some copies, and I won't say they were not sent, but they were not received in my office. On a busy day, of course, the mail is sometimes so heavy that we might get 5,000 letters in 1 day, and we do not have enough people to open all of that mail, and without these electric machines I doubt that we would have gotten it open.

With that kind of mail, I can't say I didn't get copies, but I don't recall ever receiving them. However, I thank you very much for this contribution. It is very helpful to us.

Dr. SHANNON. If you like, Senator, I could send copies of the resolutions to you in bulk form.

The CHAIRMAN. I wish you would. I would like to direct the staff to put it in the record here; I want it in the record, not for me personally, but we want to print it here to show the long years of support, how this idea is not something new that just jumped up on the spur of the moment, but something that has been needed for years.

Has it been called to the attention of Members of Congress, any of the Members during this time?

Dr. SHANNON. Yes; these resolutions have gone out to all Members of Congress, as per a part of the statement in each of the resolutions, the statement that these have to go out to Members of the Congress, and appropriate committees.

The CHAIRMAN. Well, I am really surprised I have not seen them, because I get volumes of resolutions from the American Legion when it has a convention, and the VFW, and I thumb through them carefully.

Rollcall is going on, and the hearing will be immediately adjourned. This closes the oral hearing, but we will keep the record open until September 2, and you can submit written data to that point. It will be included in the written record. We have had very fine presentations today, and I want to thank all of you.

These papers show work and were not just thrown together instantaneously, and I hope the country responds.

Before closing, I will state to Dr. Nolan the data you furnished with your statement, the supplementary data will be filed for reference, but not printed in the record, because that would hold the record up, but we will file it for reference with the committee so it will be available in debate on the bill just as fully as though it were printed.

Also, I order printed all statements of those who could not attend the hearing and all other pertinent material submitted for the record.

(The material referred to follows:)

AMERICAN DENTAL ASSOCIATION,  
Washington, D.C., September 2, 1970.

HON. RALPH W. YARBOROUGH,  
Chairman, Committee on Labor and Public Welfare,  
U.S. Senate,  
Washington, D.C.

DEAR SENATOR YARBOROUGH: I am writing you in regard to the August 28 hearing held by your Committee on S. 4106, the National Health Service Corps Act of 1970.

It is our understanding, based especially on the level of appropriations authorized in the measure, that the National Health Service Corps would essentially constitute an experimental approach—among those others already established or being considered—to facilitate the ready accessibility of health care in, as the bill states, “those communities and areas of the United States where health personnel, facilities and services are inadequate . . .” Priority, the bill also notes, would be “given to those urban and rural areas of the United States where poverty conditions exist.”

Certainly, it is true that this nation is not yet to the point where continuing, high quality health care of a comprehensive nature is readily available to all citizens. The Association has long recognized that the unequal distribution of dentists is an important factor in this situation. Efforts to remedy this problem unquestionably deserves high priority. The Association, then, is in accord with the general purposes of S. 4106.

I should like to call the Committee's attention to one section of the proposal, however, that the Association believes must be amended before enactment into law. This is the Section 399L which establishes the National Health Corps Advisory Council. Though provision is made for fully half the membership to be drawn from the Department of Health, Education and Welfare, no provision is made for any inclusion of members of the private health professions. The Advisory Council's role with respect to establishing utilization guidelines, setting criteria for site selections and in choosing personnel is such that we consider it imperative for representatives from dental private practice to be numbered among its members. Provision is made in the bill for local consultation with “medical, dental and other medical personnel” by the Council, but we believe that representation from private practitioners on the Council itself is necessary.

I should like to request, Mr. Chairman, that this letter be made a part of the hearing record on S. 4106. On behalf of the Association, may I convey to you our cordial best wishes and assure you once again of our abiding respect for your distinguished contributions to the improvement of the health of the American people.

Sincerely,

RICHARD K. MOSBAUGH, D.D.S.,  
Chairman, Council on Legislation.

WASHINGTON/ALASKA REGIONAL MEDICAL PROGRAM,  
*Seattle, Wash., August 31, 1970.*

HON. WARREN G. MAGNUSON,  
*U.S. Senate,  
 Old Senate Office Building, Washington, D.C.*

DEAR SENATOR MAGNUSON: I have read with great interest your bill S. 4106, National Health Service Corps, and write to express my approval. The promptness with which hearings on the bill have been scheduled prevents my obtaining an official response from our Advisory Committee but the bill addresses itself to a desperate health manpower distribution problem which has seriously concerned both our Regional Advisory Committee and the staff of the Washington/Alaska Regional Medical Program.

It seems clear that the maldistribution of physicians will be corrected only by a program such as you have proposed since the available evidence indicates that there are no incentives sufficient to direct physicians to the many rural and urban areas of need.

I wish it were possible to modify the Selective Service Act to assign a larger number of physicians to such areas of need, but I am told the chances of accomplishing this are out of the question for the near future and since there is real urgency to the problem, your approach seems a logical one. Under the circumstances, your bill will provide a demonstration of value which should allow a subsequent effort of greater magnitudes should it be successful as I am confident it will.

I presume the bill may still be modified and have a few suggestions to offer. It will be vital that these young men work under the supervision of experienced clinicians and this relationship needs to be clearly described. Wherever possible, it would be desirable that the young physician also have a clear and meaningful relation to a medical school or teaching center in order that he continue to learn and that the center benefit from his experience. Since RMP's have demonstrated that they can be an effective bridge between teaching centers and the community, I think they could be of real assistance to the National Health Service Corps Program.

I think it would be desirable to set up guidelines relative to fees charged for the services provided by the National Health Service Corps men so that the general medical community in which the young men practice will not feel threatened by the possibility of unfair competition.

It would be highly desirable that this program have some assurance of continuity and I am sure you have this in mind. In this regard, it should be of interest to note that a significant number of Public Health Service physicians assigned to the Alaska Native Service find their tour of duty sufficiently rewarding that they settle out in Alaska and provide much needed help to that state. I think there is a good likelihood that the same thing would happen with the young men in your National Health Service Corps.

While I have made a few suggestions for modifications in your bill, I would like to make it clear that I endorse it as an important step toward meeting one of the most serious and urgent health care needs.

Respectfully yours,

DONALD R. SPARKMAN, M.D., *Director.*

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NATIONAL TUBERCULOSIS AND RESPIRATORY DISEASE ASSOCIATION,  
*New York, N.Y., August 11, 1970.*

HON. WARREN G. MAGNUSON,  
*U.S. Senate,  
 Washington, D.C.*

DEAR SENATOR MAGNUSON: We have noted that you recently introduced S. 4106 for the purpose of establishing a National Health Service Corps. We are happy to offer our endorsement of this legislation. The availability of physicians to work in local health programs is of particular importance in tuberculosis control; their current scarcity is imposing unfortunate restrictions on outpatient services for patients with this disease.

The disallowance under the current Selective Service law of physicians fulfilling their military obligations through assignment to health programs in the states has been most disruptive to the tuberculosis control program in the U.S. Experience in the years when obligated service physicians were detailed by the

Public Health Service to work in tuberculosis clinics receiving Federal tuberculosis project grant funds was highly favorable. Reports from areas throughout the country indicated that these young physicians, who were given specific training by the Tuberculosis Program of the Center of Disease Control in Atlanta, Georgia, often greatly increased the productivity of tuberculosis control services and was a way of initiating new services.

It is important that tuberculosis patients receive adequate treatment not only for their own condition but to reduce exposure of the healthy population to a communicable disease. Since it is now possible to administer tuberculosis therapy outside of hospitals, this comparatively inexpensive treatment should be carried out to its fullest potential. To let people develop serious disease which requires hospitalization is a waste of resources.

As we interpret the bill, it would be possible to utilize commissioned officers and personnel of the National Health Service Corps in outpatient clinics receiving either 314(d) or 314(e) Comprehensive Health Program monies, currently the major source of Federal support for tuberculosis control, or in those receiving OEO funds such as the Neighborhood Health Centers, many of which also include services for tuberculosis patients.

We hope that S. 4106 will receive broad support from the public health community.

Sincerely yours,

ROBERT J. ANDERSON, M.D.,  
*Managing Director.*

AUGUST 28, 1970.

HON. WARREN G. MAGNUSON,  
*U.S. Senate,*  
*Washington, D.C.*

DEAR SENATOR MAGNUSON: Doctor Don Sparkman, Director of the Washington-Alaska Regional Medical Program, has asked me to comment upon the National Health Service Corps Act of 1970 (S. 4106) introduced by yourself and Senator Jackson and has suggested that I forward my remarks to you. I hasten to add that all of my remarks are my own personal opinion as a private constituent and physician whose home is the State of Washington and that I can in no way represent or speak for the U.S. Public Health Service or for the Department of Health, Education and Welfare. Nevertheless, it is pertinent for you to realize that I am a Commissioned Officer in the Regular Corps of the U.S. Public Health Service, Medical Director grade (0-6), whose current assignment is Director of the Seattle U.S. Public Health Service Hospital.

With that elaborate preamble, I should simply like to say that I have read your bill with a great deal of interest. I believe it represents a very small step in the right direction and that it could lead to an exciting and effective innovation in helping to correct the mal-distribution of physicians and of health services generally in the United States. Our experience here in Seattle with the various free clinics—including the Kinatchatapi Indian Clinic located at the Public Health Service Hospital—provides very convincing evidence of the great need amongst the urban poor, despite all the new programs such as Model Cities and Office of Economic Opportunity which are designed to help alleviate the problem. Virtually every rural community is "under-doctored". We have reached the point, by virtue of Hill-Burton, that we have modern hospital facilities in a number of rural communities, but NO physician to staff them. Some rural community physicians are so over-worked that they move to the city to obtain relief, even though they and their families may prefer to live in a rural setting. Many rural physicians find themselves unable to maintain their skills through continuing education programs because they cannot find a "locum tenens" M.D. to take their busy practices for a week or two per year. Public Health Service physicians now sometimes volunteer as "locums" but they must use their annual leave to do so.

I am personally very much persuaded that your bill is the first frontal assault that has been made on these problems, although Hill-Burton, Regional Medical Programs, and Comprehensive Health Planning have all been helpful in one way or another. I sincerely hope S. 4106 is passed by the Congress, and I will pledge whatever personal support someone in my position can properly provide.

Sincerely,

WILLARD P. JOHNSON, M.D.,  
*Medical Director, U.S. Public Health Service.*

FAMILY PHYSICIANS GROUP,  
Woodland, Calif., August 26, 1970.

Senator WARREN MAGNUSON,  
U.S. Senate, Washington, D.C.

DEAR SENATOR MAGNUSON: I would like to address to you a few thoughts concerning your bill, S. 4106 (National Health Service Corps). I am quite in agreement with your intentions to provide more adequate medical care for our citizens now deprived of such, as well as to mobilize the strong feelings of public service evident in our young doctors and to rejuvenate the public health service. However, I feel the bill falls short of a very great potential to provide better health care and delivery to all U.S. citizens.

The present bill would essentially provide the poor with a duplicate of our present fee-for-service, "cottage industry" type of individual, "handcrafted" medical care. This type of health care is under-organized, inefficient, and too expensive. (My opinions have been formed since graduating from medical school in 1962. I have been in general practice for the past 5 years.) Therefore, having been frustrated by, and seen the deficiencies of, the present system, I hate to see the poor saddled with the same system when, with proper planning, the poor can literally "leap-frog" ahead of our present middle- and upper-class system and end up actually years ahead of the present recipients of "mainstream" medicine.

The remarks of Senator Kennedy concerning S. 4106 are most pertinent to my own sentiments—that much of the present M.D.'s time is wasted on procedures which could be done by a para-medical personnel. In a recent letter to the state medical association officers and my state legislators, I supported a California bill to provide for licensure of physicians' assistants. I feel that progress in such a direction, plus automation, is mandatory to attain organization and efficiency in medical care delivery, and thereby lower the cost. Simply providing more physicians will probably not lower costs significantly.

