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**MEDICAL AND DENTAL MANPOWER,
COMPULSORY SMALLPOX VACCINATION,
AND AMERICAN UNIVERSITY INCORPORATION**

GOVERNMENT

Storage

HEARING

BEFORE THE

**SUBCOMMITTEE ON PUBLIC HEALTH,
EDUCATION, WELFARE, AND SAFETY**

OF THE

**COMMITTEE ON
THE DISTRICT OF COLUMBIA**

UNITED STATES SENATE

NINETY-THIRD CONGRESS

SECOND SESSION

ON

S. 2730

TO EXTEND FOR 3 YEARS THE DISTRICT OF COLUMBIA MEDICAL AND DENTAL MANPOWER ACT OF 1970

H.R. 8747

TO REPEAL SECTION 274 OF THE REVISED STATUTES OF THE UNITED STATES RELATING TO THE DISTRICT OF COLUMBIA, REQUIRING COMPULSORY VACCINATION AGAINST SMALLPOX FOR PUBLIC SCHOOL STUDENTS

S. 3389

TO AMEND THE ACT ENTITLED "AN ACT TO INCORPORATE THE AMERICAN UNIVERSITY," APPROVED FEBRUARY 24, 1893

MAY 1, 1974

Printed for the use of the
Committee on the District of Columbia

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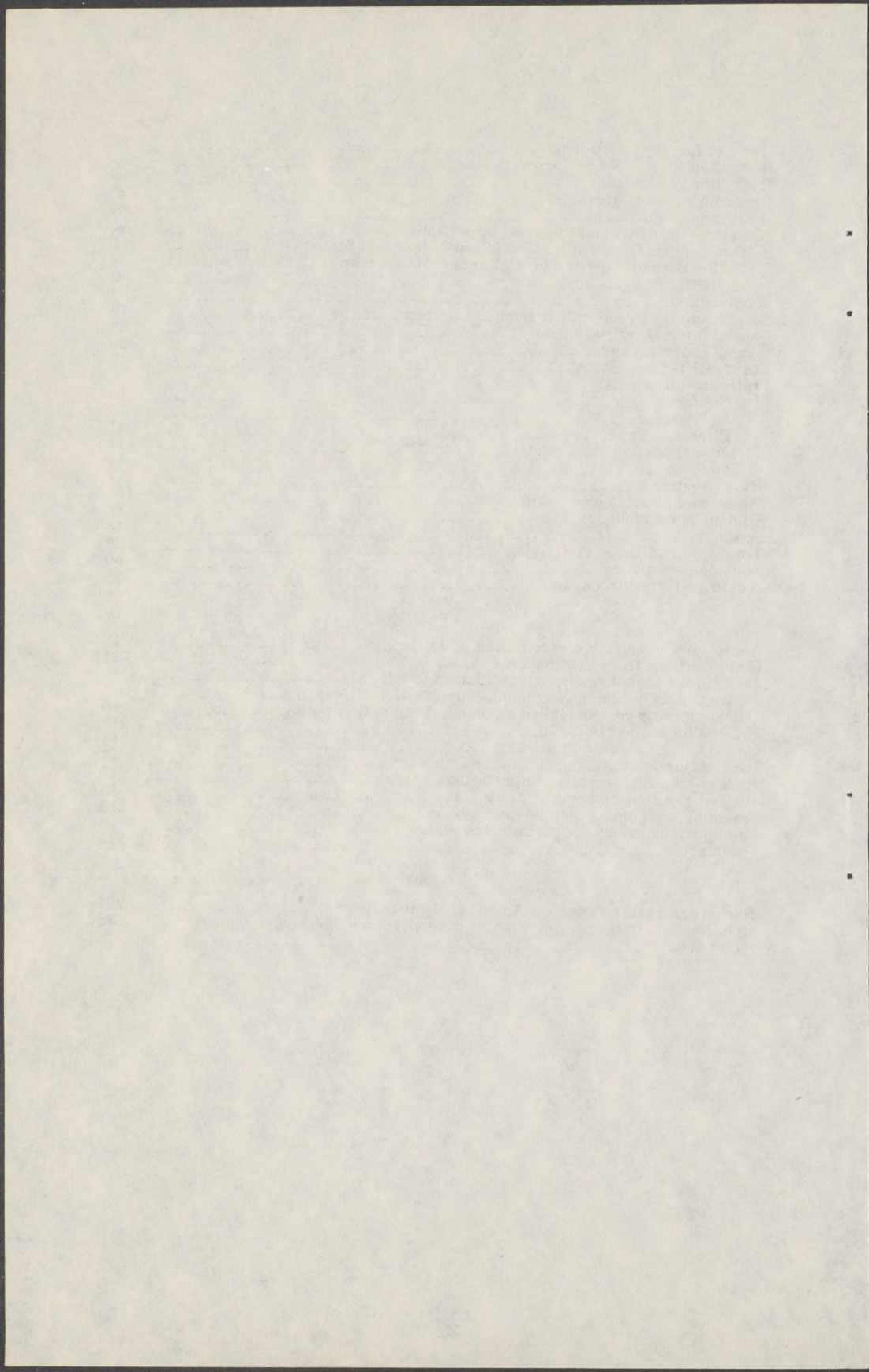
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MEDICAL AND DENTAL MANPOWER, COMPULSORY SMALLPOX VACCINATION, AND AMERICAN UNIVER- SITY INCORPORATION

MAY 1, 1974

U.S. SENATE,
SUBCOMMITTEE ON PUBLIC HEALTH,
EDUCATION, WELFARE, AND SAFETY,
COMMITTEE ON THE DISTRICT OF COLUMBIA,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 6226, Dirksen Senate Office Building, Senator John V. Tunney (chairman of the subcommittee) presiding.

Present: Senator Tunney.

Also present: Robert Harris, staff director; and Colbert I. King, minority staff director.

Senator TUNNEY. The subcommittee will come to order.

Today the Subcommittee on Public Health, Education, Welfare, and Safety, Committee on the District of Columbia will hold hearings on three bills.

H.R. 8747 passed the House of Representatives on March 25, 1974, by a vote of 316 to 1. It provides for the repeal of the requirement that there be compulsory vaccination against smallpox prior to the entry of any child in the public schools of the District of Columbia.

The second bill, S. 3389, would amend the charter of incorporation of the American University, which charter was first approved February 24, 1893. It is my understanding that this bill basically updates the charter to remove the direct control of the United Methodist Church from the university, a control which that church has not in fact exercised even though empowered to do so.

The third bill, S. 2730, would extend the District of Columbia Medical and Dental Manpower Act of 1970 for 3 years.

I now place in the record copies of S. 2730, a report from the District of Columbia government on that bill, S. 3389, and H.R. 8747.

[The bills and report referred to follow:]

93D CONGRESS
1ST SESSION

S. 2730

IN THE SENATE OF THE UNITED STATES

NOVEMBER 20, 1973

Mr. EAGLETON (for himself, Mr. BARTLETT, Mr. BIBLE, Mr. BROOKE, Mr. DOMENICI, Mr. INOUE, Mr. MATHIAS, Mr. MONTOYA, Mr. STEVENSON, and Mr. TUNNEY) introduced the following bill; which was read twice and referred to the Committee on the District of Columbia

A BILL

To extend for three years the District of Columbia Medical and Dental Manpower Act of 1970.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That (a) section 303 (c) of the District of Columbia Med-
4 ical and Dental Manpower Act of 1970 (D.C. Code, sec.
5 31-922) is amended by inserting "and for fiscal years 1975,
6 1976, and 1977" immediately after "1972,".

7 (b) Section 303 (b) of such Act is amended by strik-
8 ing out "section 772 of the Public Health Service Act (42
9 U.S.C. 295f-2)" and inserting in lieu thereof "section 773
10 of the Public Health Service Act".



THE DISTRICT OF COLUMBIA

WASHINGTON, D.C. 20004

WALTER E. WASHINGTON
Mayor-Commissioner

April 30, 1974

Honorable Thomas F. Eagleton
Chairman
Committee on the District of Columbia
United States Senate
Washington, D.C.

Dear Mr. Chairman:

The Government of the District of Columbia has for report S. 2730, a bill "To extend for three years the District of Columbia Medical and Dental Manpower Act of 1970."

S. 2730 would amend the District of Columbia Medical and Dental Manpower Act of 1970 (D.C. Code, sec. 31-922) to extend for three years the period for which appropriations are authorized to be made under the Act. The District of Columbia Medical and Dental Manpower Act of 1970, approved January 5, 1971, authorized the Secretary of Health, Education, and Welfare to make grants to the private medical and dental schools in the District of Columbia. The grants were authorized in the amount of \$5,000 per student for medical schools and \$3,000 per student for dental schools. The 1970 Act authorized appropriations of \$6,200,000 for fiscal year 1971 and \$6,750,000 for fiscal year 1972. The current bills would extend authorization to make such appropriations as may be necessary for fiscal years 1975, 1976, and 1977.

It should be noted that no appropriations were sought nor funds granted by the Department of Health, Education, and Welfare under the authority of the District of Columbia Medical and Dental Manpower Act of 1970, which expired June 30, 1972, to any of the qualifying schools — Georgetown University's medical and dental schools and George Washington's medical school. The Department of

Health, Education, and Welfare, however, has provided funds to these schools through a number of other programs, including the Health Professions Educational Assistance authorities of the Public Health Service Act. These programs have included funds for construction purposes, grants for educational programs, student aid, and assistance with special projects.

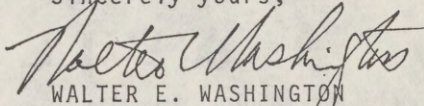
S. 2730 addresses a problem confronting local medical and dental schools, but one which is national in scope — the escalating costs of providing adequate education for a sufficient number of physicians and dentists to meet the nation's health care needs. In recognition of this need, the Congress enacted the Comprehensive Health Manpower Assistance Act of 1971 (Public Law 92-157) which has provided substantially increased Federal assistance to medical and dental schools on a national basis. The 1971 Act includes grants to medical and dental schools on a per capita student basis in a manner similar to that contained in the District of Columbia Medical and Dental Manpower Act of 1970. The Department of Health, Education, and Welfare indicates that under the 1971 Act the capitation grant program provided the following assistance in fiscal year 1973: \$1,447,563 to the Georgetown University medical school; \$859,571 to the Georgetown University dental school; and \$1,047,290 to the George Washington University medical school. These schools received additional "financial distress" assistance from the Department of Health, Education, and Welfare in fiscal year 1973 to meet their immediate financial needs.

In light of the foregoing representations and inasmuch as S. 2730 would provide an extension of grant authority vested in the Department of Health, Education, and Welfare, the Commissioner of the District of Columbia defers to the views of the Secretary of Health, Education, and Welfare on the merit of the bill.

However, in recognition of the continuing critical financial problems facing private medical and dental schools in the District of Columbia and the need to find an effective, long-range means of providing

adequate funding to alleviate this distress and assure the continuing availability of professional health services for its residents, the District Government is giving active consideration to determining appropriate methods, comparable in scope and extent to those provided by many of the States, of furnishing additional assistance to meet the health manpower training requirements of this jurisdiction. These determinations, which must be developed within the financial capabilities of the city, will require additional study and review.

Sincerely yours,



WALTER E. WASHINGTON
Mayor-Commissioner

93^D CONGRESS
2^D SESSION

S. 3389

IN THE SENATE OF THE UNITED STATES

APRIL 25, 1974

Mr. EAGLETON introduced the following bill; which was read twice and referred to the Committee on the District of Columbia

A BILL

To amend the Act entitled "An Act to incorporate the American University", approved February 24, 1893.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*
 3 That (a) the first section of the Act entitled "An Act to in-
 4 corporate the American University", approved February 24,
 5 1893 (27 Stat. 476), as amended, is amended (1) by de-
 6 leting "three-fifths of whom" and inserting in lieu thereof "at
 7 least one-fourth of whose duly elected number"; (2) by de-
 8 leting "the Methodist Church" and inserting in lieu thereof
 9 "The United Methodist Church"; (3) by inserting immedi-
 10 ately after "required for" the words "carrying out", and (4)
 11 by deleting "eleven of whom" and inserting in lieu thereof

1 "at least eleven or more of whom, as determined by duly
2 adopted bylaws,".

3 (b) Section 2 of such Act, as amended, is amended to
4 read as follows:

5 "SEC. 2. After the date of enactment of this section—

6 "(1) in order to advance the educational intention
7 and spirit of The United Methodist Church in founding
8 the university, all property, both real and personal, of
9 the corporation shall be held in perpetuity for educa-
10 tional purposes;

11 "(2) in the event that all of the property, both
12 real and personal, of the corporation shall no longer be
13 held for educational purposes as provided in paragraph
14 (1) of this subsection, all right, title, and interest of
15 the corporation, subject to enforceable liens, reserva-
16 tions, and restrictions, shall vest in the Board of Edu-
17 cation of The United Methodist Church, a corporation
18 organized under the laws of the State of Tennessee, or
19 its successor; and

20 "(3) no amendment to this Act shall be proposed by
21 the board of trustees unless first approved by not less
22 than two-thirds of the total duly elected membership of
23 such board."

93^D CONGRESS
2^D SESSION

H. R. 8747

IN THE SENATE OF THE UNITED STATES

MARCH 26, 1974

Read twice and referred to the Committee on the District of Columbia

AN ACT

To repeal section 274 of the Revised Statutes of the United States relating to the District of Columbia, requiring compulsory vaccination against smallpox for public school students.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That section 274 of the Revised Statutes of the United States
4 relating to the District of Columbia (D.C. Code, sec. 31-
5 1102) is hereby repealed.

Passed the House of Representatives March 25, 1974.

Attest:

W. PAT JENNINGS,

Clerk.

Senator TUNNEY. Since the problems of funding medical and dental schools is not without some problems, and since the Assistant Secretary of Health, Education, and Welfare for Health, Dr. Edwards, is here to testify on that bill, we will begin with Dr. Edwards.

Dr. Edwards, please proceed.

STATEMENT OF DR. CHARLES C. EDWARDS, ASSISTANT SECRETARY FOR HEALTH, ACCOMPANIED BY FRANK E. SAMUEL, JR., DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH); DR. JOHN C. GREENE, ACTING DIRECTOR, BUREAU OF HEALTH RESOURCES DEVELOPMENT, NATIONAL INSTITUTES OF HEALTH; AND DR. JEFFREY KOPLAN, MEDICAL EPIDEMIOLOGIST, BUREAU OF SMALLPOX ERADICATION, CENTER FOR DISEASE CONTROL; DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. EDWARDS. Thank you.

I would like to begin, with your permission, by introducing my colleagues.

On my immediate right, Dr. John Greene, the Acting Director of our Bureau, the Director of the Bureau of Health Resources Development, and on my immediate left, Mr. Frank Samuel, the Deputy Assistant Secretary for Health Legislation, and on his left is Dr. Jeffrey Koplan, who is a medical epidemiologist from our Bureau of Smallpox Eradication, CDC, in Atlanta.

S. 2730—EXTEND DISTRICT OF COLUMBIA MEDICAL AND DENTAL MANPOWER ACT

Mr. Chairman, we appreciate this opportunity of appearing before you to testify on S. 2730, a bill "To extend for 3 years the District of Columbia Medical and Dental Manpower Act of 1970."

The District of Columbia Medical and Dental Manpower Act of 1970 (which was enacted as title III of the District of Columbia Revenue Act of 1970) authorized the Secretary of Health, Education, and Welfare to make grants to the Commissioner of the District of Columbia for private nonprofit medical and dental schools in the District of Columbia.

AUTHORIZED GRANTS

The act authorized grants in amounts the Secretary determined to be the "minimum amounts necessary" to carry out the purposes of the act, but in no event to exceed, in the case of a medical school, \$5,000 times the number of full-time medical students or, in the case of a dental school, \$3,000 times the number of full-time dental students enrolled. In determining the amounts of grants, the Secretary was required to take into consideration any grants to the respective District of Columbia schools under the health professions educational assistance authorities of title VII of the Public Health Service Act relating to financial assistance to health professions schools in serious financial distress.

The District of Columbia Medical and Dental Manpower Act of 1970 expired June 30, 1972. The bill you are considering would extend the Act for 3 years.

would reenact it for 3 years (fiscal years 1975 through 1977) and would authorize the appropriation of such sums as are necessary for carrying out its purpose.

It would authorize the Secretary of the Department of Health, Education, and Welfare to assist private nonprofit medical and dental schools in the District of Columbia in a manner similar to that in which certain States support private medical and dental schools located in their respective jurisdictions.

HEW POSITION

Mr. Chairman, if you will recall, representatives of HEW testified in opposition to similar legislation earlier this year before the House District Committee. At that hearing before the House, the administration recommended strongly against enactment of legislation similar to the current bill. Today our position remains essentially the same. Nothing has happened in this interval to warrant the passage of this legislation.

STATE ASSISTANCE

We believe this committee should note that not all States support private medical or dental schools in their respective jurisdictions.

Of the 22 States having 50 private medical schools, 9 States provide no financial assistance to 14 such schools. Of the 14 States having 22 private dental schools, 8 States provide no financial aid to 13 of these schools.

Even in those States that do provide assistance to private medical and dental schools, the amount of support provided varies widely and the purposes for which the assistance can be used are limited. When a State does decide to support a private medical school the State usually considers specific benefits which might accrue from such support.

STATE CONSIDERATIONS

State considerations usually involve the need for an adequate number of trained health professionals for health care, research and teaching; the need to expand educational opportunities for residents of the State; the need for new knowledge; and, the need to develop new methods of providing health care to groups as well as to individuals.

California

For example, the State of California contracts with its private medical schools to expand the class sizes of these private schools.

Delaware

Delaware contracts with an out-of-state college of medicine to accept Delaware residents with a stipulation that a portion of the medical students spend their clinical clerkships in the Wilmington Medical Center.

Ohio

Ohio has a contract medical program which requires that the university supported must agree to admit a specified number of medical students.

New York

New York has three types of contractual arrangements with each private school in the State: (a) a plan which provides an award for each medical school graduate; (b) a per capita award for every medical student enrolled; and (c) a 7-year plan designed to increase enrollment during the period from 1967-74.

Illinois

Illinois provides funds to private institutions within that State to increase enrollments in medical, dental, nursing, and allied health education programs. Each private school in Illinois receives an award for each Illinois student that school enrolls with the requirement that a specified number of residents be enrolled above the average number for an earlier year. In addition, an annual stabilization grant is made to each school computed on the average number of State residents enrolled. A single nonrecurring expansion grant was also made by Illinois, but even this award was contingent upon the private school's commitment to increasing enrollment.

S. 2730 DEPARTS FROM APPROACHES FOLLOWED IN MOST STATES

In contrast to the limitations and conditions regarding State support for private medical and dental schools which obtain in the above-cited cases, S. 2730 would authorize grants to be made to the private District of Columbia schools without reference to any benefits that might accrue to District residents. In this additional respect, therefore, the legislation would depart from the approaches to support of private health professions schools followed in most of the States.

PRIVATE SCHOOLS DRAW STUDENTS FROM WIDER AREA

It is certainly the case that private schools draw their students from a wider area than do State-supported schools and to that extent serve the needs of students from other States. For example, for the 1971-72 academic year George Washington medical school had 128 first-year students, of whom only 11 were residents of the District of Columbia.

Equally significant, the Georgetown University school of medicine accepted 216 first-year students, of whom only 11 were residents of the District of Columbia. Similarly, the Georgetown school of dentistry accepted 138 first-year students during the 1972-73 academic year and only 5 were residents of the District. Thus, for 3 first-year classes totaling 482, only 27, or 5.5 percent were actually District residents.

EQUITY ISSUE

The critical equity issue that constantly arises with respect to proposals to support private District of Columbia medical and dental schools out of Department of Health, Education, and Welfare appropriations is whether there are overriding reasons of public policy to justify singling out—from the entire universe of private medical and dental schools in the United States—the schools in the District of Columbia for preferential funding treatment from the general revenues of the Nation. We feel that there are no such reasons. It is therefore difficult for the Department of Health, Education, and Welfare to rationalize selecting out three medical and dental schools in the United States for special treatment solely on the basis of their location within the District of Columbia.

Mr. Chairman, the issue which this legislation presents is basically identical to the issue that confronted the Congress in December 1971, when the House of Representatives voted down legislation (H.R. 11628, 92d Congress) to perpetuate a program of special subsidies to hospitals in the District of Columbia, over and above the benefits they received under the Hill-Burton construction assistance program.

In floor debate the opponents of that legislation effectively highlighted the inequities to other States and localities arising from continued provision of general tax resources to District of Columbia facilities in a manner and in amounts disproportionate to those available to other jurisdictions. We believe that the arguments that were successfully advanced against that earlier legislation apply with equal force to consideration of S. 2730.

I think it is important to note that to date the Department has not found it necessary to provide special funds to these schools under the District of Columbia Medical and Dental Manpower Act, but instead has provided basic assistance under the generally applicable provisions of the Comprehensive Health Manpower Training Act of 1971.

CAPITATION GRANTS

The capitation grants awarded under that act have provided increased funds to schools of medicine and dentistry—several times greater than they received under previous formula authorities—and have improved fiscal stability in such schools. In fiscal year 1973, for example, Georgetown University Medical School received capitation grant assistance of \$1,447,563 (as compared with \$259,500 under the old program in 1971); George Washington University Medical School \$1,047,290 (as compared with \$238,000 in 1971); and Georgetown University Dental School \$859,571 (as compared with \$223,000 in 1971).

FINANCIAL DISTRESS GRANTS

A number of schools temporarily needed yet additional financial assistance before they could carry out the steps necessary to solve their problems. In recognition of this fact, the Congress—in the Comprehensive Health Manpower Training Act of 1971—included special separate authority, in amounts which declined over 3 fiscal years, for grants to schools of medicine and dentistry, as well as other schools of the health professions, which are in serious financial dis-

tress, to meet their costs of operation or to meet accreditation requirements.

The act's financial distress authority was designed to provide financial assistance while at the same time identifying the factors that have led to financial difficulties and determining the appropriate means for remedying them. With this objective in mind, financial distress grants are made on special terms and conditions, including requirements that the schools agree to:

Disclose financial information or data deemed by the Secretary to be necessary to determine the source or causes of their financial distress;

Conduct a comprehensive cost analysis study in cooperation with the Secretary; and

Carry out appropriate operational and financial reforms on the basis of information obtained in the course of the study or on the basis of other relevant information.

In fiscal year 1973 the Department's Bureau of Health Resources Development awarded approximately \$7.8 million in financial distress grants to medical and dental schools in this country. Of this amount approximately \$1.4 million was awarded to Georgetown University Medical School; \$583,000 was awarded to Georgetown University Dental School; and almost \$1.3 million to George Washington University Medical School.

In other words, Georgetown and George Washington University Medical School received nearly half of all the financial distress awards to medical schools in this country, and Georgetown University Dental School received slightly over one-quarter of all such aid to dental schools. If one were to add to these amounts the dollars these schools also received under capitation awards and special project grants, the dollars awarded in fiscal year 1973 would total approximately \$2.5 million for George Washington University and almost \$5.9 million for Georgetown University.

GRANTS DISAPPROVED

I should point out, Mr. Chairman, that the two universities have applied for financial distress assistance in the current fiscal year and that the National Advisory Council on Health Professions Education disapproved those requests.

For the committee's ready reference, I am attaching copies of the letters sent by the Philadelphia regional office to the two universities notifying them of the reasons for the Council's decisions. I think this is important because it reflects an independent assessment of the financial situation of the schools with respect to special financial needs.

Senator TUNNEY. Those letters will be made a part of the record.

Dr. EDWARDS. Thank you.

[The letters referred to follow:]

APRIL 2, 1974.

Re Grants No. 1 D14 XC 00105-01 and 1 D14 XC 00106-01.

Dr. MATTHEW F. McNULTY,

Vice President for Medical Center Affairs, Georgetown University, 3900 Reservoir Road NW., Washington, D.C.

DEAR DR. McNULTY: We regret to inform you that the two applications from your Institution for Grants to Assist Health Professions Schools Which Are in

Financial Distress were not recommended for approval by the National Advisory Council on Health Professions Education. Consequently, the applications have been disapproved.

The reason for the recommended action was that the Council concluded that the Schools did not adequately meet the requirements necessary for support under the Financial Distress Program. In reaching this conclusion Council noted that the Medical Center has gift accounts functioning as endowment sufficient to cover the deficits of both schools or to provide collateral for other funding avenues. Council noted that the University also has funds functioning as endowment which, if required, could be drawn upon. Council acknowledged that the School has recently set in motion several management improvement steps and has strong and capable executive leadership. Council also acknowledged that several revenue producing steps have been initiated which should provide the Medical Center with a stable financial base in future years, and concluded that the Center will have no cash flow problems until these steps are successful.

Council did express concern over two points. The first was that genuinely austere actions had not been taken or were anticipated as necessary in the coming months. The second was the large increase in instructional and departmental research expense over the past five years.

Based on these findings the Council concluded that neither School was in imminent danger of having to close. Also, the high quality of on-going programs indicated that there was no threat of loss of accreditation to either School.

If you have questions regarding the action taken on your application, please contact Dr. Stephen Garza, Acting Associate Regional Health Administrator for Manpower, (215) 597-6464.

Sincerely,

GEORGE C. GARDINER, M.D.
Acting Regional Health Administrator.

APRIL 2, 1974.

Re Grant No. 1 D14 XC 00104-01.

JAMES J. FEFFER, M.D.,

Vice President for Medical Affairs, The George Washington University Medical Center, 2300 Eye Street, N.W., Washington, D.C.

DEAR DR. FEFFER: We regret to inform you the application for a Grant to Assist Health Professions Schools Which Are in Financial Distress from the George Washington University Medical Center was not recommended for approval by the National Advisory Council on Health Professions Education. Consequently, the application has been disapproved.

The reason for the recommended action was that Council concluded that the School did not adequately meet the requirements necessary for support under the Financial Distress Program. In reaching this conclusion, Council determined that alternative avenues exist for funding, all or most of the current year's projected deficit and that the School has not taken actions to more effectively limit increased expenditures for the current fiscal year.

Among the alternative avenues cited by Council for funding the projected deficit are: funds functioning as endowment which could be used to either cover the deficit or to serve as collateral for a University or bank loan; and the availability of funds in the Education and Research Account of the Professional Practice plan. Council expressed concern that tuition had not been raised to a higher level to serve as a greater source of revenue. Also, while recognizing the existence of the capital fund raising campaign. Council expressed concern that a more vigorous campaign for operating funds had not been underway in past years.

Among the actions not taken to more effectively reduce expenditures, Council cited the absence (in Council's opinion) of stringent control of salary levels and hiring practices; the need for more stringent control of Maintenance and Plant activities; the need for more effective budgetary control; the high ratio of general administrative costs (exclusive of hospital administrative costs and student services) to total Center operating expense; and the absence of a long-term financial management plan for the Medical Center.

Council concluded that the School was not in imminent danger of having to close and, based upon the quality of programs now being conducted, that the school was not in jeopardy of losing its accreditation.

If you have questions regarding the action taken on your application, please contact Dr. Stephen Garza, Acting Associate Regional Health Administrator for Manpower, (215) 597-6464.

Sincerely,

GEORGE C. GARDINER, M.D.,
Acting Regional Health Administrator.

EFFECTIVENESS BEING CLOSELY STUDIED

Dr. EDWARDS. The effectiveness of the Comprehensive Health Manpower Assistance Act of 1971 is being closely studied at this moment inasmuch as the development of a sound and comprehensive manpower strategy is one of the highest priorities in our Department.

The administration's recommendations on the health manpower authorities, which are scheduled to expire on June 30, 1974, will soon be sent to the Congress. The need for continued special Federal financial assistance to the relatively small number of health professions schools still experiencing financial distress, and the terms and conditions under which such aid should be provided, are questions that must be addressed by the Congress in that legislation.

We believe it would be inequitable and inappropriate for the Congress to legislate preferential treatment for the private schools in the District of Columbia, without reference to the policies that will apply to the other schools in the United States similarly situated.

SUMMARY

In summary, while we understand and sympathize with the efforts of Georgetown University and George Washington University, we believe there is not sufficient justification for special preferential Federal legislation of the kind under consideration today, to assist these particular schools of medicine and dentistry.

If public support is to be provided to these District of Columbia private schools, as it is provided by some States to private schools within their jurisdictions, we would respectfully suggest that this be provided by the District of Columbia government which in this situation occupies a role analogous to that of a State government. The District government is in a position to judge whether the schools' asserted need for such support makes a compelling demand upon the city's limited financial resources. The District government is also in a unique position to assess the extent to which these schools contribute to the health manpower needs of the District.

If financial distress assistance is to continue to be provided by the Federal Government to health professions schools, it is particularly important as a matter of national health policy that schools of medicine or dentistry receiving such aid should uniformly be required to meet the terms and conditions imposed by the provisions of the Health Professions Educational Assistance authorities. These provisions should be applied nationally to all schools of medicine or dentistry who find themselves in such a plight.

ADMINISTRATION RECOMMENDS AGAINST ENACTMENT

Therefore, Mr. Chairman, the administration recommends strongly against enactment of S. 2730.

DISTRICT OF COLUMBIA PUBLIC SCHOOL SMALLPOX VACCINATION—H.R. 8747

Mr. Chairman, you also requested that we address H.R. 8747, a bill which would discontinue compulsory vaccination against smallpox in the District of Columbia public school system.

HEW SUPPORTS RECOMMENDED CHANGE IN VACCINATION POLICY

The Department of Health, Education, and Welfare supports the recommended change in smallpox vaccination policy in the District of Columbia which would preclude the routine vaccination of children. The status of smallpox throughout the world, the risk of smallpox importation into the United States, the expected transmission after an importation, and the risk of vaccination to the population justify a policy of selective vaccination of individuals at special risk. We believe this group to be essentially comprised of travelers to and from infected areas and hospital and other health workers who would be our first line of defense in the event of a smallpox importation.

SMALLPOX OCCURRENCE THROUGHOUT THE WORLD

The areas of the world reporting endemic smallpox have steadily declined since the global smallpox eradication program of the World Health Organization began in 1966.

Then, 28 countries had endemic smallpox. Now in only four countries (Bangladesh, India, Pakistan, and Ethiopia) is smallpox considered to be endemic.

Each of these countries is engaged in massive campaigns designed to interrupt smallpox transmission as soon as possible. Intensive village-by-village surveillance activities are being carried out to detect existing smallpox foci.

This has resulted in large numbers of cases and outbreaks being identified and reported—a phenomenon which was also observed in Brazil just prior to smallpox eradication in that country.

Bangladesh and India constitute the principal strongholds of endemic smallpox. In Bangladesh, smallpox transmission has almost been broken in Chattagong division which contains over 25 percent of the country's population.

In India, smallpox transmission has virtually been interrupted in the southern states. In northern India, particularly in the provinces of Uttar Pradesh, Madhya Pradesh, Bihar, and West Bengal, smallpox is still heavily endemic.

The extent and magnitude of recent surveillance and containment campaigns in both Bangladesh and India, however, have strengthened WHO projections for the interruption of smallpox transmission in these countries by 1976.

In Pakistan, the extent of infected areas is decreasing rapidly. Smallpox is now confined to Baluchistan and Sind provinces which contain about 18 percent of Pakistan's population and transmission is expected to be broken during 1974.

In Ethiopia, the remaining foci of smallpox are primarily centered in three of the country's 14 provinces where a concentrated effort is underway to eradicate smallpox. In spite of difficult terrain and resistance to vaccination in some areas, Ethiopia is expected to be smallpox-free by the end of 1974.

RISK OF IMPORTATION

The last confirmed case of smallpox occurred in the United States in 1949. The probability of importation into this country is determined by the incidence of smallpox in endemic countries, the number of travelers from these countries, and the immunity status of these travelers.

Understandably, some risk of importation will continue as long as there are cases anywhere in the world. For this reason, the United States requires that travelers arriving in this country from a smallpox infected area show proof of immunity by having a valid vaccination certificate in their possession.

The rapid decrease over the past several years in the number of countries reporting smallpox has greatly reduced the probability of travelers being exposed to smallpox within 2 weeks of their arrival into the United States.

In 1972, and again in 1973, a survey of air travelers to the United States suggests the current probability of a case of smallpox being imported into the United States as roughly every 18 years.

RISK OF TRANSMISSION AFTER IMPORTATION

With a policy of routine nonselective vaccination as previously conducted throughout the United States (still required in the District of Columbia), immunity levels were very low.

To maintain high levels of immunity in our population we would have to have universal vaccination of children at a very young age and then revaccination at regular intervals throughout life. Surveys have shown less than 20 percent of the population fully protected against smallpox. Herd immunity concepts can be very misleading when it comes to smallpox. We have been free of smallpox in this country for the past 25 years, not because of high immunity levels, but because we have not had an importation.

An analysis of smallpox importations into Europe has shown that countries with nonselective vaccination policies and supposedly higher levels of immunity fare no better in terms of the number of cases, epidemiologic generations, or mortality than countries with selective requirements and known low levels of immunity.

The critical factor in an outbreak is not previous population immunity but the speed and quality of the containment response. The outbreak in Yugoslavia during March-April 1972 was more extensive than West European outbreaks in spite of the fact that Yugoslavia had a policy of routine vaccination and 70-90 percent of the population vaccinated at some time in their lives.

In the United States, medical epidemiologist with smallpox control experience, ample vaccine, jet injectors, and trained vaccinators are available for immediate contact tracing and appropriate containment efforts. As part of the preparation for an effective procedure for the management of smallpox in the unlikely event of an importation, the Center for Disease Control has developed a manual which provides a step-by-step approach to assist health personnel in handling suspected smallpox. This manual has been placed in the office of each State and territorial epidemiologist including the District of Columbia.

As long as a possibility exists of a smallpox importation, however, we believe a significant reduction could be achieved in the number of cases occurring following an importation if adequate vaccination programs on hospital and other health personnel were carried out.

For this reason, the Center for Disease Control supports the American Hospital Association's recommendation for the vaccination of hospital workers against smallpox every 3 years.

RISK OF VACCINATION COMPLICATIONS

Surveys in the United States have demonstrated a definite measurable risk of complications following smallpox vaccination.

These vary from local erythematous reactions to life-threatening situations and death. In 1968, over 14 million people were vaccinated; nine deaths were associated with smallpox vaccination and approximately 500 cases of serious complications reported. For most people in the United States the risk of vaccination complications clearly outweighs the benefits of being vaccinated. The recommended policy of selective vaccination affords protection to those persons at risk of exposure while reducing the vaccine associated illness and death in persons who are at very low risk of acquiring smallpox.

ACCEPTANCE OF SELECTIVE VACCINATION POLICY

The policy of selective vaccination which was formulated and recommended by the PHS Advisory Committee on Immunization Practices has been endorsed by the American Medical Association, the American Academy of Pediatrics, and the Association State and Territorial Health Officers.

Essentially all States have taken action to discontinue nonselective vaccination policies.

SUMMARY

The risk of smallpox importation into the United States is remote and continuing to decrease.

Our ability to contain smallpox is more than adequate for any outbreak. At this point in time, most signs indicate a smallpox-free world within the next 3 years. A selective approach to smallpox vaccination should be encouraged in the District of Columbia.

This concludes my statement, Mr. Chairman.

I will be pleased to answer any questions that you and other members of the subcommittee may have.

Senator TUNNEY. Thank you very much, Dr. Edwards.

Dr. Edwards, inasmuch as you feel the smallpox issue should pass, I feel that this committee will give that serious consideration.

I have a couple of questions for you with respect to the first part of your statement.

POSITION ON HEALTH MANPOWER LEGISLATION IN HOUSE

What was the position that you have taken on this legislation over in the House of Representatives?

Dr. EDWARDS. Our position, Mr. Chairman, was similar to our position this morning.

Senator TUNNEY. Did you testify?

Dr. EDWARDS. I did not testify; no, sir.

Dr. Zapp, who no longer is with us, testified at that time.

Senator TUNNEY. It is my understanding that this legislation is still in the subcommittee in the House of Representatives; is that correct?

Dr. EDWARDS. I believe it is.

Mr. SAMUEL. My understanding is that it has been passed out of the House subcommittee, which is considering and awaiting full committee action now.

SCHOOLS EFFORTS TO SOLVE THEIR FINANCIAL PROBLEMS

Senator TUNNEY. In your observation of both schools, and in the special funding under the Comprehensive Manpower Health Training Act, do you believe that efforts are being made by these schools to solve their financial problems, or are they looking to the funds you have given them as a continuing subsidy?

Dr. EDWARDS. No; I would say without any question, Mr. Chairman, that the leadership in both schools is good.

I think they are making very real efforts to try to come to grips with their financial problems. I think medical schools generally around the United States are attempting to come to grips with some of their very real financial problems, so our position today is not based upon the quality of the leadership in the schools.

I think there are other more basic issues that we have to consider. I think medical schools which are having financial problems have got to take some good, hard looks at a number of things. I think both of these schools are, I think, their program content has to be perhaps reevaluated, a lot of things have to be taken into consideration, but this is certainly no criticism of their leadership.

EFFECT IF FUNDS NOT MADE AVAILABLE

Senator TUNNEY. What will happen if the funds are not made available to those schools?

Dr. EDWARDS. Well, I think, obviously, your question depends, I would say, at least, it is my understanding, the schools will continue to operate, they will obviously operate under perhaps in a more limited, well, I do not even think their program would have to be cut back significantly, but I think they certainly would remain in operation.

Senator TUNNEY. You feel they would not have to cut back significantly on their programs?

Dr. EDWARDS. Again, I really am not in a position to say from personal experience, but according to our advisory group, which performs a site visit, I do not believe that would be necessary.

Senator TUNNEY. That is an important question, because it is a factor in your determination, whether or not you make the funds available.

I am not saying it is the determinant factor, because for instance, they would have to cut back their services substantially, I would an-

ticipate that would impact their ability to provide their services to the community here in Washington, D.C.

TOTAL ROLE AND SCOPE OF ACTIVITIES

Dr. EDWARDS. Again, we get into this trying of defining the total role and scope of activities of a medical center like George Washington and Georgetown.

There, obviously, is a very important function and services being provided here for the community.

There also, obviously, is a large educational program, part of which relates to the services, and part of which is strictly educational.

COST OF MEDICAL EDUCATION

I think we have to take a good, hard look at all medical education in this country. I think we have allowed, and I am not being critical, but I think we have allowed the cost of medical education to in some way soar out of control in this country. The cost of medical education is far greater than the cost of any other kind of education, and legitimately so, but to what extent I think is a question that needs to be very, very closely looked at. But again, according to the information I have, there is no reason to believe that either of these schools would close their doors, and obviously if we thought that were true, then I am sure our review council would not have made the recommendation that they made.

REDUCTION IN NUMBER OF DOCTORS

Senator TUNNEY. Well, of course, the problem that you raise of the cost of medical education is a very good one. But also, we now are talking about some form of national health insurance, and there is no way we are going to be able to begin to provide adequate medical care for all citizens in our country unless we turn out more doctors. As to the cost of medical education, it is certainly a part of it, and it is also making sure that we do not cut back on the number of doctors that are visiting medical schools that are turning out doctors. I am just curious to know if these medical schools will have to cut back on the number of doctors that they are turning out, as a result of not having these funds.

Dr. EDWARDS. You obviously bring up a very important issue which none of us want to see occur. We all recognize that we do need this in the medical schools. I think in this country, that we have responded over the last decade or two, and certainly the last decade, in providing more doctors. Unfortunately, we have not been providing necessarily the right kinds of doctors.

MEDICAL NEEDS

We have a lot more surgeons than we need, it is a highly specialized field; we have more professionals in certain fields than we need.

I think it also stands to reason those are some of the fields that are more expensive in terms of the budgets of our medical schools, and that is my whole point.

I think we have to take a good, hard look at what we need and what are we getting. How do we change the system to get what we need—which is obviously a lot more family physicians. Along those lines, and I am repeating again, it is my understanding that in the way with what we are suggesting this morning, we would not cut back on the production of these particular doctors.

