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AND DENTAL MANPOWER ACT OF 1970

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HEARING

BEFORE THE

COMMITTEE ON

THE DISTRICT OF COLUMBIA

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

ON

H.R. 12132

TO EXTEND AS AN EMERGENCY MEASURE FOR ONE YEAR
THE DISTRICT OF COLUMBIA MEDICAL AND DENTAL
MANPOWER ACT OF 1970

APRIL 29, 1976

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Committee on the District of Columbia

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EXTENSION OF THE DISTRICT OF COLUMBIA MEDICAL AND DENTAL MANPOWER ACT OF 1970

THURSDAY, APRIL 29, 1976

U.S. SENATE,
COMMITTEE ON THE DISTRICT OF COLUMBIA,
Washington, D.C.

The committee met, pursuant to notice, at 9:30 a.m., in room 6226, Dirksen Senate Office Building, Senator Thomas F. Eagleton (chairman of the committee) presiding.

Present: Senator Eagleton.

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

The CHAIRMAN. The committee will come to order.

Good morning, ladies and gentlemen. The Senate District of Columbia Committee is now in session to conduct a hearing on H.R. 12132, the extension of the District of Columbia Medical and Dental Manpower Act of 1970.

The bill before us passed the House of Representatives on April 12, 1976, by a vote of 264 to 90. The bill would extend for 1 year the provisions of law which allow for Federal aid to two medical schools and one dental school in the District of Columbia. The aid is limited to a maximum of \$5,000 per enrolled medical student and \$3,000 per enrolled dental student and applies only to fiscal year 1977.

I now place in the record a copy of H.R. 12132.

[The bill referred to follows:]

(1)

94TH CONGRESS
2D SESSION

H. R. 12132

IN THE SENATE OF THE UNITED STATES

APRIL 13, 1976

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

AN ACT

To extend as an emergency measure for one year 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 section 303 (c) of the District of Columbia Medical and
4 Dental Manpower Act of 1970 (D.C. Code, sec. 31-922
5 (c)) is amended by striking out "years ending June 30,
6 1975, and June 30, 1976," and inserting in lieu thereof
7 "year ending September 30, 1977,".

Passed the House of Representatives April 12, 1976.

Attest: EDMUND L. HENSHAW, JR.

Clerk.

The CHAIRMAN. We have as our first witnesses a panel from the U.S. Department of Health, Education, and Welfare. In the group are Dr. Daniel Whiteside, Director of the Bureau of Health Manpower; Gene Haislip, Deputy Assistant Secretary for Legislation; and Dr. James F. Dickson III, Deputy Assistant Secretary for Health.

Gentlemen, we welcome you, and we are pleased to have you with us, and you may proceed as you desire.

Dr. DICKSON. Thank you, Mr. Chairman.

I do have a formal statement that I would like to submit for the record. I would prefer, if I may, to make some brief summary remarks of that testimony.

The CHAIRMAN. Very good, sir. Your prepared statement will appear in the record at the conclusion of your testimony.

Dr. DICKSON. Thank you.

STATEMENT OF DR. JAMES F. DICKSON III, DEPUTY ASSISTANT SECRETARY FOR HEALTH; ACCOMPANIED BY GENE HAISLIP, DEPUTY ASSISTANT SECRETARY FOR LEGISLATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEW OPPOSES BILL

Dr. DICKSON. As you recall, Mr. Chairman, the Department has testified in opposition to legislation that is similar to the one that is before us today—it has testified in the past against it—and in 1974 the administration recommended against enactment of the bill authorizing extension of the District of Columbia Medical and Dental Manpower Act for fiscal years 1975 and 1976. And when that bill was passed, the President said that he felt that this was the last time that he intended to sign legislation that would single out medical and dental schools for favored treatment simply because of their geographic location in the District, and he reluctantly signed the bill, I judge, only because he did not wish to cause any abrupt reduction in services.

He also said at that time that if the Congress wished to subsidize these schools it should do so, he felt, through the budget of the District of Columbia.

And some 2 months ago the administration testified before the House District Committee in opposition to the bill you are considering today.

DOES NOT QUESTION THE NEED

I think that I would like to particularly note at this point, while we are in opposition to the bill, that it is not our purpose in the slightest to question the need that these three private medical and dental schools have for additional operating funds. Medical and dental schools throughout the country have been expanding, and they are trying to enrich and diversify their educational programs at a time when income that is available to the schools have not at all been rising at a comparable rate. How it is best to bring into balance the budget of the medical and the dental schools, especially those of the private schools is an issue that is far from resolved in the country, generally. We do feel, however, that to provide special Federal assistance to these Dis-

trict of Columbia schools would be inequitable as far as other private medical and dental schools are concerned, and would, in fact, create an undesirable precedence in that sense.

SPECIAL TREATMENT

The issue that arises with respect to the proposals to provide this support here out of the Department of Health, Education, and Welfare appropriations is whether, in fact, there are overriding reasons of national policy to justify singling out from the entire university private medical and dental schools in the country these three schools in the District for preferential funding and preferential treatment from the general revenues of the country. And in the absence of such reasons, it is difficult for the Department to rationalize such special treatment solely on the basis of their geographical location within the District.

HEALTH PROFESSIONS EDUCATION AMENDMENTS OF 1975

Mr. Chairman, several months ago the administration submitted to the Congress its proposed Health Professions Education amendments of 1975 to amend and extend the title VII Health Professions Education authorities through fiscal year 1979. The administration bill, H.R. 11119, would provide for capitation payments to medical and dental schools that agree to undertake specific efforts to address high priority problems that do exist with respect to geographic and specialty maldistribution at this time. In addition, this bill would authorize special project assistance for various kinds of special health manpower activities including aid to health profession schools that do happen to be in serious financial straits.

Through the provisions of this bill we have offered what we feel is a comprehensive and integrated approach to Federal support for health professions education that is designed to achieve a maximum impact in terms of the limited resources that are available to us.

I think that as the Congress now proceeds to consider the various proposals for the support of health professions education and higher education, generally over the coming weeks it will be addressing a variety of issues relating to the need for Federal financial support for health profession schools.

Among the questions that must be addressed is how best to provide special assistance to the relatively small number of health profession schools that are still experiencing financial distresses. And we believe, in summary, it would be inequitable and inappropriate for the Congress to legislate preferential treatment for private schools in the District without reference to the policies that must, in fact, relate to all schools in the country that are similarly situated.

SUPPORT SHOULD BE PROVIDED BY APPROPRIATIONS

In closing, Mr. Chairman, the District of Columbia private schools need operating support of the type provided by some States within their jurisdictions. We would respectfully suggest that this be provided through the appropriations to 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 school's asserted need for such support makes a compelling demand upon the city's financial resources, and the District Government can also assess the extent to which these schools contribute to the health manpower needs of the District.

NOT SUFFICIENT JUSTIFICATION FOR PREFERENTIAL TREATMENT

And while we understand and do sympathize with the problems and efforts of Georgetown University and George Washington University, we believe that there is not sufficient justification for special preferential legislation of the type under consideration here today to assist these particular schools of medicine and dentistry.

I believe these remarks cover the main points that I wanted to make initially, and I and my associates here will be pleased to respond to questions you may have, Mr. Chairman.

The CHAIRMAN. Thank you very much, Dr. Dickson. And I understand the position of the administration, and it is, in all candor, consistent with the previous position of the administration.

MEDICAL MANPOWER ACT

You are correct in saying that the Senate Labor and Public Welfare Committee is preparing its committee report on the Medical Manpower Act, the overall act that covers the entire Nation.

The House of Representatives has passed a bill in this area, as I recall it, but it is considerably different than the Senate bill. And the Senate bill, I am sure, will be subject to extensive debate. Some amendments undoubtedly will be offered. It is by no means a fait accompli.

That deals with the problems of medical schools across the country. If my memory serves me right, there are over 200 medical schools in the United States. None of them are affluent in the sense of having enormous surplus income. Several of them are in very precarious shape. If the Federal Government does not assist them with the Health Manpower Act, many of them could well go under.

COSTS OF MEDICAL EDUCATION ARE EXTRAORDINARY

Back 2 or 3 years ago I attended a hearing where the Dean of Johns Hopkins Medical School testified. Johns Hopkins is considered almost the Cadillac of medical education. It is one of the premier schools in the country. And they were very, very close to making a decision to close their doors. The extraordinary costs of medical education are just that—they are extraordinary.

Reverting for a moment to my own constituents: St. Louis University is a very fine university in St. Louis. Not too many years ago it was at the breaking point of either going under or needing a massive infusion of aid. Indeed, St. Louis University did close their dental school. It was a very controversial decision. And I know Father Rinehart and the others who administered that institution, and then Father Henle was there as the vice president, as I recall it. They did not do this with eagerness. They did not do it with relish. It was just a matter of financial necessity. There was no way they could keep the dental

school financially viable. That was a distinct loss to the St. Louis metropolitan area, to the State of Missouri, and to the Nation as a whole.

FEDERAL GOVERNMENT HAS NO ALTERNATIVE

If our country is to continue to have a necessary repository of medical manpower, the Federal Government has no alternative but to assist universities, both public and private, in keeping their schools open, their teaching hospital facilities functioning, and the like.

STATE SUPPORT

Now, let me get to the District of Columbia and to the three schools that are here, two medical and one dental. These schools will be the recipients of whatever Federal aid on a nationwide basis will go to Johns Hopkins, Harvard, the University of California, and the like. That is the bill to which I made previous reference. They will sink or swim. They will participate to the same degree out of that bill as will all the other schools in this country. That is the way it should be. But we have these three medical institutions here in the District of Columbia that do not benefit from any State input of dollars. And there is a wide range in this country of State support. I think it is mentioned somewhere in one of these reports. I am referring to the report of the House Committee on this bill. On page 8 it says,

Based upon the State support of public medical schools per full-time equivalent (FTE) student, the figures ranged from a high of \$23,687 per full-time equivalent student for Massachusetts, to a low of \$1,626 for Virginia. Nine States reported spending more than \$10,000 per full-time equivalent student, while 17 States spent less than \$5,000 per student,

et cetera.

And on page 13 of that House Committee report there is a State-by-State breakdown on what the various States put into their public and private medical students.

I am not very satisfied, frankly, with this table on page 13 because it blends together State support for both public and private. For instance, take Massachusetts, which was the high one here that I mentioned—over \$23,000. That would include moneys that were appropriated to the University of Massachusetts at Amherst for its medical school, and whatever additional moneys were appropriated by the Massachusetts Legislature for Harvard, Boston University, and other private medical schools in that State.

I am going to ask you, Dr. Dickson, if you will—and if you cannot get it, steer us in the right direction—I would like a State-by-State breakdown of what each State, as a State, gives per student to the private medical schools in that State. I want a breakdown on the private medical schools because this table on page 13 can be a bit misleading because if you blend into that table, as they have done, the moneys appropriated by the legislature for the total operation of a public institution, that is a far different, in my opinion, judgment than how much each State puts in for a private institution.

Do you follow what I am driving at, Doctor?

Dr. DICKSON. Yes, indeed. And we will supply that, sir.

[The information requested appears in Dr. Elliott's prepared statement on p. 58.]

The CHAIRMAN. Just drawing on my memory, but as of now, for instance, Missouri does not give any aid to the two private medical schools that are in our State. Maybe I am mistaken on that. Father Henle perhaps can later enlighten me on it. But to my recollection, we do not give any State aid in Missouri. Whereas there are other States—I think New York, California, and perhaps Pennsylvania—give a rather significant amount of State public money on a capitation basis or some formula basis to the private medical schools in those States. So I would like to have that because I think it gives us some frame of reference. And that is really what this hearing today is all about.

ADDITIONAL APPROPRIATION FOR D.C. SCHOOLS

Should the District of Columbia—which is, for some purposes, a city, for other purposes, a county, and for other purposes a State—or its financial Godfather—that is, the Congress of the United States—make some additional appropriation on a capitation basis to the three private medical and dental schools here in the District of Columbia? Is not that really what it boils down to?

Dr. DICKSON. Yes, sir.

The CHAIRMAN. And if we have that table maybe it will shed some light on how generous or how ungenerous the Congress should be in this regard.

Insofar as the District of Columbia, while a District, giving moneys out of its budget—you are making the District of Columbia City Council like a State legislature—in the purist sense of legislative responsibility, that probably would be the preferable way to go. But you and I, Doctor, and the others in this room realize that the District of Columbia budget is already heavily overburdened. It is already operating at a continuing deficit, and that it is rather remote that the District of Columbia Council would go forward with a capitation appropriation to Georgetown, and George Washington, and the like. That, in terms of political science, would be the way this should go.

Witnesses who are testifying here today really in a purer sense, ought to be testifying down in the District Building before the Council. But we do not always live in a purist world. We live in a very practical world. And the pragmatics of this situation are that there is not enough money down in the District Building and thus these medical schools turn to us as the last resort.

Sir, do you have something you wish to comment on?

SCHOOLS NEED A CONTINUING SOURCE OF SUPPORT

Mr. HAISLIP. Senator, if we could just comment on that. We are talking about here a bill that would provide a 1-year extension, and the probability is that these schools do need a continuing source of support comparable to what other schools receive in States. And if that is the case, it seems like the sensible arrangement—which is the one that we are suggesting—is that it should be done through the District Government processes. The Congress should pursue that route and provide

the kind of continuing support that is arrived at through local government processes to do it. That is really the crux of our position, not that we deny that they may have financial problems that need to be addressed. It is a question of who should address them and how they should be addressed. A stopgap 1-year measure, which is sort of in the wrong ball park, as it were, is really, from our perspective, perhaps not the way it should be addressed. That is the crux of our position.

The CHAIRMAN. Well, I do not disagree too strenuously. My own remarks prior to you responding to them encompassed one of the thoughts that you are making.

This is a 1-year stopgap. The reason for the 1 year—at least in my mind—is that until we get an ongoing overall health manpower act on the track, whichever way it is heading, for a temporary period of time as it were, for the next year, I am rather convinced that these schools are going to need some help; and for this year this is about the only place they can get it. Now a year from now, assuming that the Health Manpower Act has been signed and is in operation—I am talking about the overall bill—it may well be that these two universities will not be in a position to come to us for additional or ancillary relief and that they will have to be prepared to carry their message—if they are going to deliver a message—downtown.

SUBSTANTIAL FEDERAL ASSISTANCE

Dr. DICKSON. Again, in that connection, I think it is worth pointing out that the previous Federal manpower legislation has expired, but the program is continuing on a continuing resolution. And we are continuing to supply money to those medical schools in the District and all other medical schools under those provisions. So there is substantial Federal assistance going to these schools at this time.

The CHAIRMAN. Yes. There is substantial Federal assistance going to them as it is going to the other 200 medical schools; no more, no less.

Dr. DICKSON. That is correct.

The CHAIRMAN. Mr. Harris points out that it is his recollection that spokesmen for the medical schools here in the District stated to Congressman Diggs that this was the last and final year they would be making this request, that henceforth they would have to make accommodations with the District of Columbia Government on the downtown basis; so we will hear from them further on that.

Yes, Doctor.

HIGH LEVEL OF EXCELLENCE

Dr. DICKSON. Senator, as a physician I would like to make a comment here that I think is worth bearing in mind as time passes with respect to the support of the institutions. Regardless of the route that happens to be provided in the end. The people at these institutions over an extended period of time have tried to achieve something at a high level of excellence. It would be a shame if the support that is provided them was not provided on a level to keep up that level of excellence rather than let the activities at the schools degenerate into something more mediocre. A lot of people put in a lot of time, and made a lot of sacrifices of energy and time to achieve something par-

ticularly worthwhile. I hope that is taken into consideration when some judgment is made about the long-term resolution of this situation.

GOOD MEDICAL CARE IS A GREAT ASSET

The CHAIRMAN. I could not agree more, Doctor. These are academic institutions of preeminent excellence. And, frankly, there is no greater asset to a city or a State than the quality of the medical care that is rendered by that city or by that State. I guess cities can be judged by a whole host of measures—good schools or bad schools; good parks or bad parks; good housing or bad housing; et cetera—but very high up on any list by which a city is to be judged either by residents who live in it or people who might move to it, high up on such a list is the quality of medical care.

When I was Lieutenant Governor of Missouri, I was in charge of industrial development from the State level, trying to attract new industries into Missouri and into specific areas of Missouri where we thought it would be wise for a company to locate. I traveled around the Nation sort of as a huckster. And high up on my list of sales techniques was the quality of the medical care in these various areas. I found that businesses wanted to hear about that. They wanted to know, are there some workers who are available to work with the kind of business we are in? They would have to know that. But they wanted to know about schools; they wanted to know about hospitals; very high up on their list. And so George Washington University and Georgetown, albeit private institutions, nevertheless are in the broader sense of the term truly municipal assets.

It would be a devastating blow to this metropolitan area if either or both of these schools were to go out of existence. It would be a blow from which the area could never recover, really. And I know, based on your remarks, Dr. Dickson, you recognize that. And you have said that these are two very fine medical schools of high quality, excellent schools, and you want to see them maintain that same high quality standard and I could not agree with you more.

I do understand the position of the Department on this. It is not an outlandish position. I fully understand the good faith in which it is expressed to this committee.

Thank you, gentlemen, very much.

[The prepared statement of Dr. Dickson follows.]



FOR RELEASE ONLY UPON DELIVERY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

BY

JAMES F. DICKSON, III, M.D.

DEPUTY ASSISTANT SECRETARY FOR HEALTH

BEFORE THE

COMMITTEE ON THE DISTRICT OF COLUMBIA

UNITED STATES SENATE

THURSDAY, APRIL 29, 1976

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I am pleased to have the opportunity of appearing before you to testify on H.R. 12132, a bill "To extend as an emergency measure for one year the District of Columbia Medical and Dental Manpower Act of 1970."

Mr. Chairman, if you will recall, the Department of Health, Education, and Welfare has testified in opposition to similar legislation in the past. In 1974 the Administration recommended against enactment of the bill authorizing extension of the District of Columbia Medical and Dental Manpower Act for fiscal years 1975 and 1976. When that bill was passed, the President said that this was the last time he intended to sign legislation singling out medical and dental schools for favored treatment simply because of their geographic location in the District of Columbia and that he reluctantly signed the bill only because he did not wish to cause any abrupt reduction in services. He also said that if the Congress wished to subsidize these schools, it should do so through the budget of the District of Columbia.

- 2 -

Moreover, both the House and Senate reports accompanying H.R. 11108 in the 93rd Congress indicated that future subsidies for the District of Columbia medical and dental schools shall be sought through the District of Columbia appropriations procedure. The report of the Senate Committee on the District of Columbia 1974 accompanying H.R. 11108 in the 93rd Congress stated:

"It is the Committee's view that future subsidies should be granted only after review of the problem by the elected city officials and approval by Congress through the usual District of Columbia budget procedures. It is further the view of the Committee that the institutions involved should make greater efforts to enroll students from the immediate local area. While it is desirable that the national character of the schools not be compromised, nonetheless if the citizens of the District of Columbia are to subsidize these schools, they and their children should have a special call on the schools, just as other State subsidized schools give preference to citizens of their State. These ends may be accomplished both by special recruitment and by scholarships and loans for

- 3 -

needy local students as well as limitations on subsidies so as to tie such funds to local residents, rather than unrestricted direct funding to the universities to meet operational costs."

Two months ago, Mr. Chairman, the Administration testified before the House District Committee and recommended strongly against further extension of the District of Columbia Medical and Dental Manpower Act of 1970.

Today the Administration's position remains the same: that special Federal assistance to two private medical schools and one private dental school--wherever located--would be inappropriate.

Background

The District of Columbia Medical and Dental Manpower Act of 1970, enacted as title III of the District of Columbia Revenue Act of 1970 and extended to cover fiscal years 1975 and 1976 by P.L. 93-389 in August 1974, authorizes the Secretary of Health, Education, and Welfare to make grants to the Mayor of the District of Columbia to assist private nonprofit medical and dental schools in the District of Columbia.

The Act authorizes grants in amounts the Secretary determines 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 must 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.

As originally enacted, the District of Columbia legislation authorized the appropriation of funds for grants to the schools in the amount of \$6.2 million in FY 1971 and such sums as necessary in FY 1972. The 1974 amendments to the legislation authorized the appropriation of such sums as necessary for grants in FY 1975 and 1976. A total of \$7.5 million was awarded to the schools in FY 1975. The Department of Health, Education, and Welfare Appropriation Act for FY 1976 includes an appropriation of \$9,050,000 for this purpose.

Through FY 1974, the Department did not provide funds to the District of Columbia schools under the District of Columbia Medical and Dental Act, but instead provided assistance under the generally applicable provisions of title VII of the Public Health Service Act, as amended by the Comprehensive Health Manpower Training Act of 1971. The capitation grants provisions under the 1971 Act provided increased capitation levels to schools of medicine and dentistry--several times greater than had been received under previous formula authorities. In FY 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). This amounted to over \$2,000 per medical and dental student.

For those schools which needed yet additional assistance to solve their financial problems, the Comprehensive Health Manpower Training Act of 1971 included a special separate authority for grants to schools of medicine and dentistry, as well as other schools of the health professions, which were 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.

Of the approximately \$7.7 million in financial distress grants awarded in fiscal year 1973 to medical and dental schools in this country, over 40 percent went to the D. C. schools; \$1.4 million to Georgetown University Medical School; \$583,000 to Georgetown University Dental School; and almost \$1.3 million to George Washington University Medical School. In fiscal year 1974, the District of Columbia schools again received over 40 percent of the Federal financial distress grants--\$4,901,591 for the three schools. In FY 1975 grants in the amount of \$7.5 million were awarded for the first time to the schools under the District of Columbia Medical and Dental Manpower Act after their applications for financial distress assistance were disapproved by the National Advisory Council on Health Professions Education. That year capitation provided \$3 million to Georgetown and George Washington Universities.

Over and above the aid received under the health professions capitation and financial distress authorities, the District of Columbia schools have received support under other Federal programs. For example, of the total of \$17.9 million in revenues reported by the Georgetown University Medical School in the year ending June 30, 1975, exclusive of aid under the D. C. Medical and Dental Manpower Act, \$8.7 million was Federal assistance other than health professions capitation and financial distress grants. This assistance included health professions special project support, research grants and contracts, and various other types of aid. Since 1966, Georgetown University has received over \$100 million including amounts in the Labor-HEW appropriation, and George Washington University received over \$50 million in institutional support alone.

H.R. 12132

The District of Columbia Medical and Dental Manpower Act of 1970 as amended will expire June 30, 1976. The bill you are considering today, H.R. 12132, would extend the Act for one year (through fiscal year 1977) and would authorize the appropriation of such sums as may be necessary for carrying out its purpose. It would authorize the Secretary of Health, Education, and Welfare to continue assisting private nonprofit medical and dental schools in the District of Columbia in a manner similar to that in which some, but not all, States support private medical and dental schools located in their respective jurisdictions.

ADMINISTRATION POSITION

Mr. Chairman, the issue which this legislation presents is analogous 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

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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. The Floor debate 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 advanced against that earlier legislation apply with equal force to consideration of H.R. 12132.

The facts that the District of Columbia schools admit large numbers of out-of-State students and that their graduates practice in many other States do not in themselves warrant special support through the Department of Health, Education, and Welfare. Many of the private schools that currently receive State support from the States in which they are located share these characteristics.

Moreover, it is not our purpose to question the need of these three private medical and dental schools in the District of Columbia for additional operating funds. Medical and

dental schools throughout the United States have been expanding, enriching, and diversifying their educational programs at a time when income available to the schools has not been rising at a comparable rate. How best to bring into balance the budgets of medical and dental schools, especially those of the private schools, is an issue that is far from resolved in the Nation generally. To provide special Federal assistance to these District of Columbia schools would be inequitable as regards other private medical and dental schools and would continue an undesirable precedent.

The Administration is aware of the efforts made by the District of Columbia medical and dental schools in recent years to improve their financial status. One measure of such efforts is the increase in tuition charged to students--with, for example, the tuition levels at the Georgetown and George Washington Schools of Medicine having risen from \$2,800 and \$3,100 a year, respectively, in 1972-73, to an anticipated \$5,000 and \$7,000 a year for 1976-77. Such increases are common to many medical and dental schools and consistent with the view that taxpayers should not subsidize the educational costs of persons who will ultimately earn incomes that rank in the top 2-3 percent nationally.

Not all States, Mr. Chairman, provide support to private schools of medicine and dentistry. At the present time, 46 private allopathic and 5 private osteopathic schools of medicine are located in 23 States. Thirty-nine of the 46 private allopathic medical schools in 18 States and 3 private osteopathic schools of medicine in 3 States receive State-related funds, in the form of capitation awards, contracts or other such arrangements. Seven private allopathic schools of medicine in 4 States and two osteopathic schools of medicine in one State receive no State funds (Yale University, Connecticut; Boston, Harvard, and Tufts Universities, Massachusetts; Washington and St. Louis Universities, Missouri; Creighton University, Nebraska; Kansas City and Kirksville Schools of Osteopathic Medicine in Missouri). Of the 24 private dental schools in the Nation, 10--less than half--receive State-related support. Thus 14 dental schools and 9 allopathic and osteopathic medical institutions retain their private status without State fiscal assistance.