When I consider medical care delivery problems, I try to think in terms of very basic principles—specifically that most problems (physical, emotional, social) about which patients consult a physician are common, benign, and self-limited. Physicians today are trained to be experts in uncommon, complicated, and life-threatening illnesses. I could go on at length regarding this mismatch, including remarks about the usual arguments against having anyone but an M.D. treat *any* illness, but in short, the present system is as inefficient and costly as having every single ditch in the U.S.A. dug by Ph.D.s in Civil Engineering.

If you can get 5 million dollars appropriated from the Congress to provide health care to the poor, I think you are missing a golden opportunity if you don't make this care more efficient and organized than our present health care delivery system. If effective, these pilot programs could be examples all medical care will duplicate, with lower eventual cost to all of us.

I would appreciate hearing of the progress of S. 4106 and any changes which are made therein.

Sincerely,

N. B. SMITH, M.D.

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MENTAL HEALTH SERVICES,  
COUNTY OF YOLO,  
Woodland, Calif., August 26, 1970.

Senator WARREN G. MAGNUSON,  
Senate Office Building,  
Washington, D.C.

DEAR SENATOR MAGNUSON: Thank you for sending me the details of your excellent proposal to help redistribute scarce medical manpower to those areas of the country, and segments of the population, who are not now covered. A National Health Service Corps should complement rather than supplant the private practice of medicine in much the same way as do our county and municipal hospitals, where they exist. Now that some form of National Health Insurance seems inevitable in the near future, the Corps should help to expose new professionals to satisfying public service in communities where many of them may wish to continue if the economic barriers to such practice are to be eliminated.

The Act should provide a superb opportunity to experiment with paramedical personnel such as returned military corpsmen, pediatric nurse practitioners and nurse midwives. The team approaches that develop may establish models for physicians in other areas who wish to expand their capacities by delegating those

routine activities that do not require the physician's judgment or performance. Your bill could facilitate such demonstration projects if it stressed this opportunity explicitly.

Organizationally, I wonder if you would not strengthen the Public Health Service commissioned corps to a greater extent if you combined the positions of "Director" with that of Surgeon General. As written, the Surgeon General has nominal responsibility for the supervision and control of a "Director" who is appointed by the President with the approval of the Senate and who operates under the authority of the Secretary of Health, Education and Welfare. Why should this program not be an integral part of the commissioned corps of the Public Health Service in every respect? The advisory board and the interest the service corps will generate will certainly keep its activities responsive to the public need. Why is the answer to every new problem in America the creation of a new organization to meet it?

Finally, as a concerned community physician, I would be pleased to help with the gestation, delivery and early development of the National Health Service Corps in any way that I can.

Sincerely,

CAPTANE P. THOMSON, M.D.,

*Assistant Clinical Professor of Psychiatry and Community Health, School of Medicine, University of California at Davis.*

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STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION ON S. 4106

Mr. Chairman and members of the Committee: the American Optometric Association appreciates this opportunity to present its views in support of S. 4106, the legislation to establish a National Health Service Corps.

We believe establishment of a National Health Service Corps would be a major step in solving the problems of maldistribution of health care cited by Senator Magnuson and other sponsors of this bill.

The Nation's 18,000 optometrists actively engaged in practice today are located in 5,438 cities and towns of all sizes. However, even with this excellent geographical distribution, there are still too many areas—both urban and rural—which lack convenient access to professional vision care.

Enactment and implementation of S. 4106 would appreciably broaden the delivery of vision care, as optometrists presently serve alongside members of the other primary health care professions in the Public Health Service Commissioned Corps.

There is little doubt that revitalization of the Commissioned Corps would result from enactment of S. 4106. The career incentives it proposes, coupled with equitable special pay provisions pending action in the House Armed Services Committee, would serve to make an optometric career in the Commissioned Corps sufficiently challenging to attract a ready supply of vision care professionals. Selection or assignment of these individuals to the National Health Services Corps would help meet the vision care needs of the disadvantaged in rural areas and poverty-ridden areas of the inner city.

Utilization of Public Health Service facilities where others are lacking or inadequate could be one of the most praiseworthy benefits of S. 4106. The American Optometric Association views this legislation as an excellent opportunity to demonstrate the workability of a joint effort between the public and private sectors within the framework of a comprehensive health care plan.

We hope the Committee Report will take cognizance of the merits of utilizing existing optometric centers as facilities to which members of the National Health Service Corps might be assigned, particularly for providing vision care to the economically disadvantaged. Such relationships between the Corps and other types of existing health facilities should also be encouraged.

The American Optometric Association supports enactment of S. 4106, and subscribes to the views expressed in earlier testimony by the Commissioner Officers Association and the American Public Health Association.

Enactment of S. 4106 would represent a major step toward filling some of the glaring gaps in health care which plague some areas of our Nation today. We believe enactment of this legislation would create excellent opportunities for better utilization of existing non-profit optometric centers and similar facilities maintained by other health professions.

The American Optometric Association urges approval of S. 4106.

UNITED FARM WORKERS CO-OP,  
*Toppenish, Wash., August 25, 1970.*

HON. RALPH YARBOROUGH,  
*Senate Office Building,  
 Washington, D.C.*

DEAR SENATOR YARBOROUGH: I wish to add my voice to those supporting the proposed National Health Service Corps.

We Mexican-American agricultural workers in the Yakima Valley of the state of Washington are working hard to improve our medical and health care. We have recently received a grant to start a health center in Toppenish, Washington and we are aware of the medical manpower shortages of staffing such a clinic. Physician assignees from a National Health Service Corps to units such as our new clinic could make a great contribution to the desperate health needs of poor agricultural workers.

Our people are working hard to help themselves. Some day we will have Spanish speaking doctors from our own people but solving all the problems to bring that about will take a long time. Until then we are one of the large groups of people who need the help of a National Health Service Corps.

Very truly,

TOMAS VILLANUEVA.

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#### STATEMENT OF THE STUDENT AMERICAN PHARMACEUTICAL ASSOCIATION

The Student American Pharmaceutical Association is the national professional society of pharmacy students, with approximately 13,000 members in 74 schools of pharmacy in this country.

We are pleased to submit these comments about the proposed National Health Service Corps. (S.4106).

We are currently facing a health care crisis in this country: our practitioners are too few in number; our delivery system is archaic and our resources are poorly distributed.

Our health science schools can significantly increase the number of practitioners, if they are given more adequate support by the Congress. But even with dramatic increases in the number of graduates, the health needs of the people of this country will not be met unless we can effect a complete reordering of our health delivery system, accompanied by a redistribution of our resources.

We believe that the National Health Service Corps will be a step in the right direction because it will place dedicated young health practitioners in the areas where the need for their services is greatest. It will allow them an opportunity to learn about the problems of delivering health care in rural and urban (inner city) areas. It will encourage young practitioners to remain in the communities after they have finished their periods of service, to continue the work that they have begun.

We believe that the Corps will serve as a mechanism for increasing the efficiency of our health delivery system. For too long, our health educators and planners have paid lip service to the concept of the health team, without actually implementing its principles. The Corps could easily detail teams of health professionals into its defined target areas to demonstrate the effectiveness of increased cooperation among practitioners, and the desirability of increased utilization of allied health professionals as a part of the team.

In many of our schools, pharmacy students are receiving clinical training that will enable them to greatly expand their capabilities to serve as members of health care teams. These clinically trained pharmacists are quite capable of contributing to patient care in all aspects related to drug therapy, from the initial drug history and diagnosis to the planning of one therapeutic regimen and the monitoring of the patient's response. These health practitioners would welcome the opportunity to participate in the National Health Service Corps.

Finally, we wish to state our support for the mechanism of providing consumer input through the National Health Corps Advisory Council. In too many cases, the recipients of health care services have little say in the determination of priorities or the method of delivering the services. We welcome this recognition of the need for consumer input at the highest administrative levels.

WASHINGTON, D.C., September 2, 1970.

HON. RALPH YARBOROUGH,  
*Chairman, Subcommittee on Health,  
 Senate Committee on Labor and Health.*

DEAR SENATOR YARBOROUGH: Recently, I learned of the existence of the proposed bill entitled The National Health Service Corps Act of 1970 (S4106) which is to be considered by Congress. It is my understanding that this bill provides for improved medical services for people living in the rural areas of the United States. It is also my understanding that a major portion of these services will be provided by young physicians in the Commissioned Corps of the United States Public Health Service who may be serving for two years while discharging their military obligation.

Speaking as an individual private citizen and as a public health physician deeply interested in the health problems of the poor, particularly those living in rural areas, I would like to indicate my enthusiastic support for this legislation. It is very evident to me that one of the most urgent needs of our rural citizens is that of high quality and continuing comprehensive health care. The serious lack of this very fundamental service results in a scandalous amount of needless suffering and shortened lives among the poor in these areas.

This deficit is also one of the most important reasons why people are abandoning the rural districts for the cities at a time when intensive and rapid urbanization is aggravating other social and environmental problems. Most of the people leaving rural areas do so not because they want to but because there is a lack of 1) jobs, 2) educational opportunities, and 3) adequate health care. It appears to me that S4106 would play a significant role in providing that health care and in helping meet these basic needs.

The benefit of such a program would not be only for the patients, but for the doctors, also. It would be a superb experience for a young physician fresh from internship to spend two years practicing community and family medicine in a rural setting. We will always need the traditional specialties such as pediatrics, surgery, and internal medicine, but we have a truly desperate need for physicians with skills, interest, and experience in community medicine and family practice. A small town or rural setting is the best possible place for this kind of experience and it offers certain kinds of personal satisfaction for both the patient and the physician which we need to re-discover. Traditional medical education and modern technology have taught us to be sophisticated technicians, but there is a great need to also understand the relatedness of things and the social context of health and illness.

This is the principal benefit to the individual physician and to the American medical tradition, but it would also provide an enormously important avenue of creative activity for young physicians who feel they want to serve their countrymen for two years but prefer not to do it in a military setting. It was my privilege and honor to serve as a staff physician for the Peace Corps in Brazil for two years at the time when this assignment was still available to Commissioned Officers of the Public Health Service. This is how I discharged my military obligation and I thought it was an extraordinarily rich and creative experience.

It is truly unfortunate that that alternative is no longer available to young physicians. A great many of my colleagues long to perform similar idealistic and humanitarian services but find that they are unable to do so because of financial reasons or the military draft. It is amazing that in a country as rich as ours there are young physicians who wish to perform these services and people who need them but the needs are going unmet. Private practitioners and organized medicine have traditionally opposed such programs, but this opposition cannot be allowed to prevent the provision of better health care for the rural poor.

Sincerely,

WARREN M. HERN, M.D.

UNIVERSITY OF CALIFORNIA,  
 SAN FRANCISCO MEDICAL CENTER,  
 OFFICE OF THE CHANCELLOR,  
 San Francisco, Calif., August 28, 1970.

HON. RALPH YARBOROUGH,  
 U.S. Senate, Washington, D.C.

DEAR SENATOR YARBOROUGH: I was delighted to learn of your decision to hold hearings on S. 4106, "The National Health Service Corps Act of 1970," on August 28, 1970. I regret that University commitments did not permit me to testify before the Senate Health Subcommittee. I have long had an interest in the shortage and maldistribution of health services and I think the proposed legislation would be an important step in helping to correct these problems.

The most important deficiency in the bill, in my judgment, is the proposed authorization for appropriations. I believe that a first year authorization of \$10 million would be appropriate and subsequent authorizations should be fixed in the annual appropriations process rather than through a fixed authorization as called for in the bill.