Senator TUNNEY. Do we provide similar funds to any other medical schools in the country?

METHODS OF FUNDING

Dr. EDWARDS. No. Let me just go over again very briefly this subject. By and large, we support medical schools through two mechanisms.

This is in addition to research, training grants, and things like that, but we have the capitation support which is \$1 per student that we provide all medical schools in the United States, and it is based pretty much on enrollment.

The other source of funding is in our distress grants, and this, over the past several years, has been gradually decreasing. But these are the two basic mechanisms used for institutional kind of support.

Senator TUNNEY. Are the funds that these two schools are receiving different, in a quality sense of funding mechanism, from funds that we provide other schools?

Dr. EDWARDS. Certainly not now, but if we were to pass this special S. 2730, then they would be placed in a special category, which would make their funding different than any of the other public-private medical schools in the United States.

Senator TUNNEY. And could you just summarize for me again what those differences would be between what now is supplied in the way of funding, and what would be supplied under this bill that we have before us—which would be a unique funding mechanism?

Dr. EDWARDS. Very briefly, and very simplistically, as I say, all medical schools in the United States, be they public or private at the moment are funded by the two mechanisms I mentioned earlier, by capitation and in some special situations, via the distress grant route.

If this bill, S. 2730, were to pass, then we are saying in effect that there is something different about the District of Columbia medical schools. That they should have this special source of funds, and they need it more than any of the other medical schools in the United States. I think that really is the gut issue of this thing.

We happen to believe there are medical schools, private medical schools for the most part, which perhaps have just as much justification to request special consideration as either of these two institutions.

LOCAL RATHER THAN NATIONAL FUNCTION

Senator TUNNEY. And so what you are saying in essence, I suppose, is that this is a local function rather than a national function?

Dr. EDWARDS. I think that is exactly what we are saying. We feel very strongly that these are both, not only accredited medical schools, but very good medical schools, and we are not in any way trying to detract from the quality of the institutions.

Senator TUNNEY. I understand that and I recognize that, not only from your written statement, but from what you have said in answers to questions. As a person who is sometime resident of the District of Columbia, I have had an opportunity to have members of my family use both medical centers, and I thought that they provided excellent care for them.

SPECIAL PROJECTS FUNDS

Dr. EDWARDS. Mr. Chairman, one other source of funding that I did not mention, that is quite obvious, is special projects kind of support that we have provided both schools. Dr. Greene might want to speak to those.

Dr. GREENE. In addition to the capitation and financial distress, the schools are eligible to apply for what we call special projects. In 1973, as was stated in the testimony, Georgetown medical and dental combined, from the three sources of funds, received approximately \$5.9 million, while George Washington medical received approximately \$2.5 million from these three sources.

The special projects go toward certain types of things such as improvement of curriculum or improvement of family medicine kind of programs. We have a list of priority items that the schools know that are high priority nationally, and they can apply under those.

CREATION OF PRECEDENT

Senator TUNNEY. So, as I understand it, what in essence you are saying is that to create a national funding program like this for two schools, which is shared by other schools across the country, we create a precedent for this kind of special interest regulation which you feel would be inappropriate at a time that a general review is ongoing as to what is needed in the way of medical education in the country, and the kind of funding mechanisms that ought to be made available for education as it relates to the National Government's commitment.

Dr. EDWARDS. I think that is certainly correct, Mr. Chairman.

We believe in essence what we are doing is creating more or less a private relief kind of bill of that categorical kind of approach to the problem as it is, in our judgment, and we probably have adequate experience to make us believe that the categorical approach such as this can generate in future years some very, very significant problems.

DISTRICT OF COLUMBIA HAS THE RESPONSIBILITY

Senator TUNNEY. You would not object to the District of Columbia giving the funds?

Dr. EDWARDS. Absolutely not.

I believe the District of Columbia, like any State government, not only has the right, but has the responsibility to look at its educational institutions and the health institutions, and provide appropriate funding.

Senator TUNNEY. Thank you, Dr. Edwards.

I now place in the record the prepared statements you have submitted.

Dr. EDWARDS. Thank you, Mr. Chairman.

[The prepared statements referred to follow:]



FOR RELEASE ONLY UPON DELIVERY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

DR. CHARLES C. EDWARDS

ASSISTANT SECRETARY FOR HEALTH

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH, EDUCATION, WELFARE, AND SAFETY

COMMITTEE ON THE DISTRICT OF COLUMBIA

UNITED STATES SENATE

Wednesday, May 1, 1974

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Mr. Chairman, we appreciate this opportunity of appearing before you to testify on S. 2730, a bill "To extend for three years the District of Columbia Medical and Dental Manpower Act of 1970."

The District of Columbia Medical and Dental Manpower Act of 1970 (which was enacted as Title III of the District of Columbia Revenue Act of 1970) authorized the Secretary of Health, Education, and Welfare to make grants to the Commissioner of the District of Columbia for private nonprofit medical and dental schools in the District of Columbia.

The Act authorized grants in amounts the Secretary determined to be the "minimum amounts necessary" to carry out the purposes of the Act, but in no event to exceed, in the case of a medical school, \$5,000 times the number of full-time medical students or, in the case of a dental school, \$3,000 times the number of full-time dental students enrolled. In determining the amounts of grants, the Secretary was required to take into consideration any grants to the respective District of Columbia schools under the Health Professions Educational Assistance authorities of Title VII of the Public Health Service Act

relating to financial assistance to health professions schools in serious financial distress.

The District of Columbia Medical and Dental Manpower Act of 1970 expired June 30, 1972. The bill you are considering today, S. 2730, would re-enact it for three years (fiscal years 1975 through 1977) and would authorize the appropriation of such sums as are necessary for carrying out its purpose. It would authorize the Secretary of Health, Education, and Welfare to assist private nonprofit medical and dental schools in the District of Columbia in a manner similar to that in which certain States support private medical and dental schools located in their respective jurisdictions.

Mr. Chairman, if you will recall, we testified in opposition to similar legislation earlier this year before the House District Committee. At that hearing before the House, the Administration recommended strongly against enactment of legislation similar to the current bill. Today our position remains essentially the same. Nothing has happened in this interval to warrant the passage of this legislation.

We believe this Committee should note that not all States support private medical or dental schools in their respective jurisdictions. Of the 22 States having 50 private medical

schools, 9 States provide no financial assistance to 14 such schools. Of the 14 States having 22 private dental schools, 8 States provide no financial aid to 13 of these schools. Even in those States that do provide assistance to private medical and dental schools, the amount of support provided varies widely and the purposes for which the assistance can be used are limited. When a State does decide to support a private medical school the State usually considers specific benefits which might accrue from such support. State considerations usually involve the need for an adequate number of trained health professionals for health care, research and teaching; the need to expand educational opportunities for residents of the State; the need for new knowledge; and, the need to develop new methods of providing health care to groups as well as to individuals.

For example, California contracts with its private medical schools to expand the class sizes of these private schools. Delaware contracts with an out-of-state college of medicine to accept Delaware residents with a stipulation that a "portion" of the medical students spend their clinical clerkships in the Wilmington Medical Center. Ohio has a contract medical program which requires that the university supported must agree to admit a specified number of medical

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students. New York has three types of contractual arrangements with each private school in the State--(a) a plan which provides an award for each medical school graduate; (b) a per capita award for every medical student enrolled; and (c) a seven-year plan designed to increase enrollment during the period from 1967-1974. Illinois provides funds to private institutions within that State to increase enrollments in medical, dental, nursing, and allied health education programs. Each private school in Illinois receives an award for each Illinois student that school enrolls with the requirement that a specified number of residents be enrolled above the average number for an earlier year. In addition, an annual stabilization grant is made to each school computed on the average number of State residents enrolled. A single non-recurring expansion grant was also made by Illinois, but even this award was contingent upon the private school's commitment to increasing enrollment.

In contrast to the limitations and conditions regarding State support for private medical and dental schools which obtain in the above-cited cases, S. 2730 would authorize grants to be made to the private District of Columbia schools without reference to any benefits that might accrue to District residents. In this additional respect, therefore,

the legislation would depart from the approaches to support of private health professions schools followed in most of the States.

It is certainly the case that private schools draw their students from a wider area than do State supported schools and to that extent serve the needs of students from other States. For example, for the 1971-72 academic year George Washington medical school had 128 first year students, of whom only 11 were residents of the District of Columbia. Equally significant, the Georgetown University school of medicine accepted 216 first year students, of whom only 11 were residents of the District of Columbia. Similarly, the Georgetown school of dentistry accepted 138 first year students during the 1972-1973 academic year and only 5 were residents of the District. Thus, for 3 first year classes totalling 482, only 27, or 5.5% were actually District residents.

The critical equity issue that constantly arises with respect to proposals to support private District of Columbia medical and dental schools out of Department of Health, Education, and Welfare appropriations is whether there are overriding reasons of public policy to justify singling out--from the entire universe of private medical and dental schools in the U.S.--the schools in the District

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of Columbia for preferential funding treatment from the general revenues of the Nation. We feel that there are no such reasons. It is therefore difficult for the Department of Health, Education, and Welfare to rationalize selecting out three medical and dental schools in the United States for special treatment solely on the basis of their location within the District of Columbia.

Mr. Chairman, the issue which this legislation presents is basically identical to the issue that confronted the Congress in December 1971, when the House of Representatives voted down legislation (H.R. 11628, 92nd Congress) to perpetuate a program of special subsidies to hospitals in the District of Columbia, over and above the benefits they received under the Hill-Burton construction assistance program. In floor debate the opponents of that legislation effectively highlighted the inequities to other States and localities arising from continued provision of general tax resources to District of Columbia facilities in a manner and in amounts disproportionate to those available to other jurisdictions. We believe that the arguments that were successfully advanced against that earlier legislation apply with equal force to consideration of S. 2730.

I think it is important to note that to date the Department has not found it necessary to provide special funds to these

schools under the District of Columbia Medical and Dental Manpower Act, but instead has provided basic assistance under the generally applicable provisions of the Comprehensive Health Manpower Training Act of 1971.

The capitation grants awarded under that Act have provided increased funds to schools of medicine and dentistry--several times greater than they received under previous formula authorities--and have improved fiscal stability in such schools. In fiscal year 1973, for example, Georgetown University Medical School received capitation grant assistance of \$1,447,563 (as compared with \$259,500 under the old program in 1971); George Washington University Medical School \$1,047,290 (as compared with \$238,000 in 1971); and Georgetown University Dental School \$859,571 (as compared with \$223,000 in 1971).

A number of schools temporarily needed yet additional financial assistance before they could carry out the steps necessary to solve their problems. In recognition of this fact, the Congress--in the Comprehensive Health Manpower Training Act of 1971--included special separate authority, in amounts which declined over three fiscal years, for grants to schools of medicine and dentistry, as well as other schools of the health professions, which are in serious financial distress, to meet their costs of operation or to meet accreditation requirements.

The Act's financial distress authority was designed to provide financial assistance while at the same time identifying the factors that have led to financial difficulties and determining the appropriate means for remedying them. With this objective in mind, financial distress grants are made on special terms and conditions, including requirements that the schools agree to:

disclose financial information or data deemed by the Secretary to be necessary to determine the source or causes of their financial distress;

conduct a comprehensive cost analysis study in cooperation with the Secretary; and

carry out appropriate operational and financial reforms on the basis of information obtained in the course of the study or on the basis of other relevant information.

In fiscal year 1973 the Department's Bureau of Health Resources Development awarded approximately \$7.8 million in financial distress grants to medical and dental schools in this country. Of this amount approximately \$1.4 million was awarded to Georgetown University Medical School; \$583,000 was awarded to Georgetown University Dental School; and almost \$1.3 million to George Washington University

Medical School. In other words, Georgetown and George Washington University Medical School received nearly half of all the financial distress awards to medical schools in this country, and Georgetown University Dental School received slightly over one-quarter of all such aid to dental schools. If one were to add to these amounts the dollars these schools also received under capitation awards and special project grants, the dollars awarded in fiscal year 1973 would total approximately \$2.5 million for George Washington University and almost \$5.9 million for Georgetown University.

I should point out, Mr. Chairman, that the two universities have applied for financial distress assistance in the current fiscal year and that the National Advisory Council on Health Professionals Education disapproved those requests. For the Committee's ready reference, I am attaching copies of the letters sent by the Philadelphia Regional Office to the two universities notifying them of the reasons for the Council's decisions. I think this is important because it reflects an independent assessment of the financial situation of the schools with respect to special financial needs.

The effectiveness of the Comprehensive Health Manpower Assistance Act of 1971 is being closely studied at this moment inasmuch as the development of a sound and comprehensive

manpower strategy is one of the highest priorities in our Department. The Administration's recommendations on the health manpower authorities, which are scheduled to expire on June 30, 1974, will soon be sent to the Congress. The need for continued special Federal financial assistance to the relatively small number of health professions schools still experiencing financial distress, and the terms and conditions under which such aid should be provided, are questions that must be addressed by the Congress in that legislation. We believe it would be inequitable and inappropriate for the Congress to legislate preferential treatment for the private schools in the District of Columbia, without reference to the policies that will apply to the other schools in the U. S. similarly situated.

In summary, while we understand and sympathize with the efforts of Georgetown University and George Washington University, we believe there is not sufficient justification for special preferential Federal legislation of the kind under consideration today, to assist these particular schools of medicine and dentistry. If public support is to be provided to these District of Columbia private schools, as it is provided by some States to private schools within their jurisdictions, we would respectfully suggest that this be provided by the District of Columbia

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government which in this situation occupies a role analogous to that of a State government. The District government is in a position to judge whether the schools' asserted need for such support makes a compelling demand upon the city's limited financial resources. The District government is also in a unique position to assess the extent to which these schools contribute to the health manpower needs of the District.

If financial distress assistance is to continue to be provided by the Federal Government to health professions schools, it is particularly important as a matter of national health policy that schools of medicine or dentistry receiving such aid should uniformly be required to meet the terms and conditions imposed by the provisions of the Health Professions Educational Assistance authorities. These provisions should be applied nationally to all schools of medicine or dentistry who find themselves in such a plight.

Therefore, Mr. Chairman, the Administration recommends strongly against enactment of S. 2730.

D.C. Public School Smallpox Vaccination

Mr. Chairman, you also requested that we address H.R. 8747, a bill which would discontinue compulsory vaccination against smallpox in the District of Columbia public school system.

The Department of Health, Education, and Welfare supports the recommended change in smallpox vaccination policy in the District of Columbia which would preclude the routine vaccination of children. The status of smallpox throughout the world, the risk of smallpox importation into the United States, the expected transmission after an importation, and the risk of vaccination to the population justify a policy of selective vaccination of individuals at special risk. We believe this group to be essentially comprised of travelers to and from infected areas and hospital and other health workers who would be our first line of defense in the event of a smallpox importation.

Smallpox Occurrence Throughout the World

The areas of the world reporting endemic smallpox have steadily declined since the global smallpox eradication program of the World Health Organization began in 1966. Then, 28 countries had endemic smallpox. Now in only four countries (Bangladesh, India, Pakistan, and Ethiopia) is smallpox considered to be endemic. Each of these countries is engaged in massive campaigns designed to interrupt smallpox transmission as soon as possible. Intensive village-by-village surveillance activities are being carried out to detect existing smallpox foci. This has resulted in large numbers of cases and outbreaks

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being identified and reported--a phenomenon which was also observed in Brazil just prior to smallpox eradication in that country.

Bangladesh and India constitute the principal strongholds of endemic smallpox. In Bangladesh, smallpox transmission has almost been broken in Chittagong Division which contains over 25 percent of the country's population. In India, smallpox transmission has virtually been interrupted in the southern states. In northern India, particularly in the provinces of Uttar Pradesh, Madhya Pradesh, Bihar, and West Bengal, smallpox is still heavily endemic. The extent and magnitude of recent surveillance and containment campaigns in both Bangladesh and India, however, have strengthened WHO projections for the interruption of smallpox transmission in these countries by 1976.

In Pakistan, the extent of infected areas is decreasing rapidly. Smallpox is now confined to Baluchistan and Sind provinces which contain about 18 percent of Pakistan's population and transmission is expected to be broken during 1974.

In Ethiopia, the remaining foci of smallpox are primarily centered in three of the country's 14 provinces where a concentrated effort is underway to eradicate smallpox.

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In spite of difficult terrain and resistance to vaccination in some areas, Ethiopia is expected to be smallpox-free by the end of 1974,

Risk of Importation

The last confirmed case of smallpox occurred in the United States in 1949. The probability of importation into this country is determined by the incidence of smallpox in endemic countries, the number of travelers from these countries, and the immunity status of these travelers. Understandably, some risk of importation will continue as long as there are cases anywhere in the world. For this reason, the United States requires that travelers arriving in this country from a smallpox infected area show proof of immunity by having a valid vaccination certificate in their possession.

The rapid decrease over the past several years in the number of countries reporting smallpox has greatly reduced the probability of travelers being exposed to smallpox within 2 weeks of their arrival into the United States. In 1972, and again in 1973, a survey of air travelers to the United States suggests the current probability of a case of smallpox being imported into the United States as roughly every 18 years.

Risk of Transmission After Importation

With a policy of routine nonselective vaccination as previously conducted throughout the United States (still required in the District of Columbia), immunity levels were very low. To maintain high levels of immunity in our population we would have to have universal vaccination of children at a very young age and then revaccination at regular intervals throughout life. Surveys have shown less than 20 percent of the population fully protected against smallpox. Herd immunity concepts can be very misleading when it comes to smallpox. We have been free of smallpox in this country for the past 25 years, not because of high immunity levels, but because we have not had an importation.

An analysis of smallpox importations into Europe has shown that countries with nonselective vaccination policies and supposedly higher levels of immunity fare no better in terms of the number of cases, epidemiologic generations, or mortality than countries with selective requirements and known low levels of immunity. The critical factor in an outbreak is not previous population immunity but the speed and quality of the containment response. The outbreak in Yugoslavia during March-April 1972 was more extensive than West European outbreaks in spite of the fact that

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Yugoslavia had a policy of routine vaccination and 70-90 percent of the population vaccinated at some time in their lives.

In the United States, medical epidemiologist with smallpox control experience, ample vaccine, jet injectors, and trained vaccinators are available for immediate contact tracing and appropriate containment efforts. As part of the preparation for an effective procedure for the management of smallpox in the unlikely event of an importation, the Center for Disease Control has developed a manual which provides a step-by-step approach to assist health personnel in handling suspected smallpox. This manual has been placed in the office of each State and Territorial Epidemiologist including the District of Columbia.

As long as a possibility exists of a smallpox importation, however, we believe a significant reduction could be achieved in the number of cases occurring following an importation if adequate vaccination programs on hospital and other health personnel were carried out. For this reason, the Center for Disease Control supports the American Hospital Association's recommendation for the vaccination of hospital workers against smallpox every 3 years.

Risk of Vaccination Complications

Surveys in the United States have demonstrated a definite measurable risk of complications following smallpox vaccination. These vary from local erythematous reactions to life-threatening situations and death. In 1968, over 14 million people were vaccinated; nine deaths were associated with smallpox vaccination and approximately 500 cases of serious complications reported. For most people in the United States the risk of vaccination complications clearly outweighs the benefits of being vaccinated. The recommended policy of selective vaccination affords protection to those persons at risk of exposure while reducing the vaccine associated illness and death in persons who are at very low risk of acquiring smallpox.

Acceptance of Selective Vaccination Policy

The policy of selective vaccination which was formulated and recommended by the PHS Advisory Committee on Immunization Practices has been endorsed by the American Medical Association, The American Academy of Pediatrics, and the Association State and Territorial Health Officers. Essentially all States have taken action to discontinue nonselective vaccination policies.

Summary

The risk of smallpox importation into the United States is remote and continuing to decrease. Our ability to contain smallpox is more than adequate for any outbreak. At this point in time, most signs indicate a smallpox-free world within the next 3 years. A selective approach to smallpox vaccination should be encouraged in the District of Columbia.

This concludes my statement, Mr. Chairman. I will be pleased to answer any questions that you and other members of the Subcommittee may have.



FOR RELEASE ONLY UPON DELIVERY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

DR. JOHN S. ZAPP

DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH)

BEFORE THE

SUBCOMMITTEE ON LABOR, SOCIAL SERVICES

AND THE INTERNATIONAL COMMUNITY

COMMITTEE ON THE DISTRICT OF COLUMBIA

U.S. HOUSE OF REPRESENTATIVES

Thursday, January 24, 1974

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Mr. Chairman, we appreciate this opportunity of appearing before you to testify on H.R. 11108, a bill "To extend for three years the District of Columbia Medical and Dental Manpower Act of 1970."

The District of Columbia Medical and Dental Manpower Act of 1970 (which was enacted as Title III of the District of Columbia Revenue Act of 1970) authorized the Secretary of Health, Education, and Welfare to make grants to the Commissioner of the District of Columbia for private nonprofit medical and dental schools in the District of Columbia.

The Act authorized grants in amounts the Secretary determined to be the "minimum amounts necessary" to carry out the purposes of the Act, but in no event to exceed, in the case of a medical school, \$5,000 times the number of full-time medical students or, in the case of a dental school, \$3,000 times the number of full-time dental students enrolled. In determining the amounts of grants, the Secretary was required to take into consideration any grants to the respective District of Columbia schools under the Health Professions Educational Assistance authorities of Title VII of the Public Health Service Act relating to financial assistance to health professions schools in serious financial distress.

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The District of Columbia Medical and Dental Manpower Act of 1970 expired June 30, 1972. The bill you are considering today, HR 11108, would extend it for three years (fiscal years 1975 through 1977) and would authorize the appropriation of such sums as are necessary for carrying out its purpose. It would authorize the Secretary for Health, Education, and Welfare to assist private nonprofit medical and dental schools in the District of Columbia in a manner similar to that in which certain States support private medical and dental schools located in their respective jurisdictions.

Mr. Chairman, if you will recall, the Department of Health, Education, and Welfare has testified on similar legislation in the past, in fact as recently as April 1972. At that hearing the Administration recommended strongly against enactment of legislation similar to the current bill. Today our position remains essentially the same. Nothing has happened in this interval to warrant the passage of this legislation.

We believe this Committee should note that not all States support private medical or dental schools in their respective jurisdictions. Of the 22 States having 50 private medical schools, 9 States provide no financial assistance to 14 such schools. Of the 14 States having 22 private dental schools, 8 States provide no financial aid to 13 of these schools. Even in those States that do provide assistance to private medical and dental schools, the amount of support provided varies widely and the

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purposes for which the assistance can be used are limited. When a State does decide to support a private medical school the State usually considers specific benefits which might accrue from such support. State considerations usually involve the need for an adequate number of trained health professionals for health care, research and teaching; the need to expand educational opportunities for residents of the State; the need for new knowledge; and, the need to develop new methods of providing health care to groups as well as to individuals.

For example, California contracts with its private medical schools to expand the class sizes of these private schools. Delaware contracts with an out-of-state college of medicine to accept Delaware residents with a stipulation that a "portion" of the medical students spend their clinical clerkships in the Wilmington Medical Center. Ohio has a contract medical program which requires that the private university supported must agree to admit a specified number of medical students. New York has three types of contractual arrangements with each private school in the State--(a) a plan which provides an award for each medical school graduate; (b) a per capita award for every medical student enrolled; and (c) a seven-year plan designed to increase enrollment during the period from 1967-1974. Illinois provides funds to private institutions within that State to increase enrollments in medical, dental, nursing, and allied health education programs. Each private school in Illinois receives an award for each

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Illinois student that school enrolls with the requirement that a specified number of residents be enrolled above the average number for an earlier year. In addition, an annual stabilization grant is made to each school computed on the average number of State residents enrolled. A single non-recurring expansion grant was also made by Illinois, but even this award was contingent upon the private school's commitment to increasing enrollment.

In contrast to the limitations and conditions regarding State support for private medical and dental schools which obtain in the above-cited cases, H.R. 11108 would authorize grants to be made to the private District of Columbia schools without reference to any benefits that might accrue to District residents. In this additional respect, therefore, the legislation would depart from the approaches to support of private health professions schools followed in most of the States.

It is certainly the case that private schools draw their students from a wider area than do State supported schools and to that extent serve the needs of students from other States. For example, for the 1971-72 academic year George Washington medical school has 128 first year students, of whom only 11 were residents of the District of Columbia. Equally significant, the Georgetown University school of medicine accepted 216 first year students, of whom only 11 were residents of the District of

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Columbia. Similarly, the Georgetown school of dentistry accepted 138 first year students during the 1972-1973 academic year and only 5 were residents of the District. Thus, for 3 first year classes totalling 482, only 27, or 5.5% were actually District residents.

The critical equity issue that constantly arises with respect to proposals to support private District of Columbia medical and dental schools out of Department of Health, Education, and Welfare appropriations is whether there are overriding reasons of public policy to justify singling out--from the entire universe of private medical and dental schools in the U.S.--the schools in the District of Columbia for preferential funding treatment from the general revenues of the Nation. We feel that there are no such reasons. It is therefore difficult for the Department of Health, Education, and Welfare to rationalize selecting out three medical and dental schools in the United States for special treatment solely on the basis of their location within the District of Columbia.

Mr. Chairman, the issue which this legislation presents is basically identical to the issue that confronted the Congress in December 1971, when the House of Representatives voted down legislation (H.R. 11628, 92nd Congress) to perpetuate a program of special subsidies to hospitals in the District of Columbia, over and above the benefits they received under the Hill-Burton construction assistance program. In floor debate

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the opponents of that legislation effectively highlighted the inequities to other States and localities arising from continued provision of general tax resources to District of Columbia facilities in a manner and in amounts disproportionate to those available to other jurisdictions. We believe that the arguments that were successfully advanced against that earlier legislation apply with equal force to consideration of H.R. 11108.

I think it is important to note that to date the Department has not found it necessary to provide special funds to these schools under the District of Columbia Medical and Dental Manpower Act, but instead has provided basic assistance under the generally applicable provisions of the Comprehensive Health Manpower Training Act of 1971. The capitation grants awarded under that Act have provided increased funds to schools of medicine and dentistry--several times greater than they received under previous formula authorities--and have improved fiscal stability in such schools. In fiscal year 1973, for example, Georgetown University Medical School received capitation grant assistance of \$1,447,563 (as compared with \$259,500 under the old program in 1971); George Washington University Medical School \$1,047,290 (as compared with \$238,000 in 1971); and Georgetown University Dental School \$859,571 (as compared with \$223,000 in 1971).

The capitation grant program has contributed significantly to alleviating the financial distress of schools of medicine and dentistry. It is still

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the case, however, that a number of schools temporarily needed yet additional financial assistance before they could carry out the steps necessary to solve their problems. In recognition of this fact, the Congress--in the Comprehensive Health Manpower Training Act of 1971--included special separate authority, in amounts which declined over three fiscal years, for grants to schools of medicine and dentistry, as well as other schools of the health professions, which are in serious financial distress, to meet their costs of operation or to meet accreditation requirements.

The Act's financial distress authority was designed to provide financial assistance while at the same time identifying the factors that have led to financial difficulties and determining the appropriate means for remedying them. With this objective in mind, financial distress grants are made on special terms and conditions, including requirements that the schools agree to:

- disclose financial information or data deemed by the Secretary to be necessary to determine the source or causes of their financial distress;
- conduct a comprehensive cost analysis study in cooperation with the Secretary; and

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carry out appropriate operational and financial reforms on the basis of information obtained in the course of the study or on the basis of other relevant information.

In fiscal year 1973 the Department's Bureau of Health Resources Development awarded approximately \$7.8 million in financial distress grants to medical and dental schools in this country. Of this amount approximately \$1.4 million was awarded to Georgetown University Medical School; \$583,000 was awarded to Georgetown University Dental School; and almost \$1.3 million to George Washington University Medical School. In other words, Georgetown and George Washington University Medical School received nearly half of all the financial distress awards to medical schools in this country, and Georgetown University Dental School received slightly over one-quarter of all such aid to dental schools. If one were to add to these amounts the dollars these schools also received under capitation awards and special project grants, the dollars awarded in fiscal year 1973 would total approximately \$2.5 million for George Washington University and almost \$5.9 million for Georgetown University.

The Department is of the view that, in general, the prolonged period of financial uncertainty experienced by these schools--the end of which is not yet in sight--reflects a serious deficiency in the administration of these institutions. For instance, the schools have not followed the

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common practice in other medical school of instituting a viable intramural faculty practice plan to assure that some reasonable portion of the financial resources generated by certain of the clinical departments is applied toward keeping the other departments of the school on a sound financial footing. George Washington Medical School has given some thought to trying to reform its policies in this regard, and may be in a position to stabilize its finances in the not too distant future. The Georgetown schools, however, have thus far not moved to implement long-overdue management reforms to an extent that would correct their financial difficulties.

The effectiveness of the Comprehensive Health Manpower Assistance Act of 1971 is being closely studied at this moment inasmuch as the development of a sound and comprehensive manpower strategy is one of the highest priorities in our Department. The Administration's recommendations on the health manpower authorities, which are scheduled to expire on June 30, 1974, will soon be sent to the Congress. The need for continued special Federal financial assistance to the relatively small number of health professions schools still experiencing financial distress, and the terms and conditions under which such aid should be provided, are questions that must be addressed by the Congress in that legislation. We believe it would be inequitable and inappropriate for the Congress to legislate preferential treatment for the private schools in the District of Columbia, without reference to the policies that will apply to the other schools in the U.S. similarly situated.

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In summary, we believe there is not sufficient justification for special preferential Federal legislation of the kind under consideration today, to assist these particular schools of medicine and dentistry. If public support is to be provided to these District of Columbia private schools, as it is provided by some States to private schools within their jurisdictions, we would respectfully suggest that this be provided by the District of Columbia Government which in this situation occupies a role analogous to that of a State government. The District Government is in a position to judge whether the schools' asserted need for such support makes a compelling demand upon the city's limited financial resources.

If financial distress assistance is to continue to be provided by the Federal Government to health professions schools, it is particularly important as a matter of national health policy that schools of medicine or dentistry receiving such aid should uniformly be required to meet the terms and conditions imposed by the provisions of the Health Professions Educational Assistance authorities. These provisions should be applied nationally to all schools of medicine or dentistry who find themselves in such a plight.

Therefore, Mr. Chairman, the Administration recommends strongly against enactment of H.R. 11108.

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Thank you, Mr. Chairman, I will be happy to respond to any questions you or the members of your Committee might wish to raise.

Senator TUNNEY. Our next witnesses are: Dr. Lloyd H. Elliott, president, George Washington University; Dr. Matthew F. McNulty, Jr., executive vice president for medical center affairs, Georgetown University; Dr. Michael Ball, Association of American Medical Colleges; and T. Byron Collins, S.J., special assistant to the president, Georgetown University.

STATEMENTS OF DR. LLOYD H. ELLIOTT, PRESIDENT, GEORGE WASHINGTON UNIVERSITY; DR. MATTHEW F. McNULTY, JR., EXECUTIVE VICE PRESIDENT FOR MEDICAL CENTER AFFAIRS, GEORGETOWN UNIVERSITY; DR. MICHAEL BALL, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; AND T. BYRON COLLINS, S.J., SPECIAL ASSISTANT TO THE PRESIDENT, GEORGETOWN UNIVERSITY

Reverend COLLINS. We would like to have a panel presentation, if we may, and I would like to request that the statements of other witnesses be included in the record.

Senator TUNNEY. Without objection, so ordered, and certainly the panel discussion will be most appropriate.

Who wants to lead off?

Reverend COLLINS. Dr. Elliott, the president of the George Washington University, followed by Dr. McNulty, executive vice president of Georgetown University, then Dr. Michael Ball, and I have a brief statement at the end.

Senator TUNNEY. Fine. At some point after you have finished your prepared statements, I would appreciate it if you would address yourself to the point that was made by Dr. Edwards just a few moments ago.

You were all here and heard what he said, and I would like to have you specifically answer those questions that I raised and which he answered, if you could, after you finish your prepared statement.

Dr. ELLIOTT. Mr. Chairman, I am Lloyd Elliott, and with your permission, I will file my statement and comment briefly.

Senator TUNNEY. Your prepared statement and other statements and letters from the George Washington University, will be received and printed in the record.

[Dr. Elliott's prepared statement, and other material submitted from the George Washington University, follow:]



THE
GEORGE
WASHINGTON
UNIVERSITY

Washington, D.C. 20006 / Office of the President / (202) 676-6500

United States Senate
Committee on the District of Columbia
Subcommittee on Public Health, Education, Welfare and Safety
John V. Tunney, Chairman
Hearings - Wednesday, May 1, 1974

Mr. Chairman and Members of the Committee:

I am Lloyd H. Elliott, President of The George Washington University.

I want to thank the members of the District of Columbia Committee for the interest and concern you have demonstrated by helping to alleviate the financial distress of The Georgetown University Schools of Medicine and Dentistry and The George Washington University School of Medicine.

The passage of PL 91-650, the Medical and Dental Manpower Act of D.C. of 1970, recognized the emergency situation facing the private medical and dental schools of the District of Columbia. The sum of approximately \$1,900,000 was provided for The George Washington University School of Medicine in fiscal 1971 and approximately \$2,000,000 in fiscal 1972. The funds have been provided by the Secretary of Health, Education and Welfare from the disaster grants that were available to him in these years for schools in financial distress. The legislation authorizing these

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grants expires in fiscal 1974, and it has been forcefully indicated to us that for fiscal 1975 and thereafter our financial needs cannot be met from existing National legislation.

The total unrestricted endowment left in the School of Medicine and Health Sciences is only \$1,122,615. Even if all of this were used it would barely be enough to meet one-half of this year's deficit and, without new sources of financing, our bank account would be depleted. The University is hard pressed to make ends meet and University resources for Medical School support are not available. In recent years our fund raising campaigns have yielded among the largest returns of all medical centers in the United States. During the last two years, our alumni and friends contributed \$4,652,659.

We appeal to you as a private medical school appeals to a state legislature. Our situation is not unique -- most states now support private as well as state medical schools, and among the few schools who do not receive state support are a number of heavily endowed institutions like Harvard, Yale, University of Washington and Vanderbilt. This will be documented by testimony from The Association of American Medical Colleges, a recent report of which (see Attachment) reveals that the Regular Operating Expenditures per Undergraduate Medical Student in George Washington University were the lowest of all 92 schools surveyed and the Student-Faculty Ratio the ninth highest.

The University is proud of its public service participation in the District of Columbia and we hope we may continue to serve our community in the years to come. Our growing involvement is not that of education at the expense of the community, nor service to the community at the expense of education. By and large, it is a combination of the positive aspects of both education and service. Some current examples of Medical Center involvement are as follows:

- I. Community Care Center - The University's Medical Center, through the Community Care Center, is voluntarily serving the 39,000 residents of D.C. Area Nine. No one is turned away from the Clinic, and charges are based on the ability to pay. Area Nine has a mortality rate 15% higher than the average for the District, and a tuberculosis rate 50% higher, so the University, by its willingness to care for these citizens, is making an important contribution to preventive medicine and public health. Last year alone, more than 3,500 patients from Area Nine were treated in the Community Care Center, and 30 drug addicts were treated on a methadone-maintenance program which has recently been expanded to cover the full scale of poly-drug abuse in the entire Metropolitan Washington area. The Center admits to the University Hospital any patient requiring hospital care, regardless of his ability to pay.

- II. Health Maintenance Organization - A pre-paid practice program, covering 2,000 Medicaid beneficiaries, has been developed under a fixed cost contract with the District of Columbia government.
- III. Low Vision Clinic - This Clinic evaluates sight levels of patients with impaired vision and provides visual aids.
- IV. Emergency Care - Our Emergency Pavilion will register approximately 50,000 patient visits this fiscal year. It was recently acclaimed by the Health Facilities Council as the pre-eminent unit for the delivery of emergency care in the Metropolitan Washington area. It is accepting approximately 800 ambulance calls per month -- almost as many as the D.C. General Hospital.
- V. Ambulance Personnel Training Program - developed in conjunction with the D.C. Fire Department; enhances ambulance technicians' skills in responding to emergency situations.
- VI. Home Care Program - for cancer, stroke and chronic disease victims provides a patient transportation center for those unable to come to the Medical Center for treatment.

VII. Rehabilitation Medicine

- A. A computer-assisted cardiac rehabilitation project with D.C. Metropolitan Regional Medical Program in heart disease and stroke provides stress exercise tests for hospitals and agencies in the D.C. area and adjoining states.
- B. Provides training and job opportunities in computer industries for severely disabled homebound patients previously considered unemployable.
- C. Trains and supervises former drug addicts to carry out programs of preventive education for school children and others in the community and to enter new careers with probation, parole, social work and rehabilitation agencies.
- D. Weekly amputee clinic is available to community health professionals for evaluation, prescription and management of amputees. Prosthetic devices are developed and fitted by staff orthotist.
- E. Produces informational brochures to assist community agencies which provide aid to the disabled.
- F. Arranges seminars for rehabilitation agencies in the D.C. area on major medical subjects.
- G. Sponsors drug abuse seminars for school guidance counselors.

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- H. Opens doors for health careers for economically disadvantaged and physically disabled youth through summer work programs (100 in 1972, 115 in 1971, and 65 in 1970).
- I. Provides training in the treatment of alcoholic clients.

VIII. Sickle Cell Disease - Approximately 60,000 persons in D.C. suffer from Sickle Cell Disease, an inherited disorder for which there is presently no cure. The University runs an active screening program and SCD Clinic and collaborates with multiple channels in the city to educate the public regarding the disease.

IX. Education and Training Programs:

- A. Radiology technicians, medical technologists & inhalation therapists.
- B. Physicians' Assistants
- C. Nurse Anesthetists, in contracts with three area hospitals
- D. Burdick School programs of Nurse Aids & Operating Room Technicians.

While the primary purpose of The George Washington University is learning, we are aware that where education and community service can be combined there are more beneficial results for all. The financial support of this Bill is essential. The continuation of our ability to offer medical service to the Washington community is dependent upon the viability of our School of Medicine and Health Sciences.

ALL SCHOOLS PROFILE (Based upon Means for all 97² Schools)

Legend: All Schools

George Washington University (Revised 3/14/74) -----



THE
GEORGE
WASHINGTON
UNIVERSITY

Vice President for Medical Affairs / 2300 Eye Street, N.W. / Washington, D.C. 20037 / (202) 331-6241

United States Senate
Committee on the District of Columbia
Subcommittee on Public Health, Education, Welfare and Safety
John V. Tunney, Chairman
Hearings - Wednesday, May 1, 1974

Mr. Chairman and Members of the Committee:

I am Doctor James J. Feffer, Vice President for Medical Affairs of The George Washington University.

Our School of Medicine and Health Sciences serves as an abundant source of well-qualified medical practitioners for the District of Columbia and its environs. George Washington University medical graduates practice in all the 50 states (Exhibit A) with the greatest concentration being in the Metropolitan Washington area: 434 in the District of Columbia, 374 in Maryland, and 204 in Virginia.

Reference has been made to the essential health services our faculty and students provide to the people of Washington. Core programs of care and education are conducted by George Washington University's staff members and students in a number of hospitals -- Children's, Columbia, D.C. General, George Washington University, Fairfax, Holy Cross, Naval, St. Elizabeth's, Veterans Administration and the Washington Hospital Center. Elective

educational programs are offered at Walter Reed Army Hospital, National Institutes of Health, Armed Forces Institute of Pathology and the Malcolm Grow Air Force Base. Our resident physicians in the University Hospital and its affiliated post-graduate programs number 320 doctors who render specialized medical care to the community. Our training program for Physicians' Assistants numbers 60.

At a time when every effort is being made to increase our output of physicians and allied health personnel, we face the persistent threat of inadequate funds to support our programs. Unfortunately, we cannot continue our present academic role without the resources of this proposed legislation.

The fiscal plight of our School of Medicine is one of continuous operational losses (Exhibit B) that come as a result of conditions beyond our control. Despite efforts to reduce expenses, to effect economies, and to increase income from various sources, our deficit remains about \$5,000 per medical student per school year. Our annual tuition has risen to \$3,000, making it one of the highest in the country. In the absence of a federal guaranteed loan program, unless we are to become a "rich man's school", we have reached the limit in tuition increases.