Even in those States that do provide assistance to private medical and dental schools, the scope of the assistance often is strictly limited. Among the 18 States giving aid to allopathic medical schools, 9 offer support only for additional students enrolled, for students who are State residents, for students up to a limited maximum number, or to obtain some other specific response. At least two of the remaining 9 States give more general capitation support on the basis of the private schools' informal agreement to enroll a certain percentage of State residents.

For example, California contracts with its private medical schools to expand the class sizes of these private schools; payments are made only for additional students enrolled up to a specified number. Illinois makes payments for Illinois residents only. Delaware contracts with Jefferson Medical College in Philadelphia to accept up to 20 Delaware residents per year with a stipulation that a "portion" of the students serve their clinical clerkships at the Wilmington Medical Center. New Hampshire pays its private medical school a specified sum for up to 15 New Hampshire

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residents in each class. Texas provides general support to the private school in its State on the understanding that at least 70 percent of each entering class will be Texas residents.

In addition to numbers of States providing assistance, it is important to note amounts of assistance being provided. In fiscal year 1974--the latest year for which we have comparable data--the per student assistance provided to private medical schools by States averaged \$1,575.00. In that same year, the three D. C. schools received a Federal Financial Distress grant that averaged \$2,649.00 per student. In fiscal year 1975, the per student amount of this special Federal assistance jumped 44 percent to \$3,828.00. In the current fiscal year, the per student amount will rise an additional 18 percent to \$4,494.00.

The issue that arises with respect to proposals to support the private District of Columbia medical and dental schools out of Department of Health, Education, and Welfare appropriations is whether there are overriding reasons of national policy to justify singling out--from the universe of private medical and dental schools in the U. S.--these three schools in the District of Columbia for preferential funding treatment from the general revenues of the Nation . In the absence of such reasons, it is difficult for the Department of Health, Education, and Welfare to rationalize such special treatment solely on the basis of their location within the District of Columbia.

ADMINISTRATION PROPOSALS

Mr. Chairman, the Administration several months ago submitted to the Congress its proposed "Health Professions Education Amendments of 1975," to amend and extend the title VII

health professions education authorities through fiscal year 1979. The Administration bill, S. 2748, would provide for capitation payments to medical and dental schools agreeing to undertake specified efforts to address high-priority problems of geographic and specialty maldistribution. In addition, the bill would authorize special project assistance for various kinds of special health manpower activities, including aid to health professions schools in serious financial straits. To be eligible for financial distress grants, schools would be required to agree to disclose financial information, conduct a cost analysis study, and carry out appropriate operational and financial reforms. Such financial distress assistance would be provided on the assumption that it is a temporary relief to institutions committed to over-coming financial difficulties. To focus attention on its temporary nature the legislation limits financial distress assistance to 75% of the grant received in the preceeding year. Through these and other provisions in the bill, we have offered what we feel is a comprehensive, integrated approach to Federal support for health professions education, designed to achieve maximum impact with limited resources.

Not only has the Administration proposed continued institutional support of health professions education, but also the President's budget proposes \$35 million in service-related scholarships for which the D.C. schools' students can compete. In addition we have sent to the Congress a proposal for amending the Guaranteed Student Loan Program for postsecondary students generally. These amendments, which would (among other changes) increase the amount of loans available to a student to an aggregate of \$25,000 for training requiring exceptionally high costs, would assist medical and dental students in paying increased tuition costs and thus indirectly help meet the operating costs of medical and dental schools.

CONCLUSION

As the Congress considers various proposals for the support of health professions education and higher education generally over the coming weeks, it will address a variety of issues relating to the need for Federal financial support for health professions schools. Among the questions that must be addressed is how best to provide special assistance to the relatively small number of health professions schools still experiencing financial distress. We believe it would be inequitable and inappropriate for the Congress to legislate preferential treatment for private schools in the District of Columbia, without reference to the policies that will apply to all schools in the United States similarly situated.

To the extent that 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 alike to all schools of medicine or dentistry who find themselves in such a plight.

If the District of Columbia private schools need public operating support of the type provided by some States within their jurisdictions, we would respectfully suggest that this be provided through appropriations to 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 financial resources. The District government also can assess the extent to which these schools contribute to the health manpower needs of the District.

While we understand and sympathize with the problems and 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.

This concludes my statement, Mr. Chairman. My colleagues and I will be pleased to respond to any questions which you or the other members of the Committee may have.

The CHAIRMAN. Now we have another panel. And while they are coming to the table I will identify them for the record.

Father Robert J. Henle, president of Georgetown University; Dr. Lloyd H. Elliott, president of George Washington University; Dr. Matthew F. McNulty, Jr., chancellor, medical center, Georgetown University; and Dr. Ronald P. Kaufman, acting vice president for medical affairs, George Washington University.

Father Henle and distinguished Doctors, we are pleased to have you with us and you may proceed.

Father HENLE. Senator Eagleton, we are happy to be here and we thank you for the time.

In view of the limited time and the remarks which have already been made, I am presenting a written document which summarizes my testimony, but I will bypass the obvious parts of it and only make a few points.

The CHAIRMAN. Your full testimony will appear in the record as though read, at the conclusion of your testimony.

Father HENLE. Thank you very much.

STATEMENTS OF: FATHER ROBERT J. HENLE, PRESIDENT, GEORGETOWN UNIVERSITY; DR. LLOYD H. ELLIOTT, PRESIDENT, GEORGE WASHINGTON UNIVERSITY; DR. MATTHEW F. McNULTY, JR., CHANCELLOR, MEDICAL CENTER, GEORGETOWN UNIVERSITY; DR. RONALD P. KAUFMAN, ACTING PRESIDENT FOR MEDICAL AFFAIRS, GEORGE WASHINGTON UNIVERSITY; AND DR. JOHN P. UTZ, DEAN, GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

Father HENLE. We have attempted to follow the route which was recommended, and which is obviously a sensible route, of working with both the mayor of the District of Columbia and the District of Columbia City Council. You, Senator, have already indicated at least for the foreseeable future, that that is not a realistic source of assistance to the universities and to many other institutions in the area. I agree that if you were drawing a chart of political science, that is one thing, but the realities of the situation I think everybody is aware of, and I do not think we can look to this for any immediate solution, perhaps much longer range. I think that is very clear. But to tell us to go to the District for help right now is simply telling us to have no hope because we cannot do that. And I do not blame the District one bit.

PROTECT QUALITY OF EDUCATION AND SERVICES

The need for this money is not merely to prevent us from going bankrupt. We need it to protect the quality—to which you have very graciously referred—of the education and of the services to the entire area which these two medical schools and our dental school are able to render. A 1-year lapse in support, which would require a cutback in our expenditures as well as an increase in tuition, would have a devastating result at this moment on that quality because we would have to go into economics, we would lose students, and we would put an immediate burden on our students and their families which there is no

immediate way for them to meet. So we are asking for a 1-year extension on an emergency basis to keep us from stepping back a whole year, because as any educator knows, to step back a year in quality and cut-backs means you are stepping back perhaps 3 to 5 years. To retool and get going again is an extremely difficult thing in any medical operation. We have high momentum in these institutions in the direction of quality and service. And, therefore, what we are pleading for is a 1-year extension that will enable us to continue at the level we are at, protect our student body, help our students, and give us time—because we agree that this is not the long-range method of doing this—to give us time to work out alternate plans. As you know, Senator, we do have an alternate proposal to add to the general manpower aid which we believe would be of major assistance to us in solving this problem.

WILL NOT ASK FOR ANY FURTHER EXTENSIONS

We have said—I have signed a document, and I am sure Lloyd Elliott has also signed a document, in which we have gone on public record that neither of our institutions will ask for this kind of an extension in the future beyond the year coming.

There is also a matter of pressure of time. We have worked very hard on this for a long time. We are facing a new year for which we have no assurance. At Georgetown we have not determined our tuition for next year because we have been waiting, hoping to find solutions which would not require us to double our tuition in the medical school and to greatly increase it in the dental school. So there is some urgency and there is no immediate alternative route.

EFFECT

The effect of turning this down would have a negative and I would say a devastating effect on our student body, on their parents, on our service to the District, and on the quality of our education. Consequently, we are here to ask for this emergency legislation for which we presented, I believe, fully adequate evidence. And to your question, Senator, it is true that the State of Missouri—and I think, unfortunately, in educational matters the State of Missouri does not lead the Nation—

The CHAIRMAN. Sometimes we ranked 49th in various categories.

Father HENLE. Yes. I am glad you said that, Senator.

The CHAIRMAN. I will not embarrass them by identifying who is 50th.

Father HENLE. Yes.

At any rate, the two private medical schools in that State do not receive any State support. There is one other case, the State of Nebraska, which has a very rigid constitutional requirement that prohibits anything like State aid to the Medical School of Creighton. And outside of these States, as you know, there is a broad spread of help, and I think you presented the case certainly as well as I could.

So, in sum, I think this is an emergency, and I think we are not asking for a special privilege, and we are not asking for the establishment of a precedent, we are not asking for the beginning of long-range support along this line. We are asking it on the basis of our service,

and our quality, and for the good of the entire Washington metropolitan area and the Nation, because a good medical school is a national asset as well as a local and a city asset.

I thank you, Senator, for your time.

The CHAIRMAN. Before I get into questions: Do any of you have anything to add as opening statements? I do not want to cut you off.

Father HENLE. May I suggest, Senator, that President Lloyd Elliott might join me.

The CHAIRMAN. Yes. You are not an M.D.; is that right?

Mr. ELLIOTT. I am not an M.D.

The CHAIRMAN. Well, you are still permitted to testify.

Mr. ELLIOTT. Thank you very much. I am glad I have company.

Mr. Chairman, I, too, have a prepared statement, and I shall leave it for the record, and I shall comment very briefly.

The CHAIRMAN. It will be put in the record.

Dr. ELLIOTT. You have yourself stated very eloquently the position of these three schools.

MADE EVERY EFFORT TO INCREASE PRIVATE ENDOWMENTS

I would like to point out one thing in addition to that which has been mentioned this morning and that is that both Georgetown and George Washington have during the past 5 years made every effort to increase our private endowments, our private funds, and we have been simply unable to keep pace with the increased costs. There seems to be no way by which we can get enough money privately to keep pace with the increases in medical education.

I would like to point out, too, that these two universities are very proud of the service we give to the District of Columbia and to the greater Washington area. I will not take time here to detail them. Those services are in extensive reports and can be found very easily.

STATE SUPPORT

Let me say, finally, Mr. Chairman, that attached to my testimony is an exhibit which I think to some measure answers the question you asked earlier of an exhibit which shows the support that States give to private medical schools. And while this changes from year to year, and while it is tabulated here both as States and as regional arrangements, I think it does shed some light on your question.

The CHAIRMAN. I have a bad copy. Have you got a better one?

Dr. ELLIOTT. Somebody missed the Xerox machine partly.

The CHAIRMAN. The names of some of these States are obliterated.

Dr. ELLIOTT. Ohio has only one "O" if you will see that.

The CHAIRMAN. All right.

Now, what this will tell me is how much State aid is going to private medical schools in these States?

What is this regional business?

Dr. ELLIOTT. There are regional contracts, in the South, the West, and the New England parts of the country, whereby on a regional basis a State without a medical school supports its medical students attending the regional medical school.

The CHAIRMAN. All right. Of course, there are just a few States that do not have one. I think New Hampshire is one that does not. Is that correct?

Dr. ELLIOTT. New Hampshire and Maine I happen to know personally contract with the State of Vermont for places in the University of Vermont.

The CHAIRMAN. Yes. All right. Eliminating New Hampshire and a few States, I guess Wyoming—I am not sure if Wyoming has one—but if you cast those aside, those that do not have a medical school, then the others—let us take Pennsylvania.

Dr. ELLIOTT. Yes.

The CHAIRMAN. Jimmy Carter took Pennsylvania on Tuesday and we will take it today.

As I read this, their current students, 116; what does that tell me?

Dr. ELLIOTT. I am sorry, 116 students in the Georgetown-George Washington Schools of Medicine and Dentistry, 116 from the State of Pennsylvania.

The CHAIRMAN. Oh; I have got the wrong table.

Dr. ELLIOTT. No, no.

Now, go on across the sheet, Mr. Chairman, and you will see that Pennsylvania supports students within the State of Pennsylvania at its own private medical schools to the tune of \$4,400 per student.

The CHAIRMAN. Is that \$4,400 per student? The University of Pennsylvania is a private school.

Dr. ELLIOTT. Yes, sir.

The CHAIRMAN. Does Penn State have a medical school?

Dr. ELLIOTT. Yes. Penn State has a medical school, but that is not included in there.

The CHAIRMAN. That is not included. I want the private schools. That is what this last column tells me?

Dr. ELLIOTT. Yes, sir.

The CHAIRMAN. That \$4,400 out of the general revenues of the State of Pennsylvania is appropriated to go to a private school per student? Is that what that is telling me?

Dr. ELLIOTT. That is right; yes, sir.

The CHAIRMAN. All right.

Now let us go down this list of it. Now, California, \$12,000. Is that what that tells me?

Dr. ELLIOTT. That is correct.

The CHAIRMAN. Out of the State treasury to the private schools in California. Not UCLA.

Dr. ELLIOTT. These are three private medical schools in California: Stanford, University of Southern California—and where is the third?

The CHAIRMAN. And they appropriate \$12,000 per student?

Dr. ELLIOTT. That is the information which we have, sir.

The CHAIRMAN. All right.

Florida, \$7,680 per student, private, out of State funds.

Dr. ELLIOTT. Yes, sir.

The CHAIRMAN. Illinois, \$7,000–\$9,000 per student. Is that a guestimate on your part? Why is the range \$7,000–\$9,000? I am just curious.

Dr. ELLIOTT. These figures vary depending upon the time in which the student entered the program. It does fluctuate as prices go up and

down, and, I must point out, as the legislature in each State responds to the request each year.

The CHAIRMAN. Minnesota, \$8,000 per student.

Here is one. North Dakota, \$14,500 per student. Is there a private medical school in North Dakota?

Dr. ELLIOTT. No. But they are using these funds to buy places in medical schools not in the State.

The CHAIRMAN. I see.

Dr. ELLIOTT. Perhaps Dr. McNulty or Dr. Kaufman with us here would shed additional light on these figures.

The CHAIRMAN. Yes.

Do you other Doctors have anything you wish to add to these? I am very much interested in what the various States are doing as a State with State public moneys to assist private medical schools within their State.

Dr. McNULTY. As Dr. Elliott commented, the dollar figures do vary from time to time and the data available varies from time to time. However, I could draw your attention to a recent article in the Journal of Medical Education, published in March, which did do a more recent survey of the contribution of State funds for public medical schools. We cannot give it as per student, but, for instance, the main contribution of State funds for public medical schools is approximately \$10,750,000 per year per State, and \$2,757,000 per year per State for private medical schools.

The CHAIRMAN. That is the so-called mean average?

Dr. McNULTY. Yes, sir.

So the States indeed are contributing meaningful sums to the private schools located in the States, or, as Dr. Elliott commented, to those schools to which they have a contract service.

Dr. ELLIOTT. I would add, Senator, that New York State——

The CHAIRMAN. Yes; I was just getting to New York. It is \$3,000 to \$6,000 per student. That is quite a range.

Dr. ELLIOTT. And this is, as I understand it, not yet determined for next year because of lack of action by the legislature there.

The CHAIRMAN. Yes.

Is there a medical school in connection with what I used to call CCNY, that is now called the City of New York University? There is NYU. I am not talking about NYU. I am talking about what used to be called CCNY. Is there a medical school there?

Dr. ELLIOTT. City University of New York?

The CHAIRMAN. Yes.

Dr. McNULTY. Mr. Chairman, City University of New York has an arrangement with Mt. Sinai Medical School but they are separate institutions. They do not have a medical education program, per se.

The CHAIRMAN. Mt. Sinai is a privately supported medical school?

Dr. McNULTY. Yes; privately supported. But it has an association, and from that association also derives financial assistance.

Dr. ELLIOTT. This figure here, \$3,000–\$6,000, would go to such medical schools as NYU, Cornell, Rochester, Columbia, within the State of New York.

NUMBER OF MEDICAL AND DENTAL SCHOOLS IN THE COUNTRY

The CHAIRMAN. How many medical schools are there in the country now?

Dr. ELLIOTT. Medical schools? I think 116.

The CHAIRMAN. Yes, 116.

Dr. ELLIOTT. And I think the dental schools, when added, push it over 200. Is that correct?

Dr. McNULTY. Approximately 50 dental schools.

The CHAIRMAN. Yes. And then you add the osteopathy?

Dr. ELLIOTT. Yes, sir.

The CHAIRMAN. Well that is maybe where I could get close to my 200 if you add them all together maybe.

In the past 5 years: How many medical schools, if any, have closed their doors, medical?

Dr. ELLIOTT. None that I am aware of. There have been two that have shifted from private to public status.

The CHAIRMAN. But none have closed their doors.

NEW MEDICAL SCHOOLS

In the past 5 years: How many new medical schools have been started up?

Dr. McNULTY. I would guess, Mr. Chairman, somewhere in the neighborhood—if you extend the 5 years to be a little before that and a little after today when several are still just starting to take the students—about 10 new medical schools.

The CHAIRMAN. One of them is the University of Missouri, Kansas City, Medical School.

Dr. McNULTY. Yes, sir.

And one of them, for example, would be the University of the Armed Forces here in Washington, D.C., which is just getting started.

Father HENLE. Senator, I could point out that Marquette University had to separately incorporate its medical school to save it, and there had to be an emergency meeting of the State legislature or they would have closed in 1 month.

The CHAIRMAN. I think it is safe to say that States and other private universities are not beating the doors down to try to start up medical schools. It is a horrendously expensive undertaking. A State or a private group of hospitals would get into this business with great care and great caution knowing what the enormous costs are involved. Is not that correct?

Dr. ELLIOTT. Yes, sir.

FOREIGN MEDICAL SCHOOLS

The CHAIRMAN. Is it also not correct that we have literally hundreds, maybe thousands, of young men and women, college graduates, that are attending medical schools in Italy, Mexico, et cetera, and that many of these individuals who could not gain admittance to our domestic medical schools because of the limited number of slots available get their training abroad and come back here to practice. Is that not correct?

Dr. ELLIOTT. Yes, sir.

The CHAIRMAN. Do we have any estimates as to how many American students are studying in medical schools abroad? Is there any guess that we have on that?

Father HENLE. Yes, sir. We have none.

Dr. McNULTY. There is a relation of medical to the Central American colleges which we could obtain and file for the record, Mr. Chairman.

The CHAIRMAN. It is several hundred?

Dr. McNULTY. Yes; it is more than that, Mr. Chairman, I understand.

Father HENLE. It has been said that the University of Bologna was the largest American medical school in the world.

The CHAIRMAN. It is.

Senator Mathias just a couple of weeks ago, when he and I were traveling in the Mideast, stopped off at the University of Bologna, because it has some connection, he told me, with the University of Maryland. It is sort of a reciprocal thing, and he made that very point to me. He said there are more American medical students at the University of Bologna than any other medical school in the world. I think all of this is relevant in substantiating the case that we need medical schools. We desperately need them. With the 116 or whatever we have now, that is still not enough. A university would have to be very courageous to get in the medical school business because of the costs involved, and we just cannot afford to close one door in this country. And, as Father Henle pointed out, this is a national asset and a national problem as well.

DIFFICULT TO START MEDICAL CENTERS

Father HENLE. Senator, as you know, I have been in higher education for a long time, and I have been a consultant and a leader in Catholic higher education in this country. I have for 15 years advised Catholic universities not to start medical centers or medical schools because I could see no future for most private institutions in starting up from scratch to be able to reach quality within the next century.

ST. LOUIS UNIVERSITY

The CHAIRMAN. Father Henle, you were at St. Louis University as a vice president prior to coming to Georgetown?

Father HENLE. Yes, I was.

The CHAIRMAN. And I believe you were with St. Louis University at the time St. Louis University made the decision to close their dental school.

Father HENLE. I was.

The CHAIRMAN. Could you give us for the record just some of the thoughts you had at that time, what the problems were that St. Louis University had and why the university had to make the decision which it did make?

Father HENLE. Well, the problem was the huge deficits that the medical center at St. Louis University was running. And we thought that we had to make some decision with regard to some part of that problem, so we considered the dental school. And at that time, the dental school not only needed a lot more operating money, but if we were going to continue it we were faced with a complete rehabilitation of

our physical facilities and a complete replacement of equipment as well. We realized that the closing of a dental school that had served the State of Missouri so well for so many years, long before the State ever got into this business, would be a disaster. And that many other things in St. Louis and in eastern Missouri depended on our school. We went to the State and offered the school to them or we offered to contract with them.

We offered to cooperate with the State any way possible if they could save that school and the State chose not to enter into any relationship with us. The result was that we really very reluctantly, and as you may remember, with a great outcry from local citizens as well as our alumni, we very reluctantly did close the dental school. And it is a shame. As you probably know, at the same time Washington University almost closed its dental school. And I had been told by the authorities there, when I was in St. Louis, that if we had not closed, they would have closed. But they felt that the area could not take the elimination of two first-rate dental schools all at once.

Did I answer your question, Senator?

The CHAIRMAN. Yes; you sure did.

Is it not also true that somewhere along that same time frame when Dr. Felix was the dean, or whatever title he was at the new medical school, that there was a real question as to whether the medical school could remain open.

Father HENLE. Dean, yes; he was.

The CHAIRMAN. And but for about a \$10 million Federal grant—Eagleton helped get it—St. Louis University Medical School was in pretty precarious shape?

Father HENLE. That is correct. And you are quite right, it was an infusion of Federal funds that enabled that to stay alive, and it is now alive but still precarious.

The CHAIRMAN. Yes.

Father HENLE. But it is surviving. And I think that if it could get Statelike funds from the State of Missouri in addition to these Federal programs, they would be in the same position that we are. As you pointed out, it is worrisome at any point where State funds are not available.

LAST YEAR FOR REQUESTING FUNDS

The CHAIRMAN. Father Henle and Dr. Elliott, do I understand it that your universities—whether you were the witnesses or not—but that your universities did tell Congressman Diggs, the chairman of the House Committee, that this was the last year you would be before the Congress for this kind of a request?

Father HENLE. We said that in public hearings, and there is on record letters from both of us, signed, saying that in absolutely unequivocal terms. Not even Joshua could find a way of getting out of that letter.

MINORITY ENROLLMENT

The CHAIRMAN. I will ask the two doctors, Dr. McNulty and Dr. Kaufman—let us go with Dr. McNulty at the Georgetown University Medical School—what was the minority enrollment at Georgetown Medical School for the incoming class last September?

Dr. McNULTY. Mr. Chairman, I have it right here. Our enrollment for the year 1975-76: The minority was 35 in the school of medicine, 12 in the school of dentistry.

The CHAIRMAN. Thirty-five, school of medicine, all 4 years?

Dr. McNULTY. Yes, sir.

The CHAIRMAN. Thirty-five out of what?

Dr. McNULTY. The number of black students enrolled out of a total of 800 students.

The CHAIRMAN. This is medical now.

Dr. McNULTY. Medical. Yes, sir.

The CHAIRMAN. Thirty-five out of 800. That is black?

Dr. McNULTY. Black, yes.

The CHAIRMAN. How many Spanish surnamed, or do you have that?

Dr. McNULTY. I do not have it. It would be probably approximately 6 percent total, including the black and the Spanish surnames.

The CHAIRMAN. Thirty-five as a percent of 800, that is even less than 6 percent. Six percent of 800 would be 48. Right?

Dr. McNULTY. If I may, Mr. Chairman, I am going to ask the dean to respond?

The CHAIRMAN. Yes.

Dr. McNULTY. He has the figures for the school of medicine. And we have with us also the dean of the school of dentistry.

The CHAIRMAN. Very good.

Dr. McNULTY. Jack, if you would, please.

Dr. Utz, Mr. Chairman.

The CHAIRMAN. Spell your name, Doctor, for the record if you would.

Dr. UTZ. U-t-z.

The CHAIRMAN. All right. Thank you.

Dr. UTZ. Mr. Chairman, there were nine minority students with Spanish-American surnames and there were three American Indians.

The CHAIRMAN. All right. There were 35 blacks, 9 Spanish surnamed, 3 American Indians?

Dr. UTZ. Yes, sir.

The CHAIRMAN. For a total of 47 out of 800. That would be exactly 6 percent. Right?

Dr. UTZ. Yes, sir.

The CHAIRMAN. Well, now, let us get George Washington, Dr. Kaufman.

Dr. KAUFMAN. I am sorry I do not have the Spanish surnames. But we do have 24 black Americans enrolled in the school of medicine, and 143 females, although they are not in a minority group.

The CHAIRMAN. What is the total enrollment?

Dr. KAUFMAN. 600.

The CHAIRMAN. 600. That is 4-percent black. And Georgetown is 4½-percent black.

Do any of you gentlemen have available figures from other medical schools around the country as to the percent of black enrollment?