It is important that members of the National Health Services Corps be assigned in areas where their services can be linked to back-up support and services of highly skilled individuals and institutions. We clearly need a system that links physicians serving in low income areas with the needed back-up services in both urban and rural areas. In existing legislation there is authority to achieve this and grant funds are available to improve the delivery of health care. In the administration of the program and the assignment of physicians, these linkages should be assured and perhaps funds to provide transportation and other needed services could be coordinated. In my judgment, this would not require new legislative authority but it may be something you would wish to point out in the Record.

Let me again express my deep appreciation for your long and great service to this country.

Sincerely yours,

PHILIP R. LEE, M.D., *Chancellor.*

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WEST VIRGINIA UNIVERSITY,  
 SCHOOL OF MEDICINE,  
 Morgantown, W. Va., September 1, 1970.

HON. RALPH YARBOROUGH,  
 Chairman, Health Subcommittee, Committee on Labor and Public Welfare, U. S. Senate, Washington, D.C.

DEAR SENATOR YARBOROUGH: I want to emphasize again my appreciation for your efforts in giving early attention to the proposed National Health Service Corps Act of 1970.

In connection with section 3991(c)(3)(B), I would like to clarify my remarks concerning the possible consideration of private agencies to cooperate in carrying out the purposes of the Act. It has been my experience that faced with limitations in resources and policy restrictions, governmental agencies are not always able themselves to respond to such an effort, although in the same area a private agency could.

To offer maximum flexibility in achieving the Act's purposes therefore, I believe adding the words "or private" after "governmental" in that section would be helpful. Section 3991(c)(3)(B) would then read:

"(B) the willingness of the community or area and the appropriate governmental or private agencies therein to assist and cooperate with the Corps in providing effective health services to residents of the community or area;

Thank you very much for your efforts to provide seriously needed rural and urban health services through S. 4106.

Sincerely yours,

ROBERT L. NOLAN, M.D., J.D.,  
 Professor and Chairman,  
 Division of Public Health and Preventive Medicine.

NEW YORK, N.Y., August 29, 1970.

DEAR SENATOR YARBOROUGH: I have been asked to express my views on S. 4106 by Senator Magnuson. I am a resident physician, acquiring my training and rendering my services at Columbia-Presbyterian Hospital in New York City. I received my M.D. degree in June, 1969. I have always been around the center of the American political spectrum and, due to other commitment and my personality, I have never been politically active. I am in no way knowledgeable about the facts and figures relating to distribution of health services and how these bear on the validity of the National Health Service Corps Act as proposed. However, I feel that my point of view is important in that I would be the type of person participating in the program.

Very briefly, after a year of being a doctor, a career in a large medical center, nor the city that goes with it, are not as attractive to me as they were a year ago. The fact that I am still subjugating my professional life for a future career at the age of 29 has begun to pall. Lately, I have had the longing both to get out of the city and into a genuinely rural setting, and to get myself into a situation where I would be serving people who truly needed my services. These longings are too personal and emotional to rationalize further. Suffice it to say that there are many, many young doctors with similar aspirations, who would make a dedicated cadre indeed.

It was with this attitude that I have gotten interested, mostly through the news media in the needs of the migrant farm laborers. I am frankly shocked about two things since I have become interested in this problem: the first is that, in view of the obvious disproportion of medical care in relation to need in this country, the government does almost nothing about it in terms of employing doctors in these areas. The fact that I am having difficulty finding a single job in this area either in or out of the federal government is shocking, especially in light of the fact that it is difficult to practice medicine as a young doctor around the larger cities because of a glut of doctors in these areas. Secondly, not only do I find it shocking that there is strong opposition to this bill, but I find it embarrassing and at the same time enraging that other members of the medical profession comprise the major opposition. I cannot even imagine how a medical doctor could rationalize opposing this bill. I close with one plea: if it is the medical community which is blocking this bill—examine their motives very carefully.

Sincerely,

JOHN V. WYLIE, M.D.

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AFL-CIO MARITIME COMMITTEE,  
Washington, D.C., September 3, 1970.

HON. RALPH YARBOROUGH,  
Chairman, Committee on Labor and Public Welfare,  
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I am writing on behalf of the AFL-CIO Maritime Committee to express our support for S. 4106 that would establish a National Health Service Corps as a part of the Public Health Service. We hope that this legislation will be enacted promptly so that the health professional personnel system will be strengthened and improved. We realize that this strengthening would improve the level of medical care services for merchant seamen and other beneficiaries. We also realize that the legislation would give the PHS the opportunity to take a more aggressive role and provide leadership in the organization and delivery of health services.

We believe the potential contribution to health that is authorized by S. 4106 far exceeds the \$5 million in funds that are authorized for its implementation.

May I respectfully request that this letter be made a part of the printed record of hearings.

Sincerely yours,

HOYT S. HADDOCK,  
Executive Director.

PREPARED STATEMENT OF HERMAN EUGENE EVANS, EXECUTIVE SECRETARY, STUDENT  
NATIONAL MEDICAL ASSOCIATION, WASHINGTON, D.C.

I CONCERN; II LOVE; III ACTION

There is a problem in this country about which we in the Student National Medical Association are seriously concerned. That problem is the effective delivery of health care to black and other poor people. No health care, or extremely inadequate health care has been a womb to tomb reality for black folks. We are concerned about the reality of heart disease, hypertension, arthritis, mental disease, visual impairment and orthopedic disability all being more common among the poor. The fact that death rates from tuberculosis, syphilis, influenza, pneumonia and vascular lesions of the central nervous system are twice as high among non whites as among whites; the fact that for the poor the risk of dying under age 25 is 4 times the national average and that life expectancy for non whites is still 7-10 years shorter than that for whites are all things about which we are very concerned.

But the conditions don't stop there, they go on: the maternal mortality of blacks is much higher than that of whites, non white mothers die in childbirth 4 times as frequently as white mothers; the infant mortality, which according to the U.S. children's Bureau rises as family income decreases, is much greater amongst non whites—it's twice that of whites; and in recent years there's been a smaller reduction in infant mortality among non whites than whites, resulting in widening disparity in infant death rates by race. 50% of poor children are incompletely immunized against smallpox or measles; 60% of poor children have never seen a dentist; more statistics: Illness is twice as frequent among families with annual incomes of \$2,000 or less; 4 times as much chronic illness among our families; in the preventive services area, only 8.6% of white children have no immunizations compared with 22.5% of non white children; visits to doctors and dentists despite the obvious greater need are less frequent among the urban and rural poor; why? Because many inner city neighborhoods are far from where hospital clinics were set up a generation or more ago; doctors have moved to the more affluent suburbs; public transportation from many of the inner city neighborhoods is lacking, insufficient or expensive. If the kids are poor and if they are black Jonathan Kozol's book "Death at an early Age" literally applies. All of these things are of primary concern to the Student National Medical Association which has for its membership all of the black students as well as other minority students in this country's medical schools. We are concerned too about the production of physicians who will be both willing and eager to serve our people—I'm talking about the production of black and other minority physicians.

Dr. Paul Ehrlich, in his book "The Population Bomb" has documented how the death rate today in Costa Rica is low in part due to a large number of physicians in proportion to their population. In this country at present there is one white physician per 700 white people and one black physician per 4,000 black people. Black physicians make up barely 2% of this country's total physician population, and to carry this theme further, black medical students—hopefully the future black physicians—make up barely 2.7% of the total medical school student body. In 1938-39, over 30 years ago, the black student medical school population was 1.6% of the total, thus an increase of a one percentage point in 30 years. Over this same time period the number of total positions in medical schools have nearly doubled. These figures put in context with the leaps and bounds with which the black and other minority populations have grown make for a situation which merits grave concern. But the tune goes on, it doesn't stop there: over 50% of this country's 102 medical schools income comes from government sources, both federal and local. These are monies collected from the taxes on the hard earned wages of poor people who get little in the way of service in return. Thus for health care, as well as other things, black and other poor people remain dependent on a system that has refused to educate our young people but has demanded retention of the power to plan which services have, and will trickle into our communities. We are concerned that this situation is allowed to exist!

The Student National Medical Association at its conference in April 1970 accepted a number of commitments, all of which dealt with the improvement of the health condition of black and other minority people in this country. One of the most significant of these resolutions was: We as future black and other minority health personnel, recognizing that our first priority is to deal with

the health needs of our people, and that our skills can best be utilized to this end, intend that the selective service obligation will be spent in our communities.

We are here today to express that the National Health Corps can be that viable alternative to the military service obligation which we feel, due to our domestic priorities, is absolutely necessary. The National Health Corps will provide a number of things: (1) it will provide for needy areas, well trained personnel who are, hopefully, culturally and socially of the same vintage of the people who badly need their services (and I say hopefully because when the bill is passed we intend that the assignment of the corpsmen would be to their own, or similar community and of course, this means that these areas must be tapped for health science recruitment. (2) It will provide another avenue for the procurement of education and jobs for our people in our communities, and (3) amongst poor people in which category most blacks fall, it will provide a spark in the direction of starting the flame of faith in the administration's and congress' ability to reevaluate their priorities.

We in the SNMA are not so much concerned about who gets the political credit for the passage of this bill, but we are very concerned that the bill is passed without castrating compromises; we are concerned that this bill receive swift approval and immediate implementation.

The time is now. There have been enough studies, enough research papers, enough blue ribbon committees, enough high level commissions and yes, there have been enough even White House Conferences on the issue of health and its delivery to the people of this country for something to be done about it now. And clearly 50 million people in this country need action now. What is action? Action according to Webster, is the bringing about of an alteration by force, or through a natural agency. Force, according to one of the definitions given by Webster, is violence exerted upon or against a person or thing. Now I'm sure that everyone in this room and, that the rest of Congress, all deplore the use of violence as a means to any end, and we concur. However, in the past and today, violence has often been escalated to a tool of necessity for reaching the insensitive and indifferent elected officials and public agencies of power, which should be but are not serving the needs of black and other minority people. I am talking about the health care delivery system of this country which is in a real crisis, and this crisis situation is greatly magnified in regard to black people. When we consider the health statistics of this country we are constantly reminded of black genocide in ways that are not as blatant as a shot in the back or a lynching but just as deadly as both. We in the SNMA out of a sincere love for our fellow man are concerned that black and other minority people are still living in these unchanged sickening conditions. We are committed to seeing these conditions changed.

Several of our members are working now, have worked in the past and will be working throughout this coming year in comprehensive health units in areas where there is a tremendous need—both rural and urban. We have seen the need, many of us have lived that need, and now all of us want to address ourselves to that need. We feel confident that there are many members of congress who out of a deeply felt concern and love for humanity will see to it that this bill is passed and implemented. We are confident that you will not be dissuaded by cries of future budgetary excess by the administration and that you will remember that your main business is not to see what lies dimly at a distance but to do what lies clearly at hand. The health of 50 million people is clearly at hand. We feel confident that Congress will dispense with legal procrastinations and legislative tie-ups, the face of what we feel should be a top priority of this country, and pass a bill that will make one of the objectives of the Health Services and Mental Health Administration (Public Health Service) more of a tangible reality for many poor people and that objective is: To insure that quality health care and services are available for all.

The SNMA supports the passage of and the immediate implementation of this bill establishing a National Health Corps.

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NATIONAL MEDICAL ASSOCIATION FOUNDATION, INC.,  
Washington, D.C., September 1, 1970.

HON. RALPH W. YARBOROUGH,  
*Chairman, Subcommittee on Health, Senate Committee on Labor and Public Welfare, Washington, D.C.*

DEAR SENATOR YARBOROUGH: I have read with interest and enthusiasm a Committee Print of S4296, your proposed amendment to Title VII of the Public Health Service Act. This amendment represents a major step toward increas-

ing effective recruitment of minority, financially oppressed, and disadvantaged persons to the health professions. It additionally enhances the impact of S3586 which was passed by the Senate earlier this year.