Our faculty salary levels are significantly below the median of all the academic health science centers in the country, and faculty and non-academic salary increases have been restricted to 5.5% for each of

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the past three years. Unfilled positions have been frozen except where offsetting income could be generated or critical need established. Economies have already been effected to the point where any additional constraints would reduce quality to the point where accreditation would be in jeopardy.

Our current 564 medical students come from 42 states and the District of Columbia (Exhibit C). With the trend in medical education toward exposing students to clinical situations early in their careers, the students are an integral part of all our service programs. They learn to become physicians by working with patients in the clinic, the hospital, the emergency room and in their professors' offices. All of our community health programs depend heavily for manpower on students, house officers and faculty.

We are in the second year of operating an academic health maintenance organization, a pre-paid health plan that is of benefit to the residents of the District of Columbia regardless of whether they are publicly or privately insured. While this is essentially a community service, it fulfills an important academic model for future practicing physicians.

Through vigorous effort University officials have raised \$10 million to match federal funds for much needed and long awaited facilities for the School of Medicine, which were occupied in May 1973. Unavoidable plant and maintenance costs of the new School and Library exceed that of the old facility by over \$1 million per year. Although

Statement - Page Four

capital funding has been completed, we seek the assistance of this legislation for operational support so young men and women can continue to be educated in these new classrooms and laboratories. Expanded programs for physicians assistants and nurses, and modern postgraduate educational procedures for practicing physicians are important features of our immediate future.

Since 1825 The George Washington University School of Medicine has served with distinction as a local and national source of capable, practicing physicians. We seek support of this legislation in order that our School may continue its vital role in the preparation of future physicians to serve the health needs of our community and our country.

Thank you, gentlemen, for the privilege of appearing before you.

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Exhibit A

DISTRIBUTION OF GV/ GRADS BY STATES AS OF 1/1/72

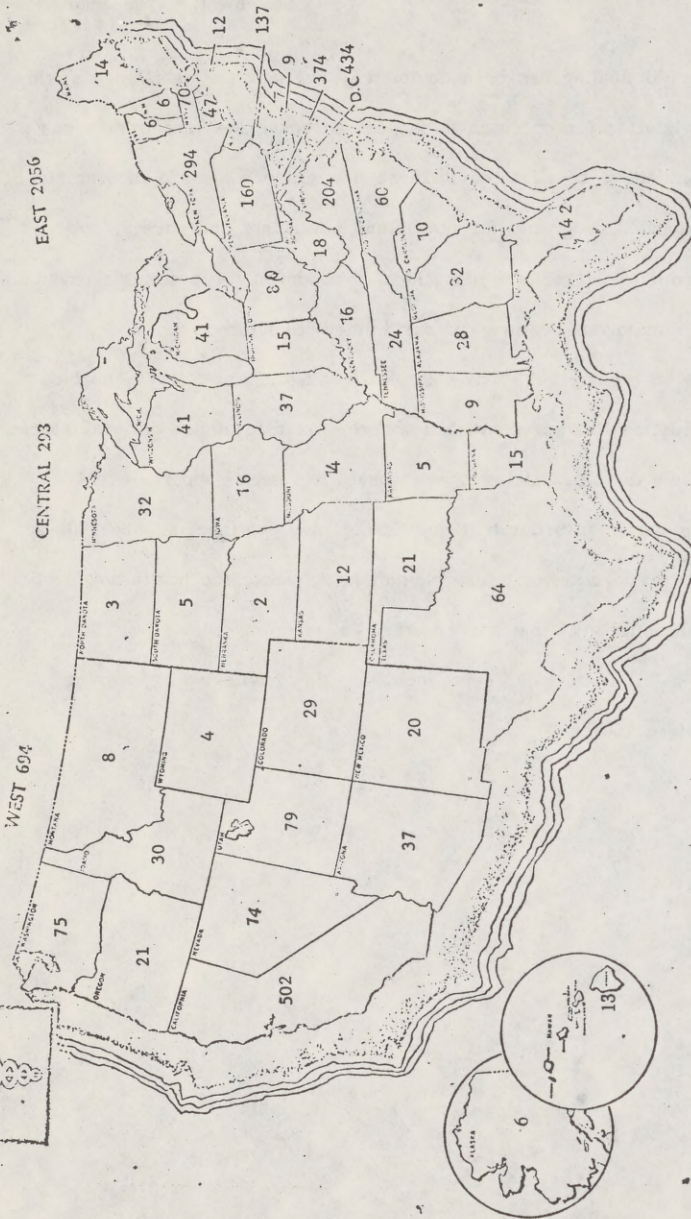


EXHIBIT B

THE SCHOOL OF MEDICINE AND HEALTH SCIENCES

SUMMARY OF ACTUAL AND PROJECTED INCOME AND EXPENSE

FISCAL YEARS 1972-73 THROUGH 1976-77

Income	1972-73	1973-74	1974-75	1975-76	1976-77
Tuition & Student Fees	\$ 1,921,763	\$ 2,412,500	\$ 2,712,000	\$ 3,000,000	\$ 3,176,000
Endowment Income	144,107	145,000	157,000	158,000	159,000
Sponsored Programs	6,194,194	6,000,000	6,378,000	6,773,000	7,193,000
Education & Development Funds	447,985	450,000	478,000	508,000	539,000
Federal Capitalization Grant	911,855	1,047,290	1,141,000	1,173,000	1,173,000
Gifts & Miscellaneous Income	526,273	599,000	600,000	650,000	700,000
Student Aid	135,040	135,000	136,000	138,000	140,000
Total Operating Income	\$10,281,217	\$10,788,790	\$11,602,000	\$12,400,000	\$13,080,000
Expenses					
Faculty Salaries	2,706,938	3,192,000	3,368,000	3,553,000	3,748,000
Non-Academic Salaries	2,901,403	3,209,000	3,385,000	3,554,000	3,732,000
Staff Benefits	583,943	697,000	735,000	775,000	818,000
Equipment	769,158	825,000	875,000	928,000	984,000
Operation & Maintenance of Plant	711,204	1,883,000	2,100,000	2,307,000	2,535,000
Other Direct Costs	2,259,901	2,483,000	2,632,000	2,790,000	2,957,000
Medical Center & University Services	998,563	1,147,000	1,219,000	1,295,000	1,375,000
Student Aid	135,040	135,000	136,000	138,000	140,000
Total Expenses	\$11,066,150	\$13,571,000	\$14,450,000	\$15,340,000	\$16,289,000
Deficit	(784,933)	(2,782,210)*	(2,848,000)	(2,940,000)	(3,209,000)
Distress Grant Received	706,459				
Enrollment	516	564	580	620	620
D. C. Manpower need per student			\$4,910	\$4,742	\$5,176
Percentage of Operating Deficit to Total Expense	7%	21%	20%	19%	20%

* Application submitted for DHEW Financial Distress Program Award.

Exhibit C

ATTENDANCE AT GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE
1973 - 1974

GEOGRAPHICAL DISTRIBUTION OF STUDENTS

Alabama	3	New Hampshire	1
Arizona	3	New Jersey	47
Arkansas	1	New Mexico	2
California	45	New York	106
Colorado	4	North Carolina	4
Connecticut	26	North Dakota	4
Delaware	2	Ohio	13
District of Columbia	40	Oregon	2
Florida	7	Pennsylvania	24
Georgia	1	Rhode Island	4
Hawaii	1	South Carolina	1
Idaho	4	South Dakota	4
Illinois	6	Tennessee	1
Indiana	6	Texas	1
Kansas	3	Utah	21
Maine	4	Vermont	1
Maryland	84	Virginia	25
Massachusetts	13	Washington	20
Michigan	6	West Virginia	1
Minnesota	1	Wisconsin	2
Missouri	2	Wyoming	1
Montana	3		
Nevada	4		

Graduating ClassNumber

1973-74	117
1974-75	147
1975-76	148
1976-77	152



THE
GEORGE
WASHINGTON
UNIVERSITY

Vice President for Medical Affairs / 2300 Eye Street, N.W. / Washington, D.C. 20037 / (202) 331-6241

February 1, 1974 .

The Honorable Romano L. Mazzoli
Chairman, Subcommittee on Labor,
Social Services and the International Community
Committee on the District of Columbia
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Mazzoli:

At the hearings before your Subcommittee on January 24th relative to H.R. 11108, a Bill to extend for three years the District of Columbia Medical and Dental Manpower Act of 1970, Congressman Fortney H. Stark requested information concerning certain racial and geographical distribution characteristics of students admitted to The George Washington University School of Medicine. This information, for the years 1971, 1972 and 1973, is tabulated on the enclosure.

As a result of participation in the Association of American Medical Colleges Application Service (MCAS), for the fall class of 1974 a substantial increase in the number of applications is anticipated from minority groups and, hopefully, this will result in improved enrollment relationships.

Again, I would like to express my personal appreciation for the opportunity to appear before the Subcommittee on Labor, Social Services and the International Community in support of legislation in behalf of the Schools of Medicine of George Washington and Georgetown Universities.

Sincerely,

James J. Feffer, M.D.

Vice President for Medical Affairs

JJF/jo

Enclosure

c/ Congressman Fortney H. Stark

THE GEORGE WASHINGTON UNIVERSITY
SCHOOL OF MEDICINE AND HEALTH SCIENCES
SELECTIVE ENROLLMENT DATA

	D.C. RESIDENTS			BLACKS			TOTAL APPLICANTS		
	1971	1972	1973	1971	1972	1973	1971	1972	1973
APPLIED	53	85	77	71	115	69	2966	4320	5114
ACCEPTED	14	16	12	12	16	19	307	310	379
ENROLLED	9	9	8	5	14	6	124	143	151

JJF/jo
2/1/74



THE
GEORGE
WASHINGTON
UNIVERSITY

Vice President for Medical Affairs / 2300 Eye Street, N.W. / Washington, D.C. 20037 / (202) 331-6241

March 12, 1974

The Honorable Romano L. Mazzoli
Chairman, Subcommittee on Labor, Social Services
and the International Community
Committee on the District of Columbia
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Mazzoli:

I am writing in response to the STATEMENT REQUESTED BY REPRESENTATIVE MAZZOLI REGARDING THE ADMINISTRATION OF PRIVATE MEDICAL AND DENTAL SCHOOLS IN THE DISTRICT OF COLUMBIA, made available during a meeting with the Assistant Secretary for Health on February 21, 1974. It is my understanding this document, with minimal modifications and/or additions, was formally transmitted to you through a covering memo dated February 22, 1974. I presume it was prepared in the office of Dr. John S. Zapp and that it is alleged to represent his response to your request during a meeting on February 7, 1974 of representatives of George Washington and Georgetown Universities and the Department of HEW with the Subcommittee on Labor, Social Services and the International Community of the Committee on the District of Columbia regarding H. R. 11108.

In my opinion, the STATEMENT referred to above does not respond to your request for documentation of deficiencies in management and administration.

-2-

Reference is made in this latest document to "intensive review" of the application during the last three years under the financial distress program "by expert consultants drawn almost exclusively from experienced Medical Center administrators and financial management personnel of such institutions". It is also stated that virtually all outside consultants voiced criticism about various aspects of our operation and uncertainty because of confusion in the data supplied which was not consistent and understandable.

It is further stated that the AAMC Cost Study generated data which "appeared inconsistent with the financial statement submitted by the school".

I repeat my testimony before your Subcommittee, and confirmed by the statement of Dr. Harry Bruce, that prior to February 27, 1974 George Washington University was never site visited under the Distress legislation; furthermore, George Washington University was not a participant in the AAMC Cost Study referred to and therefore the inconsistency referred to above could not have existed. If there are remaining "areas requiring clarification", we have not been so informed.

It should be pointed out that the STATEMENT specifically addresses only "the current round of application review" and that it was prepared prior to the very recent site visit of February 27, 1974 to which I shall refer later in this presentation. The "excerpts from reviewers" could only represent present and past HEW staff and not the opinion of any outside "experts or consultants".

Funding during the three-year period of the Distress legislation has been \$4,706,459 and not \$5,290,600 as stated on page seven of the document, and this year's requirement will be approximately \$2 million and not \$2,782,210.

The second reviewer refers to increasing deficits each year and to "huge expense increases" and "inability to curtail total expenditures". In fact, when one removes the unavoidable increased plant cost associated with the move to the new Medical School and Library, as can be seen from Attachment 1, deficits decrease substantially. This irrefutably demonstrates that costs of the Medical School have been brought under control relative to the School's income base, except for the substantial unavoidable increases in operation and maintenance of plant.

-3-

There are basically two causes for the increase in plant cost. The first is the tremendous upgrading of Medical School and Library facilities which was imperative in view of the woefully inadequate 100-year-old buildings previously occupied. The old structures were not air-conditioned; were inadequately wired for modern scientific equipment; were heated by an antiquated coal boiler system; and were located a mile from Clinical Center activities. The second cause for the substantial increase in plant cost relates to the unanticipated, skyrocketing price of fuel oil and other utilities.

The STATEMENT submitted by HEW compares percentage increases and expense from the 1972-73 actual to the 1973-74 budget. As already indicated, we anticipate budget underruns, as has been the case in the past, underruns caused in no small part by aggressive cost containment efforts.

We are accused of not having "followed the common practice in other medical schools of instituting a viable intramural faculty practice plan". In fact, The George Washington University intramural Practice Plan is now five years old, and it is one of the most sophisticated among the 115 existing medical schools. There is total participation by the full-time clinical faculty and total University control -- without exception. The income from this Plan supports 50% of all clinical faculty costs, after which the surplus, generated almost entirely by the so-called hospital-based departments of Anesthesiology, Pathology and Radiology, is used to neutralize University Hospital deficits. It is only appropriate that patient-care activity income be used for this purpose, since the Hospital is carrying 35% (\$4 million in FY73) of clinical faculty costs. If it were not, an unmanageable Hospital deficit would be created which would have to be charged back to the educational programs of the School of Medicine. The net effect would be no different.

It has been stated that the "precise disposition of the fund balances derived from the professional practice plan is difficult to determine" and "a substantial reserve exists which is operating as an endowment". In fact, the precise disposition of these funds is fully and clearly disclosed in the Distress Grant applications and appendices thereto, including the annual University Financial Statement. The funds are functioning as an operating reserve and not as an endowment.

-4-

Even with the full utilization of all reserve funds, the cash position of the Medical Center Fund Balance Sheet on 6/30/73 showed a \$1.5 million negative balance. Without these appropriated and unappropriated funds the Medical Center, with a \$45 million budget and substantial accounts receivable from patient care activities, would have virtually no working capital. Furthermore, it is these funds which provide the fiscal assurance necessary to budget for a succeeding year.

The STATEMENT refers to actions taken by other medical schools, and implies that similar actions have not been taken by The George Washington University School of Medicine and Health Sciences. It refers specifically to "shifting costs to Hospital budgets where appropriate". As already indicated, in FY73 The George Washington University Hospital carried \$4 million of educational costs and this level of support is projected into the future. Since 1966, costs have been shifted from the Medical School to the Hospital to the maximum extent allowable by third party reimbursers.

Finally, as a result of your suggestion during the recent hearings, we were site-visited for a full day on February 27, 1974. The site visit team was composed of high-ranking individuals in four major medical centers. Our records were examined and we were interviewed exhaustively. The results of this review have not been made available to us, however, the report of these consultants may shed light on the true nature of our distress.

In conclusion, reference is made to the recently released Institutional Profile Ranking Report of the Association of American Medical Colleges which provides data for FY72 on sixteen selected school characteristics for all 92 medical schools fully operational at that time. As you can see in Attachment 2, The George Washington University School of Medicine & Health Sciences ranked as follows:

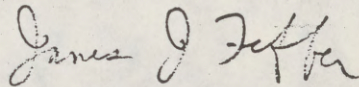
- | | |
|--|------|
| 1. Number of full-time faculty | 76th |
| 2. Student-faculty ratio | 9th |
| 3. Regular operating expenditures
per undergraduate medical student | 92nd |
| 4. Total regular operating expenditures | 91st |

-5-

The financial problems of The George Washington University are not caused by extravagant expenditure rates, but rather by an insufficient income base. In recognition of these facts a number of actions have been taken to correct this shortfall -- not the least of which are the development of a mature Practice Plan; increased Sponsored Program support; and, finally, the efforts to secure the extension of the District of Columbia Medical and Dental Manpower Act of 1970, currently under consideration by the House Committee on the District of Columbia. Without a state-like support supplement, our only alternative is to raise tuition to cover full costs, and this action would have a disastrous effect on our institution.

Your personal support, and the support of the House Committee on the District of Columbia, are vital for our future. We are deeply appreciative.

Sincerely,

A handwritten signature in cursive script, reading "James J. Feffer". The signature is written in dark ink and is positioned above the typed name and title.

James J. Feffer, M.D.
Vice President for Medical Affairs

JJF/jo

Enclosures

THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE
AND HEALTH SCIENCES

OPERATING INCOME AND EXPENSE RESTATED FOR FISCAL YEARS 1970-71 THROUGH 1973-74
BY EXCLUDING THE COSTS OF OPERATING AND MAINTAINING THE PHYSICAL PLANT

	<u>1970-71</u>	<u>1971-72</u>	<u>1972-73</u>	<u>1973-74</u>
Total Income	\$6,921,303	\$7,610,371	\$9,997,603 *	\$10,843,000
Total Expense	9,076,762	9,397,633	11,066,150	12,843,000
Deduct Costs of Operating and Maintaining Plant	<u>(501,770)</u>	<u>(626,534)</u>	<u>(711,204)</u>	<u>(1,712,048)</u>
Adjusted Expense	\$8,574,992	\$8,771,099	\$10,354,946	\$11,130,952)
Adjusted Deficit	(1,653,689)	(1,160,728)	(357,343)	(287,952)
% Deficit to Total Expense Restated	19.3%	13.2%	3.5%	2.6%

* Total recorded income for 1972-73 was \$10,281,217, of which \$283,614 was an extraordinary item related to the recovery of indirect costs on sponsored programs for prior years.

[illegible]

Legend: All Schools

George Washington University (Page 1 3/14/74)



THE
GEORGE
WASHINGTON
UNIVERSITY

Vice President for Medical Affairs / 2300 Eye Street, N.W. / Washington, D.C. 20037 / (202) 331-6241

March 18, 1974

The Honorable Romano L. Mazzoli
Chairman, Subcommittee on Labor, Social Services
and the International Community
Committee on the District of Columbia
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Mazzoli:

In response to a request late last week from your office, we are enclosing a presentation which contrasts the methodologies underlying the recently released Institute of Medicine report on the cost of medical education and those documents previously supplied to your Committee portraying the fiscal situation at The George Washington University School of Medicine and Health Sciences. Calculations are also provided which reconcile the data previously supplied by us and the average medical student instructional cost recently released in the Institute Study.

The enclosed document has been reviewed with Ruth S. Hanft, Study Staff Director of the IOM Study, and she has expressed a willingness to make comments and observations to your staff if you so desire. Ms. Hanft can be reached at 389-6721.

Sincerely,

James J. Feffer, M.D.
Vice President for Medical Affairs

JJF/jo
Enclosure

RECONCILIATION OF THE COST OF MEDICAL STUDENT EDUCATION AS BETWEEN
THE METHODOLOGY EMPLOYED BY THE INSTITUTE OF MEDICINE OF THE
NATIONAL ACADEMY OF SCIENCES AND THE AMOUNTS REPORTED BY THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The income and expenses reported in Exhibit 1, pages 1 and 2, include only those fiscal items actually recorded in the accounts of the School and of its research activities. They do NOT include any items of cost or income included in hospital or clinic accounts. It is a fiduciary accounting report of the School as historically reported and as it is consolidated into the audited financial statements of the University.

The AAMC profile (Exhibit 2) essentially takes the officially reported income and expense of schools of medicine and compares them to national averages on a consistent basis, using certain indexes and ratios (i.e. numbers of students, numbers of faculty) as well as certain nonfiscal data such as MEDCAT scores. The AAMC profile is a comparison of data contained in Exhibit 1.

The report of the Institute of Medicine/National Academy of Sciences* sets out a cost per student based on a consistent methodology using program cost-finding techniques. The cost elements and methodology involved in these techniques are so different from those in Exhibits 1 and 2 as to make any direct comparison between them completely meaningless. For example, the total average educational cost per undergraduate medical student reported in the study (\$12,650; range \$6,900 - \$18,650) includes the incremental teaching costs incurred in the patient-care setting, which are typically recorded in hospital or clinic accounts. It also imputes a medical school facility cost related to depreciation based on acquisition costs (p. 27 of IOM study). Depreciation is not ordinarily recorded in the accounts of a university medical school, and such costs are not included in our audited financial statements nor in Exhibit 1 or 2. Educational costs experienced by medical schools attributable to other health professionals, for example, physician assistants, are not included in the IOM average cost per medical student.

In Exhibits 1 and 2 the full Sponsored Program cost and income are included, while the IOM study includes only those research costs considered (on a judgment basis) necessary for the education of MD's.

It is not our purpose to draw point-by-point comparisons, but generally the IOM study attempts to cost the milieu necessary for medical student education wherever those costs may be found in an academic health care center - at the patient's bed, in the clinic, at the laboratory bench. The IOM study does not confine itself to costs as traditionally recorded in medical school accounts, but rather reassembles those costs, discards some, adds others, allocates resources used in joint product productions, and arrives at an average cost per medical student based on fairly sophisticated and consistently applied program cost-finding techniques.

* Report of a Study - COSTS OF EDUCATION IN THE HEALTH
PROFESSIONS - Parts I and II - January 1974

-2-

The IOM study makes a distinction between educational costs and instructional costs. The average instructional cost for the M.D. degree in the 14 schools studied was \$7,650 (range \$4,000 - \$11,000, Table 39). The IOM study also introduces the concept of net educational expenditure (p.89 of study), which offsets total educational costs with research and patient-care income attributable to the educational program.

Although it would take 4 to 6 weeks to complete a program cost-finding study using the methodologies developed by IOM, assuming staff resources were available, it is possible to approximate the instructional costs of The George Washington University School of Medicine & Health Sciences from the financial data contained in Exhibit 1 for fiscal year 1972-73, which is the year used in the IOM study.

Total Recorded Costs (from Exhibit 1)	\$11,066,150
Deduct:	
Sponsored Research Costs	4,633,985
Service Income (1)	279,038
Income from other than M.D. Students (1)	419,153
Indirect Costs Attributable to Programs other than M.D. Students (see Attachment)	<u>2,045,572</u>
Estimated M.D. Instructional Costs	\$3,688,402
Number of Students	516
Estimated M.D. Instructional Costs per Student	<u>\$7,148</u> (2)
IOM Average	<u>\$7,650</u>

- (1) By assuming that income and expense of these programs are equal, we are blending two related but separate concepts discussed in the IOM study, namely, instructional costs and net educational expenditure.
- (2) The deduced cost above does not include the incremental patient-care costs attributed directly to instructional costs (see discussion on pages 68 and 69 of the IOM study). We do not believe that the inclusion of this cost factor--were it known--would materially affect the M.D. instructional costs at The George Washington University Medical Center.

Attachment forIndirect Costs Attributable to Programs
other than M.D. Students

Although the cost study for the School covering 1972-73 is not yet complete, the preliminary indirect cost pool as determined by principles promulgated under Federal Management Circular 73-8 (formerly Bureau of the Budget Circular A-21) amounts to \$3,071,000. It appears that one method used for allocating indirect costs in some of the 14 schools included in the IOM study was on a total direct cost basis (see page 27 of the study).

Calculation of the Assumed Costs
of other than M.D. Instruction

Sponsored Research	\$4,633,988	
Service Income	279,038	
Income from other than M.D. Students	<u>419,153</u>	\$5,322,176
Indirect Costs		<u>3,071,000</u>
		8,393,176
Total Costs		<u>11,066,150</u>
Deduced Direct Costs of M.D. Instruction equals difference		<u>\$2,672,974</u>

Indirect Cost Attribution to Programs
other than M.D. Instruction

$$\frac{5,332,176}{5,332,176 + 2,672,974} \times (3,071,000) = \$2,045,572$$

THE SCHOOL OF MEDICINE AND HEALTH SCIENCES
SUMMARY OF ACTUAL AND PROJECTED INCOME AND EXPENSE
FISCAL YEARS 1970-71 THROUGH 1976-77

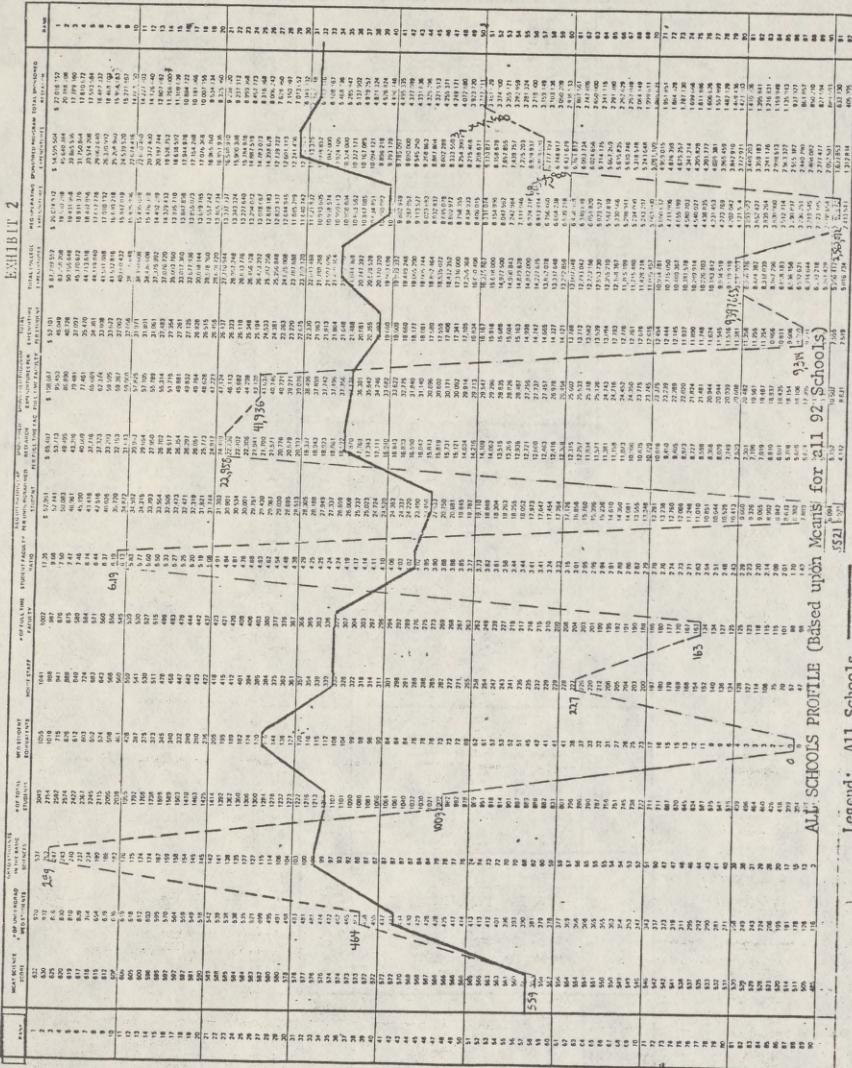
EXHIBIT 1, page 1

Income	1970-71	1971-72	1972-73	Projected 11/1/73			
				1973-74	1974-75	1975-76	1976-77
Tuition and Student Fees							
Medical Student Tuition	\$880,669	\$1,030,162	\$1,375,270	\$1,692,000	\$1,856,000	\$2,100,000	\$2,232,000
Application Fees	86,597	112,325	127,340	132,500	139,000	146,000	151,000
Applied Health - On Campus			80,158	158,000	166,000	174,000	183,000
Allied Health - Off Campus			116,474	205,000	315,000	332,000	347,000
University Tuition Credit	84,834	116,820	168,018	170,000	178,000	187,000	197,000
CGS Off Campus Credit		55,422	54,503	55,000	58,000	61,000	64,000
Endowment Income	149,740	146,009	144,107	145,000	157,000	158,000	159,000
Sponsored Programs							
Direct Costs	4,531,664	4,719,332	4,931,213	5,000,000	5,315,000	5,650,000	6,006,000
Net Indirect Cost Recovery:							
Current Year	583,153	764,584	979,367	1,000,000	1,063,000	1,123,000	1,187,000
Prior Years	161,869	175,873	283,614	450,000	478,000	509,000	539,000
Education and Development Funds			447,985				
Gifts and Other Income							
Annual Support	83,970	67,710	47,881	60,000	70,000	85,000	100,000
Faculty Allocation	187,106	188,288	131,674	189,000	190,000	200,000	210,000
Division of General Medicine	141,335	160,097	279,038	325,000	330,000	350,000	370,000
Miscellaneous	10,366	13,749	67,680	25,000	10,000	15,000	20,000
Federal Capital Grant			911,855	1,047,290	1,141,000	1,173,000	1,173,000
Student Aid			135,040	135,000	136,000	138,000	140,000
Total Income (Before District Grant)	\$6,921,303	\$7,610,371	\$10,281,217	\$10,788,790	\$11,602,000	\$12,400,000	\$13,080,000

Expenses	1970-71	1971-72	1972-73	Projected 11/1/73			
				1973-74	1974-75	1975-76	1976-77
Faculty Salaries	\$2,398,000	\$2,209,460	\$2,706,938	\$3,192,000	\$3,368,000	\$3,553,000	\$3,748,000
Non-academic Salaries	2,528,000	2,431,525	2,901,403	3,209,000	3,385,000	3,554,000	3,732,000
Staff Benefits (Net of Leave Credits)	600,000	525,504	583,943	697,000	735,000	775,000	818,000
Equipment	468,000	741,943	769,158	825,000	875,000	928,000	984,000
Operation and Maintenance of Plant	501,770	626,534	711,204	1,883,000	2,100,000	2,307,000	2,535,000
Other Direct Costs	1,709,690	2,040,381	2,259,901	2,483,000	2,632,000	2,790,000	2,937,000
Medical Center and University Services	871,302	822,316	998,503	1,147,000	1,219,000	1,295,000	1,375,000
Student Aid			135,040	135,000	136,000	138,000	140,000
Total	\$9,076,762	\$9,397,663	\$11,066,150	\$13,571,000	\$14,450,000	\$15,340,000	\$16,289,000
Deficit	\$(2,155,459)	\$(1,787,292)	\$(784,933)	\$(2,782,210)	\$(2,848,000)	\$(2,940,000)	\$(3,209,000)

Distress Grant Received	\$1,900,000	\$2,100,000	\$706,459				
Enrollment	445	464	516	564	580	620	620
Deficit per Medical Student	\$4,844	\$3,852	\$1,521	\$4,933	\$4,910	\$4,742	\$5,176
% of Operating Deficit to Total Expenses	24%	19%	7%	21%	20%	19%	20%

EXHIBIT 2



Dr. ELLIOTT. Perhaps I can address myself to some of the comments which Dr. Edwards made and submitted in his testimony.

Senator TUNNEY. It would be very helpful, because I think when we get around to marking up the legislation, the points that Dr. Edwards made, and your response to those specific points, will have a very important bearing on what happens to this legislation.

FINANCIAL PROBLEMS OF MEDICAL SCHOOLS CONTINUE TO MOUNT

Dr. ELLIOTT. We shall respond. First of all, let me observe that Dr. Edwards and his colleagues certainly gave the implication that many medical centers and medical schools around the country seem to have their financial problems under control.

I would like to dispute that, because it is my impression that even the most highly subsidized, in terms of endowments and so forth, are in trouble, and we are no exception.

Our financial problems continue to mount in the George Washington Medical Center—the medical school. I believe that university presidents who find themselves with medical schools under their administration will pretty well agree with that statement around the country.

I listened to Dr. Edwards's testimony with a certain amount of shock, because I think some of the things said and implied exhibit neither sympathy nor understanding for the problems which we face.

Quite briefly, we are building and have built a good medical center which extends to the community, and the many programs of outreach, critical services, to thousands of Washingtonians, and we have put together a medical education program which he said, as you will recall, was good.

WOULD BE FORCED TO CUT BACK

Now, what we are faced with is maintaining that quality and that outreach. Without this legislation, Senator, we would be forced to cut back both in breadth of outreach and service programs, and in the quality of the programs. This is a conclusion that needs no proof from our point of view.

It will happen unless this legislation is passed.

EXPENDITURES PER STUDENT LOWEST IN COUNTRY

To mention specifically a couple of points: A study conducted by the office itself shows that George Washington University's expenditures per student in the medical school are the lowest of all 92 schools of medicine in the United States.

I believe these figures are for 1972.

From that figure alone, it should be obvious that we have no funds to waste. If we are spending the smallest amount now, how can we do it more efficiently? We do not see how.

Second, and this is a statistic of which we are not necessarily proud, the student-faculty at George Washington is the ninth highest in the United States among the medical schools, which means that per student, there are fewer faculty members, and putting the expenditures at the bottom seems to indicate to us that we are getting as much out of the dollar or more than other medical schools.

STUDENT ENROLLMENT

Senator TUNNEY. How many students do you have in each class?

Dr. ELLIOTT. We are building up to 150. We now have 150 in each entering class. Four years ago, we had less than that, so our total enrollment is just slightly under 600 as of this point.

Senator TUNNEY. And would you have to cut back on that enrollment if you do not receive these funds?

Dr. ELLIOTT. There would be little economy to be gained in cutting back in the numbers.

INCREASE IN TUITION

I would point out, instead, the medical school would lose the tuition of those whom it did not enroll, and our tuition is now \$3,000, scheduled to go to \$3,500 shortly.

You asked Dr. Edwards what would these schools do without these funds. One of the things which we would be forced to consider would be a further increase of tuition of the medical school—at \$3,500, that is pretty high already.

This is the kind of action which we can take only with the greatest reluctance, and as a last choice. We would probably do that rather than see quality erode from that which we have spent so long on, and so hard working to achieve.

Senator TUNNEY. How many students are on scholarships provided by the school?

Dr. ELLIOTT. I do not have the figures in front of me, but at our place, we have very small or limited financial aid funds for medical students.

Senator TUNNEY. So in other words, every time there is an increase in tuition, there is a consequent decrease in the number of students who can afford to go to your institutions?

Dr. ELLIOTT. We are afraid that is true.

With each increase, it eliminates a student from another economic bracket who otherwise is qualified to benefit from a medical education.

SPECIAL INTEREST LEGISLATION

Senator TUNNEY. What about the argument that is made, doctor, that this is in effect special interest legislation. That we are helping two medical schools in a very special way, not helping other medical schools in the same way, and that this is not a good way to organize our medical education in this country through the use of the Federal dollar.

Dr. ELLIOTT. I believe the Secretary's testimony to report completely and fully the support which private medical schools are getting from their respective States, and of course, this legislation asks for that kind of support from the Congress. While he and his associates would not object if this funding came from the District of Columbia government, I would observe that we are in a transitional period, we believe that it will be another 2 or 3 years before the District of Columbia government would be able to assess adequately and fairly our claims to them for such support. In the interim, we believe this legislation is badly needed to carry over these two schools through this period. Let

us assess it in 2 or 3 years again, and see if the District of Columbia government is then in a position to respond in the way that other States are already responding.

Senator TUNNEY. Your argument then is based upon an analysis of what other States are providing to their medical schools—public and private.

Dr. ELLIOTT. Yes; and particularly private.

Senator TUNNEY. The District of Columbia is providing significantly less, and this legislation merely makes up the difference?

CONGRESSIONAL RESPONSIBILITY

Dr. ELLIOTT. Well, of course, the District of Columbia has not had authority or responsibility over its own budget, and, therefore, that being a congressional responsibility, we believe it is perfectly in order for these two universities to come to the Congress to present their case.

In this case, the Congress acting in the place of a State legislature for the purposes of this legislation, we see nothing contradictory in that approach to the Congress.

Senator TUNNEY. Have you, at any time, supplied to this committee, or to the House committee, the differential between the support that the typical private medical school receives from State government in this country, as contrasted to what you believe in the way of public funds from the government of the District of Columbia acting as a funnel for money that is provided by the Congress or by the Congress directly?

Dr. ELLIOTT. At this point, of course, we do not get funds.

Senator TUNNEY. You get no funds at all?

Dr. ELLIOTT. Not for these purposes.

Senator TUNNEY. What about for the other three funding categories?

Dr. ELLIOTT. All of these categories come directly from the Federal Government—those related this morning in the testimony.

Senator TUNNEY. So you get some of these funds?

Dr. ELLIOTT. Yes.

ASKING FOR A FOURTH CATEGORY

Senator TUNNEY. What you are asking for is a fourth category?

Dr. ELLIOTT. Yes; the differential which we do not get is that supplied by the State of New York to its private medical schools, and the State of California for its private schools, and so on around the country.

STATE PROGRAMS

Senator TUNNEY. And have you extrapolated any data from that source material which may be available to indicate what the differential is between what you receive in the way of assistance per student?

Dr. ELLIOTT. Senator, these figures have been supplied. They are available. I would point out simply they range all the way from two States that give nothing to their private medical schools to the State of Texas which gives, as I recall, \$15,000 or \$16,000 per year per student

to the private medical school or schools in Texas, and the others are in between.

Senator TUNNEY. What does California do?

Dr. ELLIOTT. I should know that.

Reverend COLLINS. If I may answer that, Senator Tunney, California has a program of \$12,000 per student for an increase of student body in the private school.

That is the specific program in California. That is the present program, the legislation itself is being considered to amplify and broaden it.

The first step has been made.

Senator TUNNEY. Does that apply to all students, or just the residents of the State?

Reverend COLLINS. Just to the residents of the State. However, the State residency program, because of the change of law, enables the student to go in a senior year to a school in California, and qualify under that as a resident. A senior therefore can come into the private medical school with a \$12,000 subsidy to the medical school.

This in summary to your question, we have submitted, and will submit for the record the average support given by States to private medical schools across the Nation is greater than the support we are asking of you as our State legislature.

Senator TUNNEY. And that has been supplied?

Dr. ELLIOTT. It has.

Senator TUNNEY. That has been supplied to this committee?

Dr. ELLIOTT. It has.

Dr. Ball has an item of information.

RESIDENCY REQUIREMENT

Dr. BALL. In the Journal of the Association of American Medical Colleges we published an analysis of how the various States support the schools, and what Father said is correct. But the way we interpret it is that residency in the State is not a prerequisite for this particular kind of support for the schools, for the reasons stated, it is a very open phraseology.

You can qualify for residency with a minimal period of time in the State.

Senator TUNNEY. What about the money you will be receiving under this legislation if it passes?

Do you get this assistance irrespective of whether the student is a resident of the District of Columbia or not?

Dr. ELLIOTT. This certainly is one of the peculiarities of the school. The schools are local, in the sense that we provide broad programs that reach thousands of citizens of the District, of adjacent Maryland, adjacent Virginia, but we have also over the years, the decades, accepted students from all over the country, and from foreign countries as well. So in that sense, we play a dual role, we are local and we are a national institution, and this becomes, in our view, a national resource—a medical school with national responsibilities, as well as local responsibilities.

OUTREACH OF MEDICAL SERVICES

Senator TUNNEY. Besides providing medical services to the Members and the families of Congressmen, do you provide medical services for residents of other States, mainly Maryland and Virginia, in addition to the residents of the District of Columbia?

Dr. ELLIOTT. Well, of the living alumni of the George Washington University Medical School, 434 now live in the District of Columbia, 374 in Maryland, 204 in Virginia, and our educational and health care progress through hospital affiliations are shared with Children's Hospital, Columbia, District of Columbia General, Fairfax, Holy Cross, Naval Hospital, St. Elizabeths, the Veterans' Administration, and the Washington Hospital Center.

In addition, we serve the local area with a health maintenance organization, which is now 2 years old, that takes care of all residents of that area of the city, without regard to their economic status.

Yes; our outreach is into Virginia, Maryland, as well as the District of Columbia.

REDUCTION OF SERVICES

Senator TUNNEY. Would you have to cut down on these community services, if you do not receive these funds, and would you have to cut down on such services as emergency care?