Doctor, what do you have available on that?

Dr. UTZ. That figure is within a decimal point of 6 percent, Mr. Chairman.

The CHAIRMAN. National?

Dr. UTZ. Yes, sir.

The CHAIRMAN. How many students are there at the Howard University Medical School? Do you have any idea?

Dr. UTZ. No; I do not know.

Dr. KAUFMAN. I think it is about 600, Senator.

Dr. McNULTY. Yes; I was going to say the same. About 150 blacks, Mr. Chairman.

PREFERENTIAL TREATMENT FOR DISTRICT OF COLUMBIA APPLICANTS

I might add, if I may, Mr. Chairman, for the District of Columbia, because it is contained in my testimony which, with your permission, is being filed for the record, that the problem in the District of Columbia is to create a larger pool of applicants. At Georgetown we give preferential treatment to the District of Columbia applicants. For example, for the year that we are now in, on an average we have made it 4 percent for the applicants. We have a very large applicant pool. We admitted 14.9 percent of the District of Columbia residents from that pool, so we do give them preferential treatment. However, in medicine, as an example, there were only approximately 170 applicants for the District of Columbia nationally—residents of the District who are applying nationally for admission to medical school.

We have initiated a program with Federal City College—to be the Federal University. We are in active—and I do not mean rhetoric, I mean actual—we are in active collaboration with the legislative and executive branch of the District to create programs which will enlarge the pool of applicants to medical education and of the pool to dental education—for dental education is even smaller than the medical pool. And that is our big structure, if you will, in the channel of flow from undergraduate education into medicine and dentistry. This we will probably be able to do through some financial interest on the part of the District, and through the commitment of the District City Council, and the office of the mayor, and the three universities here. We are even broadening it to include Howard because they, too, suffer from the difficulty of recruiting students from such a very small pool.

Father HENLE. Senator, may I add just a word that Dr. McNulty has passed over quickly?

OUTREACH PROGRAM

We do have a program that goes into the elementary and the high schools in the District. What do we call it—Outreach?

Dr. McNULTY. Yes.

Father HENLE. The Outreach program in which we are trying to guide and inspire young people in the District to think of health careers. And this is one of our efforts to increase the pool to which Dr. McNulty refers and which is now all too small.

MANY JOB OPPORTUNITIES FOR D.C. RESIDENTS

Dr. McNULTY. We are emphasizing in large measure, to date, our educational contribution to the District and to the Nation. But you brought up the asset of these two universities in terms of the opportunity they present for employment to the District. This is one of our efforts in terms of going into elementary and secondary education

to emphasize that there are many job opportunities to the residents of the District of Columbia in the large health centers operated by Georgetown and George Washington.

OFFER SCHOLARSHIPS

Dr. ELLIOTT. Mr. Chairman, if I may add one point. We, at Georgetown, believe that in order to get more students into medicine and dentistry, in fact, the other professions, we must offer some attractions below that level, and so we offer 40 scholarships per year to District of Columbia high school graduates, adding up to 160 for the 4 years. And we try to develop with the students interest in medicine, dentistry, law, engineering, et cetera.

The CHAIRMAN. What is the ratio breakdown of those 40? Forty times four being 160, but how many blacks were in that 40 last year?

Dr. ELLIOTT. Of last year's entering group of 4, 37 were black.

The CHAIRMAN. You may not have this figure. How many of the 37 evidenced some potential interest in the health sciences?

Dr. ELLIOTT. I do not have that.

The CHAIRMAN. Do you have a standard curriculum for what might be called premedical?

Dr. ELLIOTT. Yes. It is a large program with a number of very competent advisers. And the student who expresses this interest is carefully guided from preregistration days in the freshman year all the way through the 4 years.

The CHAIRMAN. Dr. McNulty, if you have got a pencil and piece of paper there you could get some statistics for me, if you will, through any association that you know.

PERCENT OF BLACK STUDENTS

I would like to know the percent of black students enrolled at the following medical schools: Harvard, NYU, University of Pennsylvania, Chicago University, St. Louis University, Washington University, the University of Missouri at Columbia, University at Kansas City, Tulane, Johns Hopkins, University of California at Berkeley, UCLA, Stanford, Rice, University of Maryland, University of Virginia. Is there another medical school in Virginia?

Dr. McNULTY. Yes. The Medical College of Virginia and Eastern Virginia, at Norfolk.

The CHAIRMAN. Let us put that on the list.

What did we give you there, about 20? Is that what that about adds up to, roughly?

Dr. McNULTY. Twenty, yes; I believe.

The CHAIRMAN. I am not trying to put you through needless work. I have to in all candor say I am disappointed in these percentage figures. But before I become too vocal in my disappointment I want to know what comparable situation is in other parts of the country, even including the greater Washington metropolitan area, which would, you know, go into Virginia and Maryland, and then across the Nation as a whole. And I picked these medical schools off the top of my head. I am not trying to rig the answers. I do not know exactly what the answers will be for my own State, but I have included those in the program.

[The statistics follow:]

THE MEDICAL CENTER
GEORGETOWN UNIVERSITY
WASHINGTON, D. C. 20007

OFFICE OF THE CHANCELLOR
202/625-7006

May 4, 1976

The Honorable Thomas F. Eagleton
Room 6235
Dirksen Senate Office Building
Washington, D.C. 20010

Dear Senator Eagleton:

In response to your request during the hearings before the Senate Committee on the District of Columbia on Thursday, April 29, 1976, reference the emergency one-year extension of P.L. 91-650, as amended by P.L. 93-389 (the Medical and Dental Manpower Bill of the District of Columbia), we have researched various source material available. Therefrom we have compiled a listing of black student enrollment information for a number of U.S. medical schools (Attachment #1). In addition to the specific schools you requested, we have tried to provide you with additional statistical information that we trust you and your staff will find useful.

A review of available data for these cited schools indicates further a point made in testimony by Arthur H. Hoyte, M.D. Dr. Hoyte is the Director, Office of Programs for Student Development and Community Affairs, Georgetown University Medical Center. The attached data does suggest that the more heavily endowed schools (with greater student aid and student scholarship resources at their disposal) more successfully attract, recruit and retain qualified black students at their schools.

The percentage of black students of total enrollees at schools with reported private endowments of market value in excess of \$200,000,000 (Stanford University, Harvard University, University of Chicago, Columbia University, Cornell University and Yale University) is 7.7%. On the other hand, the percentage of black students of total enrollees at public and private schools with reported private endowments of market value less than \$50,000,000 (Georgetown University, George Washington University, Tulane University, Saint Louis University, Johns Hopkins University, University of Missouri at Columbia, and the University of Missouri at Kansas City) is 4.4%.*

*Source: Voluntary Support of Education, prepared by the Council for Financial Aid to Education and jointly sponsored by the Council for Advancement and Support of Education, the Council for Financial Aid and the National Association of Independent Schools.

May 4, 1976

Another significant note of interest is the total black enrollment figures for U.S. medical schools in 1975, excluding black enrollees at Howard University and Meharry Medical College (Attachment #2). This data indicates that only 5.0% of all enrollees attending medical schools in the U.S. are black.

A major concern of Georgetown and George Washington Universities, as expressed at the April 29th hearings, and an extremely important point of fact for the Washington, D.C. area is the need to increase the pool of qualified black applicants. This need seems to be demonstrated by review of the enrollment figures for first year black students since 1971 (Attachment #3).

Enrollment correlates at least to some degree with the number of applicants. These national figures (Attachment #3) reveal that the actual number of first year black enrollees was less in 1975 than in 1974. In fact, the figures indicate that, since 1971, the percentage of first year black enrollment as a percentage of total first year enrollment has declined. Contrary to this national trend, Georgetown University has been able to increase both the number of black enrollees and the percentage of black students as a percentage of our total enrollment over this same time frame.

As we indicated during testimony, both Universities have taken major steps toward increasing the qualified applicant pool of black students from the District of Columbia. These efforts are now beginning to motivate student interest in the health professions. However, such a program to produce meaningful results must continue into the future with much more emphasis.

How to finance this urgently needed commitment for enlargement of the minority student applicant pool is a challenge. Both Universities meant it when they testified that the one-year extension of P.L. 93-389 is the last such request. Unless there is some stable, continuous fiscal support, the best of intent and the expertise to follow through are intermittent at best and haphazard at worst.

The understanding and thoroughness of your Committee have always resulted in an awareness of the facts and the developing trends. Yet, it seems that the national Administration, some in Congress, and the District of Columbia executive and legislative officials do not want to assist in financing medical and dental education at Georgetown University and George Washington University. For 1978 and thereafter, the other resource for fiscal survival through severe tuition charges is totally counterproductive to obtaining stated and sincerely pursued goals of much greater enrollment of minority students.

Part of the challenge at, and contribution by, Georgetown University is demonstrated by the total enrollment figures (Attachment #1). To contribute with more than rhetoric to the local, regional and national need for physician output, and to create the opportunity for qualified applicants to pursue their goal of medical education, the Georgetown University School of Medicine has expanded its enrollment and is now the second largest private medical school in the country and one of the largest public and private medical schools in the nation. To achieve that goal while still maintaining the highest standards of excellence in face of continuing financial uncertainty has been an academic and management challenge of severe proportions.

- 3 -

Thank you for the opportunity for responding to your questions. Thank you, also, for the opportunity to present testimony to your Committee on April 29, 1976 requesting a one-year (1977) emergency extension of the Medical and Dental Manpower Act of the District of Columbia (P.L. 91-650, as amended by P.L. 93-389). If we can furnish any additional information, please just advise.

Cordially,

MATTHEW F. McNULTY, Jr., Sc.D.
Chancellor, The Medical Center

- Attachments: (1) Black Student Enrollment Information by Individual
U.S. Medical Schools, Fall 1975
- (2) Total Black Enrollment in U.S. Medical Schools in
1975
- (3) Black Enrollment in First-Year Classes in U.S.
Medical Schools (1971-1975)

BLACK STUDENT ENROLLMENT INFORMATION BY INDIVIDUAL

U.S. MEDICAL SCHOOLS, FALL 1975*

<u>Medical School</u>	<u>Total Enrollment</u>	<u>Black Enrollment</u>	<u>Percentage of Black Enrollment of Total Enrollment</u>
University of Chicago (Pritzker)	449	18	4.0%
University of California, Los Angeles	622	26	4.2%
University of California, San Francisco	613	54	8.8%
University of California, Irvine	309	20	6.5%
University of California, Southern	516	24	4.7%
Stanford University	398	29	7.3%
Georgetown University	817	35	4.3%
George Washington University	602	24	4.0%
Rush Medical College	334	28	8.4%
Tulane University	594	45	7.5%
John Hopkins University	480	18	3.8%
University of Maryland	635	37	5.8%
Harvard College	664	63	9.5%
University of Missouri, Columbia	448	12	2.7%
University of Missouri, Kansas City	299	13	4.3%
Washington University (St. Louis)	541	49	9.1%
Saint Louis University	596	27	4.5%
University of Pennsylvania	648	51	7.9%
New York University	693	29	4.2%
University of Virginia	499	6	1.2%
Eastern Virginia Medical School	107	5	4.7%

*Source: Medical School Admission Requirements, 1977-1978, Association of American Medical Colleges, 1976.

<u>Medical School</u>	<u>Total Enrollment</u>	<u>Black Enrollment</u>	<u>Percentage of Black Enrollment of Total Enrollment</u>
Medical College of Virginia	606	37	6.1%
Columbia University	602	37	6.1%
Yale University	421	46	10.9%
Cornell University	418	34	8.1%

Attachment #2

TOTAL BLACK ENROLLMENT IN U.S. MEDICAL SCHOOLS IN 1975

<u>Black American Enrollment</u>	<u>Total Enrollment</u>	<u>Percentage of Black Americans of Total Enrollment</u>
3,456	55,818	6.21

TOTAL BLACK ENROLLMENT IN U.S. MEDICAL SCHOOLS IN 1975

EXCLUDING BLACK ENROLLEES AT HOWARD UNIVERSITY AND MEHARRY MEDICAL COLLEGE

<u>Black Americans Enrollment</u>	<u>Total Enrollment</u>	<u>Percentage of Black Americans of Total Enrollment</u>
2,753	54,934	5.0%

*Source: Medical School Admission Requirements, 1977-1978, Association of American Medical Colleges, 1976.

BLACK ENROLLMENT IN FIRST-YEAR CLASSES
IN U.S. MEDICAL SCHOOL (1971-1975)

<u>Year</u>	<u>Number Enrolled</u>	<u>% of Total Enrollment</u>
1971-1972	882	7.1%
1972-1973	957	7.0%
1973-1974	1027	7.3%
1974-1975	1106	7.5%
1975-1976	1036	6.8%

*Source: Medical School Admission Requirements, 1977-1978, Association of American Medical Colleges, 1976.

ENCOURAGE MINORITIES TO PARTICIPATE

The CHAIRMAN. Now I know that the deFumis case was remanded without a decision of the U.S. Supreme Court, and it is a very, very intriguing and perplexing constitutional question. I could argue it almost both ways. I think it is that tough a case. But we all know that insofar as education is concerned, including higher and professional education, that unless somehow we can attract more minorities into this intellectual stream and prepare minority students for a professional life that we just know as a practical fact we are not going to be able to deliver proper health care to many minorities. We know that not many white doctors are likely to open their practice in Anacostia or are not likely to try to administer to the needs of a large number of poor people who, quite frankly, need medical care even more than the well-to-do, because they do not get their annual checkups and they are not in the mainstream of medical life. And as I say, it is a tough question. But I see no alternative but to go the extra step, to make the extra effort, to encourage minorities to participate in these professional academic programs. But I would like these figures just for my own frame of reference.

Dr. McNULTY. I will certainly obtain the figures, Mr. Chairman. I know what I am adding is known to you, but our two universities are also deeply concerned.

PROBLEM WITH RECRUITMENT

Our problem seems to be in recruitment. I do not know whether it would be of any value, Mr. Chairman, but from Georgetown we do have Dr. Arthur H. Hoyte with us here today who is operating our program, and with a staff of about four we are trying to extend into the community to create this larger pool. Dr. Hoyte is a Harvard graduate, a black physician, who is now a Board-certified osteophysician and gynecologist, who has by and large given up that practice for the time being as he attempts to dedicate himself and a view to this need. And if you would like to have him comment on it, he is here with us.

The CHAIRMAN. Fine.

Doctor?

Dr. McNULTY. Dr. Hoyte?

STATEMENT OF DR. ARTHUR H. HOYTE, DIRECTOR, ADMISSIONS
COMMITTEE, GEORGETOWN UNIVERSITY

Dr. HOYTE. Mr. Chairman, my name is Hoyte, H-o-y-t-e.

First of all, I think that one has to be careful in comparing schools such as the ones that you listed. I think everybody with a knowledge that those individuals that come from school systems that have lesser facilities or capabilities to prepare students well, whether they are in rural schools or in city schools, were given the fact that individual schools without studies really are not well prepared to compete in a medical school program.

POOL IS SMALL

The pool is small. Whether we are talking about rural individuals that can compete, or black, or any other type of ethnic group coming to the enlargement of the school. And as a result, the schools that you mentioned are not comparable in terms of their ability to recruit. Harvard, for example, has a very large endowment, and has been able to get a good sizable amount of Federal money for their recruitment efforts. And it also has a very prestigious name. You mentioned in reference to a Cadillac that school of medical education.

The CHAIRMAN. Well, let the record show that Georgetown and George Washington University—I placed them in that Cadillac range as well. I mean that. You do not have to hold your head in shame that you cannot compete with Harvard or Johns Hopkins.

Dr. HOYTE. I am not trying to suggest that. I am just saying that as a result of Harvard's great endowment and long history in the medical field—certainly black medical students are certainly attracted to that school. So out of that pool that I mentioned, I think that they do have a selection factor over most other schools in the country. I would say every other school in the country, to be honest with you.

FINANCIAL AID AN ADVANTAGE IN RECRUITMENT

And any schools that have financial aid in sizable amounts to support students, I think have an advantage in recruitment. That is the very fact we are here. We are indicating that we do have a problem with student aid; we do have a problem with tuition. Now, given that fact, I think that Georgetown is incredible in two areas. No. 1, we have a good sizable number of students that do apply to Georgetown out of that pool. We only mention the number that have enrolled. We have not accepted far beyond that number. We accept about 30 students a year, and out of that 30 only about 10 to 12 are picked up.

I do not like to suggest but if you would now look at what my figures say at this time, I can say that I have been a director for 5 years, I have been on the Admissions Committee. I have gone through many national offices around the country dealing with black students and other ethnic minority students with problems as relate to the medical school. I can unequivocally state that Georgetown has committed as much, if not more, of the whole institutional resources about the dollar. Closer efforts of recruiting then became necessary for the minority. Many of the schools today have a better or a more extensive recruiting program. but they have that recruitment program supported primarily by foundation money and/or Federal moneys.

This year, for example, Georgetown is taking approximately \$40,000 of its own institutional money to support a summer enrichment program for minority students. I think that is very significant in a time when everyone is crying about his and her's financial stress. I think the students at Georgetown, as well as the administration, have a burden to support that type of ethnic program.

TAKEN A MORE ENLIGHTENED FOCUS

The other thing I would like to suggest is that we at Georgetown and George Washington have taken I think a more enlightened focus in terms of trying to deal with the problem for a long period of time. We look at the problem in the innercities to be not merely someone whom we know as another human being, but the city without help, that has cancer. And 25 more medical students or 10 more medical students in the city really does not do much in terms of affecting the overall health for a community.

We are focusing attention on that aspect, but our greater emphasis has been to try and build a much larger pool, not a pool necessarily to go into medicine or dentistry. What we are suggesting is that if a person could get a job, and if that individual has money in his pocket, he has a much better chance of a better environmental situation to live in, and better housing services to live in, better nutrition, better education for his children. In the final analysis, if he has none in his pocket, the doctor is not going to treat him, or a dentist, or any other provider.

OBTAINABLE GOALS

So our focus is, is it possible to really have goals that are obtainable? No. 1, for example, to try to enhance the ego and self-esteem of young, poor children. No. 2, is it possible to try to develop a goal for an achievement in orientation that young children have at an early age? And No. 3, is it possible to instill a greater health awareness and concern about their own health, and the health of their families as well as the health of the community?

Now we have endeavored upon that by having a program which extends from the elementary school all the way up through medical school. At the same time we have our medical students, dental students, and other discipline representatives in the public schools in terms of procurement as part of the role model and offering our resources at Georgetown. And I would like to suggest that you want to effect those goals by offering a multiplicity of positive reinforcing experiences throughout the life of the child—not just one hit-and-miss type of experience.

And we have at the same time endeavored upon embracing a very formal fashion. I think if you refer to the testimony in the House, we made reference to the fact that we would pledge the following ways to the District public schools as well as to the new public university in the District of Columbia. We are speaking of following with the deans of several schools and with the chairmen of the different departments. And I, for one, believe that in the next year or so you will see a very, very real relationship between the very well-known private university and a growing, relatively new public university. And I think that is unique. I think that is the type of input, infusion that a city like the District or any other urban area needs.

The CHAIRMAN. Thank you, Doctor. That does give me some encouragement.

POSTCOLLEGE FREE MEDICAL SCHOOL PROGRAM

May I ask this? Have you medical educators ever contemplated having a postcollege free medical school 1-year program? By that I mean this. Take a young man or woman who went to, say, less than a prestigious university or college, something considerably less than a Harvard University or other college. Assume that that individual on various aptitude tests and various other judgmental techniques shows that that individual has an aptitude, but that individual is very, very sharp in such elementary necessities as reading and writing the English language.

He has had maybe all of the basic biological sciences on a college level, whether it is biology or chemistry, or what have you. But still, nevertheless, it is a bright prospect of having that student spend yet another year but this time under the aegis of the university of that medical school. In essence, a refined remedial year, so that that person then would be better able to compete in the entering freshman class. I admit it would cost a student a year of his life, but it might be the best year that that student ever spent.

Dr. Utz. Mr. Chairman, let me respond to that.

PROBABLY NO INCREASE IN MINORITIES FOR THE NEXT SEVERAL YEARS

We are very pragmatic about that situation. Tight money, trying to reverse discrimination, strongly suggest that there probably will not be an increase in the number of minorities in medical schools for the next several years. In fact, if you look at the figures there is a slight decline that has already begun.

At Georgetown, with the Admissions Committee, we reflected on that. I said, "My goodness, if that happens what would be the overall problems that would occur?"

What I perceive—and I think I am very realistic in this—is that if that were to happen, a school like, we will say Harvard, would say, well, I cannot take 20 this year, I will just take 15. There will be five left over. Every school in the country, including Howard and many others, would go after those five. In other words, there would be a redistribution of the high performers and that would be an expensive role—those that were trained in public colleges, those that came from the small, little black colleges, and those that come from top school picks.

PROGRAM FOR D.C. STUDENTS

Now, in anticipation of that, what we did at Georgetown was to say, let us focus our energy, or a greater part of our energies, on the District of Columbia population. We have presently enrolled 35 students from a District of Columbia public school background, as well as District of Columbia Teacher's College and Federal City College. We gave preference to those individuals.

I would go so far to say that no more than two to three of them would get into medical school without the program they are involved in at the present time. What we will be doing, we will be adding approximately 30 to 40 kids that would not get into medical school if it were not for the program. I think that is a very significant thing

because if you look at the enrollment of medical schools, like the new Wilson School, they are anticipating having 50 students for the first year class. We would add 40 or more students to the total pool. And that is just a shotput effort.

What we are doing at the present time is trying to work with the new MASA School—the math and science school—in the District, saying that you can go to that school, D.C. public school child; we are going to be working with Federal City College to develop a new curriculum there. It is a collaborative effort. We can use that curriculum because we have been involved in it; and because we know that you have mastered that, we have no other choice but to take you to our school.

So I think we are moving in the right direction. And I do not think people should look at the bottom figures as they could be misleading.

The CHAIRMAN. Well, that is very, very helpful and I have definitely profited by your testimony.

TREND AROUND THE COUNTRY

I know figures can be misleading. We pointed out we are in this situation. Comparing Harvard is a different situation perhaps than here. But, nevertheless, I still would like to have the figures for whatever weight they may or may not have. I would still like to have them.

I would say that let us forget Harvard, and let us compare it like St. Louis University and Washington University in St. Louis. Those are two very fine private schools. They are in an area that has a large minority population, indeed not as large as the District of Columbia but St. Louis has a sizable black population.

I just would like to know what the trend is around the country. I do not know what one can categorically conclude from those figures, but for whatever they are worth I would very much like to have them.

Dr. KAUFMAN. Senator, may I add something.

The CHAIRMAN. Yes, Doctor.

Dr. KAUFMAN. My full testimony has been filed for the record, and I am sure you assumed that in many of these things Dr. Hoyte has mentioned that Georgetown and George Washington are collaborating in these efforts.

We, too, have accepted a larger number than are enrolled so we have the same problems of scholarships and high tuition that Georgetown has. Now to mention, in passing, the discussions with the District of Columbia Government for spaces in our two schools, as well as in colleges. These explorations are moving along quite well. And I think that within the next year we will be developing a definite program for defining a number of positions within the three schools for District residents who then, as a part of their subsidy, go to those three schools will be required in our current thinking to give service to the city in an area designated by the Mayor.

The CHAIRMAN. Thank you, Father Henle, and gentlemen. We appreciate having you here this morning.

Father HENLE. Thank you, Senator.

[The prepared statements of Father Henle, and Drs. Elliott, McNulty, Kaufman, Utz, and Murto follow:]

STATEMENT OF THE REVEREND ROBERT J. HENLE, S.J.

PRESIDENT OF GEORGETOWN UNIVERSITY

TO

THE UNITED STATES SENATE

COMMITTEE ON THE DISTRICT OF COLUMBIA

APRIL 29, 1976

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 H.R. 12132, a bill to extend for one year on an emergency basis the District of Columbia Medical and Dental Manpower Act of 1970.

The District of Columbia Medical and Dental Manpower Act provides the authority for the Secretary of the Department of Health, Education, and Welfare to award grants of up to \$5,000 per medical student and up to \$3,000 per dental student to enable Georgetown University Schools of Medicine and Dentistry and the George Washington University School of Medicine to meet their critical financial needs and operational costs required to maintain quality medical and dental educational programs as a necessary health manpower service to the metropolitan area of the District of Columbia.

When Congress passed this legislation in 1974 this Committee instructed us to present our future needs to the District of Columbia Government. At this time we requested the legislation to be for three years in order to enable

the two universities to work out a program with the newly created District of Columbia Government. The judgment of the Committee was that two years would be sufficient.

Pursuant to the directive of this Committee we have contacted the Mayor of the District of Columbia and the District of Columbia City Council. Both elements of the District of Columbia Government have responded that it is unlikely that the City will assume new financial responsibilities in the near future, because of the District's current and projected financial difficulties. The District of Columbia Government has also indicated that their prime concern and interest is for the District of Columbia residents enrolled in our schools and that the majority of our students from all other states should be a national responsibility. It is for this reason that we request a one year emergency extension of this legislation. This would indicate that our original request for three years was really necessary. (See Exhibit 1, attached)

Georgetown University Schools of Medicine and Dentistry and George Washington University School of Medicine are preparing a long range solution to meet their medical and dental educational costs. The basis of this solution is a federally guaranteed student assistance program; to achieve this program we need one more year. This program will be described in more detail by my colleagues.