The basic tenets of the proposed legislation addresses directly and concretely major problems which have heretofore effectively discouraged minority and/or disadvantaged persons from pursuing health careers. Specifically, Section 2, Part H of the bill would establish new programs to identify, encourage, and assist financially or educationally disadvantaged individuals to prepare for, enter, and complete training in the health professions. This type of comprehensive approach to "recruitment" and "retention" is necessary to encourage and insure greater representation within the health professions of those previously excluded because of economic, educational, or racial constraints.

Many of the financially oppressed fear the large loans necessary to support current academic study and shy away from consideration of a health profession because of their inability to mentally cope with this economic burden. For others, the existing ceiling on student loans makes it difficult to consider borrowing money which will only support in part their educational process. The enticement of a liberalized loan program under Section 3 of the bill is made even more attractive by the expanded program for loan cancellation, and succinctly presents added incentive for the recent graduate to return to, and practice in, health deprived communities.

The proposed increase in student loan authorization under the same section is also sorely needed. It is universally recognized that the most pressing need in the long process of producing a health professional—especially a physician—is financial assistance.

Section 4 of the bill further extends financial assistance through a change in the scholarship grant formula to schools. This change should encourage acceptance of disadvantaged students by the health schools which nationally are facing fiscal crises and hence may lean to more conservative standards and approaches to student selection.

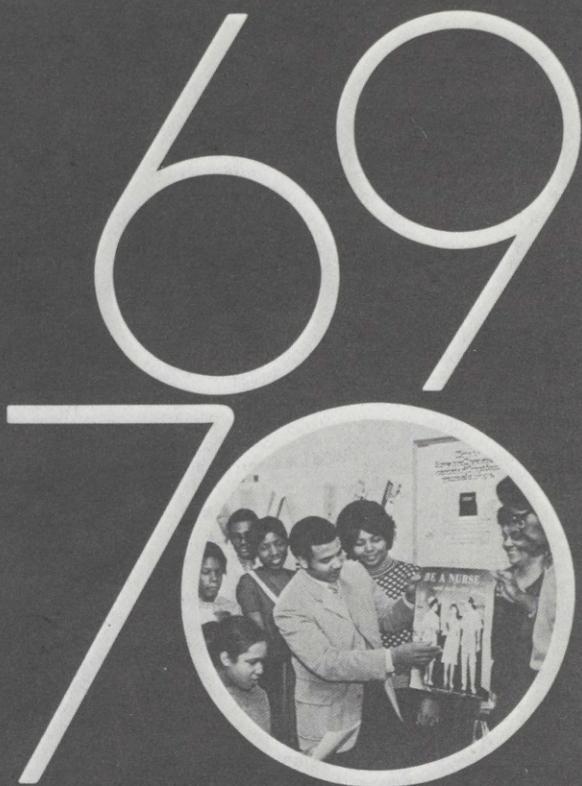
The National Medical Association Foundation is actively engaged in the development and implementation of health care programs which explore new methods of health care delivery. We are thus keenly aware of and deeply interested in the problem of health manpower. The Health Careers Program of the NMAF is our approach to meeting the need in this area. It addresses the problems of recruitment, counselling, "retention" and financial support for blacks interested in the total spectrum of health services. I enclose a brochure of the Health Careers Program and a copy of the Foundation's annual report for your perusal.

The National Medical Association Foundation heartily endorses the S4296 "The Health Professions Assistance Amendments of 1970".

Sincerely,

JEAN L. HARRIS, M.D.,  
*Executive Director.*

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Health Careers Program ■ National Medical Association Foundation ■ Annual Report

## To The Shareholders

The Health Careers Program of the National Medical Association Foundation could be described as an organization which invests in the nation's youth. And in such a venture, all Americans are shareholders.

The dividends which can be achieved by the Health Careers Program are great. But they must be measured in terms far more meaningful than dollars and cents. For what the Program has been doing for the past year, what it is doing now, and what it has planned for tomorrow, can have a dramatic effect on the health of the nation's future, and the future of the nation's health. The Health Careers Program, when fully developed, will give a vast number of underprivileged youngsters a chance to beat the odds, a chance to make a contribution, a chance to help others as they help themselves.

The Health Careers Program has made great strides in its first year of operation. It has spread the word about the many possibilities and the great rewards in the field of health, and it has awakened the interest of many who, for one reason or another, might never have considered a health career. And for many already pursuing a health career, or planning on one, HCP has been able to provide direct financial assistance or, through coordinating sources and applicants, indirect financial aid. HCP also has contacted many of the institutions of learning, to seek more information on course offerings, to request special courses to enable young and old alike to reinforce basic skills never achieved in years of substandard education, and to expand enrollment or reserve space for those who come to us for help.

Not just the young have come to the Program for help. Medical and dental students have sought us out in times of emergency. Returning servicemen, the semi-retired, and those achieving below their potential have also knocked on our door — and we have been there.

Nor is it just those who want a health career that have received our assistance. From across the nation — from librarians, from hospitals, from colleges and universities, from special armed forces programs — scores of individuals have asked for help in establishing their own programs, so that they, too, can help others help themselves. And the Health Careers Program has done whatever possible to show the way.

Perhaps more than anything else, our first year of operation has shown that it can be done. It has served to inspire others to lend a hand in what is and what has to be a communitywide effort. Youth groups and their leaders, community representatives, medical students, health practitioners, educators, representatives of business, foundations and government, and many, many more, have volunteered to serve, and to have the Health Careers Program coordinate their talents, energies and generosity to make the Program work.

The National Medical Association Foundation's Health Careers Program is not the first of its kind. Nor will it be the last. But all connected with it have pledged to make it the best of its kind — to help the underprivileged help themselves, and the nation — the nation in which we are all shareholders.

Mrs. Beecher T. Cassells, Project Director  
Health Careers Program

## Origins And Objectives

The Health Careers Program of the National Medical Association Foundation was established in the District of Columbia, April 1, 1969, through a three-year, \$113,000 per annum grant of the Ernest and Mary Hayward Weir Foundation, New York, New York.

The main objectives of the Program are to provide and enhance opportunities in health and health-related careers for disadvantaged students, as well as returning Vietnam veterans and those employed below their potentials. These objectives are to be achieved by:

- I. Cooperating with schools, churches, youth and other community groups and organizations to identify potential candidates for careers in health and health-related fields;
- II. Establishing liaison with various learning institutions to gain their cooperation in accepting disadvantaged students and in referring students;
- III. Providing information to prospective students, counselors, instructors and others

about the variety of opportunities available in health and health-related careers;

IV. Providing information regarding the locations of various schools, financial aid available, and other pertinent data relative to health and health-related fields, and

V. Providing scholarships or other financial aid when feasible.

The successful operation of the Health Careers Program will serve as a working model to help others tap the vast, virtually unexplored reservoir of manpower that exists in the inner cities of the nation. The successful cultivation of that potential talent can have a significant effect on alleviating the critical manpower shortages which exist in every phase of health and health-related fields. By the same token, successful self-improvement of the inner city young will give them the chance to lead their generation out of the ghettos circumscribed by the vicious circles which have for so long contained their abilities to advance their stations in life.

## Spreading The Word

To have objectives, of course, and to achieve them, are two entirely different things. Too often, there are those who have set objectives — reachable objectives — only to see efforts fall short of the mark.

With this in mind, the Health Careers Program's first step was to establish a multi-faceted communications program to reach all those involved — the students themselves, teachers, counselors, parents, medical and dental students and others already training for a health career, physicians and others actively working in health fields, representatives of colleges and universities, sources of funds for student financial aid, community group representatives, and many, many others.

Much of the groundwork was done by personal call and visitation — to establish an Advisory Board, enlist the support of area colleges, universities and other educational institutions, inform teachers, counselors and students, as discussed elsewhere.

The response from adults was gratifying. Virtually everyone contacted was enthusiastic and helpful. Those whose free time already was allocated to other projects gave us referrals. Those who could help, did.

At the same time, the Program mounted a public relations effort which resulted in television and radio appearances, as well as coverage in newspapers. This activity sparked student interest, and gave the Program an even more solid base for contacting adults.

To enable concentration on the youth community, the Program developed an attractive

and informative question-and-answer brochure, and also produced colorful posters for placement in junior and senior high schools. But it was well understood that brochures and posters were only a part of a whole — a means to an end. We knew that students wanted person-to-person contact and straightforward answers to straightforward questions.

If the adult response was gratifying, then the student response must be termed amazing. After contact with many area school counselors and teachers, meetings were arranged with high school and junior high school students. The range and depth of their questions showed an earnestness and sophistication which belied their years. The enthusiasm they showed — and have continued to show — demonstrated how much the Program had been needed. The willingness to work and imagination of the students demonstrated their desire to help. They have become a vital part of the Health Careers Program's cooperative team concept, based on the philosophy that if people are to do things for one another, they must work with one another. The wholehearted response of the students, as demonstrated by their participation in the Program's Junior Advisory Board, Health Careers Clubs and Health Careers Days, deserves, and has received, special mention in this report.

Spreading the word, of course, is not a "one-shot deal." It is a continuing process necessary for effective action and growth. For people to help and for people to be helped, they first must know.

## The Advisory Board

One of the first orders of business was establishment of an Advisory Board. Because the Health Careers Program was intended to be a community-based program, it was felt that the Advisory Board, to be meaningful, had to successfully represent all the many elements of the community related to the Program. For this reason, the Advisory Board comprises high school and college students, and representatives of local community action groups, of local schools, colleges and universities, of government and quasi-government community-based programs, and of the "grassroots" community itself.

The Advisory Board is not decoration. To hold a seat, each member must actively participate in the affairs of the Health Careers Program — to lend a hand, give advice and counsel, and to provide direction.

The Advisory Board has established the following objectives for its own function:

- I. To determine what means are best to judge candidates;
- II. To obtain knowledge of federal and local student aid programs;
- III. To encourage physicians and dentists to enlist the support of drug and supply manufacturers in establishing regional scholarships and other forms of student aid;
- IV. To contact directly drug and supply companies to ascertain the availability of materials such as audio-visual aids, as well as personnel trained to speak to all groups about many facets of health and health-related careers, and who also are capable of acting as resource persons;
- V. To contact physicians, dentists and others to urge them to create on-the-job training positions for the purpose of candidate career exposure, while also enabling the candidate to earn money for furtherance of his education;
- VI. To further the "buddy system" approach by "adopting" HCP students to identify progress, while also encouraging successful community practitioners to do likewise, and
- VII. To set aside a minimum of \$1,000 and a maximum of \$2,000 to be used as an emergency loan fund.

In emergency situations, or under other circumstances when the need for immediate action precludes the assembling of the entire Board, a five-man Executive Committee has been appointed to act with the full power of the Board.

In addition, a special committee has been formed to devise meaningful orientation programs for college-bound youth, to familiarize them with terminology and procedures which they will encounter on campus.

## Contacting Those Who Teach

Another first and continuing "order of business" for the Health Careers Program was enlisting the active support of area colleges, universities, technical and business schools, hospitals and other teaching facilities.

Thirty-two institutions were visited. Where applicable, we asked them to accept more qualified black students and to establish reparative educational programs to help those who need such assistance to qualify for entrance into regular academic or training programs.

Ten of the institutions visited pledged their cooperation in accepting more black students, particularly those identified by the Program. Four schools reserved space for potential candidates in their September 1969 classes. Three began working to establish reparative educational programs. Three schools of nursing identified persons working below their potential and accepted them into their professional nursing programs.