Dr. ELLIOTT. I could not say how soon we would have to cut back on what particular services, but in due time this kind of limitation would require us to cut back on nearly every program we are engaged in.

Senator TUNNEY. Including emergency care?

Dr. ELLIOTT. I would have to ask the dean of clinical services at the hospital, how this would affect that particular activity, but certainly we would have fewer staff on whom to call to perform such a service.

Dr. McNULTY. I believe I could speak for Georgetown.

I think Dr. Elliott hit the key point, that is, as the funds are reduced, the only way to reduce the program, 80 percent of expenditure is people, is talent, if the funding available for that talent is reduced, one reduces the talent, as the talent is unavailable, then it becomes less of a service capability for the hospital and the university, for the emergency department that it runs, and for other functions in which it is providing community services.

In our instance, at Georgetown, we have a heavy commitment to the District of Columbia General, and we intend in every way possible to continue that commitment. It is over decades, but every time we are placed in the role of further and further reduction, it becomes a jeopardy type of situation in which we are not always able to do what we want to do in terms of our extension, support, and collaboration of District of Columbia General operations. This is just one example.

Dr. ELLIOTT. To put it in another perspective, Mr. Chairman, we anticipate that if this legislation is passed, and fully appropriated, fully funded, that George Washington would receive \$2 million to \$3 million maximum in each of the years covered by the legislation.

The total budget of our medical center this next year will be over \$50 million. I do not know what these other institutions are doing, how they are going to continue to finance the rest of that, but we are leaving no stone unturned to continue on a path which we have staked out, and that is a better health service program, and a better medical education program.

Now, obviously, \$2 million to \$3 million cutting into a budget of \$50 million will not close the door tomorrow morning, but it will gradually erode the quality of what we are doing, because it does represent 5 percent or 6 percent of the total operating budget. We are confronted, as are others, with this onrushing case of inflation, and the moving costs of health care.

To be struck doubly without these funds, and to face the continued inflation, would make our erosion much more rapid. We think we would be in an untenable situation.

WAIT-AND-SEE POLICY

Senator TUNNEY. Do you feel the argument that Dr. Edwards made—that we ought to take a look at the overall medical education nationally before we start spending additional Federal dollars, and that we ought to have a detailed analysis as to how those moneys could be used—is a faulty argument?

Dr. ELLIOTT. Let me put it into my own words, if I may.

When we made the case for the original legislation, the representatives of HEW sat here in the Halls of Congress and said:

We oppose this legislation because we have this study underway. This comprehensive study of medical education costs on health care will be completed within the next 12 months, that is underway, and then we will know what kind of legislation should be passed for all of the medical centers of the country.

Senator, we have not seen that definitive study as yet.

Senator TUNNEY. How long ago was that?

Dr. ELLIOTT. That was in 1971. We have not seen it, and we have not seen anything as to give us any information or any guidance as to how we might better manage our own centers. It speaks for itself.

Senator TUNNEY. So you feel there is some holding action there?

Dr. ELLIOTT. I would not want to speculate on the why, but all I am saying is that the results have not appeared.

Senator TUNNEY. Does anyone else wish to speak?

I directed most of my questions to Dr. Elliott.

Does anyone else have anything they want to say?

Dr. McNULTY. If Dr. Elliott has completed, I would like to first express the apologies of our president.

I think his absence is somewhat appropriate to our meeting. He is out fundraising today. He had a commitment with a potential donor, an out-of-town donor. He spent 6 months trying to get it—he does not want to try another 6 months to get it.

I say that with greatest of sincerity.

I do appreciate the privilege of submitting our prepared testimony.

Senator TUNNEY. They will be included in the record.

[The prepared statements from Georgetown University follow:]

TESTIMONY
HEARING BEFORE THE
SUBCOMMITTEE ON PUBLIC HEALTH, EDUCATION,
WELFARE, AND SAFETY
COMMITTEE ON THE DISTRICT OF COLUMBIA
UNITED STATES SENATE
93rd CONGRESS, SECOND SESSION
ON
S. 2730
MAY 1, 1974

Mr. Chairman and the members of this Subcommittee, I am Matthew F. McNulty, Jr., Sc.D., Executive Vice President for Medical Center Affairs, at Georgetown University. I appreciate the privilege of appearing before you today to extend the testimony that our University Presidents have just prepared.

My purpose today is threefold:

1. To outline briefly some background with regard to the bill under discussion today; and
2. To describe briefly the irreplaceable service that the Medical School of George Washington University and the Medical and Dental Schools of Georgetown University provide to the District of Columbia, to the metropolitan area of Washington, D.C. and to the nation; and
3. To present briefly an overview of the continuing fiscal problems that in recent years have continually threatened the successful accomplishment of the medical and dental educational, patient service and research responsibilities of these three schools.

Deans of each of the three schools, leaders of national and professional organizations, and community representatives will present more specific information.

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Since the formation of the School of Medicine in 1851 and the School of Dentistry in 1901, Georgetown University Medical Center has developed a national and international reputation of excellence in both health science education and service. Our student body has both a national and regional character and our graduates in addition to their high concentration in the District of Columbia metropolitan area are practicing in every state in the nation.

The excellent reputations of the two schools are confirmed by the ever increasing number of applicants for admission. For the School of Medicine class entering in 1971, there were over 5,000 applications for the 205 places. This was the largest number of applications ever received by an American medical school. For the class entering in September, 1973, the number of applications rose to over 7,500. A similar phenomenon has occurred in the School of Dentistry.

For the past several years Georgetown University Schools of Medicine and Dentistry have been operating on the brink of financial disaster. The reasons for this will be dealt with in more detail later. The two schools have reduced costs to an absolute minimum. The success of these cost reduction efforts has recently been confirmed by two external sources to which I would like to draw your attention.

I believe that a single document can best demonstrate the effectiveness of the management of the Georgetown University Schools of Medicine and Dentistry. In that regard the AAMC has developed an Institutional Profile System to serve as a comprehensive data base describing each of 92 fully activated and functioning medical schools. The current report of that program was issued on February 7, 1974. It is included as Exhibit I to the testimony.

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The attached graphic profile from the AAMC indicates two essential criteria. In the scores obtained by applicants for schools of medicine admitted to Georgetown under the medical application testing science score program, Georgetown student applicants scored in the top 16 of the 92 medical schools in this country. In the expenditure for undergraduate medical school per year, Georgetown was 90th from the top in expenditure per medical student. In other words, in the quality of students as measured by the MCAT, Georgetown University students were in the top 16 schools in the country; in the expenditure per student, Georgetown was two from last in the country.

Another more recent measurement is the letter from the Department of HEW through the Philadelphia Region III Office dated April 2, 1974. That letter denied distress funding to the Schools of Medicine and Dentistry. However, the letter in speaking of the decision of the National Advisory Council on Health Professions Education to deny distress funding for FY 1974 indicated the need for having a permanent solution to meeting the deficits of the two schools.

The letter of denial from DHEW indicates, "Council acknowledged that the school has recently set in motion several management improvement steps and has strong and capable executive leadership." (underscoring supplied) This letter indicating both the need for a regular source of financial support other than distress funding and the effective management of Georgetown University Medical Center was based on the recommendations of a site visit team comprised of four nationally recognized experts on medical center operations.

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It is with reference to the recommendation for a regular source of financial support by this team of national experts that we come before you today to urge your favorable consideration of S.2730, a bill to extend Title III of P.L. 91-650, the District of Columbia Manpower Act of 1970.

Through P.L. 91-650 your Committee initiated a per student capitation award public policy for medical, dental, and other health science education. Prior to your enactment of P.L. 91-650, Gentlemen, there were not any national student capitation award programs. Subsequent to your action the Congress enacted P.L. 92-157, "The Comprehensive Health Manpower Training Act of 1971 (HMTA)."

That national legislation (P.L. 92-157 HMTA) expires June 30, 1974. Under the provisions of that law, federal "capitation grants" have been awarded annually to improve the quality of schools of medicine, dentistry, osteopathy, veterinary medicine, optometry, pharmacy, and podiatry. Concurrently, all "public" medical schools receive state support. For "private" medical schools, 19 out of the 21 states having these private medical schools support those schools with some form of state financial assistance.

It is significant to our appeal today to note that the Department of Health, Education, and Welfare and the Executive Branch are on record as encouraging the greater financing of medical and dental education by state governments. Essentially our appeal to this Committee today is for an extension of state-like support authorization - "The District of Columbia Medical/Dental Manpower Act" originally of 1970.

Assisted by the existence of your D.C. Medical/Dental Manpower Act (P.L. 91-650) and the intent of Congress which it represents, the three schools of our two Universities received Federal "financial distress awards" from the Department of Health, Education, and Welfare for the 1971, 1972, and 1973 fiscal years.

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The distress award feature of the national HMTA program was for a limited three-year period (1971-1974). Without this or equivalent assistance, these three D.C. schools could not have continued to provide the levels of education and patient care which has so benefited the community of the District of Columbia, the metropolitan area and the nation. With the "financial distress award" feature of the national HMTA expiring June 30, 1974, the extension of the D.C. Manpower Act is essential to the continued significant local and regional contribution these schools make to the health problems of society.

At the current time, as stated above, a clear majority of private universities are receiving from their state legislatures, financial support for their medical and dental schools. Without such support it would not be possible for them to survive, and the health of the nation would be placed in jeopardy by an acute shortage of the necessary health manpower.

Since the original enactment of the D.C. Manpower Act (P.L. 91-650), it is encouraging to report that there has begun a rationalization of financing for medical and dental education in our country. It is now possible to perceive a public policy that recognizes at least a five-fold fiscal responsibility for the operation of medical and dental schools. These five concurrent methods for operational resources include a federal responsibility, a state responsibility, a student responsibility, an institutional responsibility, and a research responsibility - the latter commonly called "Sponsored Program Support."

This five-fold responsibility is further recognized and supported by a recent study conducted by the Institute of Medicine on behalf of the National Academy of Sciences, and funded under contract with DHEW to determine the costs of educating students in eight different health science professions. The report of this study which bears the title "Report of a Study: Costs of Education in the Health Professions", Parts I and II was submitted to Congress on February 26, 1974.

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It is a major recommendation of the Institute of Medicine study that health professions education be funded from a combination of income from the following sources: (1) Tuition, (2) Gifts, (3) State Support, and (4) a federal capitation award program. This recommendation is the result of the study of an independent body, which has had the opportunity to review in depth the financial operations of both public and private schools of medicine and dentistry in all areas of the nation, and supports our contention that some form of state-aid is essential to private health science centers in addition to continued federal support in terms of capitation.

I have already commented on the National Health Manpower Act (P.L. 92-157). Unfortunately, for the several years of its existence, the level of that support did not approach in any way the basic need. The Association of American Medical Colleges recommended that the minimum capitation payment from this national program be \$5,000. The Carnegie Commission on Higher Education recommended \$4,000 per student. The recent Institute of Medicine study described above, recommends a level of capitation at between 20 and 40 percent of the net average annual cost of education. (Net education costs refer to the cost of education less the income received from research and patient care activities). Capitation funded at 25 percent would amount to \$2,450 per medical student and \$1,850 per dental student. Capitation funded at 40 percent would result in \$3,900 per medical student and \$2,950 per dental student in terms of 1972-1973 expenditures. The authorizing legislation of this P.L. 92-157 provided for \$2,500 per student. The appropriation authorized only approximately \$1,700 per student grant.

Related to this request for state-like support, and to the efforts of the Schools of Medicine and Dentistry at Georgetown University to cut costs, it is desirable to emphasize the results of a recent study by the Committee on the Financing of Medical Education of the Association of American Medical Colleges (AAMC).

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That study demonstrated from twelve (12) thoroughly evaluated medical schools operational models a cost of undergraduate medical education ranging from a minimum of \$16,000 per student per annum to \$26,000 per student per annum.

Georgetown University School of Medicine participated in the study mentioned. The cost of undergraduate medical education at Georgetown University was eleventh (11th) from the top of those 12 schools. In other words, we were next to last in a study of operational resources expended by 12 prototype schools across the country for undergraduate medical education. Yet, underfinanced as they are, Georgetown University Schools of Medicine and Dentistry are a major educational and service resource to the District of Columbia.

The District of Columbia Government authorized a comprehensive plan for public higher education in the District of Columbia. A summary report of the study was completed in December, 1972. Three pages of that report have been abstracted as Exhibit II for this testimony. For the need of professional education in the District of Columbia, this comprehensive D.C. plan for higher education reported "...we do not propose the establishment of new professional schools of medicine, dentistry...".

In other words, it is essential that quality professional education for physicians and dentists continue to be rendered by the three private universities in the District of Columbia. One such higher education institution, Howard University, is already supported through Federal appropriations. Such support assists in the financing of the health science professional schools of that University.

It is notable that the report prepared for the District of Columbia government indicates also "And since medical and dental schools are exceedingly expensive to establish and operate...".

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The deans of the schools of medicine and dentistry and Father Henle, the University President, will describe in more specific detail in their testimony the essentiality of the service rendered to the District of Columbia and the Washington Metropolitan Area by these three schools. I will stress only the vital service delivered to the less fortunate residents of the District of Columbia through Georgetown's programs at D.C. General Hospital and the Community Health Center in the Edgewood Terrace area of N.E. Washington.

At D.C. General Hospital the Schools of Medicine and Dentistry perform a vital service to the community. The School of Dentistry, for example, provides its services without cost to the indigent patients. An oral surgery service, as well as treatment for oral infections and extractions is included. An oral surgery intern or resident is on duty in the hospital emergency room twenty-four hours a day, 365 days a year to handle this service.

The School of Medicine is involved in the day-to-day functioning of the hospital. Its faculty, physicians, residents and students are participants. The University provides services in both medicine and surgery and their subspecialties. The staff is also responsible for the graduate training program. Technicians man the laboratories and are paid for by grant monies from Georgetown. Georgetown's only compensation from D.C. General for service provided is that the space used for research and service is received free.

At the Community Health Center in Edgewood Terrace, Georgetown faculty and staff offer a full range of health services to area residents either on a prepayment or on a fee-for-service basis. The Center is the recipient of a Family Health Center Grant which enables it to provide comprehensive medical care to 3,000 medical indigents (that is, persons whose annual income is too great to qualify them for Medicaid, but is less than \$7,000). Sixteen

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hundred persons are currently enrolled in this program, which is the only one of its type in the District of Columbia. In addition, the center under and agreement with the Department of Human Resources enrolls Medicaid beneficiaries on a prepayment basis.

Faculty, staff, students, alumni, friends and administration at Georgetown University are tremendously proud of the health science education, patient care and research contribution made by our medical and dental schools over almost 125 years. We do not want to be and do not intend to be first in the expenditure of funds. However, we believe strongly that the significance of our contribution to the citizens of the District of Columbia, the metropolitan area and the nation warrants a state-like support of a level higher than next to last!

A brief comment on medical and dental education financial support obtained from the several sources of tuition payments; institutional fund raising and funds for research for new knowledge and expansion of existing knowledge. The 3 schools have now for 1974-75 extended even further the tuition rates, the fund raising efforts, the successful solicitation of foundations, corporations, alumni, faculty, and friends, much beyond that reported to this Committee upon the initial hearings in 1970 for the bills that eventually became P.L. 91-650. Every possible avenue of tuition income, fund raising income and research income has been exhaustively searched.

The tuition range to students for our three schools now ranks among the highest in the country. The parent university and these schools have accomplished effective internal economies and effectiveness in organization and management to realize the greatest production of educational endeavors from a minimum of resources.

As evident of stringent internal management, combined with the seeking and obtaining of financial resources from multiple sources, we emphasize that the amount of funding requested per student in these two Bills for George Washington and Georgetown Universities is no more than the initial law (P.L. 91-650) established in 1970 for a then fiscal climate which has escalated rapidly in the last four years.

Under the original P.L. 91-650 there was a maximum limit of appropriation for the first year of \$6,200.00. Despite inflation, that limit continues to be our recommendation. The capitation ceiling of up to \$5,000 per medical student and up to \$3,000 per dental student is also recommended without increase.

Measured against the \$17,282 per medical student per year for FY 1973 appropriated by the Texas legislature for a private medical school or the more modest \$7,000 per medical student per year by Illinois, \$7,500 by Delaware or \$6,500 by Florida, a ceiling of \$5,000 per medical student and \$3,000 per dental student is a conservative request.

To avoid any misunderstanding of program, I should emphasize that both Georgetown University and George Washington University operate University Hospitals and HMO programs. However, these patient care endeavors are either separate corporations, or, operated as distinct fiscal entities with independent accounting records, income and expense transactions, et cetera, entirely separate from the educational activities of the schools of medicine and dentistry. Neither are we discussing here any funding for University Hospitals. They, too, operate entirely separate from the Schools of Medicine and Dentistry.

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The precedent for state-like support to medical and dental education in the District of Columbia already exists. As mentioned earlier, Howard University, a private institution, receives funding from the Congress through the Department of Health, Education and Welfare. These funds assist materially in the support of its health science educational programs. The Vice President for Health Affairs, Howard University, has understood what Georgetown and George Washington Universities are striving to accomplish through S. 2730 before you today. Dr. Alexis has expressed that support in a letter of January 2, 1974. He has given his approval for including that letter as a matter of record for the consideration of this Committee. With your permission, Mr. Chairman, I would like to file that letter as part of this testimony (Exhibit III).

The previous Act (P.L. 91-650) and the extension S. 2730 now being requested, require that both Universities submit formalized applications, supported by fully developed cost analysis and verified by independent audit statements of certified public accounting firms. In other words, if P.L. 91-650 is extended as requested here today, financial awards would be fully authorized only on documented, independently audited fiscal reports.

Gentlemen, the need for this support is real; it is immediate. The need continues as essential to the continued level of contribution of our Schools of Medicine and the School of Dentistry. The record of frugality of operation as established by independent assessment is clear and compelling. We recommend an extension of the existing legislation which is consistent with the experience of a clear majority at other private universities in obtaining from their state legislatures, financial support for their medical and dental schools.

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We urge your thoughtful consideration and full support for meeting these needs.

I would be pleased to answer any questions, Mr. Chairman, Also, I sincerely thank you and the Committee for the opportunity of presenting this testimony in support of S. 2730.

- Exhibit I: AAMC - "Institutional Profile Ranking Report", February, 1974.
- Exhibit II: Three-page abstract from "A Comprehensive Plan for Public Higher Education in the District of Columbia," Summary Report of a Study for the District of Columbia, Arthur D. Little, Inc., December, 1972, pp. 22-23.
- Exhibit III: Letter dated January 2, 1974, from Carlton P. Alexis, M.D., Vice President for Health Affairs, Howard University.

expressed student interest in them. Often the existence of manpower needs affects student interests and aspirations, as students become aware of employment opportunities. Sometimes, however, programs based upon known manpower requirements generate little interest among students.

Nevertheless, we believe that an education program related to jobs expected to be open in large numbers and desired by a significant number of students should be instituted; the odds are that it will attract students, and will enable those students to obtain such employment. In formulating recommendations for education programs for the institutions of public higher education in Washington, D.C., we considered both forecast manpower needs and student aspirations.

Arthur D. Little, Inc., forecast manpower requirements in the Washington Standard Metropolitan Statistical Area (SMSA) for 1975, 1980, 1985. Then to determine the share of those manpower requirements that might appropriately be filled by District residents, it was assumed that the District share would be proportionately equal to the ratio of the number of District residents to the total population of the SMSA. For occupations generally requiring some post-secondary education, Table 3 shows the forecast of annual District demand by target years. These estimates include the number of new people needed in these occupations in given years to meet growth needs plus replacement needs.

Professional Schools of Medicine, Dentistry and Law

While we recommend the establishment of four institutions with differentiated roles and a number of professional and graduate programs within those institutions, we do not propose the establishment of new professional schools of medicine, dentistry and law. This is, of course, an important policy issue with significant educational, public service, and cost implications. As such, it is an issue for the Board to address, and, as with all such issues, its ultimate disposition probably will rest with funding sources.

It is true that the absence of medical, dental and law schools limits the comprehensiveness of the recommended public higher education system. But we believe from interviews with officials in non-public universities and Federal and District government agencies that opportunities exist to accommodate substantial numbers of District residents and graduates of public institutions' pre-professional programs in cooperative arrangements and consortium programs with the several professional schools of the District's non-public universities. (We estimate that 85 percent of the District's annual demand for lawyers could be supplied by graduates of those law schools who elect to remain in the District.) And since medical and dental schools are exceedingly expensive to establish and operate, this would enable the District to maximize benefits to its residents within the limits of available resources, an important thrust of the recommended mission statement for the District's public higher education system.

TABLE 3

FORECASTS OF ANNUAL OCCUPATIONAL DEMAND BY
TARGET YEARS, FOR OCCUPATIONS RELATED TO
HIGHER EDUCATION, DISTRICT OF COLUMBIA,
1975-1985

	Total Demand		
	1975	1980	1985
Business, Management & Commerce Occupations	5,800	6,528	7,525
A. Secretarial	2,036	2,357	2,876
B. Accounting	394	431	490
C. Personal Services	205	241	299
D. Marketing, Purchasing, Distribution, Business & Industrial Mgmt.	65	74	89
E. Graphic Arts	63	61	59
F. Other	3,037	3,361	3,812
Data Processing Occupations	247	340	483
Engineering & Engineering and Mechanical Technical Occupations	1,950	2,457	2,966
A. Engineering	580	893	1,064
B. Aeronautical & Aviation Technician	42	39	37
C. Electronics & Machine Technician	89	101	123
D. Mechanical Technician	82	82	89
E. Others	1,157	1,342	1,653
Health Professions, Health Services & Paramedical Occupations	1,279	1,667	2,220
A. Physicians & Surgeons	129	165	207
B. Dentists	38	47	53
C. Pharmacists	41	42	44
D. Psychologists	13	16	20
E. Osteopaths	7	9	11
F. Optometrists	6	7	10
G. Nurses, Professional	384	492	630
H. Nurses, Practical	218	301	447
I. Medical & Dental Technicians	242	334	489
J. Other Medical and Health	201	254	317
Public Service Occupations	309	340	387
Professional Occupations, Except Health Business Engineering	1,804	1,969	2,187
A. Social Scientists	275	303	351
B. Natural Scientists	410	448	509
C. Education	583	666	735
D. Other Professional	536	554	592
Other Professional, Technical & Kindred Occupations	712	863	1,115
Occupations Not Elsewhere Classified	712	863	1,115
Grand Total	12,101	14,161	16,991

**A COMPREHENSIVE PLAN
FOR PUBLIC HIGHER EDUCATION
IN THE
DISTRICT OF COLUMBIA.**

**SUMMARY REPORT
of a study for the
DISTRICT OF COLUMBIA GOVERNMENT**

**Project completed
December, 1972
Arthur D. Little, Inc.**

**This project was supported in whole or in part by
a comprehensive planning grant awarded under
Title I of the Higher Education Facilities Act, as
amended, from the Division of Academic Facilities
of the U. S. Office of Education.**

Arthur D. Little, Inc.

**SUBCONTRACTORS:
Dudley W. Gill and Associates
The BLK Group, Inc.**

HOWARD UNIVERSITY
WASHINGTON, D. C. 20001

OFFICE OF THE VICE PRESIDENT
FOR HEALTH AFFAIRS

January 2, 1974

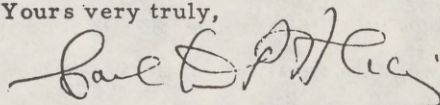
Matthew F. McNulty, Jr., Sc.D.
Executive Vice President for Medical
Center Affairs
Georgetown University Medical Center
Washington, D. C. 20007

Dear Dr. McNulty:

As per our recent conversation, please
be certain of my continued personal support of
Georgetown in its effort to obtain sounder funding.
Howard does not have a position on this matter,
and as such I cannot at this time speak for the
University.

I wish you much success.

Yours very truly,



Carlton P. Alexis, M.D.
Vice President for Health Affairs

CPA:obs



GEORGETOWN UNIVERSITY
WASHINGTON, D. C. 20007

OFFICE OF THE PRESIDENT

TESTIMONY
HEARING BEFORE THE
SUBCOMMITTEE ON PUBLIC HEALTH, EDUCATION,
WELFARE, AND SAFETY
COMMITTEE ON THE DISTRICT OF COLUMBIA
UNITED STATES SENATE
93rd CONGRESS, SECOND SESSION
ON
S. 2730
MAY 1, 1974

Mr. Chairman and Members of this Committee:

I am Robert J. Henle of the Society of Jesus, the President of Georgetown University. I have a brief statement on S 2730, a bill to extend for three years the District of Columbia Medical and Dental Manpower Act of 1970.

Georgetown University is in a dilemma over the financial position of our Medical and Dental Schools. The reputation of these Schools is on a definite ascendancy as is evidenced by the nationwide volume of applications on the part of students and faculty. We have substantially increased the student bodies of both Schools as our contribution to the shortage of medical and dental manpower in the Nation as well as in the District of Columbia with its metropolitan area. There are over 10,000 physician graduates from the Schools at George Washington University and Georgetown University in practice throughout the country, as shown on attached Exhibit.

At the same time, despite our diligent efforts to raise monies for the support of the operational costs of these Schools, the Georgetown University Medical and Dental Schools had an operational deficit in the year 1972-1973 of about three million dollars. The same range of deficit is occurring this present year.

Due to the enactment by Congress of The District of Columbia Medical and Dental Manpower Act of 1970, the Secretary of Health, Education and Welfare met the deficits of the past years and we are in process of applying for this year's deficit.

Medical and Dental School education is the most expensive individual education cost at our University. This is true of the Medical and Dental Schools across the country.

We are making every effort to keep these costs in line and have been reasonably successful. The Deans of our Schools will show this in detail in the financial statements they present.

Georgetown University does not have the financial capability from its private funds to underwrite these losses.

Why do we ask your help in meeting our problem? Private Medical and Dental Schools throughout the country have received funds from the State legislatures to meet the same problem. Experts in these fields will testify in detail on this point.

Georgetown University's Medical Center is engaged in many medical service programs that are critical to the health care system of the Metropolitan area. I point out specifically on the attached Exhibit "Community Involvement by Georgetown University Schools of Medicine and Dentistry" the programs at our own hospital with its outpatient clinic, the P Street Clinic run by Georgetown and the program at the D. C. General Hospital with our essential medical manpower service to its Departments of Medicine and Surgery. All of these area health services come from our having Medical and Dental Schools.

In summary: Georgetown University, despite all its efforts to meet the costs of medical and dental education from tuition, private grants and from national health legislation, cannot meet these costs without the continuation of the District of Columbia Medical and Dental Manpower Act of 1970.

What if we do not obtain these funds? At best, our medical and dental educational programs will deteriorate, our services to the District and the Metropolitan area of Washington will be curtailed and reduced in quality; at worst, we will have to progressively and finally close out most of our medical center

operations, thereby seriously injuring health education and services both nationally and locally.

THE CONTRIBUTIONS OF
GEORGETOWN UNIVERSITY MEDICAL CENTER
TO THE HEALTH AND WELFARE OF THE
WASHINGTON METROPOLITAN COMMUNITY

October, 1973

There are several categories of programs through which the services, facilities, faculty and students of the Georgetown University Medical Center contribute significantly to the health and welfare of the community in the Washington metropolitan area. These include:

- A. Information to the Public
- B. Educational Opportunities
- C. Medical and Dental Services

A. INFORMATION TO THE PUBLIC

1. "Opinion Line" is broadcast over radio station WUST. Faculty members of the Schools of Medicine and Dentistry participate on the program. The faculty discuss a topic in their respective fields, then answer questions from listeners. Station WUST offers the University an opportunity to perform an important service for the predominantly black listening audience in Washington's inner city, as well as providing an important community service.
2. Through the Speakers Bureau, the University brings its faculty and staff one step closer to the community through its more than 300 talks scheduled annually. There are approximately 53 speakers in this volunteer service who are faculty members or students in the Schools of Medicine and Dentistry. They speak not only on areas of their expertise, but are available to talk on career opportunities in their fields. The latter topic is especially popular in high schools.

B. EDUCATIONAL OPPORTUNITIES

1. Health Professions Seminar Program for Local Minority High School Students

Twice yearly, groups of minority high school students, primarily from the Washington, D.C. public school system, attend two series of five all-day sessions, each related to the medical sciences, emphasizing medical and paramedical career opportunities. In addition, nursing faculty work with juniors in area high schools introducing them to levels of nursing practice, educational opportunities in the Washington, D.C. area and the advantages/disadvantages of each.

2. Explorer Post of Boy Scouts of America, National Capital Area Council Program

The program provides the participants with an overview of the services offered at the Georgetown School of Medicine and the Medical Center. It is open to all 14-18 year olds in Washington, Virginia and Maryland high schools. The students attend demonstrations of clinical facilities associated with such departments as orthopedics, surgery, physical medicine, rehabilitation, and ophthalmology. This is the only program of its kind offered by local area medical schools.

3. Community Scholars Program

Special courses are provided to strengthen the students drawn from low-income families, who are interested in pre-medical and pre-nursing programs. The courses are selected from those judged to be critical to the students' success during their first academic year, i.e., biology, chemistry, et cetera.

4. Human Biology Program for High School Students

The program is designed to enrich the academic levels of high school students in the District of Columbia in the area of human biology; to motivate them to achieve higher academic levels in their studies; to introduce them to careers in medicine; and to provide counseling that enables them to understand better the relationship of medicine to themselves and to their community. It is assumed that a by-product of this program should be the dissemination of information by discussion of the program between participants and their classmates. The program is conducted largely by students of the School of Medicine, although the faculty acts in a counseling and supervisory role.

5. Continuing Education Programs for Graduate Physicians, Dentists and Nurses

The Schools of Medicine, Dentistry and Nursing conduct programs designed to provide continuing education for people employed in health services. The School of Medicine, for example, conducts the Thursday Night Medical-Surgical Cardiovascular Conference. It is attended by about 200 graduate physicians and students weekly. Heart specialists, using patients for demonstration purposes, instruct in the diagnosis and treatment of complicated cardio-vascular problems.

The School of Dentistry offers 8-12 courses of 2-3 days duration for dentists and dental assistants. Participants come from a wide area, including the District of Columbia.

In Nursing, where continuing education is likely to become a requirement for annual licensure renewal, the School offers summer and evening courses for area practitioners and educators.

6. Nurse Midwifery

In cooperation with the D.C. Department of Human Resources and the D.C. General Hospital, the School of Nursing is offering an educational program in nurse midwifery for area nurses wishing preparation in this extended role. The intention to practice in the District of Columbia is a requirement for admission, and preference is extended to personnel of the Department of Human Resources.

C. MEDICAL - DENTAL SERVICES

1. University Affiliated Center for Child Development

A multi-disciplinary training center, dealing with mental retardation and related handicapping conditions in children, includes in its three-fold purposes that of "serving the metropolitan Washington community by providing exemplary settings for the care of handicapped children." Additional programs at the training center include dental evaluation and care provided by Georgetown School of Dentistry.

2. The Area A Community Mental Health Center

The Area A Community Mental Health Center serves one of the four geographic areas of the District of Columbia and is sponsored jointly by the Georgetown Department of Psychiatry and the D.C. Department of Human Resources. Comprehensive mental health services are provided for 140,000 people of varied socioeconomic levels. The bulk of the emergency and outpatient services is provided at Georgetown University Hospital. The Day Hospital, located in the Georgetown area, has an average of 35 patients in active treatment. The Youth Services facility, which is one block from Georgetown Hospital, includes a day treatment school, outpatient diagnostic and treatment services, a drug clinic, and school consultation services. In addition, the Center operates two satellite clinics in the area. The psychiatric staff of the Center hold Georgetown faculty appointments. Many attending faculty also teach and supervise the residents and students assigned to the Center. Georgetown residents are assigned to all components of the Center; and a major portion of our residency training is centered within the Area A program both in the community and at Georgetown University Hospital.

Medical students are also assigned to most of these components. In addition, 6 third year psychiatric residents provide weekly consultation to the Social Rehabilitation Administration (Welfare Department) of the District of Columbia. Residents are also consulting with the police, a half-way house, and Regency House within the District of Columbia.

3. Children's Kidney Disease Prevention Center

The Pediatrics Department, in collaboration with the Division of Urology, operates a screening and diagnostic program for kidney disease for all children in the Washington metropolitan area.

4. Psychiatric Walk-In Clinic

Designed to provide "immediate attention to those in crisis", this clinic is staffed by faculty, social workers, residents and students of the Medical Center. It is the only one of its kind in the District of Columbia. A fee of \$10 is charged for initial interview and assistance if the patient can pay. Referrals are made when appropriate. Seventy-five percent of the patients are residents of the District of Columbia.

5. Home Care Program for Cancer Patients

A team of physician, nurse and social worker from the Medical Center cares for the advanced cancer patient in his home, thus enabling the patient to be with his family. No charges are made to the patient for these services. 2960 days of home care were provided last year.

6. Hypertension Program

This program takes medicine to the people in Washington's inner city.

Patients were screened for high blood pressure without cost at block parties, in grocery stores, churches and community centers by physicians and students. In a recent program, more than 3,000 persons were screened. Follow-up treatment is being given on a private-patient basis at the D.C. General Hospital's Hypertension Clinic, operated by Georgetown physicians. Six Eastern High School students were taught to take blood pressure and were sent to check patients waiting in various specialty clinics at D.C. General Hospital. Fifty-four percent were found to have high blood pressure. A similar check run at our own outpatient clinic yielded about 39% with high blood pressure.

7. Outpatient Clinics

Forty-eight specialized clinics (allergy, eye, pediatrics, et cetera) provide health care for medically indigent persons in the Washington community. Over 40,900 patient visits per year are recorded. Approximately 90% of the patients are black. While the clinics are reimbursed by those who receive Medicare, Medicaid or other health coverage programs, the University clinics run an annual deficit of approximately \$475,000 for non-reimbursable indigent services.

8. Emergency Room

The emergency room is open 24 hours a day, providing emergency medical care to all citizens seeking it. At least 20,000 additional patients are seen in the Emergency Room and the Orthopedics Treatment Room each year.

9. Inpatient Services

The Georgetown Hospital provides approximately 400 beds for the care of patients. Services are rendered to about 14,775 persons annually,

the majority of whom are from the Washington metropolitan area. While the majority are private patients, the Hospital does provide in-patient care for indigents at a cost of more than \$0.8 million in non-reimbursable funds annually. This exceeds by a factor of 4 the legal requirement of 39% free care for hospitals that have received Hill Burton Funds.

10. School of Dentistry Clinics and Services

The dental clinics, which are open to all citizens in the community, receive more than 200,000 patient visits annually. While the clinic receives no indigent patients, fees charged are at a minimum of what private care would demand. Over 7,000 new patients are seen yearly. In the clinics, junior and senior students, working under the immediate supervision of the faculty, provide the treatment and care in this program.

11. D.C. General Hospital Program

The School of Medicine and the School of Dentistry perform a vital service to the community in this program. The School of Dentistry, for example, provides its services without cost to the indigent patients. All oral surgery service, as well as treatment of oral infections and extractions, is included. An oral surgery intern or resident is on duty in the hospital emergency room 24 hours a day, 365 days a year, to handle this service.

The School of Medicine is involved in the day-to-day functioning of the Hospital. Its faculty, physicians and residents and students are participants. The University provides services in both medicine and surgery and their subspecialties. The staff is also responsible for graduate training program. Technicians man the laboratories and are

paid for by grant monies from Georgetown.

Georgetown's only compensation from D.C. General for service provided is that the space used for research and service is received free.

12. Affiliations of School of Medicine and School of Dentistry at Other Metropolitan Area Hospitals

The faculty and staff of the School of Medicine and the School of Dentistry conduct patient care, teaching and research programs in a number of affiliated hospitals in the Washington area, including D. C. General, the Veterans Administration, Arlington, Fairfax, Providence and Sibley Memorial Hospitals, the Hospital for Sick Children, Columbia Hospital for Women, Children's Hospital and the Walter Reed and National Naval Medical Centers. Complementing the faculty in the programs are approximately 300 interns, residents and fellows from Georgetown.

13. Georgetown University Community Health Plan, Inc.

The Georgetown University Community Health Plan (GUHP) is a prepaid comprehensive health care plan offering services to a broad cross section of people in the Washington metropolitan area. The plan is designed to offer enrollees a full array of integrated health services with easy access through "on location" sites near their homes. The plan is family oriented with a strong emphasis on preventive medicine.

The plan is currently operating through two locations: Reston, Virginia, and Edgewood Terrace in Northeast Washington.

In addition to the services provided at the two locations on a fee-for-service basis and to privately enrolled subscribers, the GUHP at the Edgewood Terrace location has contracted with the D.C. Department of Human Resources to provide medical benefits to 2,000 D.C. Medicaid

recipients.

The Edgewood Terrace location is the recipient of a Family Health Center Grant which enables it to provide comprehensive medical care to 3,000 medical indigents (that is, persons whose annual income is too great to qualify them for Medicaid, but is less than \$7,000).

Sixteen hundred persons are currently enrolled under this program, and it is the only one of its type in existence in the D.C. metropolitan area.

14. Program to Eliminate Major Nutrition Problems.

This program is working with physicians in the two Georgetown University Community Health Plan locations to determine the most critical nutrition problems in the communities and set in motion a broad scale attack against these problems. The project will focus on:

- a. Treatment of obesity and malnutrition on an individual basis through the doctor/patient relationship in the health maintenance organization. Emphasis will be placed on the critical role of nutrition in preventive medicine. This will be done through heightened physician sensitivity to a person's nutrition needs in addition to whatever other health problems may bring him to the health center. Approved procedures will also be developed for diet control relative to specific diseases.
- b. Involvement of the community in the decision-making process and support of the project. All community institutions including civic organizations, government, schools, food industry, families, churches, supermarkets, doctors, will be vital to changing nutrition habits.

The man-in-the-street must decide how important nutrition

is to him and have access to education concerning good eating habits.

15. Cleft Palate Center

The Cleft Palate Center has been in existence for more than two decades. This is the only facility of this type in the D.C. Area. It is staffed by specialists from all dental and medical specialty areas. These unfortunate patients, both adult and children, are evaluated, treated and rehabilitated regardless of their ability to pay for this service.

GEORGETOWN UNIVERSITY
SCHOOL OF MEDICINE
WASHINGTON, D. C. 20007

OFFICE OF THE DEAN

S. 2730

Senator Tunney and Members of the Committee,

I am Dr. John P. Utz, Dean of Georgetown University School of Medicine. I should like to elaborate briefly on: our student body, the service rendered to the District of Columbia and the Washington Metropolitan Area by our medical school, and the cost of medical education at Georgetown.

Our student body has both a national and a regional character. Thirty-nine states and the District of Columbia are represented among our 780 medical students during the current academic year, 1973-1974. Of these students, 33 listed their residence as in the District of Columbia, 26 in Virginia, and 73 in Maryland.

These students are highly selected, highly motivated, and hard working. The applicant pool has grown steadily in size and quality. For the class that entered in September 1971, there were over 5,000 applications for the 205 places. That was the largest number of applications ever received to

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that time by an American medical school. For the class entering September 1973, the number rose to over 7,500. For this year's class the number further increased to 8,350.

In our admissions process there are no restrictions or quotas in regard to race, religion, sex, or geographic region. It is important to note that the problem of a national shortage of minority group physicians has received special attention in our school. We have been able to expand considerably our pool of minority group applicants. The result has been an increasing number of minority students in our classes.

In response to the national health manpower problem, particularly the supply of physicians, we have nearly doubled the size of our entering first year classes in the past several years. Georgetown is now the second largest private medical school in the United States.

In regard to service to the Washington Metropolitan Area, over 700 of our alumni now practice in the District and in the surrounding Washington Metropolitan Area. Many more D.C. physicians received all or portions of their postgraduate training at Georgetown University Hospital or other hospitals affiliated with our medical school.

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Some think that only our older alumni settled in this area. To test this, we reviewed the current location of the 1,687 physicians who graduated from Georgetown between 1950 and 1965. Of these, 283 stayed to practice in the Washington Metropolitan Area. The principal office of these 283 physicians is located as follows: District - 112, Maryland - 101, Virginia - 70.