Medical and dental education are the most expensive individual educational costs at Georgetown University, and medical education is the most expensive educational cost at George Washington 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. In order to meet

these costs our universities have strained all existing programs both private and federal. The details of these efforts will be presented by the appropriate officials of the schools.

The respective Boards of Directors of the two universities are vitally concerned and have established guidelines which will not permit the schools to operate at a deficit. Without the funds provided in this bill (H.R. 12132) there is no way our schools can continue to operate with their present programs and their present student bodies.

The only alternative for this emergency of one year would be to increase tuition for medical students from the current level of \$5,000 to \$10,000 plus, and to increase tuition for dental students from the current level of \$4,400 to \$7,400 plus in fiscal year 1977. To do this for one year while we establish our loan program would decimate the student bodies and educational programs. We wish to point out that all the schools have substantially increased their student bodies so that the total enrollment of the three schools is now 2,000 students. This increase was carried out in response to the request of the Secretary of the Department of Health, Education and Welfare to increase the national supply of medical and dental manpower. For this reason we believe, therefore, it seems incumbent on the Secretary to provide funds for one more year until our long range solution becomes fully operational.

Mr. Chairman, I sincerely thank you and your Committee for the opportunity of presenting this testimony in support of H.R. 12132.

EXHIBIT 1

COUNCIL OF THE DISTRICT OF COLUMBIA

WASHINGTON, D. C. 20004

November 17, 1975

Reverend R. J. Henle, S.J.
President, Georgetown University
Dr. Lloyd H. Elliott
President, George Washington University
Washington, D. C.

Dear Fr. Henle and Dr. Elliott:

This is in response to your letter of October 22, 1975, and your discussion with my office on the contents of the letter.

The District of Columbia Budget for Fiscal Year 1976 does not include funds for the support of the Medical School at George Washington and the Medical and Dental School at Georgetown University. Although, I recognize the acute need for funds to assist in the tuition costs of the schools, the District of Columbia cannot fund this program at this time.

I, therefore, support your effort to extend the Medical Dental Manpower Act of the District of Columbia for one year, on an emergency basis. This would enable you to continue to receive funds from the Department of Health, Education and Welfare as you have for the past six years. This support recognizes the national character of your schools.

I am encouraged by your presentation that shows your program to expand your enrollment of D. C. students through your program with Federal City College, which soon will be incorporated in the new University of the District of Columbia. Likewise, your plan to increase health services, especially at D. C. General Hospital, is one that I heartily endorse.

Sincerely,

A handwritten signature in dark ink, appearing to read "Sterling Tucker", written over the printed name and title.

STERLING TUCKER
Chairman

STATEMENT OF LLOYD H. ELLIOTT, ED.D., PRESIDENT,
THE GEORGE WASHINGTON UNIVERSITY

on H.R. 12132, The Medical and Dental Manpower Act of D.C.

to The United States Senate
Committee on the District of Columbia
The Hon. Thomas F. Eagleton, Chairman, presiding
April 29, 1976

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 plight of The George Washington University School of Medicine and The Georgetown University Schools of Medicine and Dentistry.

The passage of P.L. 91-650, the Medical and Dental Manpower Act of the District of Columbia, recognized the emergency situation facing the private medical and dental schools of the District of Columbia. In fiscal year 1975, this legislation provided a total of \$7.5 million for The George Washington University School of Medicine and the Georgetown University Schools of Medicine and Dentistry. No funds have yet been received under this legislation for the current fiscal year 1976, but all three schools have submitted applications for funding. The legislation authorizing these grants expires on June 30, 1976, and it has been forcefully indicated to us that for fiscal year 1977 and thereafter our financial needs cannot be met from existing National legislation.

Neither The George Washington University nor Georgetown University has substantial endowments. Endowment funds which the two Universities do have are to be kept intact and are restricted both by the wishes of the donor and by the prescriptions of the University. Both Universities have initiated intensive campaigns to increase the size of their endowments in order to provide a future source of income. Both Universities are hard-pressed to make ends meet and there are no University resources

- 2 -

for the support of medical or dental education.

We appeal to you for necessary support as a private medical or dental school appeals to a state legislature. Our situation is not unique, many states are now supporting private as well as state medical and dental schools, as shown by Exhibit A, attached. We do however have a long-range solution which we hope will be implemented for the 1978 fiscal year.

Both Universities are proud of their public service participation in the District of Columbia, and we hope that through the wisdom of your committee 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. More detailed information on these service programs will be presented by the officials of the Medical Centers.

Mr. Chairman and members of the Committee, it is because of your support over the past five years that these Schools are still in existence today. I urge you to support the bill H.R. 12132, in order that the Schools may meet their costs of operation in fiscal year 1977, and be thus given the opportunity to establish a viable long-range solution to their financial problems.

Thank you for this opportunity to present testimony in support of H.R. 12132.

JANUARY 1970

GRAPHIC DISTRIBUTION OF CURRENT STUDENTS
5-76) ATTENDING THE GEORGETOWN UNIVERSITY
SCHOOLS OF MEDICINE OR DENTISTRY AND
GEORGE WASHINGTON UNIVERSITY SCHOOL OF
DENTISTRY. ALSO, GRADUATES IN PRACTICE.

President Elliott's Testimony
Exhibit A

	CURRENT STUDENTS	GRADUATES IN PRACTICE	TYPE OF SCHOOL		STATE SUPPORT OF PRIVATE INSTATE MEDICAL SCHOOL OR REGIONAL MED- ICAL SCHOOL
			PUBLIC	PRIVATE	
ALABAMA	5	45	2	0	Southern Reg. \$3250 per student
ALASKA	0	10	0	0	Western Reg. \$5000 per student
ARIZONA	9	50	1	0	Western Reg. \$5000 per student
ARKANSAS	2	5	1	0	
CALIFORNIA	188	910	5	3	\$12000 per add. stu. over base yr.
CANADA	5	65	1	0	
CONNECTICUT	95	508	1	1	
DELAWARE	7	44	0	0	\$8000 per student
DIST. OF COL.	81	892	0	3	D.C. Med-Dent Act
FLORIDA	32	376	2	1	\$7,680 per student
GEORGIA	9	71	1	1	South Reg. \$1250 to \$6500 per stu.
ILLINOIS	2	33	1	0	
INDIANA	4	38	0	0	Western Reg. \$5000 per 2.3-yr. st.
IOUISIANA	21	105	2	5	\$7000 to \$9000 per student
KANSAS	6	47	1	0	
KENTUCKY	2	21	1	0	
LOUISIANA	5	18	1	0	
MAINE	2	32	1	1	
MARYLAND	2	27	2	1	\$5000 per student in private school
MASSACHUSETTS	7	60	0	0	New Eng. Reg. \$5000 per student
MICHIGAN	232	1,234	1	1	Southern Reg. \$3250 per student
MINNESOTA	133	637	1	3	New Eng. Reg. \$5000 per student
MISSISSIPPI	11	106	3	0	
MISSOURI	2	44	2	1	\$8000 per Minn. student
NEBRASKA	3	12	1	0	Southern Reg. \$3250 per student
NEVADA	8	37	2	2	
NEW HAMPSHIRE	2	15	0	0	Western Reg. \$5000 per 2.3-yr. st.
NEW JERSEY	1	3	1	1	
NEW MEXICO	1	30	1	0	Western Reg. \$5000 per 2.3-yr. st.
NEW YORK	13	57	0	1	\$5000 per student in its private school
NEW YORK	216	950	2	0	
NEW YORK	3	33	1	0	
NEW YORK	473	1,723	4	8	\$3000 to \$6000 per student
NORTH CAROLINA	7	131	1	2	\$5000 to \$6000 per student
NORTH DAKOTA	5	10	1	0	\$14,500
OHIO	28	193	3	1	\$7,997,000 to private sch. for 2 yrs.
OKLAHOMA	4	26	1	0	
OREGON	3	43	1	0	
PENNSYLVANIA	116	651	0	7	\$8,000 per student
RHODE ISLAND	17	183	0	1	\$700,000 grant + \$5000 per stu. (NEW)
SOUTH CAROLINA	2	56	1	0	
SOUTH DAKOTA	0	8	1	0	
TENNESSEE	4	31	1	2	Southern Reg. \$3250 per student
TEXAS	17	119	5	1	\$9,763,538 to private school
UTAH	30	102	1	0	
VERMONT	0	23	1	0	
VIRGINIA	108	729	2	1	South. Reg. (\$3250+\$400)2 per stu.
WASHINGTON	24	109	1	0	
WEST VIRGINIA	3	39	1	0	
WISCONSIN	11	54	1	1	\$7,846 per Wisc. student
WYOMING	0	10	0	0	Western Reg. \$5000 per 2.3-yr. st.
TOTALS	1,967	10,775	64	49	NOTE: West. Reg. provides \$0,000

STATEMENT OF MATTHEW F. McNULTY, Jr., Sc.D.
CHANCELLOR, GEORGETOWN UNIVERSITY MEDICAL CENTER
TO
UNITED STATES SENATE COMMITTEE ON THE DISTRICT
OF COLUMBIA

APRIL 29, 1976

Mr. Chairman and Members of the Committee, I am Matthew F. McNulty, Jr., M.H.A., M.P.H., Sc.D., Chancellor, Georgetown University Medical Center. I appreciate the privilege of appearing before you today to urge your favorable consideration of H.R. 12132, a bill to extend for one year on an emergency basis the District of Columbia Medical and Dental Manpower Act (P.L. 91-650 as amended P.L. 93-389). The primary bill, H.R. 12132, had been complemented and endorsed by H.R. 10377 and H.R. 10614.

My purpose today is fivefold:

- (1) To outline briefly the background with regard to the bills under discussion;
- (2) To emphasize on behalf of Georgetown and George Washington Universities that this is the last time these Universities shall seek extension of this legislation;
- (3) To discuss the financing of health professions education with particular emphasis on the problems of three schools (medical and dental) in the District of Columbia which at best have only limited access to either federal or state-like support for operational cost of medical and dental education;

- (4) To describe briefly the irreplaceable service that 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
- (5) To present an overview of the continuing fiscal problems that in recent years have threatened the successful accomplishment of the medical and dental education, patient service and research responsibilities of these three schools.

Other representatives of the three schools and leaders of national professional associations will also present specific information.

Legislative History - District of Columbia Medical and Dental Manpower Act and Last Request for this Act

The Bill before this Committee today, H.R. 12132, is to extend for one year on an emergency basis, Title III, P.L. 91-650, as amended P.L. 93-389, the District of Columbia Medical and Dental Manpower Act. The one-year extension would be for the fiscal year 1976-1977.

This is the last time that this appeal will be made to the Congress for extension of Title III, P.L. 91-650. For 1977-1978 and thereafter, drastically increased tuition charges in the five figure range will be the only presently known method of financial solvency. Unless other financial resources support presently not identifiable can be secured, tuition charges as mentioned will be the only remaining method for financing of other lost revenue for medical and dental education at Georgetown University and George Washington University.

This Act (P.L. 91-650) was first enacted through the initiation of this Committee in the Second Session of the 91st Congress, and extended by this

Committee in the Second Session of the 93rd Congress.

When the District of Columbia Medical and Dental Manpower Act (P.L. 91-650) was initially enacted, the Schools, on the advice of the then Secretary of the Department of Health, Education and Welfare, did not seek separate appropriations. Instead, they agreed to receive appropriations under the "Awards to Schools in Financial Distress" section of the Comprehensive Health Manpower Training Act of 1971 (P.L. 92-157). All three schools received such funds during fiscal years 1972, 1973 and 1974.

This method of financing (Financial Distress) was inappropriate for our Schools. For instance, in the 1974 fiscal year the total appropriation for financial distress awards nationally was \$15 million. In the same year applications for financial distress assistance totaling \$31 million were submitted by eligible schools in the United States. Steps were taken and implemented to eliminate the local schools' demand on these restricted national "Distress" funds. It was clear that this method of funding was inappropriate.

When P.L. 91-650 was extended by Congress in 1974 through P.L. 93-389, the Schools requested a separate appropriation as a line item in the budget of the Department of Health, Education and Welfare. In fiscal year 1975 the Schools received a total appropriation of \$7.5 million by this mechanism.

For the current fiscal year (1976) appropriations will be made in the same way. An appropriation of \$9.05 million is included in the Department of Labor, Health, Education and Welfare Appropriations Act for 1976 (P.L. 94-206).

Applications for these 1976 appropriated funds have been submitted. The Universities are in urgent need of such funds, for ten months of the fiscal year is now completed.

Financing of Health Professions Education

Since the enactment of the original D.C. Manpower Act (P.L. 91-650), there have been some changes in the financing for medical and dental education in our country. There appears to be a developing policy which emphasizes tuition payment as a major revenue source among a fivefold fiscal revenue spectrum for the operation of medical and dental schools. As mentioned later, the shifting of the reduction in federal and state support to tuition charges can and may be both a real dollar and psychological dollar barrier to medical and dental educational opportunity for many well-qualified middle class and poor undergraduate students.

These five current general sources for operational funds include a federal responsibility, a state responsibility, a student responsibility, an institutional responsibility and a responsibility for research and development funds - the latter commonly called "Sponsored Program Support."

As this Committee is aware, the national legislation providing federal support for medical and dental education - the Comprehensive Health Manpower Training Act of 1971 (P.L. 92-157) - expired on June 30, 1974. Since that time, the major provisions of this legislation have been extended by Continuing Resolution. During the Second Session (1974) of the 93rd Congress, new health manpower bills were passed in both the House of Representatives and the Senate. However, the difference between those bills proved irreconcilable; the 93rd Congress ended without enacting new legislation.

During this period of time (1974-77), the federal capitation support of Medical - Dental Education has declined 44% from \$1,800 per capita in 1974 to approximately \$1,000 per capita projected for 1977.

In July, 1975, the House of Representatives passed a bill - the Health Manpower Act of 1975 (H.R. 5546). The Senate Subcommittee on Health completed markup hearings on S3239, the Senate version of a National Health Manpower Bill on March 31, 1976. The Senate Labor and Public Welfare Committee approved S3239 on April 7, 1976. At this time, at least several sections of S3239 are in debate among members of the Welfare Committee and between the Senate and the Administration. Eventual passage of a national health manpower legislation in this Congress is still an awaited expectation.

The majority of the medical and dental schools of this country, both public and private, are currently facing serious financial problems. Two years ago when the Congress initiated debates on a new national health manpower legislation including the federal capitation payments, the Schools were optimistic that there would be a rationalization of federal financing of medical and dental education which would assist in alleviating their financial difficulties. Instead, as indicated, the financial climate has worsened.

A major purpose of federal subsidy for health science education was to encourage enrollment increases and to provide schools with supplementary funds to concurrently maintain a level of academic quality and financial stability in face of dramatically increased enrollments and significant enlarged community service functions.

The Medical and Dental Schools have been eminently successful in carrying out their commitments -- in fact, successful to a degree that a number of authorities now suggest that the presently programmed output of physicians and dentists over the next ten years is sufficient for the national need. Yet, financial stabilization is now even more elusive. Instead of stabilization, there has been a continuing erosion of financial support.

As private schools receive reduced financial support, they are being forced to either find new sources of revenue and/or reduce further the academic quality of the programs. In the interest of the public they serve, universities must reject reduction of academic quality. In the absence of state-like support without endowments, private universities can turn to only two other revenue sources; even further fund-raising endeavors and institutional initiatives (Georgetown University and George Washington University have made heroic efforts in the fund-raising endeavors and have explored every other conceivable initiative) and secondly, increasing tuition levels.

The nation may be initiating a program of medical and dental education for students from only wealthy families. A one-year emergency extension of the D.C. Medical and Dental Manpower Act would give one more year of fiscal preparation for those students presently enrolled at Georgetown and George Washington Universities. During that year, it is hoped that national health manpower authorization and appropriation legislation, including provision for maximum loan funds of \$10,000 - \$15,000 per student per year, would be enacted. Thus, students from less than fiscally affluent families, who overcome the psychological barrier of a commencement indebtedness of \$40,000 - \$60,000 would have a resource from which to borrow so as to attend medical and dental schools.

These tuition levels for medical and dental education have increased dramatically over the past few years. The Medical and Dental Schools at Georgetown University and the Medical School at George Washington University currently rank among the highest tuition levels in the nation. Further reduced support will result in our schools again having to increase tuition. Hopefully for 1978, and thereafter, the mentioned National Health Manpower Bill will make possible significant borrowing to finance potentially larger tuition charges.

The Senate Bill (33239), as now written, would provide several opportunities for financial support for medical - dental students. However, if enacted, the provision of S3239 could not be implemented until fiscal year 1978, thus the further need for a one-year emergency extension of the District of Columbia Medical and Dental Manpower Bill (H.R. 12132).

In effect, present developing national policy, on the one hand, is influencing medical and dental schools to meet their operating needs through higher tuition, while, on the other hand, presently existing student loan or scholarship funds to provide the potential ability to aid students from low income or middle income families in the payment of higher tuition are both continuing "in doubt" or at best, not applicable until F.Y. 1978. As indicated earlier, to consider raising tuition to resolve the fiscal dilemma of the schools without provisions to assist "mid-America students", is to indicate in large measure that only the sons and daughters of the wealthy shall have the opportunity to become physicians and dentists.

Without the District of Columbia Medical and Dental Manpower Act (H.R. 12132) or equivalent assistance, our three schools could not have continued to provide the level of education and patient care which has so benefitted the community

of the District of Columbia, the metropolitan area and the nation.

Community Involvement of Georgetown University Medical Center

Georgetown University Medical Center is engaged in many health service programs that are critical to the health care system of the metropolitan area. The attached Exhibit - "Community Service of Georgetown University Medical Center" (Exhibit A) - includes the programs in which the Medical and Dental Faculty, through Georgetown University Hospital with its Outpatient Clinics; through the P Street Clinic operated by Georgetown, through the Health Maintenance Organization clinic located in Edgewood Terrace in North-East Washington, and through over 30 other affiliations with District and local area hospitals and health facilities, provide health care services to all ranges of the Washington, D.C. community as well as to the nation.

Georgetown University, with Howard University, supplies the educational excellence for patient care at the District of Columbia General Hospital. Georgetown University has been associated continuously with D.C. General Hospital longer than any other university in the City--since 1913, when the Hospital was known as the Washington Asylum Hospital.

Of equal importance, the Department of Commerce reports that George Washington University and Georgetown University are, respectively, after the Federal Government, the second and third largest employers in the District of Columbia. The largest number of job opportunities in a major University are in its medical centers. When considered in the context of job opportunities in a city of a declining number of jobs (according to U.S. Department of Commerce

Report "Regional Employment by Industry 1940-1970", while the number of jobs increased in every state during the 1960's, total employment in the District of Columbia was reported as declining by 2.5 percent), the contribution of the Universities to the community labor market is a significant additional dimension. This dimension of employable opportunity will continue to develop particularly if and when a National Health Insurance Program is developed.

On October 26, 1974, the District of Columbia Public Postsecondary Education Re-Organization Act (P.L. 93-471) was signed by the President. This legislation authorizes the consolidation of existing local institutions of public postsecondary education into a single Land-Grant University of the District of Columbia. Since the passage of this legislation, some District officials have urged that medical and dental schools be established as part of this District of Columbia University. Georgetown and George Washington Universities recommend strongly the importance of the medical and dental educational programs at our two Universities. These Schools are resources of the District. Those resources should be continued, strengthened and financially stabilized so as to be able to serve the needs of the District, rather than incurring the phenomenal expenses associated with establishing additional health professions schools.

Categorically our two Universities are committed to the District of Columbia, if only stabilized financial support could be realized. Much exciting work on this possibility of enlarging the scope of medical and dental educational opportunities for District of Columbia residents is now in progress. This progress is not casually reported. The Universities and the Executive and Legislative Branches of the District of Columbia Government are meeting and evolving concrete developments.

Costs associated with establishing new health professions schools were recently widely publicized in relation to the Medical School of the Uniformed Services University of the Health Sciences. A report prepared and presented to Congress in May 1975 by the Defense Manpower Commission predicted the cost of producing each M.D. at that School "...may well exceed \$200,000", nearly five times the cost to the government of producing and obtaining the services of an M.D. through existing medical schools. That Commission report notes that actual costs for construction, start-up and operating the Uniformed Services Medical School will be well double the \$102 million originally estimated (Interim Report to the President and Congress, Defense Manpower Commission, May 16, 1975.)

In a much broader discourse on the subject (the attached article), Exhibit B, Paying the Bill for College - The Private Sector and the Public Interest, by Dr. John R. Silber, emphasizes the broad contributions of private institutions of higher education to society and illustrates how to save taxpayers' money by supporting such existing institutions rather than creating new ones. Dr. Silber notes:

"The new Boston campus of the University of Massachusetts, designed for 6,000 students, cost \$135 million. Whenever an independent University or College educates a resident of its state, that states' taxpayers are saved whatever it would have cost to educate that student in a state school. Boston University educates some 7,000 residents of Massachusetts every year.

To educate them at the University of Massachusetts would cost tax payers at least \$37 million. Full tuition scholarships for those same students at Boston University would represent a saving of at least \$16 million."

It is essential in the interest of the District of Columbia community, in the interest of the Washington, D. C. region, and in the national interest, 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. As an emergency measure for a one-year extension only, we urge the enactment of H.R. 12132 as a one-year extension of P.L.93-389 to assist the two other private universities.

The Schools of Medicine and Dentistry at Georgetown University are committed to meeting these local, regional, and national needs. University officials now are, and shall continue, working with the relevant agencies of the District of Columbia Government to ensure that meaningful developments will be implemented.

As the testimony from several of my colleagues will indicate, the absolute numbers of District of Columbia residents enrolled in our Schools of Medicine and Dentistry are small. The priority given these admissions is significant. However, the District of Columbia resident applicant pool must be increased - for it is one of the smallest applicant pools in the country - and student aid funds must be dramatically enlarged.

Records available indicate that for the class entering medical school in September, 1975, only 177 District of Columbia residents applied for admission to all medical schools throughout the nation. Fifty-nine of these applicants were accepted and enrolled; of these, twelve are enrolled at Georgetown University School of Medicine and thirteen are enrolled at George Washington University School of Medicine. While only 25 of these 59 students are enrolled at these two schools, 39 students were accepted, but because of the high tuitions and lack of adequate student aid support, fourteen students chose to enroll at other schools. Both Universities are now working with D.C. Legislative and Executive Branch officials to meet these two challenges. Assuming an ability to stabilize financial operation, these two challenges shall be met.

Overview of Actions Taken to Alleviate Fiscal Problems

A brief comment on medical and dental educational financial support from tuition payment, institutional fund raising and funds for search for new knowledge and expansion of existing knowledge. The three schools have now, for 1975-1976, extended even further their tuition rates, their fund raising efforts and their successful solicitation of foundations, corporations, alumni, faculty and friends. In fact, these efforts now have extended much beyond that reported to this Committee in 1970 at the time of the initial hearings on this legislation. Every possible avenue of tuition income, fund raising income and research income has been exhaustively searched.

Additionally, the parent Universities and their schools have accomplished drastic internal economies and effectiveness in organization and management in order to realize the greatest productivity of educational endeavors from a minimum of resources.

The results of these economies are best demonstrated by the Institutional Profile Ranking Report System of the AAMC. The latest of these reports, which refers to the 1973-1974 fiscal year, indicates that both Georgetown University Medical School and George Washington University Medical School ranked in the lowest quartile of all United States Medical Schools in terms of regular operating expenditures per student.

The amount of funding requested per student at this time is no more than the initial law (P.L. 91-650) established in 1970. This is further evidence of stringent internal management, combined with the seeking and obtaining of financial resources from multiple sources. Obviously, the fiscal climate has escalated rapidly over the last five years, yet the capitation ceiling of up to \$5,000 per medical student and up to \$3,000 per dental student is recommended without increase.

Measured against \$17,000 plus per medical student per year for fiscal year 1975 appropriated by the Texas legislature for a private medical school, the \$8,000 per medical student per year at a private school by the Delaware Legislature and the \$7,680 per medical student per year at a private school by the Florida Legislature, a ceiling of \$5,000 per medical student and \$3,000 per dental student is a conservative request.

Gentlemen, the need for support of H.R. 12132 is real: it is immediate. The need continues as essential to the continued contribution of our Schools of Medicine and our School of Dentistry. We recommend a one-year emergency extension of the existing legislation. The recommendation is consistent with the experience of a clear majority of other private universities in obtaining

from their state legislatures, financial support for their medical and dental schools.

We urge your thoughtful consideration and full support for meeting those 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 H.R. 12132.