All of the institutions visited pledged their cooperation in one or more of the following ways:

- I. Cooperative efforts to identify and provide financial aid for minority students who need such aid;
- II. Participation in career incentive programs;
- III. Identification and provision of resource personnel;
- IV. Organization and coordination of health careers clubs and related activities;
- V. Encouragement of student involvement in the Junior Advisory Board, Health Careers Clubs, as well as participation in the "buddy system";
- VI. Encouragement of faculty participation in the HCP program, and
- VII. Cooperative recruitment efforts and referral of students.

Liaison with these institutions continues on a day-to-day basis.



Dr. Adele Shumater caps Mrs. Cora Elder, February 1970



Reception after dedication ceremonies, December 12, 1969

## Contacting Those Who Give

Another of the basic goals of the Program is to identify all possible sources of funds for students seeking financial aid. Drug and supply companies, veterans' and civic organizations, fraternal groups and many other organizations have been contacted. This basic research has enabled us to answer all inquiries as rapidly and accurately as possible, even in several instances where applicants have been outside the Program's jurisdiction.

One of the great disappointments in this work resulted when the majority of the drug companies responding to our inquiries expressed their regrets that no such funds were available, or noted that monies already were allocated to specific schools or students for specific purposes.

Development of the listing of possible sources for student assistance is a day-to-day assignment for the Program's staff, one that is buoyed by continued optimism. By the end of the first year, the Program had obtained \$21,027.50 from other sources, which it distributed in financial aid.



## The Health Careers Center

Although much of the original groundwork for the Program was carried out from the offices of the National Medical Association Foundation, it was planned from the outset that, to do the job required, the Health Careers Program would need its own facility. But the move was to be made only after planning and organization were complete.

Originally, it was intended that the Program's operations would be located in the Model Cities Area of the Nation's Capital. But after an exhaustive search and inspection of a dozen different locations, it was agreed that none could do the job. Finally, a site at 1013 12th Street, Northwest, was decided upon — not in the Model Cities area, but readily accessible for all involved in the Program.

It now contains, among other things, a library, an audio-visual room, and space enough to allow for the healthy exchange of ideas and information among many participants.

The move into the new location was made in mid-August, and the Health Careers Center was officially dedicated December 12, 1969, in honor of the Ernest and Mary Hayward Weir Foundation.

Above: Advisory Board Honorary Chairman Benetta Bullock Washington, Ph.D., left, Mrs. Beecher T. Cassells, Project Director, center, and Mr. Andrew Heineman of the Weir Foundation hold the plaque dedicating the Health Careers Center to the Ernest and Mary Hayward Weir Foundation.

Below: Mrs. Lelia Carr, a community volunteer, left, stands with Miss Shirley Dave, HCP staff, and Mrs. Beecher T. Cassells, Project Director, before the Health Careers Center.

## Junior Advisory Board

One of the unique features of the Health Careers Program is its Junior Advisory Board, made up entirely of students from District of Columbia schools. Guidance comes from representatives of the Advisory Board. Likewise, Junior Advisory Board members have representation on the Advisory Board.

The purpose of the Junior Advisory Board is obvious — to let the Health Careers Program know what the youth of the community are thinking, what they are looking for, and what they want. By the same token, however, active participation in the Program informs the youth of the many problems which are involved in our day-to-day activities. In this manner, we all deal with reality — things as they are, not as we wish they were.

It also must be said that by giving the students a chance to assume responsibilities, we demonstrate the fact that we are sincere in our efforts to work with them, not just for them. The dedicated manner in which they have assumed their responsibilities demonstrates beyond a shadow of a doubt that the students are willing to work for the future they want to see.

The Junior Advisory Board meets on the third Friday of each month. Projects discussed have included fund-raising activities, means of encouraging development of school-based Health Careers Clubs, and many other items designed to assist the Program in attracting more interested students, while also providing the activities and information to make that interest worthwhile.



## Health Careers Days And Clubs

How the Health Careers Program works on a general basis can be epitomized by the workings of Health Careers Days and Health Careers Clubs, whose success has depended on the cooperative and coordinated efforts of many — Program staff, students, teachers, counselors, school principals, medical and dental students and others actively studying for a health career, physicians and other health practitioners, suppliers of audio-visual aids and health career materials, and others. Their reward — and there can be none greater — has been the dramatic interest and enthusiasm expressed and demonstrated by all the students involved — those working to make the Program a success, and those whom the Program intends to reach.

One of the first Health Careers Days was held at Chamberlain Vocational High School during its special summer program for inner city boys and girls aged 12-15. The objective of the Day was to enhance the aspirational levels of participants by providing early exposure to health careers. Activities included a "hands-on" session, involving participants' manipulation of simple equipment, handling exposed X-ray film, and examining equipment models. Filmstrips were shown, and question-and-answer sessions were held — for small groups, as well as for individuals. Follow-up was carried out by the teachers and counse-

lors involved in the special summer program.

During the regular school year, many Health Careers Days were held at junior and senior high schools throughout the District. Typical was one held at Coolidge Senior High School to disseminate health career information and to motivate students to a health-related career. Students were given information on scholarships, entrance requirements and other information pertinent to higher education. Audio-visual and manipulative teaching aids were used, and special "career stations" were manned by community health practitioners.

As an example of the students eagerness, a Health Careers Club — the first of its kind in the Washington area — was formed at Sousa Junior High School. With the assistance of Program staff, students have conducted a survey to determine which community resource persons would be most helpful to them in deciding on a career and in following it up. In another meeting, students of Howard University's College of Medicine served as panelists in a thorough question-and-answer session.

These activities, and others like them, are increasing every day. Their effectiveness depends on cooperation and coordination. Their success is absolutely mandatory if the nation is to develop the health manpower it so desperately needs.

## Financial Assistance

While a significant part of the Health Careers Program's activities concerns coordinating applicants with other sources of funds, the Program also makes grants.

By the end of the first year, the Program had 269 applicants for funds — more than one applicant for each working day. The total amount awarded was \$58,950.50 — more than half of the first year's grant from the Weir Foundation.

The Advisory Board has established the following guidelines for issuing scholarships and other forms of financial aid:

- I. The candidate must reside in the Metropolitan Washington area;
- II. The candidate must have a desire to pursue a health or health-related career;
- III. The candidate must be admitted to an accredited school offering health or health-related training;
- IV. The candidate must participate in seeking financial aid from other sources;
- V. The candidate may be required to present a completed Parents' Confidential Statement (PCS) as part of his application;
- VI. The candidate's current personal income must be within the OEO-defined poverty level;
- VII. The candidate must understand that the award is renewable annually only if he maintains the scholastic average required by the institution he is attending;
- VIII. The candidate must submit the names of three character references and a copy of high school or college transcript;
- IX. If the Board so requests, female candidates under age 18 and male candidates under age 21 must have affirmative letters from a parent or guardian;
- X. The candidate must be willing to engage in a reparative educational program if the need is so indicated;
- XI. Upon the request of any three Board members, the candidate must be willing to appear for a personal interview;
- XII. Official progress reports and/or grades for a semester, quarter, etc., are required for all undergraduate Program awardees prior to installment payment of tuition. (Awardee must notify the Program if, prior to the deadline, he expects to encounter difficulty in meeting this requirement.)
- XIII. The candidate may be considered employed below his potential if the training sought will prepare him for a more technical or professional career than that in which he currently is employed, and

XIV. All of the above criteria apply in selection of awardees.

The Advisory Board also has established criteria for granting emergency loans. The emergency loan fund proved especially useful when the federal government announced cut-backs in the funding of health professional scholarships — medicine and dentistry. The Health Careers Program received requests from Howard University and Meharry Medical School students alone for funds amounting to more than \$75,000. The Program helped as much as possible by making grants, loans, and by identifying other sources of funds.

Criteria for emergency loans, as established by the Advisory Board, are:

- I. The candidate can be recommended for an emergency loan by a responsible member of the staff of a training institution.
- II. The candidate must sign a binding contract of responsibility for the loan, or, if not of legal age, must have a responsible co-signer. (Forgiveness will be determined at the discretion of the Board.)
- III. At least two members of the Executive Committee and the Project Director may approve emergency loans up to \$100. The ability to repay loans and priority of need are governing factors.



Mrs. Mary Allen, right, mother of seven, receives her associate degree in nursing from Washington Technical Institute's Mrs. Colson.

## Buddy System



A reception for college-bound Program awardees, August 1969.



Three Health Careers Program awardees speak with NMAF Project Director M. Alfred Haynes, M.D., second from right. Students are Mr. James Bond, St. Louis University School of Medicine, left; Miss Marsha Jessup, University of Michigan School of Medical Illustration, and Mr. James Davis, Johns Hopkins University School of Medicine, right.

In addition to direct and indirect financial aid through coordination of students and available funds, the Program also sponsors a plan of moral support — the buddy system — through coordination of students and those actively engaged in the study or practice of a health career.

The concept of a buddy system within the framework of a health careers program first was presented to the National Medical Association by its past president, Dr. James Whittico.

The purpose of the buddy system, as conceived by Dr. Whittico and as it is carried out by the Health Careers Program, is to match a student of a health career with a successful practitioner of the career, to give the student support, advice and counsel on a one-to-one basis.

Unfortunately, by the end of the first year, only 33 buddies had been obtained. More are needed — in Washington, and throughout the nation, wherever Washington-based youth are attending schools.

As expressed by the Project Director, Mrs. Beecher T. Cassells:

"A word of encouragement, praise, a note, letter, telephone call or a constructive suggestion can mean the difference between success or failure for some of our young people who are struggling to beat the odds. Our commitment to invest a little time and personal effort in encouraging a buddy can yield dividends with compound interests far beyond the original value of our initial investment. We ask you to secure your share now in the HCP buddy system."

## The Future

In the future, the Health Careers Program plans to offer new and innovative procedures to expand its effectiveness, and to open similar programs in other parts of the nation.

One of the innovative procedures for which groundwork was laid in the first year is a "Health Careers Mobile," which would bring the exciting possibilities of a health career to students in those schools where the ability to assemble is limited. Cost data has been assembled, and foundations and departments of motor vehicles are being contacted for purposes for implementing the Health Careers Mobile project.

Another innovative program discussed and tentatively planned for January 1971 is an art contest open to students in from elementary to senior high schools. Entries would depict minority groups in health careers. Guidelines for participation are being formulated, and possible scholarship and other award donors are being identified. The Pepsi-Cola Company

and others already have expressed their interest.

The Program also plans to establish a student evaluation plan, wherein students who have been helped by the Program would be asked to comment on how the Program has helped and, more important, to tell of areas where the Program could be of even greater assistance, in light of experience.

Similarly, the Program also intends to develop "gab sessions," with students helped by the Program spending time with others currently in the Program — telling them what to expect, giving them ideas, etc.

Expansion plans also are being investigated. Talks already have been held regarding the proposed Baltimore Health Careers Program, with an eye to involving the entire state of Maryland. In addition, Program staff has been consulted about a possible Health Careers Program for the Appalachian region of West Virginia.



Sousa Junior High School Health Careers Club. Standing with poster are, left to right, Mr. James Matthews, Assistant Program Director; Janet Bullock, Club President; Mrs. Dorothy Hunt, Sousa counselor and club sponsor, and Maurice Weise, President, Student NMA and student at Howard University School of Medicine.