Faculty physicians, house staff, and students serve the community in the Georgetown University Hospitals and its clinics, the District of Columbia General Hospital, Arlington Hospital and Fairfax Hospital. A strong affiliation exists with the Washington Veterans Administration Hospital. We also have staff and programs at the Hospital for Sick Children, Columbia Hospital for Women, Providence, Sibley, the Bethesda Naval, and Walter Reed Army Hospitals.

Georgetown's faculty, house staff, and students serve actively in the District of Columbia Community Mental Health Program. The P Street Clinic for adolescent mental health is operated by our Department of Psychiatry with the Department of Human Resources. In the fall of 1972 a health maintenance organization operated by Georgetown opened its doors in Edgewood Terrace, a section of Washington's inner city. Lastly, Georgetown

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faculty are contributing to health care planning in many sections of the District and the surrounding counties of Virginia and Maryland.

A tabulation of annual income and expenses for Georgetown University School of Medicine for fiscal years 1973 through 1977 is attached. (Exhibit 1)

A Physician Augmentation Program grant to run over a five year period was awarded to Georgetown, beginning in FY 1971, because our school is committed to a program of greatly expanded enrollments. I direct your attention to line IV of the table, which shows our medical school's need for the provisions of the D.C. Medical and Dental Manpower Bill when we will not receive this assistance. This need averages \$2,891 per enrolled student in FY 1975, \$4,933 per student in FY 1976, and \$5,755 per student in FY 1977.

Georgetown costs have been compared in a study of 12 medical schools scattered throughout the country, and a report was published by the Association of American Medical Colleges in October 1973 under the title "Undergraduate Medical Education - Elements - Objectives - Costs". The annual cost per medical student in 1972 in these schools ranged from \$16,300 to more than

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\$26,000. Georgetown's cost was \$16,500. Furthermore, Georgetown ranked 10th in instructional cost, 10th in research cost, 8th in other administrative, scholarly, and professional costs, and 10th in the number of full-time faculty. In a more recent survey of 92 medical schools, Georgetown's costs per student were third from the bottom. (Exhibit II). Thus, it would appear that the costs at Georgetown are at an irreducible minimum.

In terms of income, the number of students in the entering first year class has been increased from 116 in 1967 to 205 in 1974, and the tuition from \$1800 to \$3500. Such increases in students (77%) has been achieved with only a 33% increase in faculty (from 236 to 314). Student requests for loans and scholarships are far in excess of the funds available. Obviously, high tuition works serious hardships on our students and their families, and yet pay but a fraction of the cost of medical education. Further increases in tuition for varying reasons are objectionable.

In terms of deficit per student the amount has dropped 38% (from \$3,593 in 1970-71 to \$2,232 in 1972-73). These figures reflect efforts to reduce costs and increase program effectiveness.

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The provisions of this legislation will assure the continuing operation of health manpower resources in the metropolitan area of the District of Columbia that have, in addition, local, regional, and national impact. Assistance to Georgetown and George Washington Universities through this legislation is the equivalent of assistance received by private medical and dental schools in 19 of the 21 states with such schools.

Thank you.

GEORGE TOWN UNIVERSITY MEDICAL CENTER

SCHOOL OF MEDICINE

FINANCIAL OPERATING SUMMARY: FY 1973-1977 (000 omitted)

January 16, 1974

I. REVENUES	FY 72-73	FY 73-74	FY 74-75	FY 75-76	FY 76-77
	\$	\$	\$	\$	\$
Tuition and Student Fees	2,113	2,650	2,850	3,000	3,150
Endowment Revenue	174	209	210	220	230
Gift Revenue	196	103	108	113	115
DHEW/BHHE Financial Distress Program Grant	1,419	1,925*			
Capitation Grant	1,387	1,447	1,440	1,230	1,230
PAP Grant	1,680	1,561	1,667		
Sponsored Programs	8,226	8,225	8,225	8,225	8,225
Faculty Medical Services	2,191	2,255	2,335	2,420	2,490
Student Aid Revenue	190	115	120	126	132
Other Revenue	374	385	400	420	440
TOTAL REVENUES	17,950	18,875	17,315	15,754	16,012
II. EXPENDITURES					
Educational Programs					
University Funded					
Capitation Grant Funded	4,319	4,805	5,227	6,638	7,204
PAP Grant Funded	946	1,342	1,310	1,180	1,180
Sponsored Programs	1,559	1,440	1,500		
Medical Center Library	6,747	6,593	6,593	6,593	6,593
Staff Benefits	132	170	190	210	230
Student Service Program	1,063	1,300	1,430	1,580	1,740
Student Aid	165	169	165	173	181
Physical Plant Operation	603	217	230	243	255
General Administration	1,013	1,171	1,270	1,320	1,385
General Institutional	1,037	1,090	1,140	1,192	1,250
	521	588	613	645	675
TOTAL EXPENDITURES	18,105	18,875	19,668	19,774	20,693
III. DEFICIT-NEED					
Enrollment	705	780	814	815	815
IV. D.C. MANPOWER BILL NEED PER STUDENT	0	0	2,891	4,933	5,744

* Application submitted for FY 1974 from DHEW Financial Distress Program

Exhibit I

[illegible]Exhibit II

Georgetown University
All universities

STATEMENT OF

Dr. Charles B. Murto, Dean

Georgetown University School of Dentistry

on

S 2730

Before the Committee on the District of Columbia

United States Senate

Mr. Chairman, and members of this Committee

I am Dr. Charles B. Murto, Dean of the School of Dentistry at Georgetown University. My presentation will touch the following points:

1. The program of the School of Dentistry at Georgetown and in the Metropolitan area.
2. A presentation of the student body and the alumni.
3. The costs as they occur at Georgetown University School of Dentistry

There has been a long history of service to the District of Columbia residents and to the residents of the Metropolitan area by Georgetown University School of Dentistry since its founding in 1901. The School of Dentistry, with its students and professors, is a major source for dental care in the District of Columbia at the Georgetown University Dental Clinic. The new Clinic Building was opened in September, 1971, and enabled the School of Dentistry to meet the challenge of increased dental care needed in the District of Columbia. Our Clinic is one of the important resources for dental diagnosis and treatment in the District of Columbia that is available to a very large portion of the area population, namely, the low income group. Many of the patients come from the inner city areas in the District of Columbia. This new modern facility permits a patient load of presently 170,000 patient visits annually.

Besides the program at Georgetown University Medical Center, there is a very active and rather large program at District of

Columbia General Hospital. More than 100 fourth year students of Georgetown University School of Dentistry are rotated through D. C. General Hospital under the supervision of faculty from Georgetown together with the supplementary health care provided by three interns and two residents, from the Georgetown University Advanced Specialty Program in Oral Surgery. The School of Dentistry also is in charge of the rehabilitation of maxillo facial patients at D. C. General Hospital and Washington Hospital Center, as well as at its own University Hospital. At Veterans Administration Hospital there are a number of our faculty who are consultants at that institution and service this hospital. At Children's Hospital there is an advanced specialty program of instruction in Pedodontics for interns and residents under the direction of members of our faculty. In summary, the Georgetown University School of Dentistry is one of the major components of the dental health care system in the District of Columbia.

Currently, 50% of the practicing dentists in the Metropolitan Area of the District of Columbia are Alumni of Georgetown University. It has been noted that there is a marked tendency for a substantial number of graduates of a School of Dentistry to locate and practice in the area where they attended school. Thus, Georgetown is a fundamental resource for dentists in this geographical area.

Our student population at present number 515, will be expanded over the next three years to 567 students with approximately 140 graduates annually. This will be a 40% increase in this dental health resource and it will be of direct benefit to the District of Columbia since

it allows an increase in dental care by an increase in outpatient load capacity, as well as providing more dental graduates for the Metropolitan Area.

All of us are aware of the continuing rising cost in higher education nationally. Similarly, the cost of dental education at Georgetown University has increased annually and this is demonstrated in the attached summary as Appendix A. One of the major reasons for this increase in total cost of operation is because of the substantial increase in the number of students enrolled at Georgetown University School of Dentistry. We have large new physical facilities that have permitted us to meet the challenge of providing additional dentists for the Metropolitan Area, and to also increase our services to the community during the student clinic program of training at the School of Dentistry.

However, the increase in cost that accompanies this student increase is rather staggering. It has been necessary to increase the number of professors in all of our departments in order to continue and enhance the individualized student instruction that has become necessary in dental education because of the advance of techniques and scientific knowledge in this field. In addition, the basic science fields of instruction have also had to be increased and will continue to increase because of the larger number of students annually.

Finally, we have a high quality and devoted faculty, a fine student body and an excellent educational program. All of these factors

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contribute to the excellent graduates that enter the dental profession each year. Funds from this bill are absolutely essential for the survival of this educational endeavor. We at the School of Dentistry urgently request your support for the passage of S 2730 as a continuation of the District of Columbia Medical and Dental Manpower Act of 1970.

Thank you for the opportunity of presenting our problems to you today.

GEORGETOWN UNIVERSITY MEDICAL CENTER
SCHOOL OF DENTISTRY

FINANCIAL OPERATING SUMMARY: FY 1973-1977 (000 omitted)

January 16, 1974

I. REVENUES	FY 72-73	FY 73-74	FY 74-75	FY 75-76	FY 76-77
Tuition and Student Fees	\$ 1,369	\$ 1,706	\$ 1,862	\$ 1,920	\$ 2,032
Endowment Revenue	35	28	32	35	35
Gift Revenue	62	48	50	55	57
DHEW/BHME Financial Distress Program	583	775*			
Capitation Grant	890	860	830	820	820
Sponsored Programs	615	654	655	655	655
Dental Clinic Revenue	949	960	1,010	1,110	1,160
Student Aid Revenue	66	42	42	42	42
Other Revenue	4	4	4	4	4
TOTAL REVENUES	4,573	5,077	4,485	4,641	4,805

II. EXPENDITURES

Educational Programs					
University Funded					
Capitation Grant Funded	1,569	1,737	1,972	2,125	2,225
Sponsored Programs	742	777	744	733	733
Medical Center Library	498	533	534	534	534
Staff Benefits	47	61	68	75	85
Student Service Program	239	296	326	358	390
Student Aid	105	103	108	113	120
Physical Plant Operation	123	92	96	200	250
General Administration	831	925	999	1,070	1,120
General Institutional	263	274	288	304	319
	241	279	297	327	360
TOTAL EXPENDITURES	4,658	5,077	5,432	5,839	6,136

III. DEFICIT-NEED

Enrollment	473	517	545	554	554
			(947)	(1,198)	(1,331)

IV. D.C. MANPOWER BILL NEED PER STUDENT

	0	0	1,738	2,163	2,403
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* Application submitted for FY 1974 from DHEW Financial Distress Program

STATEMENT REQUESTED BY REPRESENTATIVE MAZZOLI REGARDING
THE ADMINISTRATION OF PRIVATE MEDICAL AND DENTAL
SCHOOLS IN THE DISTRICT OF COLUMBIA

In the course of presenting testimony before the subcommittee of Labor, Social Services and International Community Committee of District of Columbia regarding H.R.11108 reference was made by the DHEW representatives to deficiencies of the administration of the institutions in question. Specifically, it was stated that, "The Department is of the view that, in general, the prolonged period of financial uncertainty experienced by these schools... the end of which is not yet in sight...reflects a serious deficiency in the administration of these institutions. For instance, the schools have not followed the common practice in other medical schools of instituting a viable intramural faculty practice plan to assure that some reasonable portion of the financial resources generated by certain of the clinical departments is applied toward keeping the other departments of the school on a sound financial footing. George Washington Medical School has given some thought to trying to reform its policies in this regard and may be in a position to stabilize its finances in the not too distant future. The Georgetown schools, however, have thus far not moved to implement long overdue management reforms to an extent that would correct their financial difficulties."

Subsequent to this, it is our understanding that officers of the two universities stated to the committee that they are not aware of any alleged deficiencies or of any changes suggested by your department

(DHEW) which have gone unheeded. A spokesman for George Washington University said his medical center had pioneered in the development of a plan for pooling faculty fees."

On this basis the committee chairman Hon. Romano Mazzoli invited representatives of DHEW and the institutions in question to his office for a discussion and expressed the expectation that documentation of any deficiencies in management or administration be made available.

We welcome the opportunity to discuss these matters in a constructive spirit and to this end are providing additional background material pertinent to some of the aspects of our concern.

In the first instance, we recognize that the statement as quoted from our testimony (cf. above) may appear unduly harsh, judgmental and simplistic since it was not accompanied by adequate explanation and dealt with a most complicated and difficult matter.

It should be understood by the committee and the institutions that our concern has a realistic basis. These institutions have applied for financial assistance because of need every year since 1968.

During the last three (3) years this application was made under the financial distress program. During these three years the applications have been intensively reviewed by expert consultants drawn almost exclusively from experienced medical center administrators and financial management personnel of such institutions. In two (2)

of these years the applications received additional evaluation by special review committees whose membership was largely drawn from the rolls of professional school administrators and academicians. Lastly the Advisory Council on Health Professions Education has reviewed and acted on the applications. Every year, at all levels and by virtually all outside consultants criticism and concern have been voiced about various aspects of their operation. The outside expert consultants have usually recommended disapproval or expressed uncertainty because of confusion in the data supplied. The review committees recommended disapproval in two of the prior years. (There is no review committee this year because of a change in the system occasioned by increased regional office participation.) Last year (1973), the advisory council actually disapproved the applications in toto on the first action. Later they reversed this action after special reconsideration. They finally recommended funding at a reduced level.

The criticisms and concerns have varied from year to year and from institution to institution. In the earlier years of the financial distress program DHEW had great difficulty obtaining data which was internally consistent and understandable. Sometimes studies initiated or designed by outside groups such as the AACC cost study generated data which appeared inconsistent with the financial statements

submitted by the school. The administrators were responsive to this frustrating situation. Dr. McNulty of Georgetown University and Dr. Feffer of George Washington are to be commended for a significant improvement in the data supplied to DHEW. Despite these improvements there always remain areas requiring clarification. The precise details of the faculty practice arrangements at Georgetown University is one such area.

It is our purpose at this point to present highlights of the principal criticisms and concerns, school by school, for the current round of application review. It should be borne in mind that reviewers have looked at the applications from the standpoint of the financial distress legislation. This includes the view that it was the intent of Congress to eliminate financial distress over a three (3) year period and enjoined all of the applicants to present such a plan.

Georgetown University School of Medicine

The following are excerpts from the reports of consultants and staff reviewers:

"This application reflects little progress in improving practices which have concerned reviewers in the past two years. Among these are 1) Continuance of the apparently arbitrary 60-40 percent allocation of costs in the basic science departments to the medical and dental schools

2) Lack of information regarding the schools clinical practice plan. 3) No indication of considerations of actions to reduce costs when necessary through reduction or elimination of program or activities and other actions to contain or reduce costs, 4) continued program expansion, in some cases substantial 5) continuance by the school of the contentions that in the absence of federal support the University Board of Directors will have to consider relinquishing control of the school with no satisfactory explanation of what this means, and 6) treatment of unapplied gifts as assets rather than income."

Two reviewers commented on the substantial percentage increase in the Department of Community Medicine and International Health, the Department of Biophysics-Physiology, and the Dean's Office as indicating continued program expansion. "Faculty salary expenses are slated for a 12% increase while the number of students increased only 7.5%."

One reviewer commented as follows; "My observations would indicate the lack of any substantial effort to increase the income from endowment and investment or gifts while at the same time making little effort to control salary increases or staffing." The same reviewer asks "Why there is so little increase in sponsored programs and Faculty Medicine Services?" "Why is there no allocation of University surpluses to this condition of distress."

In summary, concern has been clearly expressed by the reviewers because there is little evidence of effective cost containment and/or activities leading to expanding income. Some concluded that there is undue emphasis on additional federal funding as the only alternative. DHEW expresses disappointment that the administration of this school has not designed and/or implemented an effective plan during the last three years which would reduce costs and/or expand income such that balance in its operations is within sight.

Georgetown University School of Dentistry

The following are excerpts from reviewers of this application:

"Aside from certain specific information this application is the same as submitted by their sister school of Medicine...the majority of my comments made in the Medical School report are also applicable here....Like the Medical School the applicant points to numerous increases over which they have little control. A number of these have been initiated by the University....With financial distress support over the past years the University has not given any support and none is projected for this or future years....Little is included in the application to indicate the School's consideration of alternate potential sources of income....Their fund raising has not been good and they indicate very little commitment to improving their present...practice plan....They have stopped efforts toward cost reduction because

their Executive Faculty concluded that "further reductions would so adversely affect the quality of education that accreditation would be seriously threatened." Other reviewers echo comments about expanding the Dental Clinic income, more vigorous fund raising and some help from the parent university. There is reference by all reviewers that no plan has been presented to eliminate or substantially reduce the imbalance except obtaining additional federal assistance."

In summary, the reviewers were concerned by the lack of a plan which addressed itself to cost containment and/or expansion of income with particular reference to Dental Clinic income and fund raising.

George Washington School of Medicine

The following are excerpts from reviewers:

"The record of funding of operating needs for this private D.C. Medical School totals \$5,297,600 over the 3-year period, and this year's application will require an additional \$2,782,210 for deficit, the largest request made by the institution under the program. In fact, the earlier projections of operating deficit made by the institution fall under the deficit projected now. In short, the institution goes nowhere in resolving this matter except in a circle of deeper difficulty. * * * The institution has realigned management, revised its budget and operating procedures to program oriented purposes, imposed ceilings on spending,

position control, and instituted a wage and salary compensation program. The management effort is sincere and certainly one that is changing the life style in the institution. It is, nonetheless, to little avail in reversing the trend begun long before the distress fund mechanism. Last year the reviewers concluded that the applicant's actions were not as effective as might be expected, and the results were disappointing. The result this year is no better, in spite of additional management activities, ranging from reorganization with Center control, the tuition increase, to improved wage and salary management, and continuation of manpower freeze, to new funds for endowed chairs. In short, as management tightens its grip on areas of immediate concern, new problems arise with uncontrollable features to continue the high deficit trend. * * *. The deficit is really programmatic in origin. Retrenchment must occur if the deficit is to be removed."

The view of another reviewer is as follows:

"Deficits projected through 1976-77 increase in total amounts each year but remain relatively static in terms of percentage of total expenses. The clear implication is an inability to curtail total expenditures in the face of huge expense increases. (20% of total). * * * Expenses as a result of expansion are substantial and continue to compound at a rate of roughly 20% a year. Faculty salaries will be up 18%; staff salaries, 11%; equipment will increase 7%; operation and maintenance of plant will increase by over 100%;

and Medical Center and university services will increase 15%. One may seriously question the magnitude of these increases in light of the programmatic increase and a period of financial distress. * * *

In general, the increases are not unbelievable. However, the increases do not speak to the issue of financial distress but rather to expansion despite financial distress. * * *

Plans to curtail expenses are modest. * * *

One may be both critical and question the distribution of practice plan income which results in apparent positive balances in "Medical Center Appropriated and Unappropriated Funds." These balances were, according to the 1972-73 annual report of the university, \$1.6 million and \$2.9 million, respectively. The practice plan income is first applied as an offset to hospital losses. Balances remaining are transferred to the two funds mentioned before as well as an education and development and plant funds. The precise disposition of the fund balances derived from the professional practice plan is difficult to determine for the period in question. It is, however, evident that a substantial reserve exists which is operating as an endowment. These reserves have in the past and could presently be used to defray some of the current and projected deficits just as it has been used to defray the same short-falls in the hospital."

Schools in Financial Distress

DHEW has gained considerable experience with schools in financial distress since the implementation of this program. Many applicant schools were denied funds, some received reduced amounts and still others a full award. The actions taken by such schools have been impressive and include such drastic actions as terminating some existing faculty members, reducing faculty positions, reducing or eliminating faculty salary increases, gaining control of practice funds for general utilization, dipping into endowment funds, reducing or eliminating non-essential programs, putting community service programs on a self-sustaining basis, expanding alumni giving, deferring capital improvements and purchases, rescheduling educational programs to optimize faculty time, shifting costs to hospital budgets where appropriate, and seeking increased support of parent universities. In state schools it is usually not possible to budget a deficit. When legislatures do not expand support rapidly enough to offset loss of federal research and training funds or to offset increased costs it become mandatory to bring income and expenditures into balance. Whatever the circumstances, it is always a painful process since schools - their administration and faculty - are reluctant to reduce the scope and richness of their programs. We understand and sympathize with the efforts at Georgetown University Schools of Medicine and Dentistry and George Washington School of Medicine to maintain the diversity and range of their programs, to retain and attract faculty, in short continue at the present levels of academic excellence. We also recognize that the administrations of these schools have taken some steps in the direction of effecting economies. Nonetheless, other schools have managed to effect very significant changes without obvious harm in their undergraduate medical educational programs.

Dr. McNULTY. When I say "our" I mean Rev. Robert J. Henley, our president, and I am the executive vice president for the medical center. Beyond that, Senator, I would like to point out just three things quickly in the interest of your time, as quickly as possible.

I would like to address as item A, read from the testimony of our president, of what do we do, if we do not get these funds, this is his testimony on page 2.

I can report parenthetically our board of directors, which meets generally four times a year, has for the past 5 years had this subject of financing medical and dental education on its agenda everytime, and many times to the discouragement of a number of our board. They feel we are constantly addressing this as the emphasis of the university, when the university has 13 other schools, and 13 other endeavors in addition to those in the medical center.

They have stayed with it though, and so far we have existed in what I call a cliff-hanging type of existence, year by year, each year, but what I wanted to quote from was the president's presentation as a result of his discussions of this subject with the board.

DETERIORATION OF MEDICAL AND DENTAL PROGRAM

What do we do if we do not obtain these funds?

At best, our medical and dental education program will deteriorate. Our services to the District and the metropolitan area of Washington, if necessary, will be curtailed and reduced in quality progressively and finally close out most of our medical center.

Now, this is a statement that is realized after 5 years of deliberation. This is not one made in the heat of excitement, of disappointment, or of frustration. It is a considered, mature, time-consumed judgment in which the board of directors, representing the national leaders throughout this country, have looked at constantly. I would only point to an example, which I do not know if Dr. Elliott wants me to use or not, but I would like to use, because I think George Washington has been unjustly accused of a decision they have to make. They have to make a decision to withdraw from the D.C. General Hospital because they could not afford to continue the three-university program there, and which in effect July 1 will become a two-school university program.

I do not know where Howard stands. But I would call attention to the fact we are not breaking tradition, that Howard University receives a congressional appropriation, not because they want it that way, I assume, but because there is no other way to get it.

They are financed and we at Georgetown are not. I have indicated previously that we intend to stay at D.C. General Hospital as long as we can, but I would have you understand that this is as long as we can.

It takes resources, so that was my statement as to what would happen, if funds were withdrawn. We make no commitment. We make no prediction. We only say that we will do the best that we can, because we have been doing the best we can from Georgetown in the District for almost 200 years. But it is impossible to run the automobile, as we know so well, unless there is some gasoline for it.

Senator TUNNEY. What do the people at HEW say when you make these representations to them?

Dr. McNULTY. Well, if I may, Senator, I move to my second B point, and I have several there. One of them relates to that, on page 10 of the testimony of my colleague, a former faculty member at Georgetown.

He indicated there is understanding and sympathy, and I think we both appreciate that, both Georgetown and George Washington, all we ask is for some implementation of it.

In response to your very pertinent observation, you asked the Assistant Secretary if there would be any objection to funding from the District of Columbia. He said, as I recall, no, not at all, in fact, it is a responsibility of theirs.

DISTRICT OF COLUMBIA RESPONSIBILITY NOT REALISTIC AT THIS TIME

Now, we have no objection to that, other than we say, please, if you have understanding and sympathy, please address it in the universe of reality.

At this point in time, with the transference of Government's responsibility, and the decentralization of the District of Columbia—the two local newspapers have carried front pages of about how long it would take before that change in Government's process would be a fully implementable one. As I read the political science reporters, there was an estimate from 3 to 5 years at best, so I do not think it is either sympathetic or understanding to say it is a responsibility of the District of Columbia without adding that it is not possible for them to do that at this point of time.

We are quite willing to take our story to the District of Columbia, if that is to be our State, we believe it is our obligation to take it there.

Other private universities have taken it to their State, but we have had no State to which we could take it. That is why we are here, Senator Tunney, to this Congress, that is why, in our belief, the subcommittee in the House has approved our request to them.

That is why Public Law 91-650 was enacted the first time.

DISTRESS FUNDING

Another point I want to make, the Assistant Secretary said it was not funded. As Dr. Elliott already indicated, it was not funded because the Secretary of HEW at that time requested we take our need through another route that he had available, known as distress, so we have been constantly cast in the role of a distress institution, when all we have been doing is seeking statelike support.

Two other points, and then I will go to my third subject, I would like to quickly indicate some facts, as I think we have had a great deal of rhetoric embellishes. I do not mean the other fellow's rhetoric, I mean my rhetoric embellishes also. But I would like in a few minutes to demonstrate what are the facts as we see them, and as I believe they also apply to George Washington, but I do want to make reference to the letter that the Assistant Secretary attached to his testimony.

That letter, one went to George Washington, two went to Georgetown, one for medicine and one for dentistry.

The one from Georgetown said, in reaching their conclusion, and turning down a request for distress funding, the Council, meaning the Council that makes the decision, and I would parenthetically say, that Council received much of its information from an onsite visit to Georgetown by four experts who spent all day with us, and into the evening, exhaustively looking at every aspect of our medical and dental operations.

SCHOLARSHIPS

The Council noted that the medical center has gift accounts of funding as endowment sufficient to cover their deficits. We have been fund raising vigorously. We have taken those funds and put them in funds that function as endowment, and they provide the grants-in-aid to students, they provide the scholarships, the loans, and the gifts. We have only 20 percent of our students on any type of scholarship or any type of aid in answer to your question.

We are distressed that we do not admit more from the District of Columbia. The excellently qualified students that apply to us at Georgetown for medicine and dentistry in those two categories, we accept them, and they seldom come.

They can go to the other States, where they can get a fellowship, a tuition grant, they can get scholarships of substantial assistance to them, where ours is only a mediocre one.

Senator TUNNEY. Is that one of the reasons that you have a fair number of students accepted at your medical school, who decide to go elsewhere because of the failure to provide support?

Dr. McNULTY. Because we cannot be competitive in offering to them scholarships, tuition, a loan, competitive with what other States can.

Your own State of California attracts a number of them with very handsome help by comparison. It takes that much to put a student through school, and the student needs that sort of assistance.

STRONG AND CAPABLE LEADERSHIP

This letter goes on to say: "The Council noted that the university has a functioning endowment," the Council acknowledged that the schools had recently set in motion several additional steps, and has strong and capable executive leadership.

Now, the Assistant Secretary said the same thing. I do not know whether we do or not. I like to think that we do, since that includes me. But I do know we have strong and capable beings, we have a strong and capable president, we have a strong and capable board, who spent, since 1970, now 4 years, analyzing this, and we have not been able to visualize any other approach.

We are pleased that they think the leadership is good, but again we would like to play on that point of understanding and sympathy to give us some direction. If this is not the way, then what other way than constantly saying, this is not the way. We may be unique, but this is not the way to do it.

If I may, I would like to go to my chart, and the third part, and quickly indicate what I think are the facts.

INSTITUTIONAL PROFILE

This is a blown up copy of an institutional profile ranking report. This is the report for Georgetown.

The Association of American Medical Colleges has initiated it showing these profiles for all fully activated medical schools in the country, there are approximately 115 medical schools functioning in this study in 1971-72.

There were 92 that they could get their data on.

One of the difficulties we so much allude to the narrative, and to the articulation, is that until recently, there have been very few facts in the field of costs of medical and dental education.

In fact, I have no corresponding chart on dentistry, but for this one in medicine, I would like to point out several things.

1. The quality of the students admitted into the School of Medicine at Georgetown places 16th of these 92 schools in the country. This is on a science measurement test conducted for admission to schools of medicine by the Association of American Medical Colleges, 16th—the upper 20 percent.

2. I wanted to point out, in terms of the dotted line, it is the average, as all of this is calculated by an external organization. Second, I wanted to point out, the number of students we have places us 11th at this time in the country.

In other words, our attempt to do something both in quantity of students, and as I will now indicate, we are not trying to do something in terms of the geographic and type of practice in HMO, and other things of this type to get more to their primary care of physician.

I would then skip to our house staff, which is where actually the physicians come when they go into practice. This is lower than the national average, because we cannot finance that. Then I go to here, and so this is the column which shows the per student payment per year for Georgetown, and we are 90th.

Dr. ELLIOTT. As already indicated, George Washington is 92d.

Now, another way of saying that, in this, the Nation's Capital, for its medical schools, compared with 92 medical schools around the country, stands last and third from last in amount of money per year per medical student, and to me, that is a most distressing figure.

I could go on for other categories, but I will not take your time.

Senator TUNNEY. You are making your point.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES STUDY

Dr. McNULTY. There has been another study, previous to this one, conducted by the Association of American Medical Colleges.

This one was taken in in 1970, and then extended it to 1972. They took what they thought were 12 representative schools from around the country from their universities, and in those 12, the costs ranged from \$16,300 per medical student per year to \$26,000 per medical student.

The bottom three, separated only by \$100 each.

That is \$16,300, \$16,400, \$16,500, separated by \$100 each.

I am not going to belabor this. One then could draw comparisons of how poorly we do in instruction, research, and clinical activity.

The only point I wanted to make is that these two charts are data. They are not our embellishment. These are findings by other external bodies with regard to medical education.

I would say, Mr. Chairman, that the Senate and the House has authorized a study of the costs of medical education, the first two volumes of which have been submitted to you, from the Institute of Medicine. And utilizing their same uniques, we wind up in the same place here, and in the same place here, and I would say that the Institute of Medicine recommended strongly that statelike support be one of the methods of supporting health science education.

Incidentally, these are gross figures, sometimes if someone has a query why the difference between the spread from 16 to 26. The spread from the Institute of Medicine which were the net figures, went from 6.9, \$6,900 to \$18,650.

RESEARCH EXPENDITURES

Senator TUNNEY. I notice in that chart, you spend considerably less for research, as an example, than the No. 1 school.

It is \$10,000 the No. 1 school, versus \$4,300. It is much less in research, if you took the 4.3 figure here and compared it up to here, that figure would be the same for George Washington. Is that correct?

Dr. McNULTY. Yes; that is correct. I have another graph, which I think dramatizes I hope what Dr. Elliott said, and that is that the faculty ratio to students is one of the lowest in the country, or the ratio of students to faculty is one of the highest in the country, whichever way you put it, and that is where most of the faculty spends their time, not in extending new knowledge, not in developing new knowledge, but in teaching.

CLINICAL ACTIVITY

Senator TUNNEY. I am interested in the clinical activity. The differential there from the No. 1 is \$4,600 versus \$3,100, \$4,006 versus \$3,001—it is a much narrower spread.

Dr. McNULTY. Yes. I think both Georgetown and George Washington would fare better here because we operate HMO's—we do have extension into many of the hospitals in the community, where much of the teaching may be done by voluntary faculty. But the clinical activity, in terms of counting those dollars advanced in HMO funding, as advanced by the hospital with which we are affiliated, would make our standing here better, there would be less of a spread.

Senator TUNNEY. But the clinical activity has a direct impact on the community, does it not?

Dr. McNULTY. It does indeed.

Senator TUNNEY. Because it is a service that you are performing for the community, in providing medical care for those people who are in the clinics. Is that right?

Dr. McNULTY. You are right, Senator. To put it more harshly, the question could be very well asked by saying I am a resident in Washington for 9 months a year, and so on, why don't you have a \$4,700 expenditure to give me the quality of care for my family that is needed.

Senator TUNNEY. But the school that spends the most per capita, \$26,400, spends \$3,800 on clinical activity.

You spent \$16,500, and yet \$3,100 you spend a greater percentage of your total investment per student in the clinical activity than does the school that spends the most money per student by far.

MEDICAL AND DENTAL COSTS

Mr. BALL. Senator, I was involved with the developing of this particular study.

I think there are two points to be made, one of which are the costs. These are the costs directly related to the kind of figures you want to produce.

For example, the schools at the top of the list are those schools that have a very heavy commitment to replenishing the academic medical figures.

They are trying to train faculty for the future. Schools with lower costs, have to, for reasons they cannot afford to, help forego that role, and are putting a heavier and heavier emphasis on training physicians who are going to deliver health care. For example, Georgetown, if you want, you can contrast over the years, they have turned out about 3 percent of their graduates that ultimately end up in academic medicine, where in contrast with Harvard, it ends up in 18 percent. Although we have a shortage in academic medicine, it does show the particular emphasis that the kinds of positions these schools are training for.

These numbers do not represent those of purely health delivery systems that the schools fulfill. It is only the emphasis, the kind of material, in what it costs to expose the students to that kind of clinical material.

Senator TUNNEY. Thank you.

RATIO OF FACULTY TO STUDENTS

Dr. McNULTY. This is the chart I made that spoke to the point Dr. Elliott made, and dramatizes my figures.

These are statistics published by the American Medical Association, from which can be derived a ratio of faculty to students. At Georgetown, I think it can be seen, and I trust the drama is demonstrated, the increasing number of students to faculty, as we extend from 1970 to 1974, going from one faculty member to 1.9 students, to one faculty member to 2.6 students.

The last of our large classes will be admitted in 1974-75 year. These are the academic years ending June 30. We anticipate this figure will go to 1.28.

The national figure, using the American Medical Association material, is on a reducing scale, from 1 to 1.5 in 1970, to 1 to 1.3 in 1974.

This has some local pertinence in that the new University of Health Sciences of the Defense Department are struggling, and they are wondering whether their ratio is sufficient, 1 to 1.3, and we are talking of 1 to 2.6.

I do not have George Washington's findings, but I would suspect they are in the same range, constantly reducing the number of faculty to the increasing number of students. Finally, I think for the great

benefit of the District of Columbia, and the greater metropolitan area, this is for Georgetown, and it can also be duplicated to some extent for George Washington.

I will only speak for them for the year 1975. I do not have in focus other material.

ENROLLMENT

In 1971, when we were just starting the enlargement in terms of a class at Georgetown, we received 300 applications per annum, for the year 1972, we received 5,100, then to 7,000, and then to 7,600. For this year, starting next September, we have received 8,300 applications.

Now, the benefit of this is tremendous quality—tremendous quality.

Here in 1973-74, we were first in the country in the number of applicants. This year we are going to be second or third, because George Washington is probably going to be first.

Now, that means that at least two medical schools, I do not have the material for Howard, get the greatest quantity of applications. The brightest students throughout the country are applying here. Our acceptance rate is phenomenal. That is why on the initial chart we have 15, 16, 14, in terms of the quality of the student. Yet in terms of the amount of money we are putting into those students, and the amount of faculty available for education, if this was a chart in Texas, for example, the \$16,000 per student per year would be there, because of the pride they have in their activity. It would probably go up to \$25,000. They have said, if you have students, we will give you the money.

RESOURCES NEEDED TO MATCH GREAT OPPORTUNITY

Our problem is to get the resources that will match this great opportunity for the District of Columbia.

I will close on that note, we have no other place to turn, Senator Tunney, and we are not saying we will close down tomorrow.

I think the example of George Washington's problem at the D.C. General in financing is a case in point. I do think we are ready to go any place that we can. All we ask is that it must be a realistic policy. So far, this committee, and its similar committee in the House have been our realistic possibility.

Senator TUNNEY. Thank you very much.

I would like, if we could, I am going to have to leave for the floor for a vote in about 3 or 4 minutes, if we could get through this panel before that. I would appreciate it. And when I come back, we could hear the last two witnesses.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS LEGISLATION

Dr. BALL. The Association of American Medical Colleges does indeed support this legislation.

We feel rather strongly it should be using the term "earmark" or in some way designated rather than funds that would be in what I would call a national part in which all schools in distress would be applying.

For example, this is not an appropriate analogy. I would not like to see the problems of George Washington and Georgetown have an impact on the problems at Stanford.

If Stanford happens to need money as a basis to compete nationally, as all of the other schools, because the State of California in addition helps them out. I think if Georgetown and George Washington got specific assistance from the District of Columbia, then they should have the opportunity to compete nationally, also for other distress funds.

CREATES PHYSICIANS

It is an expense of the kind as to create physicians that you and I would like to see when we are sick.

If you go back to the 1900's, there are a lot more doctors being created, and nobody wanted to see them because they were not any good. I think medical education has gone through a significant revolution in the last 50 years, because of the quality of the faculty is such in the schools that we now produce medical students to physicians which are the kind of physicians we would like to see.

We have a new problem, which is: How do you create an atmosphere in which the students are exposed to enough scholarly activity that they continue in educating themselves?

This is one of the kinds of things that go down the drain when the schools are in trouble.

They cannot expose the schools to the stimulus of continuing to educate themselves, and in 10 or 15 years from now, we are still practicing 1974 medicine.

I think that is one of the emphases that has not been made and must be made.

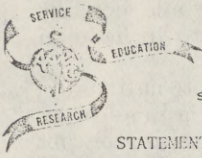
Thank you.

Senator TUNNEY. Thank you, Dr. Ball. We appreciate your testimony.

The prepared statement of the Association of American Medical Colleges will be printed in full in the record.

Dr. BALL. Thank you, Senator.

[The prepared statement referred to, and a letter from the American Medical Association received subsequent to the hearing, follow:]



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES ON
LEGISLATION TO PROVIDE SPECIAL SUPPORT FOR MEDICAL AND DENTAL
EDUCATION PROGRAMS OF PRIVATE SCHOOLS IN THE DISTRICT OF COLUMBIA*

The Association of American Medical Colleges welcomes the opportunity to testify on S 2730 and related legislation to extend the District of Columbia Medical and Dental Manpower Act of 1970.

Now in its 98th year, the Association represents the whole complex of persons and institutions charged with the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 114 operational U.S. medical schools and their students, 392 of the major teaching hospitals and 60 learned academic societies, whose members are engaged in medical education and research. The Association and its membership, which includes the medical schools in the District of Columbia, thus have a deep and direct involvement with the legislation the subcommittee is considering.

At the outset, it should be made clear that the Association strongly supports in principle the legislation which the subcommittee is now considering. Such legislation would provide critically needed local support for the private medical and dental schools of the District of Columbia.

In this statement, it might be useful, first, to review briefly some of the broader aspects of the financing of medical education in the United States. The entire structure of medical education in the nation is facing difficult and threatening financial problems. In fact, all of higher education in the nation is confronted with grave financial difficulties. The problems of medical

* Presented by the Association of American Medical Colleges before the Subcommittee on Public Health, Education, Welfare and Safety of the Senate Committee on the District of Columbia, May 1, 1974

education are particularly acute. Medical education has always been the highest cost element of higher education because of the integral laboratory and clinical care activities involved. These high costs have now been compounded by the price-wage inflationary spiral which has been advancing at the rate of upwards of 6 percent per year.

In addition, the rapid advance of science and technology has changed profoundly the character of medical education, as it has medical care and health services. The medical sciences have become increasingly complex and the process of diagnosis and therapy now encompasses a vast array of technical services, powerful drugs, and new, increasingly complicated techniques. As these changes have added to the cost of medical care, by the same token they have added to the costs of medical education.

Furthermore, medical education now embraces a wide range of tasks and responsibilities. Once confined to the limited task of educating the M.D., it now encompasses major research programs, graduate education in both the basic and clinical sciences, and a growing responsibility for patient care and community service. This process of growth has been accompanied by extensive changes in the basic financial support base for these institutions. For the better part of the post-war period, national concern with the solution of major disease problems resulted in federal support flowing to the institutions providing medical education for the single function of research. This increase in federal research support took place at a time when the role formerly played by foundations, private support sources, and other philanthropy in supporting medical education was diminishing.