EXHIBIT A

COMMUNITY SERVICE
OF
GEORGETOWN UNIVERSITY MEDICAL CENTER

1. **PSYCHIATRIC WALK-IN CLINIC.** Providing "immediate attention to those in a crisis," this clinic in the Department of Psychiatry is staffed by faculty, social workers, residents and students of the Medical Center. No appointments are necessary and patients are seen within an hour. The clinic aims at heading off serious emotional breakdowns at the time of a problem and offers each patient up to 6 visits for "crisis intervention" services. After this time referral for further treatment is made if necessary. Twenty percent of the people who come to the Walk-In Clinic are treated definitively within the 6 visits. A fee of \$10 a visit is charged if the patient is able to pay. The clinic, which offers emotional first aid to hundreds of people a year from all walks of life, all social and economic backgrounds, and all ages, was the first one established in the Washington metropolitan area. It was started in 1964. A variety of problems are handled and patients hear of the clinic through media reports, friends and family, referrals by health professionals or clergy, and social workers. There were almost 2,000 patient visits to the clinic last year. Most of these were District of Columbia residents. Extending crisis intervention further, the Walk-In Clinic is now working with outreach teams in Area "A" of the city to reach people who need help. Area "A" contains a cross section of the population with a total of 140-150,000 people. A new back-up facility, the Mental Health Care Unit for in-patient referrals, was recently opened at Georgetown University Hospital.
2. **NURSE-MIDWIFERY.** The first six graduates of a nurse-midwifery education program at Georgetown University School of Nursing received their certificates in November, 1974. The program, funded by the Department of Health, Education and Welfare for area nurses, is the only one of its kind in the Washington, D.C. area and one of the few in the nation. Experience in nurse-midwifery under this program is provided at D.C. General Hospital, Georgetown University Hospital, the Greater Southeast Community Hospital and Prince George's County Health Department. Nurse-midwives, as members of the obstetrical health care team, work to bring quality care to mother and child, lowering infant mortality rates in the management of uncomplicated births. The Georgetown program is aimed particularly at the alarming infant mortality rate in Washington's inner city. Working with a physician consultant, the nurse-midwives are involved in prenatal care, labor, delivery, post delivery, and family counseling.

3. THE UNIVERSITY AFFILIATED PROGRAM FOR CHILD DEVELOPMENT is an interdisciplinary training center serving the developmentally disabled child and his family. Such children have difficulty with normal development including such problems as mental retardation, cerebral palsy, epilepsy, autism, and specific learning disabilities. The disciplines of psychology, pediatrics, communication disorders, nutrition, genetics, instructional technology, psychiatry, special education, dentistry, community services, social work, physical therapy, occupational therapy and neurology work together as a team to provide both a diagnostic and treatment service to these children. Along with this, special interdisciplinary preschool and infant stimulation programs are available. Training graduate students in the various disciplines is one of the primary goals of the program, but there is also a major community outreach effort to train persons who are actively involved in providing care. Particular emphasis here is on such people as day care center and Head Start workers, and personnel in institutions, who are responsible for the day-to-day education or caretaking of children with developmental problems. Through the Department of Pediatrics, the Center offers a course on "Developmental Disabilities: an Interdisciplinary Approach" at the graduate and undergraduate level.

4. CHILDREN'S KIDNEY DISEASE PREVENTION CENTER. The Department of Pediatrics for the past 8 years has been operating a screening, diagnostic and treatment center for children with kidney disease from the Washington metropolitan area and surrounding communities. The program was established to answer the needs in the community of significant numbers of children suffering from chronic and fatal kidney disease. No child is turned away from this vital service. The Center was established in 1966 with the support of the National Institutes of Health and continues now with help from the National Kidney Foundation and funds raised by the Potomac Women's Club. A main objective is to identify and treat children who have kidney disease as early as possible. Physicians also receive specialty training under the program. Outpatient visits to the Center number around 1,300 yearly. In 1973 the Center expanded and initiated a dialysis (artificial kidney) and kidney transplant program. Children with any type of kidney disorder now can receive the complete, specialized care their case requires at the Georgetown Center.

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, giving the patient more time to be with his family and saving him from the spiraling cost of hospitalization. No charges are made to the patient for these services which offer excellent medical care. Medicines, supplies and hospital equipment are also provided. The program has been in operation from Georgetown University Hospital for 25 years, supported by a private trust fund. 2,960 days of home care were provided last year. One member from the medical team visits the patient each week, and the total team visits once every 3 or 4 weeks. The doctor provides medical follow-up; the nurse teaches the family nursing care; and the social worker provides counseling to the patient and his family in coping with death and dying. The program can take care of 20 patients at any one time.

6. **GEORGETOWN UNIVERSITY COMMUNITY HEALTH PLAN, INC.** The Georgetown University Community Health Plan (GUCHP) is a prepaid group practice Health Maintenance Organization 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 comprehensive health services with easy access through medical centers located near their homes. The plan is family oriented with a strong emphasis on preventive medicine. GUCHP is currently operating through three locations: Reston, Va.; Edgewood Terrace in Northeast Washington; and Kensington, Montgomery County, Md. In addition, the services are available at the three locations on a fee-for-service basis to non-enrolled patients. The GUCHP facility 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. GUCHP also enrolls the "near-poor" at the Edgewood Terrace site through a Family Health Center Program funded by HEW. Starting on January 1, 1975, federal employees are eligible to enroll in GUCHP through University Affiliated Health Plans, an umbrella corporation recently created jointly by GUCHP and the George Washington University Health Plan. There are presently 4,400 persons enrolled in GUCHP.

7. **CLEFT PALATE CENTER.** The Georgetown Center has been the only facility of its kind in the Washington, D.C. area for more than two decades. Both adults and children suffering from this congenital deformity, which is a failure of the palate and lip to form properly, are evaluated, treated and rehabilitated regardless of their ability to pay. The defect which occurs in one of every 750 live births severely impairs speech and affects swallowing action and appearance. The necessary long-range treatment involving many dental and medical specialties is offered at Georgetown to patients from the metropolitan area and from West Virginia, Virginia, Delaware, and Maryland. The Center, which works closely with families, stresses that proper treatment can enable patients to lead a normal life and prevent psychological problems. Treatment includes careful nursing care in early life, education of parents, and plastic surgery over a period of years. It also involves speech therapy, psychological and psychiatric support, and prosthodontic treatment such as speech aid prostheses. Further back-up is provided by pediatricians, ear-nose-throat specialists, orthodontists, oral surgeons, pedodontists (specialists in children's dentistry), and social workers.

8. **BREAST CANCER SCREENING PROGRAM.** Working closely with five local units of the American Cancer Society, Georgetown University Medical Center operates a free breast cancer screening center for women in the Washington metropolitan area. Using the most advanced methods of detection, the project will screen a total of 10,000 women between the ages of 35-75. The project is aimed at saving lives by detecting breast cancer early in women who do not yet have any symptoms. The Georgetown center uses multiple screening techniques, including physical examination, mammography or xerography (soft tissue x-ray), and thermography (measuring skin temperature). The five-year project arranges

for women having negative results to return annually for further examinations and careful follow-up. Women found to have breast cancer are referred to their doctors for immediate treatment. The new Georgetown project, one of 27 in the country, is also developing education and training programs. It is supported by the National Cancer Institute and the American Cancer Society.

9. **INTENSIVE CARE NURSERY.** Georgetown plays a leadership role in preventing mortality and morbidity in newborn infants. One such program involves the GU Hospital's Intensive Care Nursery, which provides constant monitoring and medical care for infants during their first critical hours of life. This unit has helped lower the death rate of babies at the Hospital to 6 per 1,000 live births, compared to the national rate of 18 per 1,000. Recently Mrs. Julie Nixon Eisenhower cut the ribbon to open new streamlined facilities for newborn infants at the Hospital which has more than doubled the size of the Intensive Care Nursery. The new nurseries offer the most advanced comprehensive care for high-risk infants. Georgetown University Hospital is a regional center where many medical disciplines contribute to the care of high-risk mother and child, combining prenatal delivery, and postnatal care. The expanded nurseries will be able to care for up to 2,000 high-risk deliveries a year. They provide a total of 53 infant beds. The 29 beds for sick babies include the large intensive care unit of 14 "isolettes;" 3 isolation beds; and 12 beds for intermediate care. There are an additional 24 beds for healthy babies.
10. **GU AT HEAD START CENTERS.** A community services team from Georgetown's Department of Pediatrics has been working with community Head Start Centers throughout the District of Columbia to identify and help pre-schoolers who have problems that interfere with the learning process. This includes emotional, educational, and social disabilities as well as mental retardation or physical handicaps. The program, funded by the Department of Health, Education and Welfare, involves 600 children ages 3 to 6. It aims to reach them at an early age before they enter the public school system. The Georgetown team of experts in child development and special education visits each center several days a week, working with teachers and parents to develop individual programs for children that need them. The problems are defined, programs implemented and followed up. Stress is placed on working with a child's strengths and interests to overcome his weaknesses. The key in how to work with a child best is to determine his individual "learning style." Such information can then be transferred for use by his future teachers. Every effort is made to work out programs within the school setting to keep the child in the mainstream and not isolate him. The Georgetown team has been visiting 12 Head Start Centers in Anacostia, 13 Capital Head Start Centers, and 4 Centers in Arlington, Va.

11. **ASK THE DOCTOR.** This public service program is part of Opinion Line. Every two weeks a faculty member of the School of Medicine or the School of Dentistry participates 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 its listeners in the Washington community.
12. **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. Psychiatric residents are also consulting with the police, a half-way house, and Regency House within the District of Columbia.
13. **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 pressures and were sent to check patients waiting in various speciality clinics at D.C. General Hospital. 54% were found to have high blood pressure. A similar check run at our own outpatient clinic yielded about 39% with high blood pressure.
14. **OUTPATIENT CLINICS.** 48 specialized clinics (allergy, eye, pediatrics, etc.) provide health care for medically indigent persons in the Washington community. Over 100,000 patient care visits and services per year are recorded. Approximately 90% of the patients are black. While the clinics are partially reimbursed by those who receive Medicare, Medicaid or other health coverage programs, the University clinics run an annual deficit of approximately \$393,070 for non-reimbursable indigent services.

15. EMERGENCY ROOM. The Emergency Room is open 24 hours a day, providing emergency medical care to all citizens seeking it. Around 21,822 patients are seen in the Emergency Room each year.
16. INPATIENT SERVICE. 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 inpatient care for indigents at a cost of more than \$0.8 million in non-reimbursable funds annually.
17. SCHOOL OF DENTISTRY CLINICS AND SERVICES. The Dental Clinics, which are open to all citizens in the community, receive more than 150,000 patient visits annually. Fees charged are at a minimum of what private care would demand. 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. Georgetown dental students and residents also provide dental service to indigent patients in the Outpatient Department of Georgetown University Hospital and at the D.C. General Hospital Dental Clinic.
18. 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, ob-gyn, and surgery, and their specialties. The staff is also responsible for graduate training programs. Technicians man the laboratories and are paid for by grant monies from Georgetown.
19. 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; and 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.

20. AMATEUR RADIO STATION. WA3FXJ, Georgetown University's amateur radio station, provides a number of community services. Primary among these is coordinating the pick-up of pledges made to the Cystic Fibrosis Research Foundation. This annual activity involves four or five of the larger amateur radio clubs in Montgomery County, Arlington County, Fairfax County, Prince Georges County and the District of Columbia. Additionally, the Amateur Radio Station handles nearly a hundred telephone patches (phone patches) from amateur radio operators in foreign countries and aboard ships at sea who wish to contact families in the greater Washington, D.C. area. Members of the State Department and members of the Armed Services have been provided this service. Frequently, faculty members who are studying in foreign countries are able to contact their fellow faculty members at the University. The station has also been instrumental in securing urgently needed, rare medical supplies for immediate shipment overseas.
21. HEALTH SCIENCE PROGRAM FOR HIGH SCHOOL STUDENTS. This spring a new series of Saturday morning programs introduce high school students to clinical and laboratory research activities. Student groups visit various areas at the Medical Center and attend complementary seminars. This program is coordinated by medical, dental and nursing students at the University. Georgetown plans to work with students from Howard and George Washington Universities in providing experiences in the health sciences that will interest local high school students in those fields.
22. SUMMER ENRICHMENT PROGRAM. This 8-week, preparatory program during the summer is offered to incoming minority medical students. They receive most major courses of the freshman year in a condensed form along with courses in reading comprehension and study techniques. Full-time faculty members teach the courses on a 5-day schedule. The medical school supports this program and provides the students with a weekly cost of living allowance.

23. CONTINUING EDUCATION PROGRAMS FOR PHYSICIANS, DENTISTS AND NURSES. The Schools of Medicine, Dentistry and Nursing conduct programs designed to provide continuing education for practicing health professionals. 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. At these sessions heart specialists, using patients for demonstration purposes, instruct in the diagnosis and treatment of complicated cardiovascular 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.
24. AFFILIATIONS OF THE SCHOOLS OF MEDICINE AND DENTISTRY. 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 these programs are approximately 300 interns, residents and fellows from Georgetown.
25. SERVICE TO COMMUNITY AGENCIES. Many faculty of Georgetown University Schools of Medicine, Dentistry and Nursing donate their time and services on a voluntary basis to various community agencies such as the Heart Association, Cancer Society, Department of Human Resources, Regional Medical Program, etc., which in turn provide community services.

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EXHIBIT B

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PAYING THE BILL FOR COLLEGE

The 'Private' Sector and The Public Interest

by John R. Silber

State legislatures, says the president of an embattled independent university, are wasting millions of tax dollars to provide education that is already available—and functioning at a high level of efficiency—in colleges and universities that are not beneficiaries of the public purse. Here are some thoughts on how to keep those independent schools in business and save tax money in the bargain.

There is no such thing as a private college or university. Until we realize this, the financial crisis that now threatens American higher education cannot be resolved. The fact of the matter is that virtually all "private" institutions are open to the public, serve public needs, and are gravely influenced by public deliberations. Some argue that a "public" institution is one owned by the government, but that is as ridiculous as arguing that there is no public air transportation in this country because our airlines are not owned by the government—as ridiculous as believing the tele-

phone system is not public because the telephone companies are privately owned.

Public education in the United States, throughout its history, has been predominately private in sponsorship. From the first colonization until the revolution, virtually all education beyond the high school level was available only in privately sponsored institutions. By 1800, only three states had sponsored any sort of higher education. Passage of the Morrill Act in 1862 was the first substantial movement toward taxpayer-supported higher education, and by 1951, only a bare majority of the college students in this country were being educated in tax-supported schools. Since the "private" institutions are really public, in the sense that they constituted for many years almost all of public education (and continue to train and educate a disproportionate number of our nation's trained professionals), we should cease to speak of public and private higher education. We should speak rather of privately sponsored versus taxpayer-sponsored institutions, or of independent as contrasted to state institutions.

To believe that present-day independent colleges and universities are citadels of privileged affluence that ignore the public interest in educating the poor and the minorities is to embrace a superstition. The achievement of equal opportunity in a democratic society requires that no qualified student be denied an education because he cannot

pay, and any college or group of colleges that restricted education to those who could pay for its cost would betray a fundamental ideal of democracy by limiting education to the affluent.

The question is not whether the state-operated schools have contributed to equal opportunity, for they have; nor is it whether they should continue to, for they must; it is, rather, whether the independent schools have made a similar contribution, and if so, how it can be continued.

One way to show the dedication of the independent schools to the ideal of equal opportunity is to show what they have been doing for the education of minorities as defined by the Department of Health, Education and Welfare—blacks, Indians, Orientals, and the Hispanic-surnamed. The education of these minorities is often thought to provide a special justification for subsidies in the state sector. If we limit our view to New York City, with its atypical combination of free tuition and open enrollment, there is merit in this assumption; but if we look at the country as a whole, we will see its falsity. In St. Louis, 7 percent of the undergraduates at the University of Missouri are from minorities, but so are 7 percent at "private" Washington University. And "private" St. Louis University outperforms both schools with 16 percent. Johns Hopkins and the University of Maryland enroll about equal proportions, and none of the branches of the University of Connecticut approaches the minority proportion at Yale. In California, the two principal independent universities, Stanford and Southern California, enroll 15 percent and 18 percent respectively. The University of California overall enrolls 17 percent. The examples could be multiplied, but the conclusion would remain: the independent colleges, with limited resources, have set a standard in the education of minorities rarely equaled by the state sector.

Boston University has for years devoted to minority students more than half of its financial aid for freshmen. In 1974-1975, 34 percent of available financial aid has been given to minority students, who make up 11.6 percent of its freshman class. The total minority undergraduate enrollment at Boston University is 9 percent, the same as at Boston State College. At the University of Massachusetts at Boston, established specifically to educate inner-city students, the figure is only 14 percent. The proportion of minority students educated at "private" Boston University is higher than that at every state-owned school save these two, and in absolute numbers, Boston University educates more minority students than the two put together.

Another useful measure of the public importance of the "private" sector is revealed in the number

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and range of degrees earned there. In 1959, the independent sector enrolled 50 percent of college and university students and awarded 50 percent of bachelor and postgraduate degrees. By 1974, the independent schools had added a million students to their rolls, but major expansion in the state sector had cut the independent schools' share of enrollment to 24 percent. Even so, they awarded 34 percent of all degrees, a disproportion even more marked when it comes to professional degrees. The independent sector in 1970-1971 graduated 43 percent of the doctors of medicine, 45 percent of the dentists, and 56 percent of the lawyers. Over the past twenty-five years, a majority of the doctors, dentists, and lawyers in this country have been trained at little or no cost to the taxpayer. After vast expenditures for professional training in the state sector, the independent sector still trains approximately half of the members of these three key professions.

In view of their remarkable sensitivity and responsiveness to the problem of educating minorities, and their responsibility through graduation and certification for most members of the learned professions, the independent colleges are clearly as entitled to be thought of as "public" as are schools owned and operated by the government.

Some hold that the state educates more cheaply than do the independent colleges and universities, a notion that gains wide credibility because every taxpayer knows that he can send his child to a state-owned institution and pay substantially less tuition than would be required by an independent institution of comparable quality. Few taxpayers note that the difference is not one of cost, but of price. Tuition is the price charged by state institutions and may be as little as one tenth that of the independents, but the cost of education in the two sectors must be approximately the same, for the state cannot buy goods and services more cheaply than anyone else. The cost of education in comparable institutions is comparable. In 1973-1974, current expenditures at state colleges and universities, nationwide, totaled some \$18 billion, in addition to \$3 billion in capital outlays. Since the state sector educates about 8 million students, the average cost within it was \$2625 per student, some 500 higher than average tuition in the independent sector.

But \$2625 is only an average: costs in the newest parts of the state sector are very much higher than in the parts where construction costs have already been amortized. Building a new campus from scratch adds immense capital costs to its operating expense. The new Boston campus of the University of Massachusetts, designed for 6000 students, cost \$135 million. The annual cost of amortizing these places over twenty years at 5.7 percent

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is about \$11 million. To this must be added operating costs, currently \$19 million. The total cost of educating 6000 students is \$30 million per year. Thus, each student costs the taxpayer approximately \$5000 a year to educate. Compare these figures to the cost of providing tuition scholarships for students at pre-existing campuses in the independent sector. Current tuition at Harvard is \$3400, and at Boston University, \$2890. Tuition at both schools will rise next year, but so will costs at the state schools, for they are as vulnerable to inflation as any other educational facility. Why, on balance, should a state spend \$5000 to create and operate each new classroom place when those available in the independent sector could be "leased" for no more than \$3500 a year?

Expansion of capacity in the state sector, when it duplicates spaces in the independent institutions, must inevitably be very expensive. At the University of Massachusetts at Boston, the state spent \$135 million for 6000 students before admitting a single one. All those millions used as an endowment would have funded scholarships in perpetuity for at least 3000 students. These scholarships would make up the difference between tuition in the state sector and any independent school in Massachusetts, without incurring a penny of operating cost. An equivalent scholarship program for the other 3000 students could have been funded for \$9 million annually. Such a scholarship program would have cost the taxpayer \$10 million a year less than the current operating budget for the University of Massachusetts at Boston. Or scholarships for all 6000 students could have been funded out of the annual operating budget and the entire capital outlay of \$135 million could have been saved.

This example is not an isolated phenomenon. No one can turn back the clock, and no one proposes to dismantle the University of Massachusetts at Boston or any other recently developed campus. Most of these are here to stay and should be made to prosper. Nevertheless, it is important that we learn from such examples and avoid their repetition.

The millions of dollars spent to create new places in state-owned colleges do not add proportionately to their use by state residents. In 1958-1959, 57 percent of the entering freshmen at Boston University were state residents. By 1963-1964, the figure was down to 45 percent, and by 1973-1974, to 34 percent—chiefly because thousands of places were made available in the state schools at a very low price. Since Boston University has increased the percentage of out-of-staters in its student body, the result is that Massachusetts taxpayers have expanded educational opportunity—but for residents of other states. When the legislature creates a new place in the state system, it does not automatically provide an additional place for a state

resident; it may only shift a student from the independent to the state sector, and the cost of educating him from the independent sector to the taxpayer.

Given current indications of a dwindling pool of college recruits, the eventual result may well be empty seats in classrooms where students would be sitting were it not for a state-manufactured redundancy. Empty places will mean higher costs per student and, in sufficient numbers, bankruptcy for a great many colleges and universities dependent upon student tuition rather than state subsidies.

The rational solution is to use already existing schools and facilities in the independent sector by subsidizing tuition. Taxpayers would then be paying for education rather than for debt service, and annual spending could be more precisely adjusted to annual need by reducing or eliminating endowment or appropriation.

Ignoring these possibilities can be very expensive. In 1962, Massachusetts was already second in the nation in resident doctors per capita. But it did not have a state-owned medical school, and the lack was represented to the legislature as a cause for shame. The resulting medical school (which, it should be emphasized, was established before the present University of Massachusetts administration took office) has already cost the taxpayers some \$115 million to build, and will cost \$6.56 million to run this year, an average cost of \$43,160 for each of its 152 students, four times the cost in any one of the state's three independent medical schools. When people read that the annual cost of educating a doctor at this school is currently \$43,160 per student in operating expenses and \$117,000 per student in debt service, they sometimes assume that it must be a misprint for the total four-year cost. But the scandalous truth is that the annual cost to the taxpayer, per student, is \$160,000.

The three independent medical schools, when the state first proposed its own institution, offered to contract with the state to provide for the increase in the number of Massachusetts medical students. In the time since the offer was rejected, the independent schools have created, at no cost to the taxpayer, 564 new places—164 more than the state medical school will have at full strength. These new spaces could have been taken by as many qualified residents as applied. Had the state opted to use their resources, rather than encouraging the independent schools to look for students elsewhere, the taxpayer would have saved not only three fourths of the \$115 million construction cost, but millions annually in operating expenses. The building of this school is a monument to the folly of forgetting that all universities are public, and of allowing anything other than educational need to dictate expansion of the state sector.

How the States Support Colleges Here are estimates of their comparative efforts, based on the latest available figures

	1974-75		Appropriations per student (b)		Appropriations per capita (c)		Approp. per \$1,000 of personal income (d)	
	Amount (\$100,000)	Rank	Amount	Rank	Amount	Rank	Amount	Rank
Alabama.....	\$ 153,110	25	\$2,035*	35	\$ 44.08	36	\$11.54	19
Alaska.....	36,073	41	8,552	1	109.31	1	18.42	1
Arizona.....	152,549	26	2,229	23	74.12	2	15.80	5
Arkansas.....	82,421	35	2,431	13	40.46	45	10.24	31
California.....	1,365,861	1	2,704	30	66.30	8	12.01	18
Colorado.....	167,154	24	2,024	36	63.59	6	13.64	11
Connecticut.....	135,247	28	2,618	12	43.97	39	7.40	45
Delaware.....	37,206	43	2,373	21	64.59	12	11.18	22
Florida.....	412,269	7	2,855*	7	53.70	23	10.91	24
Georgia.....	237,416	14	2,581	6	49.61	30	11.29	21
Hawaii.....	58,740	38	2,020	37	70.60	4	12.74	13
Idaho.....	50,233	39	2,631	13	65.24	11	14.78	8
Illinois.....	612,545	3	2,914	5	51.52	21	9.45	37
Indiana.....	247,119	12	2,490	15	46.49	35	9.32	40
Iowa.....	147,765	27	2,407*	20	50.89	25	9.65	36
Kansas.....	126,502	31	1,873*	44	55.51	18	10.47	29
Kentucky.....	169,604	23	2,676	11	50.75	26	12.53	14
Louisiana.....	185,531	19	2,119	34	49.29	32	12.54	15
Maine.....	46,705	41	2,454	17	44.46	38	10.89	25
Maryland.....	181,704	20	2,233*	26	44.61	37	8.13	45
Massachusetts †.....	199,761	16	2,179	31	31.33	49	6.54	49
Michigan.....	524,173	4	2,493*	16	57.86	16	10.44	28
Minnesota.....	194,311	18	2,162*	32	49.86	28	9.71	35
Mississippi.....	130,729	29	2,270	24	57.31	17	16.12	3
Missouri.....	197,911	17	2,207	29	41.60	42	8.59	43
Montana.....	38,249	42	1,854	45	53.05	24	11.33	20
Nebraska.....	85,400	34	2,292	23	55.38	20	10.51	27
Nevada.....	29,720	47	2,244	25	54.23	22	9.44	33
New Hampshire.....	18,380	50	1,162	50	23.24	50	4.95	50
New Jersey.....	289,512	11	2,724*	10	39.33	47	6.73	48
New Mexico.....	61,322	37	1,967	39	55.50	19	14.40	10
New York.....	1,159,830	2	3,515*	2	63.50	14	11.13	23
North Carolina.....	337,044	9	3,025	4	63.92	13	14.93	7
North Dakota.....	31,730	46	1,350	49	49.53	31	8.71	42
Ohio.....	386,017	8	1,919*	41	35.97	48	7.09	47
Oklahoma.....	105,970	32	1,475	48	39.79	46	9.17	41
Oregon.....	129,839	30	1,913	42	58.38	15	12.03	17
Pennsylvania †.....	485,242	6	2,770*	8	40.77	44	8.17	44
Rhode Island.....	47,036	40	2,752	9	48.34	33	9.59	33
South Carolina.....	180,558	21	3,409	3	66.24	9	17.06	2
South Dakota.....	32,221	45	1,908	43	47.04	34	9.93	34
Tennessee.....	169,833	22	2,161	33	41.16	43	10.05	32
Texas.....	509,180	5	1,783*	46	43.17	41	9.44	38
Utah.....	75,740	36	1,950	40	65.46	10	16.08	4
Vermont.....	20,120	49	1,760	47	43.36	40	10.70	26
Virginia.....	242,359	13	2,417*	19	50.38	27	10.31	30
Washington.....	232,343	15	2,016	38	67.76	7	13.15	12
West Virginia.....	89,034	33	2,231	27	49.63	29	12.53	16
Wisconsin †.....	327,321	10	2,542*	14	71.64	3	15.03	6
Wyoming.....	24,306	48	2,303	22	68.85	5	14.67	9
Total U.S.....	\$10,965,160		\$2,373		\$52.25		\$10.36	

* Indicates states whose appropriations included at least one percent specifically appropriated for private institutions or students attending private institutions.