## Health Careers Program Financial Report

April 1, 1969 Through March 31, 1970

	Total For Fiscal Year
<b>Revenue: Weir Foundation</b>	
Operating and Health Careers Scholarships . . . . .	\$100,000.00
Special Scholarships: Johns Hopkins U. & Univ. Maryland . . . . .	13,250.00
Special Scholarships: Howard U. Coll. Medicine & Meharry Medical College . . . . .	5,000.00
	<u>\$118,250.00</u>
<b>Expenditures:</b>	
Salaries . . . . .	\$ 32,818.50
Benefit Expenses . . . . .	2,725.73
Total Salaries & Employee Benefits . . . . .	<u>\$ 35,544.23</u>
Consultants . . . . .	<u>\$ 1,949.26</u>
Supplies, Telephone, Etc.:	
Supplies . . . . .	\$ 1,931.25
Telephone & Telegraph . . . . .	1,091.75
Postage & Shipping . . . . .	404.88
Printing . . . . .	1,339.82
Subscriptions & Publications . . . . .	99.06
Total Supplies, Telephone, Etc. . . . .	<u>\$ 4,866.76</u>
Travel . . . . .	\$ 263.29
Occupancy Costs . . . . .	6,256.85
Equipment and Furniture Purchased . . . . .	7,620.77
Equipment Rented . . . . .	1,303.33
Exhibit & Related Expense . . . . .	1,819.92
Scholarships . . . . .	54,476.00
Miscellaneous Expenses and Overhead . . . . .	2,608.71
Total Other; . . . . .	<u>\$ 74,348.87</u>
<b>Total Expenditures</b> . . . . .	<u>\$116,709.12</u>
Distributed in Loans to Students . . . . .	500.00
<b>Total Expenditures &amp; Loans For The Year</b> . . . . .	<u>\$117,209.12</u>
Excess Revenue over Expenditures . . . . .	\$ 1,040.88
Obligated as of March 31, 1970 . . . . .	7,672.32
<b>Balance (Amount Needed To Meet Obligations) as of March 31, 1970</b> . . . . .	<u>\$ 6,631.44</u>

(Compiled by Office of Asst. Secretary-Treasurer)

## Career Preferences

Distribution of Health Career Students Showing the Number Listed in Each Field, Their Ages, Sex, Educational Status, and Amount of Financial Aid Received.

HEALTH CAREERS	STUDENTS		AGE		SEX				EDUCATIONAL STATUS				FINANCIAL AID	
					Male		Female		1st yr.	2nd yr.	3rd yr.	4th yr.	Total	Average
	No.	%	Average	Range	No.	%	No.	%						
MEDICINE	39	35	25.8	21-34	30	77	9	23	14	15	4	5	23,690	607
DENTISTRY	24	22	24.9	18-38	23	94	1	4	23	1	—	—	11,209	467
NURSING	14	13	21.5	18-41	1	7	13	93	9	3	2	—	6,981	537
PRE-MED	8	7	20.7	18-27	5	63	3	37	6	1	1	—	5,036	629
PHARMACY	1	1	20.0	20.0	0	0	1	100	—	1	—	—	1,000	1,000
PARA-MEDICAL	24	22	26.5	19-43	0	0	24	100	24	—	—	—	8,997	409
TOTALS	110	100	24.8	18-43	59	54	51	46	76	21	7	5	56,913	522

## A Note Of Thanks

Because of space limitations, a list of those people who have helped make the first year of the Health Careers Program a success would be incomplete. Literally hundreds have pitched in, devoting countless hours of their time, sharing their knowledge, giving ideas and information, and dedicating funds. To all these people, our most sincere thanks. We look forward to your continuing active interest and concern in the days ahead.

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[Telegram],

AUGUST 31, 1970.

Hon. RALPH W. YARBOROUGH,  
*Chairman, Subcommittee on Health, Committee on Labor and Public Welfare,  
 Senate Office Building, Washington, D.C.*

DEAR SIR: The National Dental Association has followed with great interest the developments of the Senate bill 4296 which proposes to amend title VII of the Public Health Service Act to meet the needs of additional personnel in the health professions by encouraging and assisting disadvantaged individuals to pursue training designed to prepare them to engage in the practice of such professions and for other purposes.

We highly favor and support the general description and amendments as proposed and strongly encourage passage of the bill.

Unfortunately we of NDA cannot overlook the fact that there are only 2,000 black dentists in this entire country. Obviously this number in proportion to patient populations and demands for service is totally inadequate. Moreover, in proportion to patient populations increase, the number of black dentists is steadily declining. Equally distressing, there were only 356 black dentists in all America dental schools in 1969.

The passage of S. 4296 will help to catalyze a reversal of the decline in the number of black students entering dentistry and assist in short circuiting the startling fact that black dental students comprise less than 3 percent of all dental students in this country.

Additionally, the bill, as proposed, would facilitate accelerated recruitment programs in attempts to improve the ratio of dentists among blacks (1 to 12,500) which is more than 600 percent worse than it is among the population generally (1 to 2,000). Lastly, it appears that the proposed Health Professions Assistance Amendments of 1970 appropriately focuses on several essential considerations for special assistance to our disadvantaged youth and would lead to resolution of the lack of adequate health care in those areas of this country and in those sections of our cities where health care is needed most.

DR. EDDIE G. SMITH, Jr.,

*Vice President, National Dental Association;*

*Chairman, Civil Rights Committee; Chairman, Political Actions Committee.*

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AMERICAN OSTEOPATHIC ASSOCIATION,  
 Washington, D.C., September 1, 1970.

Hon. RALPH W. YARBOROUGH,  
*Chairman, Senate Committee on Labor and Public Welfare,  
 Washington, D.C.*

DEAR MR. CHAIRMAN: The American Osteopathic Association appreciates this opportunity to express its opinion concerning Senate Bill 4296, "The Health Professions Assistance Amendments Act".

Enclosed please find a copy of our statement on the proposed legislation, as per your request.

Thank you for your consideration.

Very truly yours,

ROY J. HARVEY, D.O., *Director.*

#### STATEMENT OF THE AMERICAN OSTEOPATHIC ASSOCIATION

The American osteopathic professional appreciates this opportunity to present its views on Senate Bill 4296, "The Health Professions Assistance Amendments Act". The American Osteopathic Association is the national professional organization of osteopathic physicians and surgeons. There are in excess of 13,454 osteopathic physicians and surgeons in the United States. Some 252 hospitals with a bed capacity in excess of 22,117 are staffed by doctors of osteopathy. There are six colleges of osteopathy all approved by the A.O.A. and there are 79 intern training and 68 residency training hospitals likewise approved by the Association, which is the recognized accrediting agency by Division of Education of the Department of HEW, and The National Commission on Accrediting.

The objective of the A.O.A. is to promote the public health, to encourage scientific research, and to maintain and improve high standards of medical education in osteopathic colleges.

Our osteopathic colleges, like many other health professional schools, are today confronted with a problem of *major proportions*, resulting from the ever increasing national demand for more physician manpower while contemporaneously experiencing *inadequacy of urgently needed funds*.

The proximate result of the shortage in funds available for student assistance is that our osteopathic colleges cannot begin to meet the needs for financial assistance to their present enrollment, let alone being in a position to meet the needs which are being generated by the increased enrollment demanded.

Our profession is acutely aware of the nation's physician shortage, but our attempts to fill the gap are being thwarted by the unhappy combination of increasing costs in medical education, on the one hand, and decreasing per capita assistance on the other.

We would like to be in a position to admit every academically qualified student who applies to our institutions. Presently, however, the cost of a medical education is simply beyond the reach of many students from lower-middle and disadvantaged families in our country. In fact, funds are now so tight, that even students from relatively affluent backgrounds are hard pressed to secure the necessary funds.

At a time when expansion of the number of persons entering the health professions is so critical and the need for greater representation from traditionally excluded socio-economic groups is so obvious, our efforts to alleviate these problems will be handicapped if sources of financial assistance at all levels of government are not substantially enlarged.

An insidious effect of a protracted shortage of financial assistance will be that, for the long pull, the level of competence in the healing arts will be determined not by the availability of capability, but by the accessibility of money—loans, scholarships, gifts or other. This, of course, will be inimical to the long term development of medicine generally, health care and, in broader terms, science, itself in America.

In their efforts to respond to the nation's increasing demand for physical manpower, our colleges have taken significant steps to encourage and assist representation from disadvantaged groups in their expanded enrollments.

To that end, one of our schools, Philadelphia College of Osteopathic Medicine, inaugurated a program in 1969 whereunder the physical plant operates from 8:00 a.m. to 10:00 p.m. daily. This has enabled disadvantaged individuals to continue to work and still participate in a full medical curriculum.

While programs such as the one referenced above, manifest a willingness to increase enrollments from disadvantaged groups, we cannot hope to fully insure the broader representation that we all want without expanded Federal support.

It is also important that those schools which do take substantial steps to accommodate increased enrollments, predicated on the belief that continued Federal assistance to prospective students will be forthcoming, will not be acting to their detriment because of an unappropriated Federal commitment.

Health manpower is at a critical crossroads. Unless we can find a means to ease the present financial crisis experienced by students, we cannot hope to draw on the resources available in the disadvantaged element of society, while attempting to meet our nation's goal of providing adequate numbers of qualified health manpower personnel.

Your continued efforts to solve these and related problems toward assuring high quality health care for all Americans are most deeply appreciated, and substantially supported by the American Osteopathic Association and its colleges.

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AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY,  
September 1, 1970.

HON. RALPH W. YARBOROUGH,  
Chairman, Subcommittee on Health, Committee on Labor and Public Welfare,  
New Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: The purpose of this letter is to express the support of the American Association of Colleges of Pharmacy for S. 4296, the Health Professions Assistance Amendments of 1970, introduced August 27 by Senator Cranston for himself and you.

The legislation would make changes in the health professions student loan and scholarship programs, would encourage greater representation of the educationally and economically disadvantaged in the health professions, and would

provide incentives for health professionals assisted through Federal student loans to practice in urban and rural poverty areas.

The 74 schools of pharmacy comprising the American Association of Colleges of Pharmacy are making every attempt to provide an adequate supply of pharmacists. An increased number of pharmacists is essential to meet the pharmaceutical needs of our expanding population and to keep pace with a continually increasing number of prescriptions being written by the increasing population of physicians.

Currently, schools of pharmacy are not graduating a sufficient number of pharmacists to replace those who leave the practice annually.

About 85 per cent of the pharmacist population is practicing in the 52,500 community pharmacies and about 7.5 per cent is practicing in hospitals. Of the approximately 7,000 hospitals, only 67 per cent had a pharmacy with a pharmacist in 1967. The demand for pharmacists in these institutions is greater than the supply.

In addition to the demands of hospitals, the profession is attempting to meet the pharmaceutical needs of the many nursing homes and extended care facilities. Through training courses offered by schools of pharmacy and pharmaceutical associations, about 1,000 community pharmacists have been trained to serve as consultants to these facilities and to small hospitals.

The American Association of Colleges of Pharmacy will welcome the assistance provided by the legislation to assist in increasing the number of students from those who are educationally and economically disadvantaged. To assist in increasing students for pharmacy, the Association has added a staff member whose principal duty will be to recruit students from all groups, including the groups for which the bill is designed to assist.

Several of our schools have already initiated programs to increase the number of students from among the underrepresented. While some progress is being made, assistance which will be provided by S. 4296 is essential to assure more marked progress. In 1964 only 318 black students (2 per cent of the last three classes) were enrolled in our schools, and in 1968 these figures were but 511 or 3 per cent. By far the greatest number of blacks were enrolled in the three predominantly black schools.

The Association is cognizant of the program of the National Urban Coalition and presently is cooperating with it. Also, the Association, through the Federation of the Association of Schools of the Health Professions, is participating in programs funded by the Office of Economic Opportunity through the Association of American Medical Colleges. These programs have objectives consonant with those of S. 4296.

The feature of S. 4296 is commendable which would encourage health professionals to practice in areas, both urban and rural, where the need is the greatest. While pharmacists are not included in the loan forgiveness program of the current legislation, it is respectfully requested that S. 4296 be amended to include them.