At the same time, the medical schools were being asked to expand their educational functions in the production of M.D.s and other health professionals

and to extend their capabilities in the community health scene. In recent years, because of general budgetary pressures, national efforts to control inflation, and shifting priorities on the national scene, there has been a substantial turn-down in the flow of federal research funds to medical schools. Although federal programs were initiated to expand the production of physicians, these new programs have only recently begun to deal with the underlying instability of the financial base of American medical education. This is the set of problems which today confronts the entire medical school community.

These trends have had their earliest and most serious impact upon private medical schools because of their crucial dependence upon operating income and endowment earnings. Many of these schools, as a result, have been brought to the very brink of financial disaster. The repeated deficits that they have faced have, in many instances, forced the use of endowment capital to cover operating costs. The prospect of substantial cutbacks in these private medical educational programs has resulted in substantial concern on the part of many state governments for the private institutions within their boundaries.

All states are aware of the valuable asset that an academic medical center constitutes in the community and the state in which it is located.

First and foremost, it offers the opportunity for medical education to aspiring students, and thus expands the critically short pool of physicians available for medical care.

Secondly, the academic medical center exerts an important and pervasive qualitative influence upon the whole of the medical practice and health service scene in the areas contiguous to the community in which it is located.

It serves as a valuable referral center for specialized services; its educational training programs, including continuing education, assert a widespread influence on the numbers and quality of medical care personnel; and its research programs assist in solving important health problems, as well as serving as an important economic asset.

As a consequence of the state governments' concern with the financial condition of their private medical schools, an increasing number of states have enacted some form of direct state assistance to the private medical schools within their boundaries. The data in the attached tables, prepared by the Association of American Medical Colleges, show the extent to which states are supporting the private medical schools. Fourteen of the 21 states with private medical schools provide some form of state aid to the private schools.

These developing state arrangements have been reviewed briefly to convey to the subcommittee the growing recognition on the part of the states of the importance of preserving and advancing the stability and programs of their private medical educational institutions as an asset of considerable worth to the state and its citizens.

The Comprehensive Health Manpower Training Act of 1971 (PL 92-157) provides certain institutional support for the regular operating budgets of the medical schools. However, the capitation support furnished under the Act is predicated on substantial resources from the state and private sectors. The amounts provided under the Act cover only about one tenth the estimated cost of educating a medical student. Thus, the 1971 legislation does not diminish the need for continuing support of the private medical and dental schools by the District of Columbia.

- 5 -

The Congress of the United States, particularly the District Committee of the House of Representatives, stands in loco parentis, as the state legislature, to the District in its position as a governmental unit comparable to a state. The Association urges that in this role the Congress provide additional support above that provided through national programs for the nation's medical schools for the critically important medical and dental educational institutions in the District of Columbia.

In the past the District's private medical schools have in practice received special relief from funds appropriated to meet the financial distress of all the medical schools across the country after other sources available to the schools, including state assistance, have been exhausted. The District's schools, to be sure, should have equal access to the national pool of financial distress funds. It is the Association's strong belief, however, that funds provided to the District's schools in Congress' role as a state legislature for the District should be provided as a separate line-item in the regular Labor-HEW appropriations legislation. Such an appropriations process seems to be the only equitable method for Congress to supplement, as so many states do for their schools, the national sources of financial support available to the District's medical and dental schools.

To achieve the Association's objectives, it recommends that the pending legislation be modified to require that funds appropriated under the District of Columbia Medical and Dental Manpower Act of 1970 be appropriated for the District of Columbia through the annual Departments of Labor and Health, Education and Welfare appropriations legislation. The Association also recommends that the receipt of such funds by the District's private medical and dental schools through the Labor-HEW appropriations measure shall in no way affect the eligibility of the District's schools to seek financial

distress assistance under section 773 of the Public Health Service Act.

The intent of the Association's recommendations is (1) to clearly separate that portion of the Congressionally provided assistance to the District's private medical and dental schools which Congress is providing in its role as a state legislature for the District of Columbia; and (2) to preserve the District schools' access, if necessary, to nationally available funds to relieve the financial distress of health professions schools.

DATAGRAM

State Roles in Financing Medical Education

State legislatures in fiscal 1972 provided a total of about \$334.2 million for the operation of medical schools, exclusive of funds to schools in development and to teaching hospitals. Of this total, \$303.2 million went to 63 public medical schools located in the states providing the funds; \$1 million was made available through regional compacts to public medical schools located outside the states providing the funds. Private medical schools received approximately \$30 million from state governments—\$29.4 million in direct payments and \$0.6 million through regional compacts. Additionally, public and private medical schools received approximately \$1.8 million from city and county governments.

The level of funding provided by each state is presented in Table 1. These figures exclude funds channeled through regional compacts. On a total funding basis, state appropriations ranged from a high of over \$36 million for New York to a low of \$765,000 for South Dakota. Table 1 also lists the state appropriation per capita and the state appropriation per \$1,000 of personal income. In fiscal 1972 there was considerable variation in state expenditures for medical school operations relative to population and personal income. Missouri spent 99 cents per capita while 11 states spent over \$2 per capita. One state, Arizona, spent \$3.57 per capita for medical school operations. Based upon the state appropriation per \$1,000 personal income, the figures ranged from a low of \$0.21 per \$1,000 personal income for Minnesota to a high of \$0.76 for Arizona. Ten states spent over 50 cents per \$1,000 personal income for medical school operations.

Support of Private Medical Schools

State legislatures have been limited by institutional and legislative prohibitions in awarding

state funds to private institutions. In recent years, however, pressures to increase the supply of physicians have led a number of states to offer support to private medical schools. The following is a summary of fiscal 1973 state and District of Columbia programs for the support of private medical schools:

California—The state contracts with its private medical schools to expand class sizes. In fiscal 1973 it appropriated \$660,000 to provide for 55 additional students at a rate of \$12,000 per student. This award was not contingent on the residency of students.

District of Columbia—In fiscal years 1971 and 1972 awards were made to the private medical schools—Georgetown and George Washington—not under the special legislation authorizing such support but under the Department of Health, Education, and Welfare's special project grants program to alleviate financial distress. Similar awards were made for fiscal year 1973.

Delaware—The state contracts with an out-of-state college of medicine to accept up to 20 Delaware residents per year. A provision stipulates that a "portion" of the medical students spend their clinical clerkships in the Wilmington Medical Center. The state of Delaware pays \$7,500 per student to the private medical school, with an arrangement that guarantees a minimum annual payment of \$120,000.

Florida—In 1952, Florida enacted legislation to provide support to the first accredited medical school in the state, which happened to be a private institution. Continuing legislation was passed to provide \$6,500 per Florida student for those completing their education in four years (or \$8,500 per Florida student for those completing their education in less than four years) in fiscal 1973. Use of these funds is limited to operating purposes.

Illinois—In the spring of 1969, the Illinois General Assembly enacted the Health Services Education Grants Act providing funds to

Legislative information contained in this article is current as of June 1973

TABLE 1
STATE APPROPRIATIONS FOR PUBLIC AND PRIVATE MEDICAL SCHOOLS*
(Fiscal Years)

State	1972 State Appropriation (Thousands of Dollars)	1972 Private School Component of State Appropriation (Thousands of Dollars)	1972 State Appropriation per Capita (Dollars)	1972 State Appropriation per \$1,000 Personal Income (Dollars)
Alabama	6,086		1.77	0.52
Arizona	6,317		3.57	0.76
Arkansas	2,395		1.25	0.36
California	32,109		1.61	0.31
Colorado	4,365		1.98	0.42
Connecticut	4,085		1.35	0.25
Florida	7,438	2,780	1.10	0.25
Georgia	7,623		1.66	0.42
Hawaii	1,070		1.39	0.27
Illinois	13,656	3,539	1.23	0.24
Indiana	10,187		1.96	0.44
Iowa	8,067		2.86	0.65
Kansas	4,864		2.16	0.47
Kentucky	5,284		1.64	0.45
Louisiana	4,293		1.18	0.33
Maryland	5,386	800	1.37	0.27
Michigan	20,283		2.29	0.46
Minnesota	4,197	32	1.10	0.21
Mississippi	3,348		1.51	0.48
Missouri	4,622		0.99	0.23
Nebraska	3,504		2.36	0.53
New Jersey	12,526		1.75	0.33
New Mexico	2,182		2.15	0.56
New York	36,105	8,814	1.98	0.37
North Carolina	8,632	477	1.70	0.45
North Dakota	795		1.29	0.34
Ohio	16,921	2,250	1.59	0.35
Oklahoma	3,779		1.48	0.38
Oregon	5,544		1.63	0.59
Pennsylvania	20,822	6,765	1.77	0.39
South Carolina	5,243		2.02	0.57
South Dakota	765		1.15	0.30
Tennessee	4,143		1.06	0.28
Texas	30,556	2,083	2.73	0.65
Utah	2,473		2.34	0.59
Virginia	6,995		1.50	0.35
Washington	7,028		2.06	0.46
West Virginia	3,781		2.17	0.59
Wisconsin	5,141		1.16	0.27
Total	332,610	29,416		

* The data relate to funds provided directly by the state to fully operational medical schools located within the state and to state-related schools in Pennsylvania. They exclude funds provided to medical schools through regional compacts. Data are not available for direct state support provided to the medical schools located in Puerto Rico and Vermont. The 1972 state appropriations are derived from the 1972 Liaison Committee on Medical Education Annual Medical School Questionnaire. Data for Indiana and Kansas universities are based on estimates from the 1971 LCME questionnaire. Population data for the "State Appropriation per Capita" calculation are for 1970 and are taken from the *Statistical Abstract of the United States*, 1972, 93rd Annual Edition, page 12. Personal income data for the calculations in the last column are based upon preliminary 1972 figures from the *Survey of Current Business*, April 1973, Vol. 53, No. 4, page 17.

private institutions for increasing enrollments in medical, dental, nursing, and allied health education programs.

Each school is allowed \$6,000 annually for each additional Illinois resident which it enrolls, with the requirement that at least 20 additional Illinois residents be enrolled in each entering class over the average number of Illinois students enrolled per class for the years 1964 to 1967.

In addition, an annual stabilization grant of \$1,000 per student, based on the number of Illinois resident students enrolled in the year 1967, is to be awarded. This grant was contingent upon a commitment by the school to the minimum expansion of 20 Illinois resident students in fiscal 1968.

A single, nonrecurring program expansion grant was made for each of the private medical schools for planning and capital construction, attendant upon increasing this enrollment. No grants were given for any expansion of less than 20 Illinois resident students, and grants to schools that expanded beyond 20 additional students were based on the projected size of the additional increment. Fifty thousand dollars was awarded for each of the first additional 20 Illinois resident students. Beyond this initial grant for each additional Illinois resident, \$20,000 is awarded each year for each enrollee projected above the initial increment of 20 such students.

Maryland—The state's private medical school received \$800,000 per year on an emergency basis in fiscal 1972 and 1973.

Minnesota—Legislation was passed for the 1973 fiscal year awarding \$8,000 per Minnesota resident.

New York—The state university system has three types of contractual arrangements with each private medical school in the state—(a) the Bundy Plan, providing \$2,400 for each medical school graduate; (b) a per capita award of \$1,500 for every medical student enrolled; and (c) a seven-year plan designed to increase enrollment during the period from 1967-68 through 1973-74. In the seven-year plan the average enrollment for each class of medical students enrolled from July 1961 through June 30, 1966, was computed as the

base; \$6,000 is paid for each additional student enrolled over the base period average.

An individual student may be counted only once for all of these programs through his first three years. However, both the \$1,500 grant and the \$2,400 grant may be awarded in the fourth year.

North Carolina—This state's contract medical program with its private schools of medicine provides a per capita grant of \$3,000 for each North Carolina resident enrolled. Five hundred dollars of this \$3,000 per capita awarded is held in a special scholarship fund to provide financial assistance to deserving North Carolinians enrolled. The only restriction is that the sum must be utilized so as to be highly beneficial to the overall welfare of the state of North Carolina.

Ohio—This state has a contract medical program whereby the private university agreed to admit and maintain not less than 110 first-year students in fiscal 1972 and to admit 125 first-year students in fiscal 1973. A subsidy payment of \$4.5 million was paid to the university for the biennium 1971-73. The subsidy was not contingent upon the residency of the students.

Pennsylvania—The amount of the awards measured on a per capita basis for fiscal year 1972 were as follows: (a) \$7,465 per capita to three state-related schools and (b) \$4,400 per capita to four state-aided schools. There was no change for fiscal year 1973. These awards are not contingent upon the students' state of residency.

One of the major characteristics that differentiates "state-related" from "state-aided" schools is the university board of trustees. The state appoints a certain number of members to the board of trustees of a "state-related" university, thereby giving the state a direct hand in making policy decisions that govern the operations of the institution.

Rhode Island—The state's private medical school received a \$200,000 grant from the state for fiscal 1973, with no restrictions placed upon the use of the funds.

Tennessee—The state appropriated \$40,000 for support of its private medical schools for the 1973 fiscal year. This amount was divided

TABLE 2
REGIONAL EDUCATION PROGRAMS IN MEDICINE, FISCAL 1973

Program	Participating States	Contracting Institution		Number of Students		Total Funds To	
		Public	Private	In Program	Per Capita Award	Public Schools	Private Schools
New England Board of Higher Education	Maine, Massachusetts, and Rhode Island	1	—	159	\$5,000*	\$720,000	—
Southern Regional Educational Board	Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, Tennessee, and Virginia	—	1	110	3,250	—	\$357,500
Western Interstate Commission for Higher Education	Alaska, Arizona, Hawaii, Idaho, Montana, Nevada, and Wyoming	13	3	246	3,000	656,000	82,000
Total				515		\$1,376,000	\$439,500

* \$2,500 each for 30 students who are Maine residents.

between the state's private schools on a formula basis reflecting the increase in the number of Tennessee residents who enrolled in each school over an established base.

Texas—The Texas legislature appropriated close to \$2.1 million in fiscal 1972 for that state's private medical school. That figure has doubled to \$5 million for fiscal 1973. This represents a change of from \$14,370 per private student for fiscal 1972 to \$17,282 for fiscal year 1973.

Funds are channeled through a coordinating board which contracts directly with the private medical school. The support to the private medical school, during each scholastic year, equals the average annual state tax support per undergraduate medical student at the established public medical schools multiplied by the number of Texas undergraduate students at the private medical school.

Wisconsin—The state has appropriated funds on a biennial basis for medical educa-

tion in its private medical school since 1969. The amount appropriated during the 1971-73 biennium was \$3.7 million. No restriction on the use of the award was made, nor was the grant contingent upon increased enrollment or the residency of an enrolled student.

Regional Contracts

The three regional boards—New England Board of Higher Education, Southern Regional Education Board, and the Western Interstate Commission for Higher Education—have a combined total of 18 contracts with accredited public and private institutions. Funds flowing through the boards for contract programs in medicine totaled nearly \$1.6 million for fiscal 1972. Nearly \$1.8 million was made available for fiscal 1973 (Table 2).

ROBERT CAROW
AAMC Division of Operational
Studies
Washington, D.C.



AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 527-1500 • TWX 910-221-0300

ERNEST B. HOWARD, M.D.
Executive Vice President

May 8, 1974

The Honorable John V. Tunney
Chairman, Subcommittee on Public
Health, Education, Welfare and Safety
Committee on the District of Columbia
United States Senate
Washington, D. C. 20510

Dear Senator Tunney:

On behalf of the American Medical Association, I would like to submit for your consideration our comments on S. 2730, which we understand is now under consideration by the Subcommittee on Public Health, Education, Welfare and Safety. This legislation would extend for three years the District of Columbia Medical and Dental Manpower Act of 1970 which authorizes assistance to the private non-profit medical and dental schools in the District of Columbia.

The Association has long stressed the importance of the nation's medical schools and their needs for adequate financial support from diverse sources if they are to continue to perform their essential functions in society of preparing competent practitioners of medicine to provide timely and effective medical services to the American people.

Among the important sources of funds for medical education have been those from the States. In many States privately supported as well as publicly supported medical schools receive financial support from States to assist the schools in carrying out their education of medical students. In a sense, the District of Columbia bears the same relationship to the private medical schools within its borders that States do to the private medical schools within theirs.

The American Medical Association would therefore support S. 2730 to authorize such assistance to the private medical schools in the District of Columbia. However, since it is most important that all of the nation's medical schools continue to receive adequate financial support, funds made available through this legislation should not diminish the availability of Federal funds for medical schools throughout the nation and for which all such schools are eligible to compete.

Thank you for this opportunity to present these views. I respectfully request that this letter be made part of the record of your hearings on S. 2730.

Sincerely,

A handwritten signature in cursive script that reads "E B Howard".

Ernest B. Howard, M.D.

LIMIT BILL TO 2 YEARS

Father COLLINS. In summary, Senator Tunney, we come to our State legislature, in view of the points made by the Secretary, I believe, we can keep congressional logic by limiting the bill to 2 years.

It is proposed to be 3 years.

We would propose it to be a 2-year bill—namely, until the District of Columbia has its own capability. We come to you asking that we continue to receive the statelike aid for 2 years.

Senator TUNNEY. Father, thank you very much, and I thank all of you for a very articulate presentation to the problem.

I certainly understand a lot more about it right now than I did 1½ hours ago. I know that other members of the committee working on this bill appreciate the fact that you have been able to present the facts and arguments so cogently, and that record will be available, of course, to the other members of the committee by the time we mark up the bill.

I am going to have to recess the hearing now for 15 minutes, and when we come back, Dr. Standard and our final witness will be Mr. Anthony Morella.

I apologize, but I cannot control the activity of the floor. I am going to ask the remaining witnesses to try to condense their testimony, because we are going to have a number of votes between now and 3 p.m. That means probably every half hour we would be voting, so I would like to get the other two witnesses' testimony in between this vote and the next vote coming up.

I have a number of prepared statements on this bill which I now place in the record.

Thank you.

[Whereupon, the subcommittee was in short recess.]

[The prepared statements follow:]

THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

2007 EYE STREET, N.W.



WASHINGTON, D. C. 20006

STATEMENT ON

THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

ON S. 2730

THE SENATE COMMITTEE ON THE DISTRICT OF COLUMBIA

SUBCOMMITTEE ON PUBLIC HEALTH, EDUCATION, WELFARE AND SAFETY

JOHN V. TUNNEY, CHAIRMAN

MAY 1, 1974

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I am Dr. Clifton R. Gruver, a physician in the practice of Internal Medicine in Washington, D. C., for over twenty years. I appear today as President of the Medical Society of the District of Columbia, the only state society ever chartered by Congress, and a society which has a membership of 3,000 physicians who practice in this metropolitan area.

I shall not dwell at any great length on the reasons why this bill should be passed. I believe these to be well-documented from testimony which has been given in years past, and that which will be given here today. However, I would emphasize that the medical manpower needs of the District of Columbia are supplied in great measure by the Georgetown and George Washington University Schools of Medicine. Combined, these two schools graduate approximately 350 physicians each year. Over 30 percent of these physicians choose to stay in this community for their continued education, and subsequently remain here to enter into practice. Statistics show that at the present time approximately 1,000 graduates of each of these schools of medicine are practicing in this area.

We believe that the financial plight of private medical schools in

this country is also well-documented. You have heard in testimony that income from tuition and other sources is not sufficient to support the cost of a four-year medical education. It would, therefore, be a real catastrophe for medical education, especially in this nation's Capitol, if these schools were once again forced to consider closing their doors because of the lack of funds. To lose this great source of physician manpower, would have a serious effect on the high ratio of physicians which this city enjoys. And, their services are essential to the delivery of good health care to the citizens of this community.

In compliance with previous national legislation, both of these schools have made tremendous progress in increasing the size of their student bodies and the number of physicians graduated each year. In keeping with this increased effort, we recognize the strenuous effort which both schools have made, in the past and present, to find new sources of private funds to support ever-increasing costs. In spite of these efforts, however, as we have heard, they find themselves unable to continue without the assistance which this bill will provide.

In closing, I reiterate that The Medical Society of the District of Columbia strongly supports the passage of this bill so as to make it possible for the private, nonprofit medical schools of this city to continue their great work.

Thank you for the opportunity and the privilege to present our views.

Mr. Chairman, my name is William M. Bucher. I serve as the Executive Vice President of the Hospital Council of the National Capital Area, Inc., a voluntary organization of thirty community hospitals in the Washington Metropolitan Area.

I have served in this capacity since 1951 and I have been intimately involved in the area health manpower programs including those provided by the Universities under the legislative request before you today.

The Hospital Council has had as one of its major programs the provision of health manpower of a quality and quantity necessary to meet the health needs of our metropolitan community. It has developed and operated a Center for Continuing Education for physicians and allied health personnel. Further, the Council has developed educational programs for health personnel in hospitals at the job entry, skill improvement, and management levels. Working with programs under the Departments of Labor and HEW, for illustration, we have trained upwards to five hundred health and hospital workers in a single year.

Because of this responsibility and experience, I am pleased to appear today in support of the extension of the District of Columbia Medical and Dental Manpower Act of 1970. My testimony will also support the fact that the services provided by these medical centers by affiliation, and otherwise, with the hospitals throughout the Washington Metropolitan Area are essential to the quality of health care enjoyed by our resident population and our visitors both national and international.

The Georgetown and George Washington Universities have assumed an impressive role in contributing to the sophistication of health care in this community. They have been intimately involved in the problems associated with the dissemination of new and researched life-saving medical techniques and procedures both within the University hospitals and the community hospitals. The provision of multi-faceted university medical center programs are geared to the needs of all income segments

of our population.

The Georgetown University Medical School's teaching faculty, house staff and students, for illustration, are found in Arlington Hospital, Children's Hospital, the Hospital for Sick Children, and the District of Columbia General Hospital. In addition, the Georgetown University Medical School maintains medical specialty affiliations with the Washington Veterans Hospital, Providence Hospital and Sibley Memorial Hospital. Further, from time to time, staff specialists are made available to supplement and plug voids within the District of Columbia Government's health service. The Georgetown University Dental School program has similar community involvements.

Next, I would like to illustrate the important contributions of the George Washington Medical School, its University Clinical Center and its University Hospital to the health professional area and the entire metropolitan community. This university's medical school teaching faculty, its hospital house staff and its students can be found in its affiliated programs at the Columbia Hospital for Women, the Fairfax Hospital, St. Elizabeth's Hospital, the Washington Hospital Center, Children's Hospital and the District of Columbia General Hospital.

George Washington University's Medical Center has also extended its educational programs and specialty services throughout the community into Walter Reed Army Hospital, the Bethesda Naval Hospital, the Armed Forces Institute of Pathology and the National Institutes of Health.

The George Washington University Clinical Center recently opened its impressive Comprehensive Care Program. This prototype service center is one of the few of its type in the country. It provides its patients from all income levels with the highest quality of care available at the most economical rate. Both Universities became deeply involved in the development of Health Maintenance Organizations before

the passage of Public Law 93-222 on December 29, 1973.

Mr. Chairman, these are some of the facts which illustrate the George Washington University School of Medicine and Georgetown University Schools of Medicine and Dentistry position as integral elements of the health care system in the Washington Metropolitan Area. The absence or curtailing of the services provided by these institutions would seriously jeopardize both the quality and quantity of health care here at a time when federal programs and the public demands for health care are increasing at an unprecedented rate. Another point worthy of emphasis is that these two medical schools and the dental school perform the function of State schools. Their staffing of the public health institutions, especially at the District of Columbia General Hospital, is a responsibility that in most States is performed by State schools.

The Metropolitan Washington Area is a national resource and a national responsibility. Statistics show that over 70% of the residents in the Metropolitan Area are employed by Congress and the Federal Government, or their supportive and related industries. By virtue of services that these schools render within the Metropolitan Area hospitals, they constitute the health manpower resource for the residents of the Washington Metropolitan Area. It is, therefore, sound rationale to consider deficit funding at the national HEW appropriation level.

In terms of dollar service contributed by these Schools of Medicine and Dentistry to the Washington Metropolitan Area, I would like to point out that the services rendered by these medical centers, for which they do not receive reimbursement, are calculated in millions of dollars. One such program is the Medical Charities Program which provides hospital and clinical care to indigent patients by the Medical School staffs of these University Hospitals. In the fiscal year 1972 services were provided to the District Government patients which cost millions of

dollars above the amount that was actually paid. Congress has provided no economic relief from this problem within the fiscal 1974 D.C. Budget.

In conclusion, there are three basic points:

1. It can be amply demonstrated that the financial assistance requested for these Schools of Medicine and Dentistry differs from other educational programs, since the medical centers of these schools provide unenumerated services to the Washington Metropolitan Area which run into millions of dollars annually.

2. Since the Federal Government is by far the largest employer in the National Capital Area, it assumes the legislative and financial obligations to ensure the operation of the Nation's Capital as a national asset. It should provide the comparable "state-like" funds to allow these schools to serve the health needs of the National Capital Area.

3. The George Washington University School of Medicine and the Georgetown University Schools of Medicine and Dentistry are in dire need of financial assistance as their accounting records demonstrate. It is less costly to the Federal Government to support their needs rather than to take them over.

Therefore, I urgently recommend that your Committee act favorably on S. 2730 since these schools are essential elements of the health care system for the residents and visitors of the Washington Metropolitan Area.

COMMITTEE ON THE DISTRICT OF COLUMBIA
SUBCOMMITTEE ON PUBLIC HEALTH, EDUCATION,
WELFARE, AND SAFETY

Date of Hearings: May 1, 1974. 9:30 a.m. at the D.C. Committee Room
6226 New Senate Office Building

Mr. Chairman and Members of this Committee:

My name is Henry J. Johnson, Jr. I serve as President of Rogers Memorial Hospital's Chaplains Staff as well as President of the Capitol Hill Group Ministry. I am an active member of the Baptist Ministers Conference, "Universal Justice and Goodwill" and "One Hundred Baptist Ministers". I represent the Baptist Ministers Conference of the Washington Metropolitan Area and in particular the Southeast and Northeast sectors of Washington. I believe that the work done by the medical schools at Georgetown University and The George Washington University at Rogers Memorial Hospital and the D.C. General Hospital is of great service to the patients attending these hospitals.

I understand that these schools are in need of money from Congress in order that they may continue to do their work. For this reason I strongly support the bill S. 2730.

Thank you for allowing me to present my testimony.

Statement Submitted on:

D.C. Medical and Dental Manpower
Act 1970 Extension

By: Vijaya L. Melnick, Ph.D.
Assistant Professor of Biology
and Premedical Advisor
Federal City College
1321 H Street, N.W.,
Washington, D.C. 20005

To: The Senate Subcommittee on
Public Health, Education,
Welfare and Safety of the
Senate District Committee

On: May 1, 1974

Statement of Dr. Vijaya L. Melnick

My statement presented here is not made on behalf of any organization or group but as that of a private citizen. However in making the statement, I have freely drawn from my experience as a premedical advisor and one deeply concerned with the problems and opportunities faced by D.C. residents in their attempts to secure professional education and training in medicine, dentistry and related health professions.

I urge the support of the bill which would allow federal subsidies to the Georgetown Medical and Dental Schools and to the George Washington Medical School. In this time of large national deficits in trained health professionals and personnel at all levels, we cannot afford to close down or reduce effective programs of any medical or dental school. However, the medical and dental schools asking for such substantial public support should be required to demonstrate definite programs that reflect public commitment. The amount of federal subsidy asked by the schools approach 20 to 25 percent of their total budgets. My support for the bill is hence contingent upon the following:

1. Past and present records indicate that the enrollment of D.C. residents in the medical and dental programs of these schools is barely 5%, and of D.C. minorities far less (Attachment #1). In my direct experience the schools have done little to encourage participation of D.C. residents, especially minorities. Many of my students who are presently at other medical or dental schools had applied to Georgetown and George Washington Schools but without success. These students are continuing in the programs that they have entered and, from all follow up reports, are doing well (Attachment #2). The schools must make a concerted and written commitment to actively recruit and preferentially enroll D.C. residents, especially from the under-represented segments of society such as minorities and women.

Page 2

An analysis* of the state by state origin of entering students in all the medical schools in the United States during the past few years (latest data released is for 1972-73) reveals that when ranked according to the proportion of students who reside in the state or territory in which the school is located, Georgetown Medical School and George Washington Medical School rank at the bottom of the list. This analysis is based on the AMA's report on Medical Education in the United States and includes private as well as publicly supported schools. For example, in the year 1972-73, the proportion of instate (D.C.) students in George Washington was 0.0634 while it was 0.0386 for Georgetown University Medical School. This compares with instate proportions of 0.188 for Harvard Medical School, 0.1397 for Howard Medical School, 0.291 for Johns Hopkins, 0.388 for Stanford, and 0.123 for Dartmouth. If we compare these schools to medical schools which function as state medical colleges, the results are even more dramatic. For example in the same year, the University of California at Davis had 0.931 instate enrollment compared with 0.871 at Irvine, 0.822 at Los Angeles, 0.730 at San Diego and 0.795 at San Francisco.

2. Washington D.C. has great needs for allied health personnel. Are the schools willing to train paraprofessional health personnel along with medical and dental students, in accordance with types of manpower most needed in the city?

*This analysis is part of a report that is being prepared for Congressman Ronald Dellums (D-Calif), Chairman, D.C. House Subcommittee on Education to be submitted to the District House Committee.

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3. Are the schools willing to initiate and institute more community based health programs to serve D.C. residents in areas of the city which are presently underserved in health care facilities?
4. Federal appropriations for medical education, that in the past was designed to encourage innovative education and to increase total enrollments, are now being drastically reduced or cut. What could be asked of these schools in return for this large amount of federal support, in the way of changing their emphasis and methods in the medical education process itself?
5. What is the assurance, if this budget is channeled through the same congressional committee that handles the D.C. budget, that it will not negatively affect other local health care and health training programs and their funding in the D.C. budget.

It is my firm belief that the medical schools have a primary obligation to serve the community in which they are located and in doing so, they serve the nation as a whole.

Attachment #1Georgetown

1971	<u>213</u>	Total number entering
DC Res	11	
	31 Women	
	13 Black	
	1 Mexican American	
	3 oriental	

1972	<u>213</u>
	34 Women
	10 Black
	2 Puerto Rican

1973	<u>210</u>
	37 Women
	8 Black
	2 American oriental

George Washington

<u>128</u>
11
17 Women
5 Black
0
4 oriental

<u>143</u>
25 Women
3 Black
3 American oriental

<u>153</u>
37 Women
6 Black
3 American oriental

Above data received from Assoc. of Amer. Med. Schools

Attachment #2

Federal City College students in medical and dental schools (by entering freshman class of the listed schools).

1971 - 72

Univ. of Ohio Medical School - 1
 Temple Univ. Medical School - 1

1972-73

Howard Medical School - 1
 Howard Dental School - 1
 New Jersey Medical School - 1

1973-74

Rutgers Medical School	- 1
Downstate Medical School, N.Y.	- 1
Meharry Medical School	- 1
Univ. of Miss. Medical School	- 1
Jamaica Medical School	- 1
George Washington Medical School	- 1

1974-75

Univ. of Penn Medical School - 1
 New York Univ. Dental School - 1
 (list is ⁷⁸complete, since students are being considered currently)

All of these students had applied to either or both Georgetown and George Washing Medical Schools.

In addition we have students in the Bio-medical graduate programs at such places as State Univ. New York, Stony Brook; Howard University; Univ. of Calif. Veterinary School, Davis; American University; and George Washington.

Our students also successfully completed summer school or research programs in such institutions as Harvard University, Univ. of Tenn-Oak Ridge Natl Lab. Bio.med program and Meharry Medical School.

1

First 3 pages
are summary

Testimony in behalf of the Medical Committee for Human Rights (MCHR)

Presented by Ava Wolfe, M.D., member of the D.C. Chapter's Steering Committee

In opposition to H.R. 11100, the D.C. Medical and Dental Manpower Act

S-2730

We would like to present first of all a summary of our opinion, and to follow this with a longer discussion of each point. Addenda to the written testimony include specific examples of problems cited, and of suggested positive action programs, both for the House District Committee and for the two schools in question. The oral testimony presents only the basic issues.

We hope that you will accept this report, not as an MCHR position only, but as a composite of the opinions and suggestions we received over the past two weeks from many other groups and individuals outside our membership. These sources, and how we solicited their comments, are listed in the addenda.

In Summary:

MCHR's opinion is that as long as George Washington and Georgetown Medical Schools (hereinafter referred to as G.W. and G.T.) continue their present policies toward their community, workers, and patients; toward admitting D.C., minority, and women students; and toward development of other health manpower training programs for D.C. residents -- we cannot support their getting D.C. money at all. They have no reason to plead poverty or to claim concern for D.C. A number of other private medical schools around the country have neither had to lean on federal disaster funds nor had to ask for state aid.

The only kind of bill we could find acceptable would be one that included all, not just some, of the following features:

- 1) It must have teeth in it -- specific requirements of the schools, not just simple "assurances". These must include time-tables for increasing D.C. enrollment, active recruitment methods, and tutorial services to assure retention of D.C. students once admitted. A certain number of slots must be kept open for D.C. students.
- 2) It must state in writing that the House District Committee would in no way reduce the overall city budget, or the budget for training other types of health manpower than doctors and dentists, because of this appropriation. Your committee is notorious for making general budget cuts every time categorical funds are channelled into the District.

- 3) It is insufficient to require only approval of the amount of the appropriation by the Secretary of HEA and the Mayor-Commissioner. The schools must not be allowed to receive the money anywhere and to set themselves up so independently of the City if they receive City funds. The proposed use of the funds must be subject to approval by the City Council, D.C.'s Board of Higher Education, and/or D.C.'s Comprehensive Health Planning Agency. In addition, the bill must require that a citizen's board be chosen to participate in the administration of any new programs set up with the funds.
- 4) Cost control mechanisms must be built in, as with any other appropriations made to bail out institutions with spiralling costs.
- 5) Funds must not be given per/student for the entire enrollment, but only in the form of scholarships and loan guarantees for those students enrolled from D.C., and those who agree to obligatory service to needy areas in D.C. for 2 to 3 years after completion of their training. The total number of students receiving both these types of scholarships should be the same percent of the total enrollment as the percent of the total school's budget comes from this appropriation. The funds must not be given as a lump sum in advance to the schools, but only after these students have been signed up.
- 6) Any further funds appropriated must not be on a per/student basis but on the basis of the number of indigent D.C. people provided with fairly comprehensive services, and/or on the basis of the number of hours of staff time provided to facilities and services in needy areas. Only in this way could we be sure that D.C. money would be used for D.C. purposes.
- 7) The manpower trained must fit D.C.'s needs, both with respect to geographic areas and economic brackets where care is most needed, and with respect to the types of health manpower needed most. If that need is for public health nurses and technicians more than for physicians, they must provide training for those categories as well. The two schools must be required to develop more pre-professional training programs for D.C. residents, and upward mobility programs for their school and hospital employees. They must give aid and support to such programs in other parts of the city, and to union efforts to negotiate for such programs.
- 8) If the amount of funds appropriated were to represent a sizeable proportion of the schools' entire budgets as suggested in H.R. 11100, the opportunity must not be passed by to use the bill as a means to ask for changes in the methods and content of the educational process itself, to emphasize community consciousness for all students.

But even if all these provisions are placed in the bill, there is another overriding problem. A multi-million dollar program is being pushed over

on the D.C. people, not only without their consent, but without their knowledge. It must be the choice of the D.C. people whether they want to support a medical school with their tax money at all, and if so, which one. Once this bill passes, it will be in effect indefinitely. This is too important an issue to have less than full public consideration.

MCHH urges your Committee to hold public hearings in several sections of the city, with full publicity in the media, to solicit opinions. Our guess, from the sampling of opinion that we received in preparation of this testimony, is that the public's last choice would be G.W. or G.T.

Now, to illustrate each of these points:

We grant that the cost of medical education has increased astronomically over the last few years, from \$1 or 2,000/student/yr to \$16 to 25,000/student/yr. We are aware of the cuts, not only in federal disaster funds to health science schools, but likely soon in the other major HEW medical manpower bills, and in research and mental health monies to support faculty. Our chief disappointment is in the reduction of capitation funds that required increasing total student enrollment, and in scholarship funds for poor and minority students. Students are losing federal loans they already had, and are finding it difficult to get guarantees for increased bank loans. Only 200 scholarships are available under the new Public Health Service program, whereas there are 5,000 military scholarships. If other scholarship monies are not made available, only the rich and military will be able to go to medical school. MCHH is greatly disturbed as it sees this already happening.

On the other hand, we have serious concerns about the request of these two particular medical schools for D.C. funds. To the community, they are the two richest institutions in the city and have no reason to plead poverty. We are told that G.W. University is second only to the federal government in land holdings in D.C., and that G.T. University is third in the number of employees. As for the medical schools, G.W. has two large new expensive buildings, and G.T. is planning a multi-million dollar coronary care unit, plus two new floors for their Kennedy medical ethics unit. D.C. is already subsidizing them to the extent that this property is tax-exempt.

Also, to the community, these two institutions have little basis on which to claim concern for D.C. and its residents. They do little for their own immediate neighborhoods, let alone for the city at large.

They treat too few indigent patients, and in some ways still segregate them from the private patients. They still transfer emergency cases from outside their service area to D.C. General if they cannot pay, and discharge in-patients sooner than might be medically advisable if they cannot pay.

They set up services without community input, and make promises to the community that they do not keep.

They do not consult with their faculty and students when making decisions that directly affect them.

They do not respect the rights of their employees to adequate pay increases.

What convinced D.C. people once and for all of G.W.'s lack of concern (both for the community and for meeting D.C.'s health manpower needs) was their announced intent to pull out of D.C. General Hospital -- the one place in the city that is the most understaffed, and the most in need of their aid.

The other prime example of their lack of concern (both for D.C. employees, and for developing health manpower from among D.C. residents) was the recent arrests, firings, and suspensions of G.W. Hospital workers who wanted a union. One of their main desires was for upward mobility programs and in-service training. Such a program is needed to fill D.C. health manpower needs for more than D.C. needs 3 medical schools to produce doctors, with a fourth military medical school in the offing. But G.W. could not see beyond its own self interest and cost-efficiency when asked to recognize the workers' rights to negotiate for such a program.

More specifically with relation to this bill, G.W. and G.T. have an extremely poor record on D.C. admissions to their medical schools, especially of minorities, and on retaining them until they graduate. This is true despite their admitting a fair number of foreign students. Even the M's and L's figures they give of graduates staying in D.C. after graduation (and the 30% figure for the total number of doctors in the D.C. area who are their graduates), include those in federal service and research. These functions are not satisfactory to the community as meeting the needs of the area. Howard's 16%, by comparison, are largely practitioners; and even though many of them are in lucrative suburban practices, there is still a greater discrepancy than these figures suggest in which school provides the most physicians to needy areas and to indigent patients.

We have the following major concerns about H.R. 11106:

1) It is beyond our comprehension that this bill should pressure that these institutions act in good faith toward the community, and that only their "assurances" are necessary to insure increased D.C. admissions. Only if this bill has teeth in it in the way of requirements, only if the money is restricted to D.C. students and D.C. manpower development, will they comply. There must be a time-table with a specified number of slots to be reserved for D.C. residents, to increase each year. There should also be a requirement for increasing the admissions each year of poor and minority students from elsewhere, and of women. And in lieu of loss of federal funds to encourage increasing total enrollment, that requirement might also be added.

Active recruitment programs must be required. A program with high school or college students should be begun to encourage their interest and to recognize their talents. A summer brush-on semester should be offered to prepare those admitted for the transition. And to insure that D.C. residents admitted are retained and graduated, retention programs should be made available.

The schools have too long excused themselves on the basis that they cannot find qualified applicants from D.C. At least 4 D.C. students (from Howard Univ. College) were refused last year by G.W. and G.T. as

underqualified, but they were admitted to other medical schools around the country and are doing well. D.C. residents don't have the same right to go to medical school as do residents of states with state schools. If this bill does not rectify that situation, there is no justification at all for D.C. funding.

2) We are concerned as to whether this will affect the overall D.C. budget, and to what extent the money will come from D.C. taxes. Your Committee has been notorious for cutting the general D.C. budget every time categorical funds are channelled in. Even your promise not to do so this time will not be believed unless you write it into the bill. If the budget were reduced accordingly, this bill could be a gross disservice to the community at large, because there are a number of D.C. needs that are far more pressing now than the need for more doctors and dentists -- such as for T.B. and V.D. control, prison health, etc.