† Estimate

(a) Reprinted by M. M. Chambers of Illinois State University

(b) State appropriations divided by number of full-time students in public institutions in fall, 1973, reported by U.S. Office of Education.

(c) State appropriations divided by Jan. 1, 1973, population, reported by U.S. Bureau of the Census.

(d) Per capita appropriations divided by thousands of dollars of per capita personal income for 1973, reported by U.S. Department of Commerce.

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The independent sector, unable to burden the taxpayer with the cost of imperialist ambitions, generously provides education for the public in exchange for very few of the taxpayer's dollars. If a man stood on the corner selling authentic dollar bills for two cents each, from the point of view of his customers, he would operate at 5000 percent efficiency. If he raised his price to thirty cents a dollar, he would lose no customers, nor should he be criticized for his rapacity or inefficiency. That man on the corner stands to his customers in the relation of the independent colleges and universities to the taxpayer.

Whenever an independent university or college educates a resident of its state, that state's taxpayers are saved whatever it would have cost to educate that student in a state school. Boston University educates some 7000 residents of Massachusetts every year. To educate them at the University of Massachusetts would cost taxpayers at least \$37 million. Full tuition scholarships for those same students at Boston University would represent a saving of at least \$16 million. In 1973, some 2.2 million students were enrolled in independent colleges and universities throughout the nation. Their education relieves the taxpayer of at least \$6 billion annually that would have to be spent to educate them in state schools.

An independent college or university is a goose that lays golden eggs on a ration of a few pennies from the taxpayer. The fable warns us against killing any goose whose eggs exceed in value the cost of its ration. There is more than one way to kill a goose, and slow starvation is sure. The goose would thrive on no more than thirty cents' worth of ration per dollar's worth of egg, and the policy of slow starvation is absurdly shortsighted.

A state college or university is no golden goose. For every dollar of services it provides to the public, it charges the taxpayer the full dollar, and, typically, it burdens him with an additional twenty-five cents in redundant capital investment. Fair, perhaps, but no bargain.

Any legislature that shifts the taxpayer's educational business from existing independent colleges to newly created state colleges shows about as much sense as a man who eats his golden goose and buys his golden eggs at the bank.

Whenever it is proposed that independent colleges must be helped by an infusion of public funds, critics of the scheme propose conditions that would convert the independent colleges into wards of the state. Usually these conditions reveal assumptions about the independent sector that are totally misleading. For example, Robert Kibbee, chancellor of the City University of New York, and other proponents of the state sector have spoken of the need for the inde-

pendent sector to accept strict audit and fiscal restraint before receiving substantial tax money. An orgy of speculation and waste impressive even in government would be required before the taxpayer could be a loser at current or prospective levels of tax support for independent higher education.

Ironically, independent schools are usually held to more demanding standards of accounting than the state schools. The budget document of an independent university details all its expenses, while the budget of a state university may represent only those expenditures that have not been squirreled away in other state accounts. In Massachusetts, for example, debt service, retirement, group insurance payments, cost of living and fuel adjustment supplements, totaling some \$123 million for higher education in 1974-1975, are reported separately in the state budget. The standard survey of state appropriations for higher education reports that Massachusetts spends \$200 million a year. Because the survey is limited to the operating budgets of the state institutions, it is short of the truth by at least \$123 million.

When the taxpayer looks at the budget of one of these institutions, he is deceived. Yet this deceptive standard of accounting is being urged upon the independent schools as a price of taxpayer funding.

Nor is there much evidence of any widespread or substantial waste in the independent sector. Substantial waste is not possible for any but heavily endowed colleges.

When Chancellor Kibbee and others say that the independent schools, as a condition of tax support, will have to become like state schools and eschew deficits, they are using an isolated event in the history of New York University to make a point rarely applicable to other institutions. Independent universities must eschew deficits, for there is no way they can survive them: Banks honor overdrafts only in wealthy accounts. Universities that spend more than they earn, once their savings are gone, face bankruptcy as surely as private citizens who behave in the same way. Only the state institutions, drawing on the presumed bottomless well of the public treasury, or the handful of independent institutions that draw on large endowments, can run deficits. New York University, the only independent school to run a series of huge deficits, was finally forced to face reality and settle accounts by the sale of an entire campus. In the state institutions, tuition income falls far below expenses as a matter of policy, and the taxpayer makes up the difference.

When Ernest Boyer, chancellor of the State University of New York, tells the independent schools that they must learn to be as accountable as the state schools, we may be misled still further. An independent college or university, to a far greater degree than a state institution, is accountable in the marketplace. Its budgets inevitably assume a certain enrollment; any failure to achieve it will in-

evitably lead to deficit, and any series of substantial deficits will inevitably lead to disaster. Independent colleges and universities, like any other business, face the possibility that their product may not attract customers. This danger is not mitigated because a university seeks no profit, or because its product is by nature intangible and freighted with purposes and values beyond the merely financial.

Ten years ago we might not have understood Dr. Johnson's dictum, but now we can all agree that there's nothing like a hanging to concentrate the mind. The economist Paul Rosenstein-Rodan has named the effect of this knowledge "the tremble factor." It is a dreadful but essential benefit to the independent sector, and the state sector has rarely faced it. One of the most effective uses to which the tremble factor has ever been put was in the building practices of ancient Rome. For when the scaffolding was removed from a completed Roman arch, the Roman engineer stood beneath. If the arch came crashing down, he was the first to know. His concern for the quality of the arch was intensely personal, and it is not surprising that so many Roman arches have survived.

The state's subsidy of tuition charges in the state sector deprives the state schools of the invigorating benefits of the tremble factor. In 1974-1975, tuition at Boston University is a little over eight times that at the University of Massachusetts. I hardly know which is more marvelous: that independent universities, facing that kind of price competition, manage to survive, or that state universities, thus protected from the tremble factor, manage to achieve an extraordinary level of quality. State universities are among the most distinguished because their faculties, like those of the independent sector, have been accountable to the ideals and standards of the community of scholars. To the extent that this may no longer be true, the problem affects both sectors.

Another common myth, based more in pseudodemography than in education, has resulted in encouraging mindless expansion in the state sector. It is the foolish belief that additional facilities are needed to meet the requirements of an expanding student population, and that independent colleges have been neglectful or insensitive to the provision of these additional spaces.

As recently as 1970, educational planners, noting the high birth rate of the fifties and sixties, believed that the population was becoming increasingly younger, and they wondered where we would find all the teachers to handle the hordes of students promised for the eighties and nineties. The fact is that the people whose activity is predicted by the fertility rate have played a little joke on

those who predict their activity. The birth rate has dropped through the level needed for a stable population, and in 1973 there were only 3.1 million births, compared to 4.3 million in 1961. This means that the total number of students available for the freshman class of 1991 will be at least 31 percent smaller than for that of 1979. Within four years, as enrollments decline, an increasing number of both independent and state institutions will face serious difficulty. By 1995, assuming that Americans continue to go to college at the present rate, both state and independent colleges and universities will be educating nearly 3 million fewer students. Even with extraordinary expansion in continuing education, the deficit cannot be less than one million students. The full significance of this number is not obvious so long as it remains merely a number: think rather that 200 universities of 5000 students each, or 500 colleges of 2000 students each will have been annihilated. Many of these abandoned monuments to the folly of overdevelopment will be state institutions.

These are not the linear extrapolations of a Herman Kahn or the futuristic fantasizings of an Alvin Toffler. Rather, they describe what must happen as a result of what has already happened. The freshman class of 1991 was born last year. It is inconceivable that we shall educate children who have not been conceived. The baby-food and toy manufacturers already know this; educators and legislators will eventually find out.

For the next few years, the state colleges and universities can maintain their enrollments at the expense of rapidly declining enrollments in the independent sector. Their advantage is the obvious one of a subsidized, and thus artificially lowered, price to the student. The time will come, however, when existing classrooms cannot be filled at any price, when both public and private sectors would have extra space even if tuition were free.

We must learn how to balance supply and demand in the context of higher education as a whole. *The independent sector cannot ignore the need to provide educational opportunity for all citizens, and the state sector must avoid the wasteful policy of imperialist duplication.* If we balance supply and demand in higher education by destroying the independent sector, society will pay a fearful cost in wasted facilities and in wasted lives and in loss of educational opportunity and options. Balance must be achieved by some regular and effective plan of state support for independent schools and by a willingness on the part of the state to avoid redundant expansion.

Let no one propose the protectionist expedient of raising tuition in the state sector in order to lower consumption in it. Tuition increases in the state schools are not an attractive solution—unless they are compensated for in advance by greatly increased scholarship programs. Equal educational

Paying the Bill for College

opportunity for every citizen of the United States is more important than the survival of any one educational institution. Attaining a balanced system of higher education responsive to the goal of equal opportunity need not require the death of any college, though it does require the abandonment of plans for new colleges that will never be needed. If further redundant expansion is avoided, independent colleges can survive to share in extending equal opportunity.

Independent institutions with small endowments are dependent upon tuition, and their income has no floor to sustain it. Some schools, through imaginative management and good fortune, may be able to survive the coming situation while complaining of nothing more serious than "underutilization of facilities." But a great many independent colleges and universities will be forced to close their doors. Small colleges are doing so—forty-eight of them since 1970. Many of these were marginal, but some were not. In 1973, for example, the College of Emporia, a small college in Kansas with almost a century of service, was forced to close. When its facilities were offered to Kansas State Teachers College, they were refused, for enrollment at that institution had already declined 500 below capacity. We have long assumed that the failure of a "private" school represented no great loss, because the state would step in, claim the body, and operate a successor on the site. The case of the College of Emporia shows us that such hopes are delusory.

The higher-educational resources of the United States have been lessened by such closures, and these are but the start. As yet, no large, urban, independent university has gone to the wall. Within five years we shall see either the collapse of more than one large university or an awakening of taxpayers and politicians to the fact that the survival of these schools is in their own self-interest—that they must be willing to provide the requisite support.

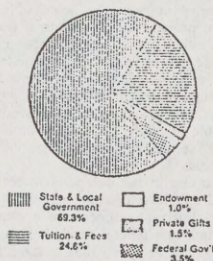
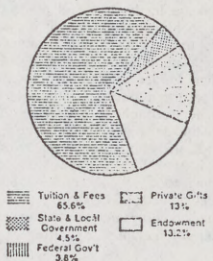
Dollar values for the educational services offered to the public by independent schools are not difficult to determine. When an independent school enrolling 6000 students closes, the state has the choice of either assuming this educational cost by further expansion of the state system or denying 6000 of its citizens access to higher education. But the collapse of any large urban university would result in losses of another sort.

Because it has one student for every 123 people in greater Boston, Boston University swings considerable economic weight. Its payroll in 1974 totaled \$63.7 million, making it as large an employer as Boston Edison or one of the largest multi-office banks. The payroll numbered 4500 people, and the institution generated an additional 1000 off-campus jobs. The university's total expenditure exceeded \$100 million, about half the total budget of a state like New Hampshire or Wyoming. Student and vis-

itor spending added another \$60 million. Most of this \$160-million windfall went to businesses and individuals in greater Boston. Boston University's students and staff maintained bank accounts totaling \$23 million; out-of-state students, parents, and visitors spent \$35 million, making the university a major tourist industry and one of the few that operate the whole year round. The loss of \$35 million in tourist money alone would send financial shock waves through any community.

Some argue that universities, by occupying vast tracts of otherwise valuable land, deprive the community of its proper revenues. But all the institutions of higher education, independent and state owned, in the educationally abundant city of Boston occupy only 2 percent of the land area. Boston or any other city could tax its educational institutions into bankruptcy without substantially increasing its tax revenue, while damaging and perhaps destroying its local economy.

The average college or university has no less impact upon its city than Boston University has upon

SOURCES OF INCOME
PUBLIC AND INDEPENDENT
UNIVERSITIESPublic
Universities
1971-72Independent
Universities
1971-72

greater Boston. Indeed, in many metropolitan areas, the dominant university enrolls one student for every fifty residents, and in many towns, a college has one student for every fifteen.

Money spent by the state in support of independent colleges and universities is seed money, for the benefits far exceed the costs. And an increasing number of legislators and governors throughout the United States are becoming increasingly sensitive to the importance of developing a comprehensive plan for higher education that encompasses both state and independent sectors.

The Need for Tuition Vouchers

At present, no state has a pattern of aid that will ensure the most economical continuance of a composite system of higher education. All in all, New York has the most developed and elaborated system of state aid. Its direct institutional aid, the Bundy plan, pays \$800 to each independent college or university for each bachelor's degree awarded, \$600 for each master's, and \$3000 for each doctorate. In 1973-1974, these payments totaled nearly \$56 million. In the same year, various scholarship awards tenable at independent or state schools amounted to some \$85 million. The state also arranges tax-exempt bond issues for construction at independent schools, and supports ten chairs (at \$50,000 per chair per annum) in the independent sector. Moreover, the new Tuition Assistance program provides direct grants of up to \$1500 a year, depending upon parental income. To take one example, for parents with a taxable income of \$8000 and a tuition charge of at least \$1500, the tuition assistance would be \$1100 a year. This is comparatively generous, but the student would still be unable to afford the cost of tuition in the independent sector without substantial aid from other sources.

No one in the independent sector is likely to regard any level of state or federal aid with indifference, but no argument for a much larger infusion of state and federal funds has so far been seriously proposed. Suppose that a state estimated the annual operating cost of educating an undergraduate in a state institution, and made this amount available to him in the form of a tuition voucher. This sum, nationwide, would now average \$2250, although in many states the figure would be much higher. Under such an arrangement, the operating budget for a state school would be the sum of all vouchers brought to it by its resident students plus any tuition paid by them. For an independent school, this sum would be part of its operating tuition income from resident students, and the annual income to a school enrolling 6000 state residents would be about \$13.5 million.

Such a program would not call upon the taxpayer for increased operating expense, for the op-

erating cost to him would be the same whether a student took his voucher to the state or the independent sector. A student's choice between the two sectors could not affect capital costs in the state sector, for existing structures must be paid for, used or not. But the taxpayer would be relieved of any need to duplicate facilities already in existence.

The plan sketched here would correct the relationship between the two sectors; superfluous expansion in the state sector would cease, for taxpayers could never be persuaded to duplicate at their own cost facilities already extant in the independent sector if they were always available, so to speak, on lease. State institutions would acquire the advantage of living with the tremble factor as their operating budgets began to reflect not the number of students who found their tuition an irresistible bargain, but the number of students who preferred their educational offerings. The result would be a competition based, as it should be, on educational quality rather than on price-cutting. The independent schools would gain the income they need to stay alive, and would continue to provide a capital subsidy to state education. But the state sector would no longer be parasitic upon the independent, nor would the latter need to sacrifice its autonomy. Its accountability would continue to be assured by the marketplace.

The dominion that superstition can hold over human perception is well illustrated by the remoteness of any such rational scheme for dividing the labor of higher education and sparing the taxpayer needless costs. We are trying to muddle through with something far less than rational; the public is being educated, and in a steady state we could perhaps struggle along indefinitely. But the situation is not stable, and we in the independent sector cannot indefinitely prolong our invigorating career at the brink of disaster.

The best we can hope for is that when one or more major independent universities go over that brink, state legislatures and the federal government will make a saving gesture in the tradition of their salvage of *Lockheed, Aircraft and the Penn Central Railroad*. If the government can save corporations too incompetent to survive on their own simply because they are too important to be allowed to die a disorderly death, the government should find no scruple in sustaining institutions that have been operating in a highly competent and socially beneficial way.

The long-range interest of all higher education, and even more the public interest, demand that the contribution of the "private" colleges and universities to the education of the public be recognized, and that the independent and the state sectors unite in the cause of rational coordination. The financial crisis facing all of higher education requires no less. □

STATEMENT OF RONALD P. KAUFMAN, M.D.,
ACTING VICE PRESIDENT FOR MEDICAL AFFAIRS
THE GEORGE WASHINGTON UNIVERSITY

THE UNITED STATES SENATE COMMITTEE ON THE DISTRICT OF COLUMBIA

April 29, 1976

Mr. Chairman and Members of the Committee:

I am Dr. Ronald P. Kaufman, Acting Vice President for Medical Affairs of The George Washington University. I want to thank the Members of the District of Columbia Committee for the opportunity to speak, and I appreciate the continued interest of the Committee in the financial problems of both The George Washington University School of Medicine and Health Sciences and the Georgetown University Schools of Medicine and Dentistry.

Chancellor McNulty of Georgetown has just reviewed, in some detail, the legislative history which has provided the vehicle for relief of the fiscal distress of our three schools. Nonetheless, I feel compelled to emphasize a number of specific elements of this history. We recollect well and took very seriously, the charge from President Ford upon signing the extension of the District of Columbia Medical and Dental Manpower Act (PL 93-389), that future fiscal support of the schools be pursued through the District of Columbia. We explored this avenue of possible financial assistance with vigor. The problems confronting our schools were recognized and respected by the District Government, however, Mayor Washington when addressing such a request stated that "given the District's current and projected financial difficulties, I believe it is unlikely that the city will assume any major new financial responsibilities in the near future." Therefore, we reluctantly return to the Congress for one more year of "state-like"

support of up to \$5,000 per medical student and up to \$3,000 per dental student. In addition, I would like to focus the Committee's attention on the fact that the tuition for medical education has been raised from \$3,200 per student in Fiscal Year 1975, to \$5,000 per student in Fiscal Year 1976 at The George Washington University and from \$3,500 per student in Fiscal Year 1976 to \$5,000 in Fiscal Year 1976 at Georgetown University. The tuition of Georgetown University School of Dentistry rose from \$3,200 per student in Fiscal Year 1975 to \$4,400 per student in Fiscal Year 1976.

The faculties and the Administrations of these three schools, with some reservation, have supported the concept of increasing tuition to more accurately reflect the true expenses associated with medical and dental education. However, neither the faculties nor Administrations can in good conscience escalate the fees and tuitions to offset the true educational costs without having in place adequate scholarship support and/or loan programs. Since, to do so, would not only radically impact the socio-economic mix of our students, but would place an extreme burden on our presently enrolled students. We sincerely hope to maintain a broad mix of students based on scholastic and humanitarian qualities rather than the ability to pay a high tuition. We urge this Committee, therefore, to favorably consider a one-year extension of the District of Columbia Medical and Dental Manpower Act so that we might put in place for our students either scholarship or loan options to meet the rising tuitions.

As the members of this Committee are acutely aware, National Health Professions Legislation has not yet been authorized, although, one might hope for such legislation to emerge from the 94th Congress. We are presently exploring a number of student assistance proposals with a variety of jurisdictions, including the District of Columbia, for specific aid to students who are residents of these

jurisdictions. In addition, on November 18, 1975, we presented to the United States Senate Committee on Labor and Public Welfare, Subcommittee on Health, a proposed demonstration project (exhibit A) the essential elements of which are as follows:

1. Tuition would be increased by September 1977, to fill the gap created by the loss of state-like support (\$7,400+ for dental students and \$10,000+ for medical students).
2. With the firm belief that the present socio-economic mix of our students should be maintained and that the impact on presently enrolled students minimized, 50% of the students selected by the institution would be eligible to borrow up to \$10,000 per year to meet their educational expenses. The maximum would be \$40,000 per student.
3. The capital funds for the program would be provided by the private sector. They would be federally insured, and the interest rate would be federally subsidized. An integral part of the program would be to test the capability of health professions students financing their own education from funds borrowed from the private market.
4. Repayment by the individual would commence after completion of medical school education and residency training programs and total repayment of principal and interest would be required within five years of that date.
5. Provisions are made for variable forgiveness of this indebtedness through federal grants to individuals who serve in federally designated

underserved areas, the Armed Forces, the Veterans Administration, the Public Health Service, the National Health Service Corps, or other Federal programs approved by the Secretary of the Department of Health, Education and Welfare.

The schools would develop educational content so that these students would be prepared for such endeavors and appropriate residency programs would be broadened to provide examples of such training experiences.

Georgetown University and The George Washington University believe that such a program is in the national interest and will succeed. Since:

1. The students themselves will assume the responsibility to finance their own education.
2. The program substantively addresses geographic and speciality maldistribution.
3. The level of indebtedness and amortization of those in the program will be so substantial that repayment other than by service payback will be exceedingly difficult.
4. The cost to the Federal Government associated with the proposed program will be significantly lower than current programs or presently proposed programs, since it does not require from the Federal Government either front-end capitalization or state-like support.

It is our sincere belief that if the District of Columbia Medical and Dental Manpower Act is extended through Fiscal Year 1977, such an extension will provide an opportunity for the implementation of such a project and the development of other student support opportunities.

MANPOWER

We believe that The George Washington University School of Medicine and Health Sciences and the Georgetown University Schools of Medicine and Dentistry have an enviable record as a manpower resource since their establishment. At the present time, there are 8,041 physician alumni and 3,057 dental alumni of these schools living and practicing in the fifty states, Puerto Rico and the District of Columbia. Of these, over 1/3 practice in Maryland, Washington, D.C. and Virginia. Nine hundred and eighty-one of which are in the District of Columbia.

Of the presently enrolled 2,000 students, they are residents of 48 states; 81 from the District of Columbia, 232 from Maryland, and 108 from Virginia. All three schools have been involved in a sincere effort to meet our moral and ethical commitment to an Affirmative Action Program. For example, there are presently 317 females and 71 black Americans enrolled in the schools; of the latter group, 21 are residents of the District of Columbia.

In addition to medical students, in 1972 a Physician's Assistant Program was inaugurated at The George Washington University as part of our initiative to meet the stated health manpower requirements of this country. This program was launched with the assistance of a Bureau of Manpower Grant with a charter class of 30 students. The program received provisional AMA accreditation in October 1972, and was fully accredited in 1974. The program is now in its third year, and the Class of '76 has been increased to 37, of which 22 are from rural areas. Of these classes, approximately 40% are disadvantaged students, 30% are minority students, (the majority of this group being black Americans), and 30% are female. It is our belief that these physician's assistants will be an important health

manpower resource in solving the health care delivery problems of this country, especially in the rural areas. In addition to physician's assistant students, we have 879 other allied health students enrolled in a variety of programs, such as Medical Services Technology, Laboratory Technology, Radiological Sciences, Nuclear Medicine Technology and similiar programs.

Of the 2,000 students currently enrolled in the three schools, 55% have applied for some assistance through the respective Financial Aid offices of the schools. In addition, George Washington medical students lead the nation with 79 applicants for the 850 scholarships available in the Public Health Service and Georgetown University dental students have the highest number of applicants of any dental school. All this, I would remind the Committee, at a level of \$5,000 per year tuition for medical students and \$4,400 per year for dental students.

To summarize our health manpower efforts: The George Washington University School of Medicine and Health Sciences and the Georgetown University Schools of Medicine and Dentistry have continued their long tradition of supplying the Nation, the region and Metropolitan Washington with a superb practitioners of medicine and dentistry; all three schools have greatly increased their class sizes - The George Washington School of Medicine from 115 per year in 1971 to 150 per year in 1973; Georgetown University School of Medicine from 124 per year in 1970 to 205 in 1972, and Georgetown University School of Dentistry from 111 in 1970 to 150 in 1974. The George Washington University has inagurated a physician's assistant and other allied health programs in order to meet an enunciated National need for health manpower; all three schools have developed Affirmative Action Programs, which at the level of \$5,000 and \$4,400 per year tuition have resulted in indebtednesses of over 50% of the student classes. This latter issue is so acute that many of our students who are residents of Maryland have initiated efforts to transfer

to the University of Maryland School of Medicine for fiscal reasons. Communication from Maryland has indicated that they will not be able to accept even a small fraction of these students attempting to transfer.