The development of health centers with health professionals working as a team would be most desirable. The educational program in pharmacy enables the pharmacist, working with the physician, the nurse, and other health personnel, to make an important contribution in the delivery of health services. While continuing to provide the pharmacy graduate with detailed knowledge on drugs, recent curricular changes provide him with greater knowledge of the action of drugs in the disease state. This knowledge is available through clinical pharmacy courses where students develop a patient-oriented attitude thus complementing his expertise as a drug specialist.

The American Association of Colleges of Pharmacy is pleased to support S. 4296.

Sincerely yours,

CHARLES W. BLIVEN,  
*Executive Secretary.*

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AMERICAN PHARMACEUTICAL ASSOCIATION,  
Washington, D.C., August 31, 1970.

HON. RALPH W. YARBOROUGH,  
U.S. Senate, Chairman, Subcommittee on Health, Committee on Labor and  
Public Welfare, Washington, D.C.

DEAR SENATOR YARBOROUGH: On behalf of the American Pharmaceutical Association, I appreciate the opportunity to comment on S. 4296, The Health Professions Assistance Amendments of 1970.

The American Pharmaceutical Association is the national professional society of pharmacists in the United States. Its approximate 50,000 members are composed of practicing pharmacists, pharmaceutical educators, pharmaceutical scientists and pharmacy students.

APhA applauds Senator Cranston's bill as well as you and your fellow co-sponsors for your efforts to provide incentives for health professionals to practice in urban and rural poverty areas and to encourage greater representation of the economically disadvantaged in the health professions. The provisions of S. 4296 should well serve this end.

APhA recognizes both the need for more pharmacists, especially serving rural communities and disadvantaged neighborhoods, and the need for increased financial and educational assistance for the disadvantaged in order to assure that the profession includes a greater number of minority group members.

For example, the 1960 Census showed that only 2.6 percent of all practicing pharmacists in the United States were non-white, while 12 percent of the total population were non-white. A close examination of the availability of pharmaceutical services to rural communities and disadvantaged neighborhoods clearly demonstrates the maldistribution of pharmacists created in part by this lack of ethnic and racial representation within the profession. The Bayview-Hunters Point district of San Francisco with a population of 22,000 persons, 91 percent of whom are non-white, was reportedly served in 1969 by only two pharmacies. This ratio of one pharmacy to 11,000 people contrasts with the nationwide ratio of one pharmacy to 3,200 people. Adverse effects on the health care system in Bayview-Hunters Point district must result from this dearth of pharmaceutical services.

Recognizing these needs, APhA's Board of Trustees has appropriated funds to support a study of those factors which may or should influence minority group recruitment efforts by the profession. The Association is soliciting proposals from all schools of pharmacy for such a study. This work will be undertaken with the expectation that its results will assure maximum effectiveness of full scale efforts in the recruitment field. We are also aware that the American Association of Colleges of Pharmacy has recently added a staff member whose responsibilities lie solely in the area of student recruitment, with emphasis on minority group recruitment.

In order to fill the present needs for more pharmacists, as well as to assure the continued flow of qualified pharmacists from our nation's schools in the future, provisions such as those found in S. 4296 are urgently needed.

In offering our strong support for this bill, we should like to offer one important suggestion. Subsection 3(b) of the bill, as presently drafted, would permit the cancellation of student loans at an annual rate of 33 $\frac{1}{3}$  percent under certain conditions for physicians, dentists and optometrists—but not for pharmacists. As we have earlier indicated, there exists today a particular shortage of pharmaceutical services in many rural communities and disadvantaged neighborhoods. We, therefore, submit that this provision should be amended to add pharmacists to those whose indebtedness can be forgiven as an inducement to work in the areas wherein the need is greatest.

We again thank you for the opportunity to comment on these Health Professions Assistance Amendments of 1970.

Sincerely,

WILLIAM S. APPLE, Ph. D.,  
*Executive Director.*

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STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION ON S. 4296

Mr. Chairman and members of the Committee: The American Optometric Association, with a membership of over 15,000, recommends adoption of the basic concept of S. 4296, the Health Professions Assistance Amendments of 1970.

The purpose of the bill is to add a new Part H to Title VII of the Public Health Service Act. This new section would provide the authority necessary for the Secretary of the Department of Health, Education and Welfare to make grants to State or local educational agencies or other public or non-profit private agencies, institutions, and organizations for the purpose of identifying those individuals with a potential for education or training in the health professions who might not otherwise have an opportunity for such education due to socio-economic factors.

Encouragement and assistance provided to those who have the potential for successfully completing courses of education preparatory to entering the health care field can provide a great deal of needed impetus for increasing the numbers of health care personnel in the Nation.

A critical shortage of health care professionals exists today in virtually every health care discipline and specialty. A recent study completed by Dr. Herbert Mote at the Ohio State University College of Optometry, for example, shows that the number of optometrists practicing in the United States must be more than doubled by 1980. The opening of a new college of optometry at the University of Alabama at Birmingham in 1969 and authorization for establishment of another such college under the New York State University system represent two important steps toward meeting this increased need for optometrists. Similar facilities are now being considered in other States. Combined with the expansion programs of present schools, there is some hope that schools and colleges of optometry may, with adequate assistance of the Health Professions Educational Assistance Act, have enough physical facilities and faculty to produce the optometric manpower required in the next decade.

Supplying enough physical facilities and faculty will not get the job done, however. These aspects of the professional education of optometrists are but a part of the picture. Our schools and colleges have been doing an exceptionally good job of seeking out qualified students for the six-year course which includes two years of pre-optometry and four years of graduate level study leading to the Doctor of Optometry (O.D.) degree. But in all too many instances, the qualified students who apply for admission find they are unable to enroll because of a lack of funds. Likewise, as living costs and the costs of education have gone up, more and more students who have started their optometric education have had to either reduce their class hours or drop out of school entirely to seek employment which will provide the necessary finances to continue their studies at a later date.

Obviously, the goal of doubling the number of practitioners within a 10-year period will be increasingly difficult to meet unless some of these financial roadblocks are eliminated.

To obtain enough optometry students and provide them with the kind of financial aid they need to enter and pursue their optometric education requires a more flexible Federal program of assistance to students in the form of scholarships and student loans.

S. 4296 represents an enlightened approach to identifying students who have good potential for education in the health professions. Just as importantly, the bill recognizes the need for providing educational opportunities in the health field to well qualified students in minority groups, who, upon completion of their courses in the health professions, may return to their original areas of residence to apply their skills.

Young people who are interested in health careers must be advised of the opportunities which exist in the health care field; they must be informed of the availability of government and private financial assistance and how it can be obtained; and they must be supplied with every possible kind of help to establish their practices, upon graduation, in geographical locations where their services are most urgently needed.

With respect to overcoming the present problems of maldistribution of health care professionals, S. 4296 broadens the existing forgiveness of loans provisions. Under this bill, student loans for health professions education would be forgiven, up to the full amount of the loan plus accrued interest, at the rate of 33 $\frac{1}{3}$  percent for each of the first three years a physician, dentist, or optometrist practices in either an urban or rural poverty area where a shortage of his type of health care practitioner exists.

The American Optometric Association believes the forgiveness of loans provision of S. 4296 is a very practical approach to the problem of maldistribution of health care professionals, as it provides the new practitioner with an opportunity to establish his practice without the extreme economic pressures so common to the recent graduate, and at the same time assures that he will be providing his services in areas where they are in short supply.

S. 4296 also revises the scholarship formula in such a manner that a school or college would receive an additional \$2500 for its scholarship fund, based on each full time student who is disadvantaged. Revision of the maximum individual scholarship for the disadvantaged student is an excellent method of provid-

ing enough financial aid to see the student through his health professions course.

The liberalized student loan provisions contained in S. 4296 provide the disadvantaged student an acceptable alternative in the event he does not receive a scholarship. As proposed in this legislation, the increased maximum loan levels would be of particular help to the disadvantaged student, but would also facilitate financial aid for other students who could not be termed as disadvantaged but whose financial position requires a modicum of assistance.

S. 4296 is a most constructive approach toward solving the related problems of producing enough health manpower, providing educational opportunities in the health field for minority groups and the disadvantaged, and of obtaining the services of health professionals in poverty areas.

S. 4296 holds promise as the pivotal piece of legislation in the desperate battle to win quality health care for every American.

The American Optometric Association supports the concepts proposed in S. 4296.

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AMERICAN ASSOCIATION OF COLLEGE  
OF PODIATRIC MEDICINE,  
Washington, D.C., August 31, 1970.

HON. RALPH W. YARBOROUGH,

*Chairman, Health Subcommittee, Senate Committee on Labor and Public Welfare, Old Senate Office Building, Washington, D.C.*

DEAR SENATOR YARBOROUGH: The American Association of Colleges of Podiatric Medicine appreciates this opportunity to express its wholehearted support for the proposed amendments to Title VII of the Public Health Service Act as contained in S. 4296.

As your Committee well knows, the podiatry profession has been deeply concerned for many years about the problem of providing a supply of well educated professionals adequate to meet the health needs of our Nation.

Despite the increasing number of well qualified graduates (a direct result of the provisions of the Health Professions Educational Assistance Act of 1963, and its subsequent amendments and extensions), the demand for podiatrists still outdistances the supply, making critical the podiatric manpower problem.

In a most recent report DHEW's Bureau of Health Professions Education and Manpower Training clearly delineates the urgent need for increased numbers of licensed podiatrists. According to "Podiatric Education and Manpower," June, 1970, "the ratio of active podiatrists per 100,000 population is expected to increase slightly, from about 3.8 at the present time to 4.2 by 1980. With the potential utilization of one podiatrist per every 10,000 persons this ratio of ten podiatrists per 100,000 population prescribes the need for 24,000 active podiatrists by 1980, compared with an anticipated supply of 9,000." The report goes on to say, "Increased numbers of podiatrists are needed for direct services, education and research. The demand for podiatrists has been increased by the proliferation of nursing homes and extended care facilities as well as Federal health programs and prepaid insurance. Improved geographic distribution of podiatrists is dependent on increased output of the Colleges and placement of new schools in areas of particular need.

Given the fact that there exists today severe shortages in all the recognized health professions, one need not spend a great deal of time in showing the need to encourage greater representation of the educationally and economically disadvantaged in these same health professions. Speaking for the rural areas of our Nation where large numbers of our educationally disadvantaged live, there is very real reason for concern. This is clearly pointed out in the same DHEW report alluded to earlier. Table 5 on page 9 provides a clear picture of the critical shortages of podiatric manpower. Given the fact that there should be ten podiatrists per 100,000 population we find the following ratios in some states: Alabama .7, Arkansas 1.3, Georgia 1.4, Louisiana 1.1, Mississippi .4, Texas 1.9, and Virginia 1.5. The entire national average, including all fifty states and the District of Columbia, is only 4.1 percent per 100,000 population.

Given the aforementioned facts the problem becomes one of recruitment, testing, pre-professional educational standards and in accomplishing the objectives as set forth in S. 4296, the need for developing the necessary remedial programs to bring these same students up to a level whereby they can be assured a minimum level of success in a professional health school.

Needless to say, considerable planning, manpower, time and financing must be made available if we are to be assured the level of success necessary to meet the critical shortages of qualified health manpower.

The American Association of Colleges of Podiatric Medicine at its Annual Meeting in June 1970, went on record regarding the very essence of these proposed amendments by unanimously approving the following resolution:

"A state of affairs exists today in which large segments of Americans, particularly Blacks, Spanish-surnamed and other minority and socio-economically depressed groups, have been deprived of the opportunity to enter into careers in the health professions.

"In recognition of its social responsibilities, therefore, be it resolved that the American Association of Colleges of Podiatric Medicine continue to encourage and support with guidance, programs which aim towards the recruitment of minority groups into colleges of podiatric medicine."