More specifically, would the D.C. budget for development of other types of health manpower be reduced? In our estimation, there is a far more pressing need here for public health nurses, visiting nurses for the elderly, Spanish nurses and nurses' aides, better technicians, and paraprofessionals, than there is for more doctors and dentists. (D.C.'s CHF agency has more specific data on such manpower shortages.) This Committee has long neglected passing laws regarding paraprofessional licensure in D.C., and thus has held up development of training programs for them. It is time that you attended to that problem, and then consider this bill only if its funds add to those efforts, not subtract from them.

3) We are concerned about the funding mechanism suggested in the bill. The request is for funds to be separate and apart from the D.C. budget, which means that it by-passes any review or evaluation by any body of D.C. people. The schools receive the money carte blanche. Why can't these institutions work with the people of this city instead of setting themselves up so independently?

We consider it insufficient to have the Secretary of HEW and the Mayor-Commissioner to approve the amount appropriated. If this is a D.C. manpower bill, then people of D.C. should have the final say as to how that money will be spent. The institutions must be required to submit their plans to the City Council, D.C.'s Board of Higher Education, and/or the D.C. CHF agency, not only for their review and comment, but for their approval or rejection. Periodic reports of progress toward the stated goals, and as to the use of the funds, should also be sent to these bodies.

The bill should require as well that there be a representative citizen's board set up to work with the schools from the beginning stages of development of all new services and programs initiated with these funds.

4) We are also concerned about the blanket giving of this large an amount of money to bail out institutions with spiralling costs, without writing in stipulations for cost control. Haven't these lessons been learned yet? Perhaps the costs are due to excesses that could be trimmed.

Other private medical schools in the U.S., some with even higher budgets than G.W. and G.T., have not had to ask for federal disaster funds or for

state support. We are told that a G.I. Blue Grant money from the hospital is being diverted to the medical school, thus making the rich share the costs of medical education as well as the costs of their own care. The same bears investigation at G.W. because their hospital proudly announced that it ended in the black last year for the first time, but still did not give their workers a sufficient pay raise to meet cost of living increases. Can this magnitude of deficit be explained simply by there being less philanthropic foundation and church support in D.C. than elsewhere, or is this an indication of excessive spending? HSW has testified that its reluctance to fund these two schools is in large part due to evidence that they have been unable to curb increasing costs to the extent that other schools have.

One reason for the great increase in cost of medical education recently has been the competition between schools, perhaps more acute as in D.C. where several schools are in the same city, for prestige. This is done by unnecessary duplication of highly expensive equipment and facilities, especially for the training of subspecialists and research physicians. The training of family physicians, a much more needed type of manpower, costs far less. Already Washington Hospital Center is turning away indigent cases and closing its nursing school in order to use its money to keep an expensive and underutilized intensive care unit open. We should not allow this situation to be repeated at G.W. where a multi-million dollar coronary care unit is being planned. We question the need for this facility in D.C., and are concerned about the further emphasis it will place on subspecialty training.

The schools have testified that their greatest cost overrun are in the area of indigent care, and that this is where they will trim their budgets if new money is not forthcoming. We have no figures on this, but feel this bears investigation. Considering how few indigent patients they do care for, we question whether this is the most important factor, or whether the building and maintenance of these expensive units, and the emphasis on specialty training, are the factors that need trimming. Granted, at G.W. last year, three drug overdoses that required renal dialysis almost broke their HMO. But should they curtail services for indigent patients in general just because of three cases?

5) We are concerned about the appropriation of this money on a per/student basis for the entire enrollment. We propose instead that per/student money be reserved only for D.C. students, in the form of scholarships and loan guarantees, which should be larger for poor and minority students, and for women who have child care expenses. Only in this way can we insure that D.C. and these underrepresented groups will benefit from the funds. The funds must not be given to the schools as a lump sum in advance, but only after the students who qualify for these scholarships have been enrolled. As the bill now stands, the schools could increase their D.C. black enrollment from one to two (100%) and claim that they had fulfilled their obligation.

We also propose that if 1/4 of the operating budgets of these two schools is going to come from these funds, that 1/4 of the students should either come from D.C., or be required to remain and practice in D.C.'s underserved areas for 2 or 3 years after completion of their training. The difference in the number of D.C. admissions and this 1/4

of the total class, could also have scholarship money and loan guarantees on the basis of promising to fulfill this service obligation. "Forgiveness" clauses in loans would be an inadequate incentive to their staying, and the obligation must in addition state that the service will be rendered in needy areas of D.C.

6) We are concerned that the bill does not require the schools to render any services to D.C. in return for the money. Since this is a D.C. manpower bill, we propose that the remainder of the appropriation be made on a per/patient basis for indigent D.C. residents owed for, and/or on a per/hour basis for manpower provided to D.C. health facilities and services that are hurting most because of understaffing, and are the most needed to provide comprehensive and preventive services to D.C.'s most needy areas. This would not only assure that D.C. money would be spent for D.C. purposes, but would also shift the emphasis in medical education for the entire student body in the direction of family practice in needy areas.

We were told that one of G.W.'s reasons for leaving D.C. General is that the Department of Human Resources was reducing the amount of money they were willing to pay for contractual services. If this bill renewed some funding for this type of care, it might entice them to stay. Staffing time put into public health efforts such as specific disease control, transportation services, etc., should also qualify. Services to the needy in their own HMO's should qualify, but with the following reservations:

- a) If they do not take over and replace Neighborhood Health Centers already in existence.
- b) If they educate the community as to the disadvantages as well as the advantages of HMO's.
- c) If they have consumer boards to control the purse strings.
- d) If they will freely return Medicaid cards to patients who are dissatisfied with their services.

Funds designated for services must not be diverted to administrative and overhead costs, except inasmuch as this represents administration of the D.C. service projects themselves. This could include start-up funds for new services, developed at community request to fill most urgent community needs.

7) We are concerned as to whether the manpower trained under this bill will fit D.C.'s projected needs, both for types of physicians needed, and for other types of health manpower. If that need is for public health nurses and technicians, they must provide training for those categories. This might require periodic changes in the types of ancillary training programs they offer. These programs should preferentially admit D.C. residents, and should be integrated into the medical school program.

The two schools must be required to develop more para-professional training programs, and upward mobility programs for their school and hospital employees. They must give aid and support to such programs in other parts of the city, and to union efforts to negotiate for such programs.

If MCHR could design a model medical school, it would have a stepwise training program in which students who go 6 months would be Nurses' Aides, those who go 1 year would be Practical Nurses, for 2 or 3 years an R.N. or Physician's Assistant, and for 4 years a doctor. Students with lesser qualifications could therefore enter the school, and the best students at each level be retained for the next. New medical workers of all types would be produced and fed into the health care system on a steady basis and in numbers according to need and job availability. Every doctor would have gone through all the training for Nurses' Aides, R.N.'s, etc., and would therefore better understand their level of skills and their points of view. With all manpower being trained together in the same classes, they would develop the ability to work together later as teams and with mutual respect.

There are those in D.C. now, connected with the public school's adult education and job training programs, who are interested in developing such a ladder in D.C. We would like to see G.W. and G.T. funded only inasmuch as they would work in conjunction with that effort, and begin to adjust their own curriculum to fit into it once well established. The people of D.C. would be much more likely to want to support a state medical school if it were of this type. In fact, this effort might deserve a special appropriation from the House District Committee more so than the two medical schools and the dental school.

8) Lastly, we are concerned that, considering the magnitude of the funds requested, the writers of the bill did not recognize the extent to which this might be used to effect change. If the total F.Y. '73 budgets for these schools were as predicted -- \$8.8 Million for G.W. and 15.1 Million for G.T. (including the dental school) -- then the \$6.2 Million maximum requested in this bill represents 1/4 of their total budgets! This may be a smaller percent than state schools get from their state governments, but for these two schools it would likely be second only to the federal share of budget support, and this makes it all the more important to use this bill as well as HEW bills to bring about basic changes in the methods and content of medical education.

HEW is aiming toward giving its support for medical education according to the following proportions: 1/3 for educational functions, 1/3 for services, and 1/3 for research. This is likely a fairly wise distribution, and this bill should also aim in this direction.

First, funds for services are probably currently the lowest, and those now available require only that a small percent be utilized for the poor. Under this arrangement, the community considers the services rendered to the poor to be only tokenism, not altruism, as they are provided only at the minimum level required for keeping the grants. Only if the percent of the total given for services is equal to the percent of poor in the total population of D.C., does this cease to be tokenism. Reserving funds under this bill for services to indigent only would help to correct this imbalance at G.W. and G.T.

Second, funds for research are certainly essential to the progress of medical science and to medical education, but they probably already represent over 1/3 of the total budgets of the schools. Also, research

erves more of a national than a local function, and is more appropriately funded through national channels. This bill should specify that its funds not be used for research.

Third, funds for the educational process itself may still be lacking in the 1/3, 1/3, 1/3 distribution. Funds for education under this bill, would, as already pointed out, be in the form of scholarships and loan guarantees to specific students. However, the bill should further require the schools to use this money, once paid to them by the students, in ways that would alter the emphasis and methods of the educational programs for all of their students. These could be:

- a) For curriculum innovation, especially to emphasize family practice and community medicine. Students say that family practice and the whole-patient approach are emphasized considerably by certain of the faculty, though they themselves are subspecialists. This is in no way objectionable, but it would help to have some "hero models" around who were true family practitioners.
- b) For salaries of faculty who, rather than producing multiple research papers, are simply excellent teachers; and for faculty who will develop para-professional training programs for D.C. residents and integrate these with the training of the medical students. They could help to develop new roles in the city for paraprofessionals as well -- in preventing fire and traffic deaths, etc., etc.

All of these shifts in the schools' budgets may help to bring needed changes in the relative emphasis between education and research on the one hand, and services on the other. If education and research take precedence, then chiefly the patients with the rare interesting diseases get the best care, and the student learns good specialty medicine. If service takes precedence over education and research, then the greatest public needs are given the best attention, and the student learns good general practice and develops a community conscience.

A recent innovation in medical education is the school-without-walls concept. One community group we spoke to said, "Theory and practice must be integrated in medical education". Another said, "Why should D.C. W. pull out of D.C. General? Why not move the whole school to D.C. General and teach the students on-the-job?" In this way the students would learn from the real world, from taking real responsibility for meeting a community's health care needs, seeing preventive care work, determining their success or failure on whether they effect a change in the city's health statistics and general state of health, and learning to face their failures as a group dedicated to find new approaches that might work the next time. This would replace the current view of "success" which is good marks, good papers, and eventually good money and prestige. This would also replace the current incentive to academic competition between students, and get them to see that success depends on group effort. They would at the same time be providing very real services to D.C.

In conclusion:

There is nothing in this bill as it now stands to indicate that much thought was given to the issues, that any national or local overview was

sought in its preparation, or that anyone recognized the great potential for either good or harm that it holds. There is no current body to provide this national overview of medical schools from outside the self-interest groups, other than the health subcommittees of the House and Senate as they distribute funds. If this Committee appropriates money to medical schools, it is the only other body (except the military and V.A., perhaps) that can write in requirements to bring these schools into conformance with some national schema. It behooves this Committee to work closely with the health subcommittees in determining what that national schema should be. Stipulations can then be added to the bill to prevent use of the money for inappropriate duplications of training programs for unneeded manpower.

With all due respect to the A.M.C., it is a self-interest group and as such should not suggest how to police itself. Even National Academy of Science suggestions may be heavily weighted since most Institute of Medicine members come from medical school faculty backgrounds. These groups are doing some excellent work, but do not have either the authority or the public view that the Congressional committees can offer.

We repeat, in closing:

Public Hearings Must Be Held

This decision should be in the hands of the people of D.C.

We want to thank you for inviting MCHR to give testimony. We, like hundreds of thousands of D.C. residents, even those working in the area of health, even in conjunction with these medical schools, would have had no idea that this bill was even being considered had you not called us.

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Groups who contributed ideas for this testimony:

One Free Clinic

Southwest Community House

Adams-Forgén residents and health organizers

Several senior citizen groups, and Gray Panthers, who were attending a meeting on the subject of aging.

The Consumer Requirements and Underserved Areas subcommittee of RHP

Students from G.W. and G.T. medical schools, and G.T. nursing school.

A pre-med advisor at Federal City College

A member of the D.C. Statehood Party

D.C. Public Interest Research Group which draws students from both

G.W. and G.T.

Petitions with complaints about hospital services

Union 1199 at G.W. Hospital

Announcements were placed in one newspaper and on one radio station to solicit individual comments.

A number of other specific groups and individuals were called by phone.

I. Specific examples of problems cited

Relations of the medical schools to the community, workers, and students:

- 1) About 22 years ago, in starting their HMO, G.W. called a community meeting in Southwest, their target area, to ask for community input. The services the residents requested were refused (pharmacy and ^{dent}ental services in the neighborhood). They spoke to patients in the waiting rooms of the Southwest Clinic about the advantages of services at G.W., and how they would provide transportation to and from. We asked Dr. Thomas Fienne at G.W. about this, and he said angrily, "We offered to take over the Southwest Clinic, and they wouldn't let us!" Also, they waited until well after the HMO plans were designed and under way to start seeking for community representatives for the board. They wrote to MOIR to ask how we thought these reps should be chosen. We responded that they should be chosen by the community. A few days later we received another letter asking us to name a representative. We refused on the basis that this was what we had told them not to do. It was such attitudes as these that evidently led HMO to fund Georgetown's HMO (which seemed better on these points), but not G.W.'s.
- 2) In some ways, the poor and black are still segregated in their facilities. At Georgetown, the medical wards for the poor are on the second floor of the hospital, whereas the private rooms for paying patients are on the two top floors. Patients complain that care on the second floor is poorer than on the upper floors. At G.W., the HMO has enrolled only Medicaid patients initially, which means that the poor and black largely go to the facility across the street, while the paying patients still go to the hospital's outpatient department. This condition will hopefully be corrected as they enroll new members from other categories in the HMO.
- 3) Faculty and students at G.W. are very angry at the administration for not including or even consulting them about the decision to pull out of D.C. General. Evidently there are many of them who feel this move was unwise.
- 4) G.W. went into Southwest, again about 3 years ago, to do a community survey. This was published, for the school's benefit, but a copy of the results was not given to Southwest. Also, they drew up plans for urban development in Southwest, which the community was fairly pleased about, but these plans have never gotten beyond the blueprint phase.
- 5) Last month as G.W. hospital employees approached the expensive Christmas holiday season, the hospital announced proudly that it had ended its year in the black for the first time. Yet instead of giving the workers a pay raise commensurate with cost-of-living increases, or even a small Christmas bonus, they instead asked the workers to give the hospital a donation to prove their devotion.
- 6) There have also been efforts by Union 1199 to organize at Georgetown. There they met a very different approach by the administration. Whereas at G.W. the supervisors on wards were instructed to squelch union efforts, and 2 or 3 workers were actually fired simply for wearing union buttons, at Georgetown the supervisors were instructed to do nothing to obstruct the union. They

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were allowed a union election, but lost, partly because the hospital had not given them enough issues to organize around because of their passive stance. It cannot get Georgetown on the back for this, because their motivation in taking the passive stance might have been to suppress union efforts. Yet it certainly was a more humane approach than C.W.'s refusal of an election, refusal to meet with union representatives or answer their telegrams, and then having 50 arrested and even more suspended and fired because they were justifiably angry about this.

- 7) About 11 years ago, an inter-hospital board met and discussed the problems arising from hospitals transferring indigent cases from their emergency rooms to D.C. General. This is sometimes done by closing the doors to any further ambulance-brought cases for the rest of the night. A gentlemen's agreement was made that the hospitals would cease these practices since they recognized that some patients' lives would be endangered by these practices. A few months later, a Washington Post article carried data about how many emergency cases were still coming to D.C. General emergency room after having been turned away at other hospitals. Several hospitals were named.

Financial information regarding the medical schools:

- 1) The total budget for the two medical schools is about at the national average per student; yet their tuition is in the top 25% (or higher) by comparison. Their appropriation from federal disaster funds was almost twice each what other medical schools received (in fact, only 5 others received any funds at all). The military appropriations at G.W. must be large considering the number of uniformed personnel at medical school functions.
- 2) The information we received concerning Blue Cross monies from G.T. Hospital being diverted to the medical school is said to have come from the House Officers' Association at the hospital. They might be contacted for further information. They had reviewed the entire hospital budget.
- 3) More than half the offices and laboratories in the new medical school building at G. . appear to be empty, yet a grapevine figure of \$1 Million will be needed yearly just to maintain the building. Either the unused sections should be rented for income, or closed off, or medical students should participate in cleaning up after themselves. This is certainly a cost overrun that should be dealt with.
- 4) The new coronary care unit at G.T. is designed for 150 beds, when the intensive care unit at Washington Hospital Center with 75 beds already sits partially empty. This unit is a life-long dream of an excellent physician, but is it really needed in D.C., and should fund-raising for such a subspecialty program that serves only a few take priority over fund-raising for the more basic emergency, outpatient, and preventive care so desperately needed by so many people on the streets? Or even priority over getting money for student scholarships? G.T. has already spent a great deal renovating their surgical intensive care unit twice in the last 2 years, the second time because they didn't do it right the first time. Is that not sufficient?

Deficiencies in the training of other types of health manpower:

- 1) Partly because of lack of support from G.W. and G.T., a Physician's Assistant program at D.C. General that was planned about 4 years ago, never got off the ground. G.W. set up its own P.A. program later,

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- which is under good leadership and provides good training to ex-medics, but to our best knowledge they are not rotated through D.C. General, nor do they admit D.C. residents with any priority.
- 2) Training programs elsewhere that do primarily take D.C. residents have received little aid or interest from these institutions.
 - 3) G.W. has a school of Health Care Administration, but 2 graduates of that program that I have personally worked with hold upward mobility for other workers (than themselves) as being counter to their primary measuring stick of cost efficiency.
 - 4) G.T.'s nursing school still has very few blacks, and this year for the first time provided financial aid to one student on the basis of his having been a faithful lower-paid employee of their hospital for 3 years --- and he was white and not from D.C. --- and he must continue to work full time for the hospital while going to school full time or forfeit his benefits. No family person could take advantage of such a "wonderful opportunity".
 - 5) G.T.'s program to train Nurses' Aides draws from the greater metropolitan area, while the Spanish community is begging for slots to train some of their people in this skill area.
 - 6) Upward mobility programs in their University hospitals are almost non-existent, and in-service training sessions for lower-paid staff, though excellent, are few and far between and hold no promise of increased pay for those who learn the material presented.
 - 7) Job Corps trainees learn health-related skills and then cannot get jobs in these institutions. Veterans who are trained medics cannot get further training for health careers, and remain unemployed, work only as hospital orderlies, or leave the health care field entirely -- a great loss to our nation's health care system.

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II. Specific services that people we interviewed wanted these institutions to provide:

Services requested of G.W. in the past which they did not honor:

- 1) A small low cost pharmacy outlet in Southwest that would stock only more commonly prescribed and generic drugs
- 2) Adult dental services in Southwest

Services G.W. formerly promised, but so far as we know never came through with:

- 1) Transportation services
- 2) A dispensary in a residential building for senior citizens

Services requested in current interviews:

- 1) The Spanish need more clinics. G.W. did start a para-professional clinic for the Spanish at one time, but the people complained that it was staffed too extensively with para-professionals, and that they were not getting seen by M.D.'s when they felt they should have been. G.W. did not rectify this, or give proof to the satisfaction of the Spanish that the paying patients had no loss of their care provided by para-medics, but discontinued the clinic instead.
- 2) The Free Clinics have repeatedly asked for volunteer personnel from G.W. and G.T., and one had to close several months ago despite being equipped, because they could not find even one physician from either of these schools, or elsewhere.
- 3) The elderly want a geriatric rehabilitation hospital to be started in D.C. Patients with particularly problematic cases must be sent to facilities in other states, too far for their families to visit there.
- 4) More alcohol treatment centers are needed, not house officers who bodily throw alcoholics out of the emergency rooms, and compete for who can throw the most out in one day.
- 5) More V.D. treatment, free of moralizing, is needed. One woman complained that she went there for treatment, and was in tears from 5 minutes after she got in the doctor's office until she left, because of his moralizing. His name wasn't remembered.
- 6) Citizens' and employee groups want patients' rights materials to be distributed at the hospitals, and advocacy-legal aid services to be set up. Even the American Hospital Association has recommended that its member hospitals distribute patients' rights materials, but to our knowledge, not a single hospital in the D.C. area has posted even the AHA's watered-down version.
- 7) The poor need dental services that give them the same benefit of fillings and root canal work, etc., as paying patients have, rather than just pulling all their teeth because they cannot pay for anything more.
- 8) Dental services are also needed that don't require repeated visits for work that could have been done in one sitting.

Facilities where the two schools could provide services on a per-hour basis for staffing, to qualify for funds under this bill:

- 1) D.C. General -- where deaths are still occurring due to under-staffing.
- 2) Emergency rooms -- so that waiting time can be reduced.
- 3) Neighborhood health centers -- hopefully to provide some night hours.
- 4) Community Mental Health Centers -- where they need to have a medical doctor as well as psychiatric staffing.

- 5) Jails -- another high priority need, and merese with time.
- 6) East of the River Health Services -- Perhaps G.T. and G.H. could some way help speed up their opening their doors.

No geographic area should get as much emphasis as Southeast.

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III. Specific suggestions concerning the teaching of community medicine

Students we spoke to from both G.V. and G.T. asked for better community medicine programs in the first 2 years of school. This could be done through increasing community service electives, doing more in community medicine than conducting questionnaires, having an exciting department that turns students on to community medicine rather than turning them off. G.T.'s 200 students/class who are "falling all over each other in the halls", and G.V.'s 110/class could carry on major public health projects such as:

- 1) Screening, referral, and follow-up programs, especially for hypertension, T.B., and lead poisoning.
- 2) Reducing infant mortality through seeking out teenage pregnant women and getting food and services to them and to high-risk infants through outreach.
- 3) Supplementing the overworked Public Health Nurses in providing outreach for neighborhood health centers and community mental health centers where communication with the community and door-to-door follow-up are so essential.
- 4) Carrying out public health education programs concerning communicable diseases, smoking, etc., in the public schools and waiting rooms.
- 5) Providing services to senior citizens, including transportation to clinics, home health aid, getting food stamps, etc.
- 6) Training community residents to take over these functions in time; in fact, matching the number of students at least one-to-one with community residents in administering and conducting these functions, lest projects suffer too greatly for lapses in student commitment during exams, vacations, and schedule changes.

In their 3rd and 4th years, medical students could do more to provide direct patient care within clinic and mental health center settings, not just in hospitals. There must be assurance, however, that they will have adequate supervision, and will respect patients' desires to limit the number of students examining them, etc. The Out-Patient Departments in the University Hospitals themselves should be restructured so that patients are seen by a consistent student or house officer over a long period of time. Patients are tired of seeing a different student or doctor everytime they go to the clinic.

A program similar to one at Western Reserve and Tufts could extend throughout the 4 year program -- in which each student is assigned a family to follow for that entire period of time, with increasing responsibilities for the care of that family as the student's level of training increases.

For dental students, preventive dentistry and public health education about dental care could be services provided.

IV. One other comment on a national schema for the Committee to consider

All medical schools should provide high quality training for family practitioners, and generalists, and only selected schools provide the expensive training -- for one specialty in one school, and another in another school. Slots for subspecialty training programs should be limited in number to correspond with nation-wide manpower needs, and students allowed to go from one school to the other to receive the subspecialty training they offer, and to have those credits transferred. The need for a coronary care unit at C.T., for example, should be judged not only on the basis of whether D.C. needs it, but whether a sufficient amount of this type of subspecialty training is already being offered in other medical schools around the country.

May 1, 1974

Mr. Chairman and Members of the Committee:

My name is Minnie Bowick Edwards, a citizen of the District of Columbia. I represent the Central Northeast Civic Association as its Vice President. I am also Chairman of Ward 7 in the District, a member of the President's Bicentennial Committee for the District for area 3, and a member of many other civic groups. As a community leader I appear today on behalf of Georgetown University School of Medicine. I am a supervisor of their field staff of medical interviewers who conduct door-to-door screening for hypertension in the inner city. I appreciate this opportunity to give you an evaluation of the program as carried on by the Georgetown Medical School in the area of hypertension.

High blood pressure is the most devastating disease there is in the annals of medical research. It is commonly called the silent killer for there is often no attendant pain. High blood pressure is a leading cause of strokes, heart attacks, arteriosclerosis, and kidney diseases. Many medical authorities have placed hypertension among the nation's most pressing priorities. Georgetown University Medical School under the guiding skill of Dr. Frank A. Finnerty, director of their Hypertension Clinic at D.C. General Hospital, is doing a tremendous job at the community level. It is here where we detect, treat and prevent hypertension, thus staving off strokes, heart attacks or other attendant fatal diseases.

Mr. Chairman, it is my wish that you and your committee think kindly of the bill S. 2730 to its maximum allotment for both medical and dental students enrolled at Georgetown University. This amount, I believe, is up to \$3,000 per dental student and \$5,000 per medical student. Without this upward bound fund, Georgetown University School of Medicine would find it difficult to function. Since 48% of the individuals in one study by our Georgetown University clinical doctors had high blood pressure, this is a high potential mor-

Statement of Mrs. Edwards - 2

talities rate to conceive. Such fatalities are precisely what will happen if Georgetown University is not adequately funded to continue its service.

Finally brethren: in the language of the greatest Healer of them all, I beg of you to think on these things. Thank you, Mr. Chairman.

STATEMENT OF DR. JOHN H. CALLANAN

President, District of Columbia Dental Society

on

S 2730

Before

Committee on the District of Columbia

United States Senate

Mr. Chairman and Members of the Committee:

I am Dr. John H. Callanan, President of the District of Columbia Dental Society.

The dental manpower needs of the District of Columbia is supplied in a large measure by Georgetown University, School of Dentistry. Fifty percent of the practicing dentists in the Washington Metropolitan Area are alumni of this school.

It would be a catastrophe to dentistry in this locality if this school was forced to close because of a lack of funds. The services provided by this school are essential to the delivery of good dental health care for our citizens. This is a time when dental care must be expanded rather than curtailed and the number of available dentists must be increased.

We note the great efforts that Georgetown University has made to increase private funding and control operating costs. The District of Columbia Dental Society supports S 2730 and requests your approval of this urgently needed financial assistance for this private, non-profit school of dentistry.

Mr. Chairman, in addition, I would like permission to file for the record a statement from the American Dental Association supporting these bills.

Thank you for the opportunity to appear before this committee.

STATEMENT OF
THE AMERICAN DENTAL ASSOCIATION
AND
THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS
ON
BEFORE THE
COMMITTEE ON THE DISTRICT OF COLUMBIA
UNITED STATES SENATE

Mr. Chairman and Members of the Committee:

The American Dental Association is grateful for this opportunity to present this statement in support of S 2730 a bill to extend for three years the District of Columbia Medical and Dental Manpower Act of 1970.

The ability to meet the dental care needs of our country now and in the future depends upon a financially stable system of dental education. In most instances this requires a sharing of costs among state, federal and private sources. In the absence of state legislature for the District of Columbia, it is entirely appropriate and proper to provide authority for special assistance to the Health Professions Schools covered under S 2730. This would be consistent with the recent developments that have occurred in a number of states which now provide direct-support to private dental schools.

District of Columbia Medical
and Dental Manpower Act of 1970

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The fight to put each existing school on a sound financial basis has a basic, economic rationale. Obviously, each region of the nation needs to have a certain number of educational institutions producing the dentists its citizens must have. Any existing institution that fails must, of necessity, be replaced sooner or later. It is, however, a far more expensive proposition to build a new school than it is to preserve an existing institution with its buildings, its equipment and its faculty. Additionally, the time gap between the first planning of a new school and the time when it graduates its first dentists can be as much as ten years.

The basic cause of the financial crisis of the dental schools today lies in the spiraling maintenance costs and in the ever-growing base of knowledge that a health professional must have in order to give modern, high-quality care. On a per student basis, it now costs a school some \$11,000 on the average to provide each enrollee with the necessary education while it receives, in income from all sources, some \$2-3,000 per student less than this figure. Such deficits as these need to accumulate for only a short time before they become unbearable and a school faces the necessity of phasing the dental school out of its curriculum.

Dentistry is the most expensive professional health education for the student as well as the schools, primarily because of the highly specialized instruments and equipment that must be utilized. A main source of income for professional health schools, of course, is tuition and fee charges to students. Schools have raised these charges faster and higher than they wish in an

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effort to keep the gap between income and expense from broadening fatally.

We are now at a point where typical tuition and fees that a student must pay can range as high as \$11,000 to \$15,000 during his four years. This is entirely exclusive of such personal expenses as room and board. And these costs, it must always be remembered, come in addition to the costs of four years of undergraduate education that a typical dental student has already undergone. Clearly, tuition and fees can go no higher if dental education is to remain accessible to a broad range of scholastically eligible students. Dental education is not heavily endowed from private sources and thus does not draw on that kind of resource in its effort to maintain itself.

Of the nation's dental schools, the financial crisis has been most crushing for those affiliated with private universities. The Association believes philosophically, that it is infinitely better for the nation to have its professional health education system rooted in both private and public universities. But even more to the point, the pragmatic fact is nearly one-half of the existing 59 dental schools are private. They produce some 50 per cent of the annual graduates. They must, then, be preserved.

There has been, in the past five years, an increasingly clear recognition by the public sector of the priority it needs to give to professional health education. This has led to federal legislation presently embodied in the Comprehensive Health Manpower Training Act of 1971. It has also led a number of states and jurisdictions to the realization that they too must be attentive to the needs in this area. Precedent now exists whereby a state or jurisdictional

District of Columbia Medical
and Dental Manpower Act of 1970

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authority would provide to a dental school within its purview, whether private or public, operating funds based on an equitable formula derived from its enrollment, graduates and attendant educational expenses. It is the conviction of the Association that such arrangements are, at a minimum, highly desirable and, in some cases, essential.

Despite the increasing funding available to private schools for dental education under the Health Manpower Act, the increases will not meet the need for continued support at present levels of education. Present legislation will soon phase out the availability of specific "financial distress" money and force private institutions in a monetary crisis to compete for operating expense money with better-endowed schools.

It is obvious from the figures cited by the Dean of the Dental School that Georgetown University School of Dentistry occupies a vital position in the District of Columbia. Without it, the District would find it, in our view, impossible to provide its citizens with the dental care they need. It is this relationship that we believe should be the focus of the Committee's judgment on the measure before it. The American Dental Association strongly urges approval of S 2730.

State Assistance to Dental Schools

DENTAL SCHOOLS

By Type of Ownership

(State and non-State)

<u>States which have State Schools only</u>		<u>States which have State and non-State Schools</u>		<u>States which have non-State Schools only</u>		
		<u>State</u> <u>non-State</u>				
1. Alabama	1	1. California	2	3	1. Massachusetts	3
2. Colorado	1	2. Georgia	1	1	2. Pennsylvania	3
3. Connecticut	1	3. Illinois	2	2*	3. Wisconsin	<u>1</u>
4. Florida	1	4. Michigan	1	1*		7
5. Indiana	1	5. Missouri	1	1		
6. Iowa	1	6. Nebraska	1	1	(D.C. - 2)	
7. Louisiana	1	7. New Jersey	1	1		
8. Maryland	1	8. New York	2	2		
9. Minnesota	1	9. Ohio	1	1		
10. North Carolina	1	10. Tennessee	1	1		
11. Oklahoma	1	11. Texas	2	1		
12. Oregon	1					
13. South Carolina	1					
14. Virginia	1					
15. Washington	1					
16. W. Virginia	1					
17. Kentucky	<u>2</u>					
	18		15	15		
(plus Puerto Rico-1)						

(plus Puerto Rico-1)

*Non-State schools receiving State assistance

State Schools of Dentistry

A total of 28 States (and Puerto Rico) have State schools of dentistry)

17 States (and Puerto Rico) have their own State dental schools and no private schools of dentistry in the State.

11 additional States have both State and private dental schools in their States.

Non-State Schools

14 States (and the District of Columbia) have private schools of dentistry.

3 States (and the District of Columbia) have private schools only.

Patterns of State Support to Private Dental Schools
within Their Respective States

In general, state support to private dental schools is not as well developed as it is for medical schools. At the present time 6 States -- Illinois, Michigan, Pennsylvania, Ohio, Texas and Wisconsin have program of direct support to private dental schools.

Regarding the particular programs:

1. Illinois: (2 private schools)

The State of Illinois has included Dentistry with Medicine in the subsidy programs.

Illinois has provided enabling legislation. 1970-71 funding will depend on the level of appropriations. The Illinois formula calls for a subsidy for operating expenses, a second subsidy for "stabilization support" and the third for capital construction. All three of these are related to the number of new places created in the entering class with emphasis* on Illinois residents as follows:

(a) \$6,000 per new place for operating expenses, (b) \$1,000 per new place for stabilization costs, and (c) \$50,000 for each new place (for the first 20 with \$20,000 for each new place beyond the number of 20) for capital construction.

2. Michigan: (1 private school)

The State approved legislation in 1969 for a five year period to provide support to private dental schools on the basis of the number of degrees

*Schools must, within 3 years, increase enrollments of Illinois residents by at least 20.

granted in a given year to residents of the State. At present the University of Detroit School of Dentistry is the only eligible institution. The amount to be granted is \$2,400 per eligible graduate per year and the legislature appropriated \$150,000 in the 1969-70 fiscal year to inaugurate this subsidy program.

3. Pennsylvania: (3 private schools)

Provides support to schools of higher education. The 3 private dental schools derive benefits only through the indirect support to the University as a whole in contrast to the direct aid to the medical schools. The amount is negotiated annually by the parent University.

4. Ohio: (1 private school)

Amounts: On a biennial basis for years 1971-73, \$860,000 and for years 1973-75, \$1.5 million. The amounts are negotiated by the State and the school on a contractual basis.

5. Texas: (1 private school)

Amounts: 1972-73, \$1.7 million on basis of a contract between the State and the school. For academic year 1973-74 the amount of \$4.2 million has been appropriated.

6. Wisconsin: (1 private school)

Amounts: none for 1972-73. For 1973-74, \$1,305,000 based on \$3,000 per Wisconsin student enrolled.

7. Georgia: Emory University Dental School received \$190,000 for the academic year 1972-73 from S.R.E.B. for students enrolled from Florida and North Carolina. For 1973-74 Emory expects to receive \$285,000 for students enrolled from Florida and North Carolina.

STATE ASSISTANCE TO MEDICAL SCHOOLS

DATAGRAM

State Roles in Financing Medical Education

State legislatures in fiscal 1972 provided a total of about \$334.2 million for the operation of medical schools, exclusive of funds to schools in development and to teaching hospitals. Of this total, \$303.2 million went to 63 public medical schools located in the states providing the funds; \$1 million was made available through regional compacts to public medical schools located outside the states providing the funds. Private medical schools received approximately \$30 million from state governments—\$29.4 million in direct payments and \$0.6 million through regional compacts. Additionally, public and private medical schools received approximately \$1.8 million from city and county governments.

The level of funding provided by each state is presented in Table 1. These figures exclude funds channeled through regional compacts. On a total funding basis, state appropriations ranged from a high of over \$36 million for New York to a low of \$765,000 for South Dakota. Table 1 also lists the state appropriation per capita and the state appropriation per \$1,000 of personal income. In fiscal 1972 there was considerable variation in state expenditures for medical school operations relative to population and personal income. Missouri spent 99 cents per capita while 11 states spent over \$2 per capita. One state, Arizona, spent \$3.57 per capita for medical school operations. Based upon the state appropriation per \$1,000 personal income, the figures ranged from a low of \$0.21 per \$1,000 personal income for Minnesota to a high of \$0.76 for Arizona. Ten states spent over 50 cents per \$1,000 personal income for medical school operations.

Support of Private Medical Schools

State legislatures have been limited by institutional and legislative prohibitions in awarding

state funds to private institutions. In recent years, however, pressures to increase the supply of physicians have led a number of states to offer support to private medical schools. The following is a summary of fiscal 1973 state and District of Columbia programs for the support of private medical schools:

California—The state contracts with its private medical schools to expand class sizes. In fiscal 1973 it appropriated \$660,000 to provide for 55 additional students at a rate of \$12,000 per student. This award was not contingent on the residency of students.

District of Columbia—In fiscal years 1971 and 1972 awards were made to the private medical schools—Georgetown and George Washington—not under the special legislation authorizing such support but under the Department of Health, Education, and Welfare's special project grants program to alleviate financial distress. Similar awards were made for fiscal year 1973.

Delaware—The state contracts with an out-of-state college of medicine to accept up to 20 Delaware residents per year. A provision stipulates that a "portion" of the medical students spend their clinical clerkships in the Wilmington Medical Center. The state of Delaware pays \$7,500 per student to the private medical school, with an arrangement that guarantees a minimum annual payment of \$120,000.

Florida—In 1952, Florida enacted legislation to provide support to the first accredited medical school in the state, which happened to be a private institution. Continuing legislation was passed to provide \$6,500 per Florida student for those completing their education in four years (or \$8,500 per Florida student for those completing their education in less than four years) in fiscal 1973. Use of these funds is limited to operating purposes.

Illinois—In the spring of 1969, the Illinois General Assembly enacted the Health Services Education Grants Act providing funds to

Legislative information contained in this article is current as of June 1973

TABLE 1
STATE APPROPRIATIONS FOR PUBLIC AND PRIVATE MEDICAL SCHOOLS*
(Fiscal Years)

State	1972 State Appropriation (Thousands of Dollars)	1972 Private School Component of State Appropriation (Thousands of Dollars)	1972 State Appropriation per Capita (Dollars)	1972 State Appropriation per \$1,000 Personal Income (Dollars)
Alabama	6,086		1.77	0.52
Arizona	6,317		3.57	0.76
Arkansas	2,395		1.25	0.36
California	32,109		1.61	0.31
Colorado	4,365		1.98	0.42
Connecticut	4,085		1.35	0.25
Florida	7,438	2,780	1.10	0.25
Georgia	7,623		1.66	0.42
Hawaii	1,070		1.39	0.27
Illinois	13,656	3,539	1.23	0.24
Indiana	10,187		1.96	0.44
Iowa	8,067		2.86	0.65
Kansas	4,864		2.16	0.47
Kentucky	5,284		1.64	0.45
Louisiana	4,293		1.18	0.33
Maryland	5,386	800	1.37	0.27
Michigan	20,283		2.29	0.46
Minnesota	4,197	32	1.10	0.21
Mississippi	3,348		1.51	0.48
Missouri	4,622		0.99	0.23
Nebraska	3,504		2.36	0.53
New Jersey	12,526		1.75	0.33
New Mexico	2,182		2.15	0.56
New York	36,105	8,814	1.98	0.37
North Carolina	8,632	477	1.70	0.45
North Dakota	795		1.29	0.34
Ohio	16,921	2,250	1.59	0.35
Oklahoma	3,779		1.48	0.38
Oregon	5,544		1.63	0.59
Pennsylvania	20,822	6,765	1.77	0.39
South Carolina	5,243		2.02	0.57
South Dakota	765		1.15	0.30
Tennessee	4,143		1.06	0.28
Texas	30,556	2,083	2.73	0.65
Utah	2,473		2.34	0.59
Virginia	6,995		1.50	0.35
Washington	7,028		2.06	0.46
West Virginia	3,781		2.17	0.59
Wisconsin	5,141		1.16	0.27
Total	332,610	29,416		

* The data relate to funds provided directly by the state to fully operational medical schools located within the state and to state-related schools in Pennsylvania. They exclude funds provided to medical schools through regional compacts. Data are not available for direct state support provided to the medical schools located in Puerto Rico and Vermont. The 1972 state appropriations are derived from the 1972 Liaison Committee on Medical Education Annual Medical School Questionnaire. Data for Indiana and Kansas universities are based on estimates from the 1971 LCME questionnaire. Population data for the "State Appropriation per Capita" calculation are for 1970 and are taken from the *Statistical Abstract of the United States*, 1972, 93rd Annual Edition, page 12. Personal income data for the calculations in the last column are based upon preliminary 1972 figures from the *Survey of Current Business*, April 1973, Vol. 53, No. 4, page 17.