COMMUNITY SERVICE

In addition to our educational efforts in adding to the manpower pool, The George Washington University Medical Center is deeply involved in community service. I would like to very quickly enunciate some of these services.

1. The George Washington University Hospital is a 535 bed general medical-surgical hospital which admits over 21,000 patients per year. These patients are derived from the following catchment areas:

District of Columbia	46%
Montgomery County	16%
Prince Georges County	15%
Virginia	16%
Other	7%

In addition, there is a specific commitment to the service of the residents of the District of Columbia Area 9. Area 9 encompasses a population of over 40,000 with an estimated 17% of that population in poverty. Such initiatives have resulted in over a half-a-million dollars per year of "charitable and/or free work" in the University Hospital. The University Hospital houses a number of highly specialized programs such as a coronary care prevention and treatment program; an in and out surgery unit; an obstetrical clinic for methadone mothers; an ovarian cancer study center; a pacemaker clinic; a papanicolaou test program; a radiation therapy center; a major rehabilitation research and training center; a renal dialysis and transplantation center; to mention only a few.

2. The Emergency Services register nearly 50,000 patient visits per year. This unit was recently recognized by the Health Facilities Planning Council as one of the outstanding emergency rooms in the Washington Metropolitan area and has been identified by the District of Columbia Medical Society as one of the city's rape centers. This program also results in an additional net operating deficit of approximately a half-a-million dollars per year.
3. The Ambulatory Care Division of The George Washington University Medical Center is a clinic which houses over 140 physicians adjacent to the University Hospital. This enterprise records over 100,000 visits per year and offers a large number of highly specialized services. Some of these are: a low cost psychiatric clinic; a psychiatric intervention clinic; a family planning program; a service to the Florence Crittenden Home of the District of Columbia; a sickle disease clinic (it is estimated that 6,000 people of the District of Columbia suffer from this inherited disorder of the blood); a low vision clinic; a drug abuse program; an obstetrical clinic for methadone mothers; a prevention of blindness program; an end-stage renal disease program; a home care program; to mention only a few. From the operations of these ambulatory services net income is expected to develop. This net income is made available to offset hospital, emergency room or clinic deficits which might occur.
4. The George Washington University Health Plan is a prepaid health maintenance organization initiated in an effort to avoid costly hospitalization and illnesses by keeping enrollees well through a regular program of medical care. This plan offers the full range of preventive medicine, emergency treatment, full hospitalization, and all diagnostic

and therapeutic resources at a fixed annual fee. The plan was inaugurated in 1972 and it is expected that there will be approximately 10,000 persons enrolled in the health plan by the end of this fiscal year. Through this plan approximately 2,000 Medicaid (Title 19) enrollees of the District of Columbia have been provided with high quality medical care at a charge lower than the regular Medicaid fee for service (35%). In order to house this rapidly growing health maintenance organization, the University has leased two floors of a building at 1229 25th Street, N.W.

The Medical Center and its affiliated institutions have a very extensive graduate medical education program which also produces high quality patient care and graduates of excellence for the community. Presently, there are approximately 300 physicians in the graduate education programs encompassing the major specialties and subspecialties and all are fully accredited by the American Medical Association Council on Medical Education. Some of the major affiliated institutions for medical education are the Children's Hospital National Medical Center, Columbia Hospital for Women, The Hospital for Sick Children, St. Elizabeth's Hospital Center, the Washington Hospital Center, the Washington Veteran's Administration Hospital, the Armed Forces Institute of Pathology, the Naval Hospital Medical Center, Holy Cross Hospital of Silver Spring, and the Fairfax Hospital of Virginia. In addition, the Department of Nursing of The George Washington University Hospital has ongoing affiliation relationships with American University, Georgetown University, Catholic University of America, Marymount College of Virginia and Burdick Vocational High School to afford clinical experiences for their students. Additional affiliations have evolved to support the physician's assistant program such as in the Psychiatric Institute,

Doctor's Hospital, Veteran's Administration Hospital of Martinsburg, West Virginia among others. Recently, the Medical Center has initiated a major program for continuing education of practicing physicians linked to medical audit and utilization review in order to assure effective and economic utilization of health facilities and services, and to assist in the promotion and maintenance of high quality of care through continuing education and evaluation of practicing physicians.

ADMINISTRATIVE ORGANIZATION

The fiscal plight of our School of Medicine and Health Sciences is one of continuous operational losses (Exhibit B). These operational losses have resulted despite vigorous efforts to reduce expenses, effect economics and to increase income from a variety of sources. In early 1974, the Medical Center was site visited by the Department of Health, Education and Welfare. The site visitors commented on the sincere, forceful management effort, the development of a practice plan initiative, and on the consolidated administrative format. The site visitors also noted that the Medical Center Administration enjoys a strong and supportive relationship with the University. Additionally, in April 1974, the Liaison Committee on Medical Education, the formal accrediting agency for schools of medicine, visited The George Washington University School of Medicine and Health Sciences to evaluate and accredit the undergraduate program in the medical education leading to the M.D. Degree. The Liaison Committee on Medical Education did confer approval of the program terminating an M.D. Degree for a duration of seven years. Normally a resurvey of the program would be expected during the 1980-81 academic year. However, the Liaison Committee noted the very serious problem relating to the operating deficit and related concerns with respect to the future finances of the school. Therefore, they requested that a yearly report of the financial

status be submitted to the Liaison Committee on Medical Education. As part of the narrative of the visit, the site visitors noted numerous organizational and administrative changes which had been salutatory. These positive changes not only encompassed the educational effort, but also an improved organizational management of ambulatory facilities, inpatient facilities and the research activity.

The purpose in quoting these reports is to suggest that outside review teams have found the administrative organization of the Medical Center to be sound. How can one, therefore, correlate sound management with a progressively increasing total expenditure for the School of Medicine and Health Sciences since 1971, at a rate greater than the CPI for a like period? I believe that the following explanation is valid. The new educational facility, Ross Hall, built to house the expanded enrollment of 600 students was completed and occupied in the fourth quarter of Fiscal Year 1973. This facility is four times larger than the old building with concomitant increases in energy costs and maintenance. As this Committee is well aware, in addition to plant, the other major cost of operation is personnel. Although faculty were added in parallel with the increase in class size, I must note that our student/faculty ratio is 6.6, one of the highest in the Nation, wherein the average student/faculty ratio is 3.5 according to the Association of American Medical Colleges survey. As a resultant, our regular operating expenditures per student is one of the lowest in the country.

Can one relate alleged good management, low expenditures per student, and high student/faculty ratios with the rapidly escalating tuition requirements and our request for continued state-like support? An explanation might be forthcoming from a recent survey of the role of the states in financing medical education to be published in the March issue of the Journal of Medical Education. The

data reveals that the mean contribution of state funds for public medical schools is approximately \$10,759,000 per year per state and \$2,757,000 per year per state for the private medical schools. Perhaps a more concrete way of looking at this data would be to note that the vast majority of states involved in medical education, support private in-state medical schools or regional medical schools with approximately \$3,000 to \$7,000 per student per year. Such fiscal support, we believe, is comparable with our request at this time and would eliminate the projected deficit.

In conclusion, Mr. Chairman and Members of the Committee, we thank you for your patience in allowing me to present this detailed testimony which I hope demonstrated that The George Washington University and its Medical Center is deeply involved in developing health manpower for the Nation, the region and locally; is concomitantly offering a multitude of sophisticated and general health services to the community; that such community service and education are intimately interlocked and that the continuation of one is dependent upon the viability of the other; that the University, its Medical Center, Administration and faculty, despite a meaningful increase in students, has exhibited effective administrative control of expenditures; that although home rule for the District of Columbia has become a reality, the fiscal straits of the District do not allow for support of the private medical schools of the District; and, therefore, that we of The George Washington University School of Medicine and Health Sciences along with the Georgetown University Schools of Medicine and Dentistry urge extension, as an emergency measure for one year, of the District of Columbia Medical and Dental Manpower Act of 1970 so that our students might take advantage of the opportunities that may well develop from national health manpower legislation as well as from our proposed model student assistance program.

Thank you for your attention and interest.

GEORGETOWN UNIVERSITY - GEORGE WASHINGTON UNIVERSITY
 PROPOSED MODEL OF STUDENT ASSISTANCE PROGRAM
 NATIONAL HEALTH MANPOWER BILL PROVISIONS

Purpose:

The purpose of this Medical and Dental Student Assistance provision is to demonstrate a way to finance medical and dental education for students of medium and needy economic levels and to provide a method for distribution of medical and dental graduates to serve in underserved areas. This would be achieved by a national demonstration model for a federally guaranteed loan program to provide assistance to medical and dental students and by means of grants to pay annual interest on privately borrowed educational funds. The program would also provide grants to repay privately borrowed educational funds through service for medically underserved areas.

Method:

(1) Student Assistance Program

All students participating in this program would enter an agreement with the Secretary of the Department of Health, Education and Welfare (henceforth referred to as the Secretary) for service in medical or dental underserved areas and on repayment of principal and federally subsidized interest. Fifty percent of the students at institutions participating in this program would be eligible to borrow up to \$10,000 per year to meet their educational expenses. The maximum would be \$40,000 per student. Tuition would be charged at approximately the full level of educational cost. The loans would be made by private lenders arranged through the Schools with a federal guarantee. There would be an annual federal grant to the borrowing

- 2 -

student of fifty percent of the annual interest charge. The program would have a provision for a hundred percent grant for the annual interest charge in the case of a financially needy student.

Appropriated funds for this section would not exceed \$3.5 million per year for the private medical and dental schools in the District of Columbia.

(2) Residency Service Program

(a) Residents who formally agree on completion of residency to serve in doctor service programs in medical or dental underserved areas for one year or longer and who elect residency training in primary medical care or general dentistry programs approved by the Secretary would receive an annual grant to cover the full cost of the annual interest during the full period of residency.

(b) Residents in other programs aside from primary medical care or general dentistry who formally agree on completion of residency to serve in the doctor service program in medical or dental underserved areas as approved by the Secretary for one year or longer would receive an annual federal grant to cover fifty percent of their annual interest during residency.

(c) Residents who do not elect primary medical care or general dentistry residency programs and do not elect to serve in medical or dental underserved areas, as approved by the Secretary, would be liable for full annual interest payments during the period of residency.

The schools will establish an area health education center-type program (AHEC), with preparatory features in the programs in the medical and dental schools. The Secretary will provide funds in the amount of up to \$4 million per year for this program.

- 3 -

Appropriated funds for this section would not exceed \$8.0 million per year for the private medical and dental schools in the District of Columbia.

(3) Doctor Service Program

(a) Doctors in the Service Program

Doctors who agree to be in the service program would receive a \$10,000 federal grant for repayment of principal for each year of service they complete in a designated underserved area in the United States as approved by the Secretary, and also for primary medical care/general dentistry service in the Armed Forces, Veterans Administration, Public Health Service, National Health Service Corps or other federal programs approved by the Secretary. (These doctors would not be eligible for the additional special benefits associated with these programs.)

The federal one hundred percent interest grant payment per year will continue for those physicians and dentists participating in the doctor service program.

(b) Doctors not in the Service Program

Doctors who do not agree to be in the service program but who participated in the student assistance program shall begin repayment of the loan, both principal and annual interest, immediately after the completion of residency training. A maximum period of five years will be allowed for repayment. The repayment program will be based on an escalating principal payment program. The doctor who has an annual interest grant but elects not to go into doctor service shall repay over a two-year period to the Secretary of the Department

- 4 -

of Health, Education and Welfare the total accrued interest received in the annual interest program during undergraduate and residency.

Appropriated funds for this section would not exceed \$9.0 million per year for the private medical and dental schools in the District of Columbia.

Principle of Repayment Program

Loan repayment will commence after the completion of the education and residency training programs either by doctor service or out of personal income.

January 30, 1976

GEORGETOWN UNIVERSITY - GEORGE WASHINGTON UNIVERSITY

ESTIMATED ANNUAL FEDERAL COSTS OF PROPOSED MODEL

STUDENT ASSISTANCE PROGRAM

1. Undergraduate Programs Costs

Number of Participating Students = 250 per year x 4 years = 1000.

Student Assistance = \$10,000 per student per year.

Maximum Student Assistance = \$40,000 per student over 4 years.

Federal Interest Grant = \$10 % per year.

(Assuming all students are financially needy)

Maximum Federal Undergraduate Program Cost Per Year = \$3.5 million.

Estimated Federal Undergraduate Program Cost Per Year = \$2.5 million.

2. Residency Program Costs

Number of Participating Residents = 250 per year x 3 years = 750.

Federal Interest Grant = 10% per year.

Maximum Federal Interest Grant Per Year = \$4.0 million.

Estimated Federal Interest Grant Per Year = \$3.0 million.

Maximum Federal AHEC Program Cost Per Year = \$4.0 million.

Estimated Federal AHEC Program Cost Per Year = \$3.0 million.

Maximum Federal Residency Program Cost Per Year = \$8.0 million.

Estimated Federal Residency Program Cost Per Year = \$6.0 million.

- 2 -

3. Doctor Service Program Costs

Number of Participating Doctors = 250 per year x 3 years = 750.

Federal Grant for Repayment of Principal Per Year = \$10,000 per doctor.

(Assuming average length of doctor service = 3 years)

Federal Interest Grant = 10% per year.

Maximum Federal Principal Cost Per Year = \$7.5 million.

Maximum Federal Interest Grant Per Year = \$1.5 million.

Maximum Federal Doctor Service Program Cost Per Year = \$9.0 million.

Estimated Federal Doctor Service Program Cost Per Year = \$8.2 million.

Total Federal Costs

Maximum Total Federal Costs Per Year = \$20.5 million.

Estimated Total Federal Costs Per Year = \$16.7 million.

The George Washington University School of Medicine
Statement of Revenues and Expenses
Fiscal Years 1970 Through 1975

<u>REVENUE</u>		<u>1970-71</u>	<u>1971-72</u>	<u>1972-73</u>	<u>1973-74</u>	<u>1974-75</u>
<u>Tuition and Fees</u>		\$ 1,052,100	\$ 1,374,729	\$ 1,921,763	\$ 2,584,941	\$ 3,003,163
<u>HMO & Community Care Programs</u>		141,335	160,097	279,038	308,448	555,709
<u>Sponsored Research</u>		5,114,817	5,483,916	6,194,194	6,508,172	7,981,746
<u>Capitation</u>				911,855	1,047,290	1,104,798
<u>Education and Development</u>		181,869	175,873	447,985	621,342	741,857
<u>Endowment</u>		149,740	146,009	144,107	162,390	127,298
<u>Student Aid</u>				135,040	125,507	114,214
<u>Other</u>		281,442	259,747	247,235	208,996	155,692
<u>TOTAL REVENUE</u>		<u>\$ 6,921,303</u>	<u>\$ 7,610,371</u>	<u>\$10,281,217</u>	<u>\$11,567,086</u>	<u>\$13,784,477</u>

EXPENSES:

<u>Regular Operations Funds</u>		\$ 4,545,098	\$ 4,678,331	\$ 6,134,937	\$ 8,326,049	\$ 9,654,394
<u>Sponsored Programs</u>		4,531,664	4,719,332	4,931,213	5,326,070	6,821,944
<u>TOTAL EXPENSES</u>		<u>\$ 9,076,762</u>	<u>\$ 9,397,663</u>	<u>\$11,066,150</u>	<u>\$13,693,119</u>	<u>\$16,276,338</u>
<u>DEFICIT</u>		<u>\$ (2,155,459)</u>	<u>\$ (1,787,292)</u>	<u>\$ (784,933)</u>	<u>\$ (2,126,033)</u>	<u>\$ (2,491,861)</u>
<u>ENROLLMENT</u>		445	464	516	564	591
<u>DEFICIT PER MEDICAL STUDENT</u>		\$ 4,844	\$ 3,852	\$ 1,521	\$ 3,770	\$ 4,216
<u>SPECIAL GRANT RECEIVED</u>		1,900,000	2,100,000	750,767	2,202,312	2,900,000

D80:91s
2/27/76

The George Washington University Medical Center
 School of Medicine and Health Sciences
 Financial Operating Information FY 1977

	FY 1976-77 <u>Budget</u>
<u>REVENUES:</u>	
Tuition and Student Fees	\$ 4,875,000
Patient Care	1,234,106
Sponsored Programs	10,168,170
Capitation (carry forward)	600,000
Education and Development	817,500
Endowment	96,800
Student Aid	126,000
Gifts and Miscellaneous	90,000
Faculty Affiliation	51,400
<u>TOTAL REVENUE</u>	<u>\$18,058,976</u>
<u>EXPENDITURES</u>	
Educational Programs	\$ 4,842,997
Patient Care	1,156,567
Sponsored Programs	8,228,500
Education and Development	817,500
Library	386,000
Student Aid	126,000
Direct Administration and Support	828,388
Medical Center Services	1,293,973
University Services	979,657
Operation and Maintenance of Plant	2,380,699
<u>TOTAL EXPENDITURES</u>	<u>\$21,040,281</u>
<u>DEFICIT</u>	<u>\$(2,981,305)</u>
ENROLLMENT	600
DEFICIT PER STUDENT	\$ 4,968.84
REQUIREMENT FROM D.C. MANPOWER BILL	\$ 2,981,305

Statement of John P. Utz, M.D., Dean, Georgetown University School of Medicine.

Mr. Chairman and members of this Committee, I am

John P. Utz, M.D., Dean, School of Medicine at Georgetown University.

I should like to thank the Chairman of this Committee for the opportunity of appearing before it.

In my testimony I should like to emphasize four points.

I. Increasing Student Body.

Last year, May 1975, Georgetown University School of Medicine graduated its first class of 205 students, the goal to which we aimed in 1967 in response to the N.I.H. supported Physician Augmentation Program, and the demands by the American people, as well as by the Congress for increasing number of graduating physicians. This number represents an increase of 77% from the class size of 116 in 1967. Georgetown thus became the second largest medical school among private universities and the eighth largest in the nation. This increased size, furthermore, was achieved at efficiency of operation such that the faculty was increased only 45% from 236 to 344 during the period described.

II. Increasing Tuition

During the same time framework, 1967-1975, Georgetown's students have been asked to bear an increasingly heavy burden

of the total cost of their education. In 1967 tuition was \$1800, whereas in 1975 students were required to pay \$5000. The greatest part of this increase has occurred over the past three years when for senior students tuition has almost doubled from \$2600 to \$5000. Georgetown is proud that so far no student has had to withdraw from school as a result of inability to pay this increasing burden. However, an increase in student aid has lagged far behind the increase in tuition partly because of the lack of endowment for the School of Medicine. Much of the total assistance available to medical students, estimated over \$1,000,000/year currently, comes from private loan sources outside of the School, which for the most part the students have arranged themselves. In addition, many students have volunteered for the Armed Forces and Public Health Service Corps, an indication of their interest in serving this country, but parenthetically also of need for their tuition support. In fact Georgetown is second in the nation among Schools of Medicine in numbers of students (54) who currently hold Public Health Service Scholarships.

III. Georgetown, A National School

Students from 24 of our 50 states were admitted in Georgetown's first-year class last August 1975. Forty-six students were residents of New York, 26 of New Jersey, 17 of

California, 16 of Connecticut and 12 of Massachusetts. Furthermore, 109 schools of undergraduate study were represented in that class.

IV. Georgetown, A District of Columbia School

In the first-year class admitted in August 1975, 12 students are District of Columbia residents. An even greater number, 18, were offered acceptances by us but for a variety of reasons elected to attend other schools. Additionally the proportion of D. C. residents accepted as a ratio to applicants is far greater (one of seven) than the similar ratio (one of 25) for all other students. Last year of the 177 residents of the District of Columbia who applied to all schools, 111 applied to Georgetown. In addition, Georgetown seeks to accept applicants from the metropolitan area: 33 residents of Maryland and Virginia were among the first-year class.

The School of Medicine is actively encouraging the application of minority students and is handling their applications in an especially affirmative way. The percentage of minority students, six percent of last year's freshman class, is approximately equal to the overall medical schools average. Georgetown's high tuition, especially when contrasted to that in their state schools, and scarcity of student aid support doubtless

act as a strong deterrent to many minority students.

For the record, I am pleased to provide, as an attachment, a copy of the School of Medicine Budget for the fiscal year July 1, 1976 - June 30, 1977, which illustrates the need for continued D. C. Manpower support.

If there are any questions, I would be pleased to attempt to answer them.

I thank you again for the opportunity of testifying.

GEORGETOWN UNIVERSITY MEDICAL CENTER
FY 1977 BUDGET
SCHOOL OF MEDICINE

Revenue

Tuition and Fees	\$ 4,430,625
Endowment	311,847
Gifts	85,000
Capitation	1,200,000
Sponsored Programs	8,000,000
Overhead Recovery	1,050,000
Affiliated Hospitals	2,168,000
Faculty Practice	3,079,900
Student Aid - Endowment	79,168
Student Aid - Dailey	21,790
Student Aid - HPEA	20,000
Other	67,900
Total	<u>\$20,514,170</u>

Expenditures

Instruction and Research - University	\$12,171,821
Sponsored Programs	8,000,000
Library Support	389,130
Academic Support	289,909
Med. Maintenance	160,000
Student Aid - School	358,210
Student Aid - Dailey	21,790
Student Aid - HPEA	20,000
Crisis Fund	44,728
Sub-Total Direct	<u>\$21,455,588</u>
General Administration	\$ 1,442,628
General Institutional	87,154
Debt Service	160,163
Staff Benefit Adjustment	(60,511)
Student Services	160,662
Physical Plant	1,341,486
ICC Student Aid	81,000
Sub-Total Indirect	<u>\$ 3,158,582</u>
Total	<u>\$24,614,170</u>

Summary

Revenue	\$20,514,170
Expenditures	\$24,614,170
Need from D.C. Bill	\$ 4,100,000
Enrollment	820
Need Per Student	\$ 5,000

STATEMENT OF

Dr. Charles B. Murto, Dean

Georgetown University School of Dentistry

on

H.R. 12132

Emergency Extension of the District of Columbia
Manpower Act (PL 91-650 as amended PL 93-389)

U. S. Senate

Committee on the District of Columbia

Mr. Chairman, and members of this Committee

I am Charles B. Murto, Dean of the School of Dentistry at Georgetown University. My presentation will touch the following points: One, student body and the alumni; Two, the program of the Dental School and community service; and Three, cost of dental education and student aid.

Students and Alumni

Our students, at the present time, are numbered 579 from 31 states including the District of Columbia. The origin of our students, to the larger extent, are from the District of Columbia and the states on the eastern seaboard with the one exception of California which is tied for second in the total number of students enrolled. This large increase in the total number of students in the past several years, has resulted in an increase in the dental resources and it is a direct benefit to the District of Columbia since it allows an increase in dental care by an increase in the outpatient load capacity of the Georgetown University Dental Clinic, as well as providing more dental graduates for the metropolitan area.

Graduates

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 the 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.

Program and Community Services

This is the seventy-fifth anniversary of the founding of Georgetown University School of Dentistry, as it was established in 1901. As I have men-

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tioned before, 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. This new Dental Clinic Building, established in 1971, has 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 now permits a patient load of approximately 200,000 patient visits annually.

In addition to this program at Georgetown University Medical Center, there is a very active program at the District of Columbia General Hospital. Nearly 150 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 two 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. Also, at Veterans Administration Hospital, there are a large number of our faculty who are consultants at that institution and service this hospital. At Childrens Hospital, there is an advanced specialty program and 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 of the District of Columbia.

Costs and Student Aid

The continuing rising costs in higher education, and especially in dental education, is a national fact. 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 for the national scene, 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 costs that accompanies this student increase is rather staggering. In addition, we have been faced with a yearly escalation of the cost of living, which has been especially noticeable in the cost of dental equipment and supplies. Also, 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 the field. Even with this continued increase in the number of Professors at the School of Dentistry, the Evaluation Committee of the Commission on Accreditation for Dental Schools, in their January 1975 Survey, recommended that the numbers of faculty and supporting personnel should be increased in order to meet the needs of dental instruction at this School of Dentistry.

In the current academic year, 54% of our student body are receiving some sort of student aid. This consists of Georgetown University support, support from private sources, federal and state aid in scholarships and loans and, finally, veteran benefits and military and public health scholarships. The

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total amount of financial aid for the School of Dentistry for 1975-1976 is \$1,884,910. However, I must point out that some of these loans that were available to our students at an interest rate of 11% have now been discontinued, effective June 30, 1976.

Finally, my more than ten years as Dean have been very rewarding. We have an excellent Dental School that is fully accredited by the Commission on Accreditation of Dental Schools. I have attempted to conduct a modest operation to conserve our resources as much as possible. Funds from this Bill are absolutely essential so that we can continue our effective educational program and not burden our students with a towering amount of debt as they enter their professional career.