To accomplish this monumental and extremely important goal it is incumbent that the Congress lead the way by providing the necessary resources necessary to accomplish the objectives as set forth in S. 4296. The provisions for amending student loans and scholarship grants are an absolute must. Seed or grant funds will provide the mechanism whereby meaningful action type programs can be implemented.

It is imperative that increased financial assistance to individual students be made available if we are to insure for the future practitioners and students better qualified to pursue studies in an atmosphere not characterized by omnipresent financial worries, and without limiting matriculants to the upper socio-economic strata.

The American Association of Colleges of Podiatric Medicine wishes to go on record as fully approving the provisions of S. 4296. Unless these amendments are approved and implemented with the necessary financial underpinning, the essential objectives of the original legislation, increasing the pool of qualified health manpower, will be placed in grave jeopardy.

On behalf of the American Association of Colleges of Podiatric Medicine it is respectfully requested that this statement be included in the record of these hearings.

Respectfully yours,

JAMES E. BATES, D.P.M., *President.*

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THE ASSOCIATION OF AMERICAN  
VETERINARY MEDICAL COLLEGES,  
*September 1, 1970.*

Senator RALPH W. YARBOROUGH,  
*Chairman, Subcommittee on Health, Committee on Labor and Public Welfare,  
U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: The Association of American Veterinary Medical Colleges (AAVMC) wishes to take this opportunity to comment upon S. 4296, a bill to amend the Public Health Service Act of 1970, to encourage physicians, dentists, optometrists, and other medical personnel to practice in areas where shortages of such personnel exist. This effort to stimulate services by such medical personnel, through the "forgiveness" of educational loans, is commendable and should receive support. The addition of veterinary medical practitioners to receive eligibility for "loan forgiveness" under the bill is appropriate.

Improving the conditions of this segment of our society and aiding the financial strength of our medical science resources requires that the health professions' loan and scholarship programs, as now constituted, must be continued and expanded, as provided in this proposed legislation.

The veterinary medical practitioner is being trained to serve both as a member of the health teams, as well as in his traditional role of guardian of animal health and related economic interests. With his background of basic sciences, epidemiology, ecology and environmental studies, the veterinarian is adequately equipped to serve with, or in place of, the physician in town or city, county or State Health Department duties that do not involve human medical care.

Adequate veterinary services can help, materially, in improving the health services, as well as the economy, in depressed rural areas.

Veterinary medical education, as with the other health professions, is costly. It requires a minimum of 6 years of education to earn the Veterinary Medical degree. Recent studies at several universities indicate that the cost of medical, dental, and veterinary education is equivalent.

Unless financial help is provided to the student, only those from reasonably affluent families can receive education in this field. This situation makes it

extremely difficult for those young persons from poorer areas to even consider a career in Veterinary Medicine.

There are only 18 Veterinary Medical Colleges to serve the 50 United States. Each school of veterinary medicine, therefore, is a national resource in the truest sense and merits, at least, the same consideration for Federal funding as do other medical schools.

The Association of American Veterinary Medical Colleges strongly recommends that the words "Veterinary medicine" be added, in Sec. 741(f) of the Public Health Service Act, to assure the eligibility of veterinarians under the provisions of this proposed legislation.

We appreciate the privilege of offering our comments on this bill and urge your favorable consideration of the same. Thank you for your courtesy in this matter.

Sincerely yours,

GEORGE C. POPPENSIEK,  
*President; and Dean, New York State  
Veterinary College, Cornell University, Ithaca, N.Y.*

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AMERICAN VETERINARY MEDICAL ASSOCIATION,  
*Washington, D.C., August 31, 1970.*

Senator RALPH W. YARBOROUGH,  
*Chairman, Subcommittee on Health, Senate Committee on Labor and Public  
Welfare, Washington, D.C.*

DEAR MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE: The American Veterinary Medical Association is pleased to avail itself of this opportunity to present its views on S. 4296, a bill designed to, among other things, encourage and assist persons who are financially and educationally disadvantaged because of socio-economic factors, to pursue education in the health professions; to raise the maximum limits on loans for all students; and on scholarships for disadvantaged persons; and to provide increased incentives for practice in urban and rural poverty areas, by providing for full cancellation of student loans in return for three years of practice in these areas.

Education in the health professions is long and expensive. Without financial aid, only those students from fairly affluent families can afford this education. The average graduate veterinarian has studied more than seven years to earn his veterinary medical degree. It is not possible for the student to pursue a veterinary medical career unless he can call upon significant resources to defray his educational expenses. This situation is particularly severe for those students coming from economically deprived areas.

Community health, today, depends upon cooperative action of all the disciplines in the health sciences. Most students of the health professions are not searching for free gifts. They are, however, seriously looking for sources of funds that they can plan on having available during the required period of education, at interest rates and repayment schedules that will not seriously strain their abilities during their early career years.

The general concept of S. 4296 seems to us to be particularly worthy, in that it would offer new opportunities to students, with added assurances of improved health services in the economically deprived areas.

This office is in receipt of correspondence from State health officers and Commissioners of Agriculture, expressing their concern for the lack of veterinary medical personnel for public health purposes and preventive medical activities within certain areas of their States. As an indication of its concern for these problems, the American Veterinary Medical Association has, for some time, been encouraging graduates of the 18 Colleges of Veterinary Medicine in the United States to enter into private practice where public health services and animal health protection programs are needed.

The American Veterinary Medical Association respectfully requests that in Sec. 741(f) of the Public Health Services Act, the words "Veterinary Medicine" be inserted, to make veterinarians eligible under the provisions of this proposed legislation.

Thank you, Mr. Chairman and members of the Subcommittee, for your consideration of our views.

Sincerely,

FRANK A. TODD, D.V.M.,  
*Washington Representative.*

## ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH, INC.,

September 3, 1970.

HON. RALPH YARBOROUGH,  
*Chairman, Committee on Labor and Public Welfare,  
 U.S. Senate, Washington, D.C.*

DEAR MR. CHAIRMAN: I am writing on behalf of the Association of Schools of Public Health to express our full support for the enactment of S. 4296, the Health Professions Assistance Amendments of 1970. Our member schools are acutely aware of the need to encourage and assist disadvantaged individuals to pursue graduate training in public health. Let me take this opportunity to assure you that the schools of public health will cooperate most fully in the implementation of this legislation when it is signed into law. I hope you will not hesitate to let me know if the Association can be of assistance to you.

May I respectfully request that this letter be made a part of the printed record of hearings.

Sincerely,

JOHN C. HUME, M.D.,  
*President.*

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UNIVERSITY OF CALIFORNIA,  
 SAN FRANCISCO MEDICAL CENTER,  
*San Francisco, Calif., August 28, 1970.*

HON. ALAN CRANSTON,  
*U.S. Senate,  
 Washington, D.C.*

DEAR SENATOR CRANSTON: Thank you very much for the opportunity to review your new proposals to increase minority representation in enrollment figures at medical schools and to expand scholarships and loan programs for students in the health professions. There is no doubt in my mind that this is the single most important area in providing equal educational opportunity in medical and other professional schools. A number of medical schools throughout the country have now made major commitments to provide equal educational opportunity for minority students and the most significant barrier to the achievement of this goal is the lack of adequate student financial aid.

You will recall that last November I wrote to you and Senator Murphy regarding these problems, and attached information on financial problems facing students here. I am enclosing updated statistical information for student financial aid in 1969-70 on this campus and information based on estimations of funds available for the academic year 1970-71. It is clear that the situation is becoming more critical as increased numbers of students from low income families, including minority students, are being admitted and costs continue to rise.

The kind of financial aid you have proposed would make, in my judgment, a very significant contribution to correcting this most serious inequity. It would also help to overcome the serious health manpower shortages, particularly among physicians serving minority groups. Thus, it has a dual benefit: increasing educational opportunity and ultimately contributing to availability and quality of medical and other health services available to all Americans.

Your continuing concern for problems relating to health care and health professions education is greatly appreciated.

Sincerely yours,

PHILIP R. LEE, M.D., *Chancellor.*

Enclosure.

SAN FRANCISCO MEDICAL CENTER,  
 OFFICE OF THE DEAN OF STUDENTS,  
*August 24, 1970.*

VICE PRESIDENT KIDNER:

As requested in your memorandum of July 27th to Chancellors, enclosed is the Financial Aid Inventory, 1969-70 for the San Francisco Campus. The information is similar to the report submitted to the California State Scholarship and Loan Commission in February, 1970.

The following table is our estimate of unmet need for 1969-70 by curriculum. Need data by graduate and under-graduate is not available and probably not meaningful in our case.

Curriculum	Estimated total need	Estimated unmet need
Dentistry.....	\$431,460	\$153,158
Dental hygiene.....	16,260	1,244
Medicine.....	801,360	238,399
Nursing.....	90,225	-----
Pharmacy.....	292,220	31,925
Allied health.....	31,840	2,070
Graduate academic.....	42,120	-----
Postprofessional and interns and residents.....	62,330	4,428
Total.....	1,767,815	431,224

The basis for the estimates is the total financial need of the eligible and evaluated applications versus the amount of funding available. Except for priority one students (the neediest and EOP students), the awards were reduced on pro rata basis under need (Dentistry 40-65% of need, Medicine 65-80%). Evidently the FISL program, AMA Loan program, and other sources met the unfilled need, for to our knowledge, no student dropped out due to financial need. The situation for 1970-71 is bleaker than last year and therefore, there may be students leaving school due to student aid shortages during 1970-71.

PETER J. LINDBERG,  
*Acting Dean of Students.*

#### PROJECTED MAXIMUM NEED FOR 1970-71

	Budgeted enrollment, 1970-71	Estimated number of applications with need	Percent of enrollment	Average need, 1970-71 applications	Estimated need, 1970-71
Dentistry.....	302	180	609	\$3,333	\$600,000
Dental hygiene.....	47	8	17	1,675	15,000
Medicine.....	532	320	60	3,125	1,000,000
Nursing.....	249	90	36	2,222	200,000
Pharmacy.....	352	150	43	2,667	400,000
Allied health.....	64	15	24	1,333	20,000
Graduate academic.....	416	25	6	2,400	60,000
Post professionals, interns, residents.....	580	20	3	2,000	40,000
Total.....	2,542	808	32	-----	2,235,000

#### ESTIMATED FUNDS AVAILABLE FOR 1970-71

	Amount requested	Anticipated reduction percent	Anticipated available funds	Anticipated cut amount
HPSL, dentistry.....	\$237,500	68	\$76,000	\$161,500
HPSL, medicine.....	425,000	68	135,000	290,000
HPSL, pharmacy.....	285,000	69	87,000	198,000
HPSG, dentistry.....	60,000	2	59,000	1,000
HPSG, medicine.....	108,000	3	105,000	3,000
HPSG, pharmacy.....	70,000	3	68,000	2,000
Nursing student loan.....	88,500	66	30,000	58,500
Nursing scholarship grant.....	70,000	29	50,000	20,000
NDSL.....	-----	-----	-----	-----
Work-study <sup>1</sup> .....	<sup>1 2 3</sup> 232,600	-----	<sup>1 3</sup> 182,600	<sup>1 2 3</sup> 50,000
University scholarships.....	262,250	-----	262,250	-----
University grants <sup>4</sup> .....	25,000	-----	25,000	-----
EOP grants <sup>4</sup> .....	23,000	-----	23,000	-----
University loans <sup>5</sup> .....	66,000	-----	66,000	-----
Total.....	1,952,850	-----	1,168,850	784,000

<sup>1</sup> Amounts to be applied toward need.

<sup>2</sup> Amounts cut to be applied toward need are unavailable.

<sup>3</sup> Actual Federal work-study figures: Requested, \$227,632; Allocation, \$130,845; Cut, \$96,787.

<sup>4</sup> Chancellors discretionary funds not considered.

<sup>5</sup> Conservative collections included.