Datagram

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private institutions for increasing enrollments in medical, dental, nursing, and allied health education programs.

Each school is allowed \$6,000 annually for each additional Illinois resident which it enrolls, with the requirement that at least 20 additional Illinois residents be enrolled in each entering class over the average number of Illinois students enrolled per class for the years 1964 to 1967.

In addition, an annual stabilization grant of \$1,000 per student, based on the number of Illinois resident students enrolled in the year 1967, is to be awarded. This grant was contingent upon a commitment by the school to the minimum expansion of 20 Illinois resident students in fiscal 1968.

A single, nonrecurring program expansion grant was made for each of the private medical schools for planning and capital construction, attendant upon increasing this enrollment. No grants were given for any expansion of less than 20 Illinois resident students, and grants to schools that expanded beyond 20 additional students were based on the projected size of the additional increment. Fifty thousand dollars was awarded for each of the first additional 20 Illinois resident students. Beyond this initial grant for each additional Illinois resident, \$20,000 is awarded each year for each enrollee projected above the initial increment of 20 such students.

Maryland—The state's private medical school received \$800,000 per year on an emergency basis in fiscal 1972 and 1973.

Minnesota—Legislation was passed for the 1973 fiscal year awarding \$8,000 per Minnesota resident.

New York—The state university system has three types of contractual arrangements with each private medical school in the state—(a) the Bundy Plan, providing \$2,400 for each medical school graduate; (b) a per capita award of \$1,500 for every medical student enrolled; and (c) a seven-year plan designed to increase enrollment during the period from 1967-68 through 1973-74. In the seven-year plan the average enrollment for each class of medical students enrolled from July 1961 through June 30, 1966, was computed as the

base; \$6,000 is paid for each additional student enrolled over the base period average.

An individual student may be counted only once for all of these programs through his first three years. However, both the \$1,500 grant and the \$2,400 grant may be awarded in the fourth year.

North Carolina—This state's contract medical program with its private schools of medicine provides a per capita grant of \$3,000 for each North Carolina resident enrolled. Five hundred dollars of this \$3,000 per capita awarded is held in a special scholarship fund to provide financial assistance to deserving North Carolinians enrolled. The only restriction is that the sum must be utilized so as to be highly beneficial to the overall welfare of the state of North Carolina.

Ohio—This state has a contract medical program whereby the private university agreed to admit and maintain not less than 110 first-year students in fiscal 1972 and to admit 125 first-year students in fiscal 1973. A subsidy payment of \$4.5 million was paid to the university for the biennium 1971-73. The subsidy was not contingent upon the residency of the students.

Pennsylvania—The amount of the awards measured on a per capita basis for fiscal year 1972 were as follows: (a) \$7,465 per capita to three state-related schools and (b) \$4,400 per capita to four state-aided schools. There was no change for fiscal year 1973. These awards are not contingent upon the students' state of residency.

One of the major characteristics that differentiates "state-related" from "state-aided" schools is the university board of trustees. The state appoints a certain number of members to the board of trustees of a "state-related" university, thereby giving the state a direct hand in making policy decisions that govern the operations of the institution.

Rhode Island—The state's private medical school received a \$200,000 grant from the state for fiscal 1973, with no restrictions placed upon the use of the funds.

Tennessee—The state appropriated \$40,000 for support of its private medical schools for the 1973 fiscal year. This amount was divided

TABLE 2
REGIONAL EDUCATION PROGRAMS IN MEDICINE, FISCAL 1973

Program	Participating States	Contracting Institution		Number of Students		Total Funds To	
		Public	Private	In Program	Per Capita Award	Public Schools	Private Schools
New England Board of Higher Education	Maine, Massachusetts, and Rhode Island	1	—	159	\$5,000*	\$720,000	—
Southern Regional Educational Board	Alabama, Florida, Georgia, Louisiana, Maryland, Mississippi, North Carolina, Tennessee, and Virginia	—	1	110	3,250	—	\$357,500
Western Interstate Commission for Higher Education	Alaska, Arizona, Hawaii, Idaho, Montana, Nevada, and Wyoming	13	3	246	3,000	656,000	82,000
Total				515		\$1,376,000	\$439,500

* \$2,500 each for 30 students who are Maine residents.

between the state's private schools on a formula basis reflecting the increase in the number of Tennessee residents who enrolled in each school over an established base.

Texas—The Texas legislature appropriated close to \$2.1 million in fiscal 1972 for that state's private medical school. That figure has doubled to \$5 million for fiscal 1973. This represents a change of from \$14,370 per private student for fiscal 1972 to \$17,282 for fiscal year 1973.

Funds are channeled through a coordinating board which contracts directly with the private medical school. The support to the private medical school, during each scholastic year, equals the average annual state tax support per undergraduate medical student at the established public medical schools multiplied by the number of Texas undergraduate students at the private medical school.

Wisconsin—The state has appropriated funds on a biennial basis for medical educa-

tion in its private medical school since 1969. The amount appropriated during the 1971-73 biennium was \$3.7 million. No restriction on the use of the award was made, nor was the grant contingent upon increased enrollment or the residency of an enrolled student.

Regional Contracts

The three regional boards—New England Board of Higher Education, Southern Regional Education Board, and the Western Interstate Commission for Higher Education—have a combined total of 18 contracts with accredited public and private institutions. Funds flowing through the boards for contract programs in medicine totaled nearly \$1.6 million for fiscal 1972. Nearly \$1.8 million was made available for fiscal 1973 (Table 2).

ROBERT CAROW

AAMC Division of Operational Studies
Washington, D.C.

AFTER RECESS

Senator TUNNEY. Dr. Standard, I learned on the floor that we have got 20 minutes until the next vote, which means that we have about 7½ minutes to the time until after the vote starts, which gives us about 25 minutes in total. So I hope the next two witnesses will be able to finish their testimony by then.

**STATEMENT OF DR. RAYMOND L. STANDARD, ADMINISTRATOR
AND DIRECTOR OF PUBLIC HEALTH, COMMUNITY HEALTH AND
HOSPITALS ADMINISTRATION, DEPARTMENT OF HUMAN RE-
SOURCE, DISTRICT OF COLUMBIA GOVERNMENT**

Dr. STANDARD. Mr. Chairman and members of the committee, I am Raymond L. Standard, Director of Public Health for the District and Administrator of the Community Health and Hospitals Administration of the Department of Human Resources.

DISTRICT OF COLUMBIA DEFERS TO HEW

The District of Columbia government's report on S. 2730, a bill to extend for 3 years the District of Columbia Medical and Dental Manpower Act of 1970, states that since the bill would provide an extension of grant authority vested in the Department of Health, Education, and Welfare, the District of Columbia government defers to the views of the Secretary of the Department of Health, Education, and Welfare on the merits of the bill.

As we indicated during the hearings on an identical bill in the House of Representatives, the District government would like to develop an appropriate method of furnishing additional assistance to meet the health manpower training needs of the city.

We have been reviewing what other States do and the programs which the Federal Government provides under the Public Health Service Act. When funds are available, the District government might well adopt a program that is comparable to the public health service program.

As this committee is probably aware, section 741(f) of the Public Health Service Act authorizes the Secretary of the Department of Health, Education, and Welfare to repay a portion of an individual's educational loans incurred for the costs of education at a school of medicine, osteopathy, dentistry, veterinary medicine, pharmacy, optometry, or podiatry, when the individual enters into an agreement to practice his profession for a specified period in an area determined by the Secretary to have a shortage of and need for such health professionals.

The District of Columbia is in need of professional health services. The development of draft legislation will require careful review by the city of the precise agreement and the extent to which resources will be available to the city to make such financial commitments. From a long-range point of view, however, the District government is convinced that such an arrangement—which provides financial as-

sistance to students who are residents of the District of Columbia and who agree to provide professional health services in the city—will be of great benefit to the city's residents who are in need of these services.

Thank you for the opportunity to testify. I will be happy to answer any questions you may have.

Senator TUNNEY. Thank you very much, Dr. Standard.

Could you testify on H.R. 8747?

Dr. STANDARD. Yes, sir.

Senator TUNNEY. Thank you.

DISTRICT OF COLUMBIA GOVERNMENT SUPPORTS H.R. 8747

Dr. STANDARD. Mr. Chairman and members of the committee: Thank you for the opportunity to testify in support of H.R. 8747, a bill proposed by the District of Columbia government and passed by the House of Representatives.

The District of Columbia requires that every child entering District of Columbia public schools or private elementary schools be vaccinated against smallpox unless exempted for reasons of either medical contraindication or religious objection.

SMALLPOX NO LONGER A SIGNIFICANT PROBLEM

This requirement dates to an act of Congress in 1864, a time when smallpox was a significant problem in the United States. Smallpox is no longer a problem of the same significance. It was last reported in the United States in 1949.

Discussion of the worldwide epidemiology of smallpox and the strategies to contain and eradicate this disease are left to the U.S. Public Health Service representative from the Center for Disease Control, Atlanta, Ga.

However, the U.S. Public Health Service does estimate that a case of smallpox can be expected to be imported into the United States less frequently than once in 15 years.

The District of Columbia receives only a fraction of all international travelers coming to the United States.

Therefore, the risk of importation of smallpox into the District of Columbia is significantly less than the risk of importation of this disease into the United States.

NO SMALLPOX SINCE 1932

This conclusion is supported by the absence of a reported case of smallpox in the District of Columbia since 1932. On the other hand, death and serious illness occurring as complications of smallpox vaccination remain a small but significant problem.

In 1968, the last year for which comprehensive national data were obtained, nine deaths and nearly 150 particularly serious complications of smallpox vaccination were reported to the Center for Disease Control. Extensive data for the District of Columbia are not available.

COMPLICATIONS FROM VACCINATION

Nevertheless, it is known that in the past 6 months alone three hospitalizations have resulted from complications of smallpox vaccination of children for purposes of school entry.

Thus, in the District of Columbia, as in the United States, the risk of death or serious illness from complications of smallpox vaccination appear to be far greater than from smallpox itself.

In September 1971, as a consequence of this, the U.S. Public Health Service recommended that routine childhood vaccinations against smallpox should be discontinued in the United States.

ONLY THE DISTRICT OF COLUMBIA RETAINS REQUIREMENT

Subsequently, each of the 50 States having a requirement that children be vaccinated against smallpox prior to school entry has eliminated it. Only the District of Columbia, of all jurisdictions in the United States, continues to have a requirement that its children must be vaccinated against smallpox prior to school entry.

In the District of Columbia increasing numbers of physicians in private practice, hospitals, and public health practice circumvent the school requirement for smallpox vaccination as a condition for school entry by stating that smallpox vaccination in the particular child is medically contraindicated. Thus, each, in his own way, is voicing his private objection in the requirement and it is rapidly losing its effectiveness in the District of Columbia.

SUMMARY

Because the risk of importation of smallpox into the District of Columbia is small, because the risk of death or serious illness from complications of smallpox is relatively far greater than from smallpox itself, and because the requirement for smallpox vaccination for school enterers is rapidly losing its effectiveness, the District of Columbia believes that it should be permitted to join the 50 States of the United States in repealing the requirement that children entering school must be vaccinated against smallpox.

The government of the District of Columbia requests that H.R. 8747 be approved. We hope this bill will be promptly enacted so that children preparing to enter school this fall will not have to be vaccinated against smallpox.

For the information of the committee, I have a copy of the statement of Dr. H. Bruce Dull, Assistant Director for program, Center for Disease Control, Department of Health, Education, and Welfare and the statement of the medical society of the District of Columbia, which were presented during hearings in the House of Representatives. I would ask that these be made part of this committee's record.

This concludes my testimony. I will be happy to answer any questions you may have.

Senator TUNNEY. Without objection, the statements will be made a part of the record.

[The statements follow:]



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

DR. H. BRUCE DULL

ASSISTANT DIRECTOR FOR PROGRAM
CENTER FOR DISEASE CONTROL

BEFORE THE

SUBCOMMITTEE ON LABOR, SOCIAL SERVICES AND THE INTERNATIONAL COMMUNITY

COMMITTEE ON THE DISTRICT OF COLUMBIA

HOUSE OF REPRESENTATIVES

Tuesday, January 22, 1974

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you to testify on HR 8747 which would discontinue compulsory vaccination against smallpox in the District of Columbia.

The Department of Health, Education, and Welfare supports the recommended change in smallpox vaccination policy in the District of Columbia which would preclude the routine vaccination of children. The status of smallpox throughout the world, the risk of smallpox importation into the United States, the expected transmission after an importation, and the risk of vaccination to the population justify a policy of selective vaccination of individuals at special risk. We believe this group to be essentially comprised of travelers to and from infected areas and hospital and other health workers who would be our first line of defense in the event of a smallpox importation.

Smallpox Occurrence Throughout the World

The areas of the world reporting endemic smallpox have steadily declined since the global smallpox eradication program of the World Health Organization began in 1966. Then, 28 countries had endemic smallpox. Now in only four countries (Bangladesh, India, Pakistan, and Ethiopia) is smallpox considered to be endemic. Each of these countries is engaged in massive campaigns designed to interrupt smallpox transmission as soon as possible. Intensive village-by-village surveillance activities are being carried out to detect existing smallpox foci. This has resulted in large numbers of cases and outbreaks being identified and reported — a phenomenon which was also observed in Brazil just prior to smallpox eradication in that country.

Bangladesh and India constitute the principal strongholds of endemic smallpox. In Bangladesh, smallpox transmission has almost been broken in Chittagong Division which contains over 25 percent of the country's population. In India, smallpox transmission has virtually been interrupted in the southern states. In northern India, particularly in the provinces of Uttar Pradesh, Madhya Pradesh, Bihar, and West Bengal, smallpox is still heavily endemic. The extent and magnitude of recent surveillance and containment campaigns in both Bangladesh and India, however, have strengthened WHO projections for the interruption of smallpox transmission in these countries by 1976.

In Pakistan, the extent of infected areas is decreasing rapidly. Smallpox is now confined to Baluchistan and Sind provinces which contain about 18 percent of Pakistan's population and transmission is expected to be broken during 1974.

In Ethiopia, the remaining foci of smallpox are primarily centered in three of the country's 14 provinces where a concentrated effort is underway to eradicate smallpox. In spite of difficult terrain and resistance to vaccination in some areas, Ethiopia is expected to be smallpox-free by the end of 1974.

Risk of Importation

The last confirmed case of smallpox occurred in the United States in 1949. The probability of importation into this country is determined by the incidence of smallpox in endemic countries, the number of travelers from these countries, and the immunity status of these travelers. Understandably, some risk of importation will continue as long as there are cases anywhere in the world. For this reason, the United States requires that travelers arriving in this country from a smallpox infected area show proof of immunity by having a valid vaccination certificate in their possession.

The rapid decrease over the past several years in the number of countries reporting smallpox has greatly reduced the probability of travelers being exposed to smallpox within 2 weeks of their arrival into the United States. In 1972, and again in 1973, a survey of air travelers to the United States suggests the current probability of a case of smallpox being imported into the United States as roughly every 18 years.

Risk of Transmission After Importation

With a policy of routine nonselective vaccination as previously conducted throughout the United States (still required in the District of Columbia), immunity levels were very low. To maintain high levels of immunity in our population we would have to have universal vaccination of children at a very young age and then revaccination at regular intervals throughout life. Surveys have shown less than 20 percent of the population fully protected against smallpox. Herd immunity concepts can be very misleading when it comes to smallpox. We have been free of smallpox in this country for the past 25 years, not because of high immunity levels, but because we have not had an importation.

An analysis of smallpox importations into Europe has shown that countries with nonselective vaccination policies and supposedly higher levels of immunity fare no better in terms of the number of cases, epidemiologic generations, or mortality than countries with selective requirements and known low levels of immunity. The critical factor in an outbreak is not previous population immunity but the speed and quality of the containment response. The outbreak in Yugoslavia during March-April 1972 was more extensive than West European outbreaks in spite of the fact that Yugoslavia had a policy of routine vaccination and 70-90 percent of the population vaccinated at some time in their lives.

In the United States, medical epidemiologists with smallpox control experience, ample vaccine, jet injectors, and trained vaccinators are available for immediate contact tracing and appropriate containment efforts. As part of the preparation for an effective procedure for the management of smallpox in the unlikely event of an importation, the Center for Disease Control has developed a manual which provides a step-by-step approach to assist health personnel in handling suspected smallpox. This manual has been placed in the office of each State and Territorial Epidemiologist including the District of Columbia.

As long as a possibility exists of a smallpox importation, however, we believe a significant reduction could be achieved in the number of cases occurring following an importation if adequate vaccination programs on hospital and other health personnel were carried out. For this reason, the Center for Disease Control supports the American Hospital Association's recommendation for the vaccination of hospital workers against smallpox every 3 years.

Risk of Vaccination Complications

Surveys in the United States have demonstrated a definite measurable risk of complications following smallpox vaccination. These vary from local erythematous reactions to life-threatening situations and death. In 1968, over 14 million people were vaccinated; nine deaths were associated with smallpox vaccination and approximately 500 cases of serious complications reported. For

most people in the United States the risk of vaccination complications clearly outweighs the benefits of being vaccinated. The recommended policy of selective vaccination affords protection to those persons at risk of exposure while reducing the vaccine associated illness and death in persons who are at very low risk of acquiring smallpox.

Acceptance of Selective Vaccination Policy

The policy of selective vaccination which was formulated and recommended by the PHS Advisory Committee on Immunization Practices has been endorsed by the American Medical Association, the American Academy of Pediatrics, and the Association of State and Territorial Health Officers. Essentially all states have taken action to discontinue nonselective vaccination policies.

Summary

The risk of smallpox importation into the United States is remote and continuing to decrease. Our ability to contain smallpox is more than adequate for any outbreak. At this point in time, most signs indicate a smallpox-free world within the next 3 years. A selective approach to smallpox vaccination should be encouraged in the District of Columbia.

This concludes my statement, Mr. Chairman. I will be pleased to answer any questions that you and other members of the Subcommittee may have.

STATEMENT OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

Mr. Chairman and members of the committee, I am Dr. Clifton R. Gruver, a physician in the practice of Internal Medicine in Washington, D.C., for over twenty years. I appear today as President of the Medical Society of the District of Columbia, the only state society ever chartered by Congress, and a society which has a membership of 3,000 physicians who practice in this metropolitan area.

I shall not dwell at any great length on the reasons why this bill should be passed. I believe these to be well-documented from testimony which has been given in years past, and that which will be given here today. However, I would emphasize that the medical manpower needs of the District of Columbia are supplied in great measure by the Georgetown and George Washington University Schools of Medicine. Combined, these two schools graduate approximately 350 physicians each year. Over 30 percent of these physicians choose to stay in this community for their continued education, and subsequently remain here to enter into practice. Statistics show that at the present time approximately 1,000 graduates of each of these schools of medicine are practicing in this area.

We believe that the financial plight of private medical schools in this country is also well-documented. You have heard in testimony that income from tuition and other sources is not sufficient to support the cost of a four-year medical education. It would, therefore, be a real catastrophe for medical education, especially in this nation's Capitol, if these schools were once again forced to consider closing their doors because of the lack of funds. To lose this great source of physician manpower, would have a serious effect on the high ratio of physicians which this city enjoys. And, their services are essential to the delivery of good health care to the citizens of this community.

In compliance with previous national legislation, both of these schools have made tremendous progress in increasing the size of their student bodies and the number of physicians graduated each year. In keeping with this increased effort, we recognize the strenuous effort which both schools have made, in the past and

present, to find new sources of private funds to support ever-increasing costs. In spite of these efforts, however, as we have heard, they find themselves unable to continue without the assistance which this bill will provide.

In closing, I reiterate that The Medical Society of the District of Columbia strongly supports the passage of this bill so as to make it possible for the private, nonprofit medical schools of this city to continue their great work.

Thank you for the opportunity and the privilege to present our views.

STATEMENT OF DR. CLIFTON R. GRUVER, PRESIDENT, MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

Dr. GRUVER. You know from our statement that we wholeheartedly endorse an extension of legislation for these two medical schools, and I would like to point out, too, it occurred to me this morning as I listened to the testimony that regardless of how many of these graduates stay in the area to practice, if we close the door on these medical schools, we are not going to have anybody staying and practice. We are not going to be producing physicians that now have a locality in which to stay.

HEALTH TRAINING PROGRAMS

You have to remember that there is an additional area of manpower that comes from the medical schools in the form of their health graduate training programs, and there is a significant pool of health training schools. A significant number of the people who are trained in the training schools of George Washington and Georgetown remain in this community to practice medicine.

Mr. MAZZOLI. Remain here to practice?

Dr. GRUVER. Remain in this community to practice.

I think it is good to emphasize the point as to George Washington as to their new school of physicians' assistants is concerned. If we are concerned about the health manpower situation and what to do about the inner city, this is one aspect that has to be developed in our medical society. We are certainly scrutinizing this aspect.

These schools, also, through the excellence of their faculties, provide superb facilities for continuing education for the professional citizens of this city, and are actively participating in graduate training programs, continuing education programs for our membership.

I think the point should be made that they are doing continued research programs, and these research programs have had advancements in renal disease, hypertension, as we heard earlier. These are benefits, not only nationally but benefit to our local residents, too, since they have entrance to the higher echelon of care that needs these kinds of superb skills and facilities.

FACULTIES

Their faculty, also, has become much more conversant with the privately practicing sector of medicine, and instead of there being a divergent path between the university and academia, and the privately practicing sector, they are converging, that in expediting the development of their departments of community health they are encouraging young physicians to seek careers in family practice, primary care, and I think they really are beginning to have a major impact on community health needs by these types of developments.

COMMUNITY SERVICES

They are also active, the faculties of these schools, the deans and the academic vice presidents, with our medical society, under the umbrella of our medical society with some health planning councils that have been formed. The council that meets on a monthly basis that comprises representatives of the universities, of the practicing sector of medicine, of the Department of Human Resources, of the community hospitals, meeting and having dialog and communication on a monthly basis about the health needs of this particular community, ambulatory medical care being one of the major subcommittee thrusts.

They are also actively participating in a medical society we have a medical society of 3,000 physicians, 2,000 active members, 50 active committees, 1,000 doctors who are participating on a monthly basis of committee activity that deals not only with professional aspects, professional welfare, but community aspects of mental health, drug problems, alcoholism, community health projects planning and so forth, and their faculty of these schools are members of the medical society for great part, and they are actively participating in input in it.

So I wanted to make these few points on a different slant, and perhaps the value of the presence of these medical schools may be not just for the purpose of graduating young physicians, of doctors with medical degrees, but how they have an ongoing active participation locally for our professional health needs.

Mr. MAZZOLI. Dr. Gruver, one quick question.

As a practicing physician, even though you may be on a leave of absence now as a physician, being president of the society and having been before enough of these congressional committees, do you find as a practitioner it useful to have hospitals and teaching facilities in your area, both because I guess it gives you a better resource facility for the tough cases as well as it adds to the quality of the practice and it adds to the ability to be able to render a good, complete medical service?

Is that a fair statement?

Dr. GRUVER. That is a fair statement. That is certainly one very definite service that they provide.

Mr. MAZZOLI. The closedown of these schools certainly is not going to happen if we can prevent it. If that event were to occur, would it be a detriment to the whole medical practice, to the whole medical situation in this community, in this whole area?

Dr. GRUVER. Unquestionably.

Mr. MAZZOLI. Dr. Callanan.

STATEMENT OF JOHN CALLAHAN, D.D.S., PRESIDENT, DISTRICT OF COLUMBIA DENTAL SOCIETY

Dr. CALLANAN. I would like to take one sentence out of my prepared statement that I would like to emphasize.

GRADUATES

We keep hearing about how many residents of the District of Columbia go to a school and how many graduates of a school stay in the District of Columbia. Fifty percent of the practicing dentists in the Washington area are alumni of Georgetown Dentistry. That is the Washington area. It is not the District of Columbia.

Two cases in point. By virtue of my parents buying a house half a block on the other side of Western Avenue, I was a Maryland resident, but I went to Georgetown. I have practiced here in the city. A great number of my classmates were boys from Connecticut, Rhode Island, Massachusetts, and New York. When they come to Washington they intended to become dentists and then go back to their States. Four years at that particular time in their life, they had met girls here, they had made friends here, they are still here.

These schools attract to your city permanent residents, and I think this is the problem that the gentleman was saying that the State of Maine is sending the kids to the University of Vermont and they are not coming back to Maine. You cannot very well overestimate the effect of those 4 or 6 years of a person's life.

Another point that keeps coming up, I do not think it makes much difference how many of the citizens of the District of Columbia we take in. It is how many physicians you produce in the District of Columbia. I do not care where they came from. That is the name of the game, producing the physicians.

One point that was not made, they talk about the difficulty of getting people to practice in the ghetto. I think possibly with this thrust of the Federal Government to provide funds for the poor people so that they can afford medical and dental care, this is why you cannot get anybody to practice. They cannot make a living there. Give these people the funds to pay for these and I think this problem will begin to solve itself.

The fact that it is not a particularly nice place to conduct a business, you are not going to help that except by doing away with the ghetto.

I would also like to file a statement from the American Dental Association.

Mr. MAZZOLI. That will be done.

Without objection, your statement and those of your association will be part of the record.

[The statements referred to follow:]

PREPARED STATEMENT OF DR. JOHN H. CALLANAN, PRESIDENT, DISTRICT OF COLUMBIA DENTAL SOCIETY

Mr. Chairman and members of the committee, I am Dr. John H. Callanan, President of the District of Columbia Dental Society.

The dental manpower needs of the District of Columbia is supplied in a large measure by Georgetown University, School of Dentistry. Fifty percent of the practicing dentists in the Washington Metropolitan Area are alumni of this school.

It would be a catastrophe to dentistry in this locality if this school was forced to close because of a lack of funds. The services provided by this school are essential to the delivery of good dental health care for our citizens. This is a time when dental care must be expanded rather than curtailed and the number of available dentists must be increased.

We note the great efforts that Georgetown University has made to increase private funding and control operating costs. The District of Columbia Dental Society supports H.R. 11108 and requests your approval of this urgently needed financial assistance for this private, non-profit school of dentistry.

Mr. Chairman, in addition, I would like permission to file for the record a statement from the American Dental Association supporting these bills.

Thank you for the opportunity to appear before this committee.

DISTRICT'S VIEW ON S. 2730

Senator TUNNEY. I would like to ask Dr. Standard if your position on S. 2730 is: That until such time as the changeover of government takes place, and the District of Columbia has funds available to it, at its discretion to do with these funds as it will, you favor two medical schools involved in that legislation receiving their money directly from the Federal Government, and not imposing that burden on the District, which has inadequate funds as it is?

Dr. STANDARD. That is correct, sir.

Senator TUNNEY. And you would favor those funds being made available by the Federal Government, rather than not having them made available?

Dr. STANDARD. Let me state it this way. I think the latter part of the first statement is the one that represents the District's view.

We are really deferring our own opinion in terms of the merits of this bill to the Department of Health, Education, and Welfare. In other words, I heard them testify today they were against such a bill, but certainly the District is deferring its opinion to them in terms of making that decision, but certainly the District does not feel it is financially in a position to take on that responsibility.

Senator TUNNEY. I see. In other words, you are not testifying in favor of the legislation.

You are just saying that you just do not have the money to make available those funds as other State governments make available funds to their medical schools.

Dr. STANDARD. That is correct, sir.

Senator TUNNEY. But you take no position on the merits of the bill itself.

Dr. STANDARD. We are not taking any position on the merits of the bill.

Senator TUNNEY. That is very clear. Certainly, we do appreciate your testimony. It seems to me that if the funds are going to be made available, they are going to have to be made available over the next couple of years by legislation similar to what we have before us. It is a moot point as to whether or not the District of Columbia should be the responsible governmental agency to make these funds available, because they just do not have the funds to make them available. Is that correct?

Dr. STANDARD. That is correct.

Senator TUNNEY. Thank you, Dr. Standard.

Dr. STANDARD. Thank you, Mr. Chairman.

Senator TUNNEY. Our next witness is Mr. Anthony C. Morella, general counsel, American University.

STATEMENT OF ANTHONY C. MORELLA, GENERAL COUNSEL, AMERICAN UNIVERSITY

Mr. MORELLA. Thank you, Mr. Chairman.

Senator TUNNEY. You will be testifying on S. 3389?

Mr. MORELLA. That is correct.

Senator TUNNEY. Please proceed.

Mr. MORELLA. Good morning, Senator. I will try to be brief in light of your time constraints.

I am Anthony C. Morella. I am general counsel of the American University of Washington.

I appear here today on behalf of the board of trustees and the president of the American University in support of S. 3389, a bill to further amend the act to incorporate the American University, approved on February 24, 1893, as amended.

BACKGROUND INFORMATION ON AMERICAN UNIVERSITY

In 1952, which was prior to the next amendment to the act, the Methodist Church elected to give substantial financial support to the American University, and it was their intention at that time to expand the university, and to clarify the relationship between the board of trustees of the American University and the board of education, the national policy decisional body of the Methodist Church.

In 1953, the charter of the American University was further amended to provide that no person could be elected to the board of trustees of the university without approval by the board of education of the Methodist Church, and second, to provide that all of the real and personal property of the American University would be held for educational purposes under the auspices of the Methodist Church.

In addition, in the 1953 amendment, the board of trustees of the corporation could not propose any amendment to the charter to this Congress, unless such a proposed amendment had been previously approved by the board of education of the Methodist Church, and in the event of any violation of that provision, all title and interest to the corporation would vest automatically in the Methodist Church.

The American University today is in large measure the product of the vision of its founder, Methodist Bishop John Fletcher Hurst, in the 1800's.

It was his purpose to, at that time, establish in Washington a graduate school of history and public affairs, available for students across the Nation.

The university, of course, is significantly proud of the charter conferred upon it by the Congress, and the university is equally proud of the traditions and its Methodist heritage.

The university's first class in 1914 numbered some 28. Today, the university has more than 15,000 students coming from all 50 States and over 80 foreign countries.

In 1916, the university conferred its first degrees which at that time were two in number, and in three weeks, the University, expects to award some 2,500 degrees to its graduating students.

Now, in the 80 years since the university was founded, we have established seven schools and colleges including an undergraduate college of arts and sciences, law school, a business school, a school of government, public administration, a school of international service, continuing educational school, and a school of nursing as well as a college of public affairs, and we are, of course, significantly proud of the accomplishments that the university has been able to secure over the 80 years.

A significant part of that accomplishment is attributable, of course, to the support and the programmatic assistance that has been available to the university, to its students, and to its faculty, and there are various Federal enactments and appropriations designed to enhance higher educational opportunities in the Nation.

We are also mindful of the growing concerns of the Congress in these directions, and we hope to continue to be able to sustain the partnership relationship between the university and all private educational institutions, such as ours, and the Congress of the United States in its programs.

The concern, however, with some of the constraints of the Constitution, in particular the first amendment, in terms, in our case in particular, our church heritage and the traditions of an institution such as ours. We wish to remain significant of those constraints, and it is therefore our intention in supporting S. 3389 to classify affirmatively our institutional structure with a view toward that vigilant attitude.

RELATIONSHIP BETWEEN AMERICAN UNIVERSITY AND METHODIST CHURCH

The purpose, therefore, of this proposed legislation in part is technical, to accommodate technical amendments, and in part substantive to clarify the relationship between the university and the Methodist Church.

Legislation, therefore, is designed to provide for only a minimum of the membership of the university board of trustees to be drawn from the Methodist Church, one-fourth in lieu of the current three-fifths. That the election to membership on the board of trustees of the corporation would no longer have to be approved by the Methodist Church, and that the charter would, of course, recognize its heritage and its traditions insofar as the Methodist Church is concerned. But nonetheless, all of the property of the corporation would be held in perpetuity for educational purposes, and not under the auspices of the Methodist Church that the current charter provides. Third, in the event that all of the property should no longer be used for educational purposes, then and only then would the property vest over to the Methodist Church. In effect, the university ceases to exist. And finally, the university would be in a position to secure additional amendments to its charter by its own board proposing such to this Congress, or subsequent Congresses, if necessary without the approval of the Methodist Church. Such actions could no longer constitute a possibility of reversion of which the current charter somewhat provides for.

Now, we have complied, of course, with the provisions of the current charter in that the United Methodist Church has approved these proposals as incorporated in S. 3389.

SUMMARY

In summary, Mr. Chairman, our position is simply this.

In recent times, the Supreme Court has given significant attention to this question, the question as to the constitutionality of various Federal programs, particularly to institutions that have some form of

relationship with a church, and the question of function, the question of secularies, and secular education.

These issues have been raised before the courts, and we feel those decisions are significant.

Our purpose, therefore, in supporting this legislation is to take what we might suggest as preventive steps in advance to cure our charter so that these problems, if they would materialize in terms of the Constitution, would not be problems for the American University, and I might add that any number of institutions such as ours across the Nation have been doing similar things.

We ask, therefore, the Congress to consider our position.

Senator TUNNEY. Mr. Morella, does anyone to your knowledge descend from the position you have expressed today?

Mr. MORELLA. We have many colleagues in Washington in this room, and I am sure they do not.

I know of none; no, sir.

Senator TUNNEY. Thank you very much. Your prepared statement will be made a part of the record.

[The prepared statement follows:]

STATEMENT OF ANTHONY C. MORELLA, GENERAL COUNSEL OF
THE AMERICAN UNIVERSITY OF WASHINGTON, D.C., IN SUPPORT
OF S.3389 - A BILL TO AMEND THE ACT ENTITLED "An Act to
incorporate the American University," approved February 24, 1893,
as amended.

Mr. Chairman and members of the Committee, I appear today
on behalf of The Board of Trustees and the President of The American
University in support of S.3389, a bill to further amend the "Act to
incorporate the American University", approved on February 24, 1893
(27 Stat. 476), as amended.

The Special Act of the Congress in 1893 incorporated The
American University to establish and maintain within the District of
Columbia a university for the promotion of education. That Act
required that the business of the corporation be transacted by a
board of trustees consisting of not less than forty nor more than
fifty persons, two-thirds of whom would at all times be members of
the Methodist Episcopal Church. This charter was amended by act
of Congress approved March 2, 1895 (28 Stat. 814), by which the
number of trustees constituting a quorum to do business was changed
from 15 to 11; and by act of Congress approved June 30, 1951
(65 Stat. 107) which provided three-fifths of the trustees shall be

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members of the Methodist Episcopal Church instead of two-thirds as originally provided.

In 1952 action was taken at the quadrennial convention of the Methodist Church to give substantial financial support to the American University. It was the intention of the Church at that time to expand the university and to clarify the relations between the board of trustees of The American University and the Board of Education of the Methodist Church. Accordingly in 1953 the Charter was further amended by act of Congress approved August 1, 1953 (67 Stat. 359), to provide that no person shall be elected to the board of trustees of the university without approval by the Board of Education of the Methodist Church; and to provide that all the real and personal property of the American University shall be held for educational purposes under the auspices of the Methodist Church. In addition, the board of trustees of the corporation cannot propose any amendment by the Congress to the organic Act, as amended, unless the proposal of such amendment has been previously approved by the Board of Education of the Methodist Church; and, in the event of any violation by the corporation or the board of trustees of these provisions amended to the Act of incorporation, all title and interest of the corporation shall vest in the Board of Education of The Methodist Church.

The American University today is in large measure the product of the vision of its founder, Methodist Bishop John Fletcher Hurst. It was his purpose to establish in Washington a graduate school of history

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and public affairs. The University is very proud of the charter conferred upon it by Congress. And the University is equally proud of its traditions and Methodist heritage. Its first class in 1914 numbered only 28. Today there are more than 15,000 students enrolled from 50 states and over 80 foreign countries. In 1916, The American University conferred two degrees at its first commencement; in two weeks, the University expects to award degrees to some 2500 students.

In over 80 years there has been a corresponding growth in the number of schools and colleges as the University responded to educational demands. Since Bishop Hurst established the first graduate school of history and public affairs, we have added a College of Arts and Sciences, a Law School, a School of Business Administration, a School of Government and Public Administration, a School of International Service, a College of Continuing Education, a School of Nursing and a College of Public Affairs. Indeed we are truly an American University providing higher educational opportunities in the Nation's Capitol for all who seek such.

A significant part of the University's progress can be attributed to the supports and programmatic assistances available to its faculty and its students from the various federal enactments and appropriations designed to increase and enhance higher education opportunities for all persons across the nation. We are mindful of the continuing concerns of the Congress

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in these directions and we hope to continue to be able to sustain the partnership relationships the University community has enjoyed in these regards. We are concerned, however, as we should be, with the constraints of the Constitution in terms of the church heritage and traditions of an institution such as ours. We wish to always remain vigilant to those constraints and it is, therefore, our intention in supporting S.3389 to affirmatively classify, in our institutional structural charter, that vigilance.

The purpose of the proposed legislation, therefore, is in part to accommodate technical amendments and in part to substantively clarify the relations of the University to the United Methodist Church. Firstly, the proposed legislation, if enacted, will provide for only a minimum membership of the University's Board of Trustees in the United Methodist Church: "at least one-fourth" of the duly elected number instead of three-fifths as currently provided; secondly, approvals of elections to the board of trustees of the corporation by the Board of Education of the Methodist Church would no longer be required, and, to advance the educational intention and spirit of the United Methodist Church in founding the University, which is our heritage, all property of the corporation shall be held in perpetuity "for educational purposes", but not under the auspices of the Methodist Church, nor subject to its Discipline; thirdly, in the event all of the property of the corporation shall no longer be held for

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educational purposes, then and only then shall the property vest over to the Board of Education of the United Methodist Church; and finally, amendments to the charter could be proposed to the Congress by the board of trustees so long as first approved by not less than two-thirds of the total duly elected membership of the board of trustees of the corporation. Such actions by the board of trustees of the corporation could no longer constitute a possibility for reversion of the corporate property to the Methodist Church.

On November 1, 1973 the Board of Higher Education and Ministry of The United Methodist Church approved the American University charter modifications which are incorporated in the amendments proposed in S. 3389. Such approvals are required under the current Act, as amended, and we furnish herewith for the record of these hearings copies of a certified copy of that portion of the minutes of the Board of Higher Education and Ministry of The United Methodist Church recording such approvals.

By way of summary, S. 3389 is designed to permit the University to acknowledge its heritage from The United Methodist Church and to continue to conduct its affairs as a private institution of higher education in the District of Columbia chartered by an Act of the Congress of the United States.

BOARD OF HIGHER EDUCATION AND MINISTRY
THE UNITED METHODIST CHURCH



P.O. Box 71 | Nashville, Tennessee 37202
Telephone (615) 327-2727

F. Thomas Trotter, General Secretary

December 12, 1973

This is to certify that the following is an exact excerpt from the Minutes of the Board of Higher Education and Ministry of The United Methodist Church, from the session of November 1, 1973:

Dr. Fred E. Harris reported for the Division of Higher Education:

.....

5. The division approved American University charter modifications which, in effect, reduce the specific church control over trustees and the selection of trustees in a manner that will alleviate any possible conflict in the matter of federal grants to American University. The matter was studied by the University Senate and by Mr. Boulton, legal counsel, and approved by them in all details. The division recommended board approval. (Exhibit V)

.....

On motion, it was voted to accept the report of the division and to adopt the division recommendations.

(Mrs.) Martha Lawrence
Mrs. Martha Lawrence
Assistant Secretary
Board of Higher Education and Ministry
The United Methodist Church

Exhibit V contains the recommended details, is a part of the minutes, and a copy is enclosed.

Senator TUNNEY. The record of these hearings will be kept open until close of business on May 10, 1974, for any additional statements which may be submitted.

The hearing stands adjourned.

[Whereupon, at 11:40 a.m., the subcommittee was adjourned.]