A summary of the revenue and expense budget for Fiscal Year 1977 is attached showing the anticipated deficit.

GEORGETOWN UNIVERSITY MEDICAL CENTER
FY 1977 BUDGET
SCHOOL OF DENTISTRY

Revenue

Tuition and Fees	\$2,843,750
Endowment	76,416
Gifts	50,000
Capitation	800,000
Sponsored Programs	620,239
Overhead Recovery	120,000
Dental Clinic	1,498,000
Student Aid - Endowment	1,012
Student Aid - Dailey	14,527
Student Aid - HPEA	20,000
Other	2,900
Total	\$6,046,844

Expenditures

Instruction and Research - University	\$4,504,069
Sponsored Programs	620,239
Library Support	138,975
Academic Support	61,268
Med. Maintenance	175,000
Student Aid - School	226,473
Student Aid - Dailey	14,527
Student Aid - HPEA	20,000
Crisis Fund	52,835
Sub-Total Direct	\$5,813,386
General Administration	\$ 372,177
General Institutional	52,399
Debt Service	181,981
Staff Benefit Adjustment	(15,090)
Student Services	86,312
Physical Plant	1,308,679
ICC Student Aid	47,000
Sub-Total Indirect	\$2,033,458
Total	\$7,846,844

Summary

Revenue	\$6,046,844
Expenditures	\$7,846,844
Need from D.C. Bill	\$1,800,000
Enrollment	600
Need Per Student	\$ 3,000

STATEMENT OF JOHN BARRASSO, MIKE MADDEN, MIKE NIEDERMEYER, SCOTT BARNHART, AND ROBERT SIDDOWAY, STUDENTS OF GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE AND DENTISTRY, AND THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

The CHAIRMAN. I note that we have what appear to be medical students in the audience today. I wonder, do you gentlemen have a spokesman or one or two or three of you that would come up? I have a couple of questions to ask you. If we had enough chairs I would call you all up, but there are only five or six chairs there.

I believe that you do have a prepared statement for the record—the statement of the students of Georgetown University Schools of Medicine and Dentistry and the George Washington University School of Medicine to the U.S. Senate.

Mr. BARRASSO. Yes, Senator.

The CHAIRMAN. And your spokesman is to be John Barrasso.

Mr. BARRASSO. Yes; I am John Barrasso, Senator.

We have students here from Georgetown and George Washington this morning. I would like to go down the table and have them each identify themselves and their States.

The CHAIRMAN. Spell your name for our reporter here, will you, sir?

Mr. MADDEN. Mike Madden, M-a-d-d-e-n, from Oklahoma.

Mr. NIEDERMEYER. Mike Niedermeyer, N-i-e-d-e-r-m-e-y-e-r, from the State of Missouri.

The CHAIRMAN. I know why they picked you. You are the guy who is going to reach me.

Mr. NIEDERMEYER. That is right, sir.

The CHAIRMAN. All right.

John, where are you from?

Mr. BARRASSO. Pennsylvania.

Mr. BARNHART. Scott Barnhart, from New York, B-a-r-n-h-a-r-t.

Mr. SIDDOWAY. Robert Siddoway, S-i-d-d-o-w-a-y, from Utah.

The CHAIRMAN. Why is it that not one of you students is either from Maryland, Virginia, or the District of Columbia?

Mr. BARRASSO. They are here.

A VOICE. Maryland.

The CHAIRMAN. Yes; but still not one from the District—interesting.

Your full prepared statement will be made a part of the record.

[The prepared statement follows:]

STATEMENT OF THE STUDENTS OF GEORGETOWN UNIVERSITY
SCHOOLS OF MEDICINE AND DENTISTRY AND
THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE
TO
THE U.S. SENATE, COMMITTEE ON THE DISTRICT OF COLUMBIA
April 29, 1976

I am John Barrasso, a second year student at Georgetown University School of Medicine and Vice President of the student body. With me is Andrew Filak, a second year student at George Washington University School of Medicine and a Representative of the Student Council. We are here today to speak on behalf of the medical and dental students at Georgetown University and the medical students at George Washington University in support of an emergency one-year extension of the District of Columbia Medical and Dental Manpower Act.

There are currently 2,000 medical and dental students from 48 states attending Georgetown University and George Washington University. Many families from across the country have made considerable sacrifices over the years to save sufficient amounts of money so that their sons and daughters would be able to afford the best education possible. Unfortunately, a great number of these students who have devoted many years to their studies are now having their futures jeopardized for purely financial reasons. Many students have already voluntarily joined the armed services or the Public Health Service but there is only a limited number of such service related scholarships available. This year over 3,000 medical and dental students across the country applied for the 900 available Public Health scholarships. A sizable percentage of this applicant pool was from Georgetown University and George Washington University. In addition, very few awards were granted to first or second-year students. Therefore, without this proposed one-year extension of the District of Columbia Medical

and Dental Manpower Act, tuition will increase in the Medical Schools to in excess of \$10,000 and in the Dental School to in excess of \$7,400, and approximately 50% of all current students will be forced to discontinue their education because of the lack of available sources of funding.

The students realize that this one-year extension is only a temporary solution to the very serious problem of financing medical and dental education. We support the extension because it will allow the school's administration the time to establish a permanent loan program where the students will ultimately pay the entire cost of their medical or dental education.

By adopting the emergency extension of the Medical and Dental Manpower Act of the District of Columbia, you will enable the current students to spend more time concentrating on becoming skilled and competent physicians and less time worrying about the ramifications of an increasing tuition. As you may know, the students of Georgetown University spent the day of January 28, on Capitol Hill talking to their respective Representatives with regard to H.R. 12132. While it was an enjoyable and educational experience for many of the students, these students are in Washington to learn medicine and not to lobby members of the Congress. We are here today to present the students' case to you. We hope you will carefully consider the consequences which your decision regarding this piece of legislation will have on the 2,000 students and their families. Our entire lives are invested in our education and our ultimate fate lies in your hands.

Thank you for this opportunity to testify in support of H.R. 12132.

MANDATE INCLUSION OF MINORITY GROUPS

The CHAIRMAN. We have five witnesses here. They are all white.

What do you think is sound public policy for the Nation as a whole, and specifically for a medical school in this country? Should there not be a very aggressive and affirmative action plan which would, to be blunt about it, mandate the inclusion of x percent of a particular minority group in a given medical school class, and which would by the nature of the program deny admittance to white students who might be academically superior at the time of the admittance, but nevertheless would not get a slot because a minority student was allocated to the slot?

Do you get what I am saying?

Mr. BARRASSO. Yes, Senator.

Mike and I were in the Senate for hearings for the committee, of which you are a member, of the Health Subcommittee in the Senate, Senator Kennedy's committee, on October 30, and the American Medical Student Association testified that day to increase the number of minority slots in the country to a minimum of 15 percent of all positions. The purpose there in terms of priorities for students over other students is basically the health care of the people in the United States. There is a very specific and significant problem with maldistribution both by specialty and by geography now in this country, and it is the time where there are 50,000 qualified people applying for 15,000 medical school spots each year and it is time that the admission criteria is used to try and alleviate some of the problems of the health care industry in this country.

Mr. MADDEN. I think on a personal note, John and I last spring while we were over in the House, we learned that they would have prohibited racial discrimination, as far as affirmative-action-type thing, that now occurs among the poor people.

SUBSCRIBE TO AFFIRMATIVE ACTION

The CHAIRMAN. So, basically, you subscribe to affirmative action, as I described it.

Mr. MADDEN. Right.

Mr. BARRASSO. And we are working now with the Student National Medical Association, which is an association of basically minority medical students.

The CHAIRMAN. What about your younger brothers from your own personal families, who might be denied admittance to the very schools where you are going with academic records superior to a black student that was admitted?

Mr. MADDEN. They may have a different academic record, but I think that people have to consider that an academic record is not the only thing that admissions policies look at. There is a lot more than being a physician, and a good physician, for the community that one services than just your academic record and I think those are the important things. That is what I try to count. And I work with some undergraduates at Georgetown who, you know, because of their different status, have difficulty understanding my position.

The CHAIRMAN. Would your explanation satisfy your younger brother when he was denied admittance?

Mr. MADDEN. I am not so sure it would satisfy him. I think it is the proper viewpoint to have.

KENNEDY HEALTH MANPOWER BILL

The CHAIRMAN. Are you familiar with the contents of the Kennedy health manpower bill?

Mr. BARRASSO. We are very familiar with them, Senator; yes, sir.

The CHAIRMAN. But what are your views with respect to the obligatory service for a medical school graduate if that student availed himself of Federal assistance during his tenure at the school?

Mr. BARRASSO. Yes, Senator, we are certainly strongly in favor of that. We have testified, and my testimony relates to the National Health Service Corps and the armed-services-type scholarships.

This year, unfortunately, there is only funding for 900 such service-related scholarships in the country and over 3,000 people applied. Ten thousand wrote in for applications, and when they heard there were only 900 scholarships available a number of them did not apply. But we testified in the Senate to increase that drastically, and the Senate did increase the number of positions available. So we are strongly in favor of any service-related scholarship programs.

The CHAIRMAN. Assuming that the Kennedy Health Manpower Act in some form or another becomes law, and assuming that more Federal dollars are pumped into the program to make scholarships and student aid, loans, et cetera, more readily available, do you think it is fair that if Nelson Rockefeller's son is admitted to Harvard Medical School and Vice President Rockefeller picks up his full tuition, that at the end of his medical training he is not obliged to render any public service in an area of medical need, but you, maybe, who availed yourself of the aid fund would be so obliged? Is that fair in the United States of America?

Mr. BARRASSO. The most equitable solution would be a mandatory service for all medical students, which Senator Kennedy's Health Subcommittee and full committee endorsed 2 years ago, which was defeated on the floor of the Senate. And as you say, we are dealing in a practical world, not in a pure world. So I do not think that is going to be happening.

The CHAIRMAN. I voted against the Kennedy proposal last year for several reasons, but it is very interesting.

Mr. BARRASSO. Also in terms of the Kennedy proposal, there is significantly less money in that proposal than in the Rogers' passed bill in terms of money for minority students and minority recruitment in affirmative action programs there. The Rogers' bill called for \$20 million, whereas Kennedy's bill has five programs, it would have to get \$45 million or so.

The CHAIRMAN. Yes.

What are your comments on another controversial provision of the Kennedy bill—by the way I voted for this year's bill, with some reluctance. This year's bill is considerably different from last year's. What about this regional allocation of training spots so as to not end

up with too many neurosurgeons and not enough family practitioners?

Mr. BARRASSO. Currently there are about 1.7 positions available in the country in terms of residency positions for every graduate, so that a graduate can go into any specialty without much difficulty. The Kennedy proposal is to limit that number to 1.1 spaces per people and distribute them. The main purpose is to get rid of the number of surgical residencies and to increase the number of family practice residencies.

There are certainly limitations on the freedom of a person in terms of what they want to do for a living because of this limiting the number of positions. But if we are talking about the general health care of the people of the United States, this kind of redistribution is certainly necessary.

The CHAIRMAN. Would you say that that viewpoint that you have expressed is the prevalent viewpoint at your two universities amongst the students?

RESIDENCY PROGRAMS

Mr. NIEDERMEYER. I would have to say that, you know, there are a lot of differences in opinion on a lot of these things, to be perfectly honest. Some of the questions about limiting residency programs, I think today, everybody would agree that there is a greater need for family practitioners, and yet without limiting residency programs I believe somewhere around 50 percent of last year's graduating class at Georgetown has moved into either family practice residencies or general internal medicine. And I think that students without the pressure from legislation are starting to, in some measure, moving to the areas where they need doctors without the pressure of legislation.

The CHAIRMAN. My brother is a doctor. But when does the student of today's medical school make the irrevocable choice as to his specialty? How far along in the academic training? Is it the second, third, fourth year, or what?

Mr. BARRASSO. That is during the fourth year of medical training Senator Eagleton. At that time, students enter into what is called the national intern resident matching program, where they travel around the country and see residency positions in different hospitals, and in different specialties, and then file into a computer a list of their preferences, and the schools also cross index them and the computer spits out where you go and in what residency.

The CHAIRMAN. So by the time of completion of your third year but before you have gone into your fourth year you have to have some feel for the situation as to where you can train thereafter. Is that right?

Mr. BARRASSO. Well, during your third year you rotate through a number of different specialties and general practice areas as part of the curriculum, and then you get a better feeling then as to what you like and what appeals to you. And then it is during the middle part of your fourth year in medical school that you have to make the final decision.

The CHAIRMAN. Of the five who are before us at this table, how many of you plan to be active in vigorous participation in the AMA?

Mr. MADDEN. I would think that I would probably become a member.

The CHAIRMAN. Well, I will rephrase both questions. How many plan to be a member? I threw you a curve ball. I belong to the American Bar Association.

But my question was how many of you plan to be active and vigorous participants in the AMA as you now know it to function?

Mr. MADDEN. Well, as I now know it to function, the reason that I would become an active member and a participant is that I would hope that I could, by becoming an active participant, influence their decision now and then and policy form. Although I do not agree with a lot of the things that they say, I would think that the only way that I would be able to change an organization, that is supposedly representing me, is to become an active participant in it.

ATTITUDINAL MENTALITY

The CHAIRMAN. That is a very good answer.

This is very general, and I am interested in this area, do you think that today's medical student—you are five of them—have a somewhat higher degree of societal conscience than the medical student of 20 years ago? Has the mentality—not just the academic mentality, not the intelligence portion—but has the attitudinal mentality of a medical student changed in the last 10 to 20 years?

Mr. BARNHART. I could speak for George Washington. I think very much so. In fact, presently, we are starting up an elected form dealing in the humanistic medicine area, and there are students from both Georgetown and G.W. going this weekend to a retreat that will deal with humanistic medicine, and needs of patients individually, and also the need for physicians to be really responsible as healers and not just to use medicine as a way to make a living.

NATIONAL HEALTH INSURANCE BILL

The CHAIRMAN. Have you gentlemen considered the Kennedy national health insurance bill, a very complex bill? It has lots of provisions but have you examined it in its broad brushed concept? And if you have, what are your general observations on the bill as a package?

Mr. BARRASSO. It is a pretty lengthy piece of legislation, and there are many feelings that nothing is going to be resolved, certainly this session and for a number of sessions to come.

The CHAIRMAN. That is true.

For what it is worth, I do not support that one either, but go ahead.

Mr. BARRASSO. I guess I do not understand the whole tax base of how they are going to go with the funding and what that is going to do with the country. But it looks like the type of thing where Senator Kennedy is proposing where you are going to really commit yourself to the American people and to their health needs. And if we are going to do something that is going to help the people along those lines, well then we are for something like that, in theory at least. And whether you get into the specifics of the tax base and the funding, that we are not clear on.

The CHAIRMAN. It is very clear is it not, that the health care is a national problem, and it is not just a private personal matter between a

citizen and his doctor? Would you subscribe to that fact? It is a national problem that has national implications.

Mr. BARRASSO. Well, certainly. Yes, I think we all would.

The CHAIRMAN. Do you gentlemen have anything else you would like to add?

I have enjoyed this very much and I find it very interesting. If there is anything you would like to add we would be glad to hear from you.

PUBLIC HEALTH SERVICE SCHOLARSHIPS

Mr. BARNHART. Mr. Chairman, if I could just bring up one more point. I just really wanted to point out that the students have formed a common bond on the Nation's health care needs. I remember in my first year when I was at George Washington University a fairly large number did apply, against the advice of the U.S. Public Health Service, for their scholarships, to specifically serve in primary-care capacities in shortage areas, and none of us received scholarships this year. And so people have tried to begin to meet the Nation's needs and we find that they are wrong.

The CHAIRMAN. Well, I think that is a very appropriate point. And Congress will at times criticize all other people, and private universities, and what have you, but then we have to say, by the way, we did not appropriate enough money to have the programs work anyway. So you cannot criticize on the one hand and underfund on the other hand if you are going to be intellectually consistent.

Mr. MADDEN. As far as I know, and I think my information is correct, Georgetown supposedly has the highest number of people on Public Health Service scholarships in the country.

Mr. BARRASSO. And Georgetown was the highest in terms of people that applied this year and Goerge Washington was second in the country in that respect.

The CHAIRMAN. I have a prepared statement here of Senator Mathias that will be printed at an appropriate point in the record. He regrets that he could not be here. He is attending another hearing. He thought maybe he could be here by now, but the other hearing has gone longer than he anticipated.

[Senator Mathias' prepared statement follows:]

STATEMENT OF CHARLES McC. MATHIAS, JR., U.S. SENATOR FROM THE STATE OF MARYLAND

I commend the chairman for promptly scheduling this hearing on H.R. 12132, the extension of the District of Columbia Medical and Dental Manpower Act of 1970.

The problems we face, should this bill fail to be enacted, are apparent to all. Simply stated, the medical and dental schols of Georgetown University and George Washington University will have to cease operation. The impact of these closures, however, extends beyond the two institutions. Fourteen hospitals in the National Capital region will be affected as well because of their dependency upon Georgetown and GWU for staff and programs. I would point out also, that my

State, of Maryland will feel the impact severely. A report was furnished to me by the University of Maryland School of Medicine regarding the medical school tuition crisis at Georgetown and GWU.

I ask unanimous consent that the complete report be made a part of the hearing record.

I would note, Mr. Chairman that this may well be the last time that the Congress will be called upon to enact legislation of this type for Georgetown and GWU. Both institutions, I understand, are now committed to seek alternate funding sources for fiscal year 1978. Therefore, the action we are being requested to take may be viewed, perhaps, as the final step by the Congress. This step must be taken. To do otherwise, in my judgment, raises a specter too horrible to imagine.

[The report referred to follows:]



UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE
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THE MEDICAL SCHOOL TUITION CRISIS

Various rumors relating to a crisis in medical school tuitions have arisen in the past several months. Most of the rumors are only approximately true—that is most tuitions are going up next year. For the most part these increases reflect the nationwide inflationary trend. There are, however, some factors which have spawned rumors indicating a tuition crisis.

Many schools are resisting some of the provisions in the, as yet not enacted, health manpower bill before Congress. If they do indeed decide that compliance with the requirements is not in their best interest they may have to replace to some degree the Federal subsidy they currently receive. The University of Maryland is not one of those contemplating dropping out of the Federal Program.

Another factor feeding the rumor mill is the impending plight of the schools in Washington which, without some immediate federal relief, will have to double their tuitions next year. Several inquiries have been directed at the University of Maryland, School of Medicine regarding our position in the matter and our ability to step in and accept transfers from schools whose tuitions force Maryland residents to drop out of school. The following is a brief analysis of the situation at Maryland and in the District of Columbia.

The tuition of this medical school has not been increased for two years. This year the Board of Regents is recommending an increase of \$150.00 (per year) but no increase in fees for Maryland residents. Our tuition and required fees and changes contemplated are as follows:

	<u>In State</u>	<u>Out of State</u>
Tuition 1975-1976	\$1,200.00	\$3,000.00
Fees	<u>123.50</u>	<u>123.50</u>
Total	\$1,323.50	\$3,123.50
Proposed Increases in Tuition	<u>150.00</u>	<u>375.00</u>
Total	\$1,473.50	\$3,498.50

Except for a few state schools (California, Kentucky, etc.) this is an extremely low rate. The New York State schools are currently projecting tuitions in the neighborhood of \$5,000.00 while those in the City proper anticipate their rates will climb to \$6,500.00 or \$6,700.00 next year.

The question regarding the financial plight of the medical schools in the District of Columbia is a complicated one. The basic problem lies, I suppose, in the fact that the George Washington and Georgetown Universities, while basically private institutions, have over the last decade or so become the District's medical schools, along with Howard. Unlike other "public" schools, however, they do not have a State legislature and budgetary process to turn to for funds. Thus, they have been heavily subsidized by the Federal Government. Six years ago the Congress passed the D. C. Medical and Dental Manpower Act. This act provides an annual subsidy to these schools of \$5,000 per student per year and involves the expenditure of some seven million dollars annually. The Act expires in June of 1976 and without a renewal the school's are faced with the prospect of having to raise tuitions substantially. Both Schools of Medicine project that without federal help they will have to charge tuitions of \$ 10,000 or more per year. The Office of Management and Budget has made it known that it will oppose any renewal of the Act, thus making the prospects of these astronomical tuitions a very real possibility.

The second part of the question is will the University of Maryland, School of Medicine, accept transfers from these schools in the event the worst happens, and if so, what sort of supplemental funding would we require to accomplish this move? This is a very difficult question to answer. There are currently enrolled in the two schools 189 Maryland residents as follows: 52 in the first year, 46 in the second, 41 in the third and 50 in their final year. We can disregard the seniors but at the same time must assume some Maryland residents will appear in the first year class next fall. However this works out, we can assume that there will be something like 180 students involved. If we were to accept all these students or even a major portion of them our enrollment would leap from a projected 675 with an entering class of 175 to perhaps 860 with an entering class of 225. There are several major problems such a move would create.

1. We do not have the faculty, space or funds to absorb this sort of increment. Without a considerable lead time the task simply could not be done. There will be no lead time (see below).
2. Our current first year class of 175 will be selected from 851 Maryland residents who have applied to us. If we turn down 676 students because we have no space and then subsequently agree to accept an additional 50 students there will be loud cries of "foul"—which in all candor, I believe will be justified.
3. Generation of a budget through a supplemental asking of \$1,750,000 (\$10,000 x 175) will be an extremely difficult undertaking with, I expect, a low probability of success.
4. The decision regarding the doubling of tuitions by the D. C. Schools cannot be made until the expiration of the Act and all hope for some other form of relief fails. That will be July or August. This creates two separate but related problems.

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- a. There will not be time to establish the mechanism at Maryland for transfers, hire the extra faculty, prepare space and receive the funds. The situation will be chaotic and probably disastrous.
 - b. Even if we were to pull it off, we would at the same time strip the two schools of a substantial number of their students—who could not be replaced and who would, by leaving, exacerbate the financial plight of the schools. It would probably result in either the complete collapse of these schools or a Federal takeover—neither of which is a happy prospect.
5. We have made a major commitment to use our transfer places for COTRANS students (Maryland residents studying in Foreign Medical Schools). We believe we have something of an obligation to bring as many of these students back as possible. At any rate—most of our available places are already committed.

insert The problem is further compounded by the fact that the Washington schools are a major source of physician manpower for the State. Fifteen percent of all physicians currently practicing in the State are graduates of Georgetown, George Washington or Howard. The loss of these schools through closure or because our students can no longer attend due to financial pressures would be equivalent to reducing the enrollment at Maryland by 25% or 50 students per year, perhaps 190-200 overall. The Washington schools must be viewed as a major manpower resource for the State and any failure they incur will have substantial effects on the State.

Finally, the cooperative arrangements developed over the years between the 114 medical schools represents a significant portion of the fabric of health education. Any attempt by one school, however well-intentioned, to contribute to the problems of another—particularly if the possible demise of the second is at issue—is simply not done. Aside from the breach of trust and ethical questions involved, there is the real possibility of our accreditation being jeopardized. (Let me add I believe the trust and morality issues to be of far greater importance.)

Given this array of rather formidable constraints and compounding problems it seems to us the correct approach to this problem would be as follows:

1. That every effort be made by the State (members of legislature, the Governor's Office and the State's two medical schools) to urge the Maryland Congressional Delegation to use their influence to enact a new D. C. Medical and Dental Manpower Act or its renewal or at least a continuing resolution.
2. Failing that, the Schools of Medicine at Maryland and Hopkins make an attempt to accept those transfers it can—within the capacity of the schools and recognizing the fiscal problem of the D. C. schools and,
3. The State, through a supplemental appropriation, replace the Federal subsidies for Maryland Residents enrolled at the time (including the entering first year class.) These subsidies would be phased out over a four year period—or until the first year students had graduated as follows:

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- a. Students who cannot transfer and who have a demonstrated need will receive tuition subsidies of \$5,000 per year until they graduate.
- b. These subsidies will be paid as loans—repayable at prime interest or
- c. Will be excused if the student serves two years or some specified period to time in a medically underserved area in the State of Maryland.

I confess the analysis presented is sketchy at best and the solution perhaps suspect but given all the options and problems I believe this to be the best solution to a most difficult problem. The key factor in all of this is, of course, whether the subsidy act will be allowed to expire.

Frederick J. Ramsay, Ph.D.
Associate Dean and Director
Office of Governmental Liaison

FJR:pb

December 22, 1975

Mr. NIEDERMEYER. Senator, I would just like to add that we really appreciate the opportunity to testify before your committee today. Most of us right now had to cut classes or other activities to come down here. Basically, we tried to be a representative group, but these were the students that could get away from their regular curriculum, and we just knew, of course, that some of the Senators on the committee were going to be talking today. So we came down.

The CHAIRMAN. Well, it has not been a total loss. A morning with Eagleton transcends a morning with your pathology professor. At least I am a breathing cadaver.

All right. The committee will conclude its hearings on this matter. We will poll the bill out of the committee and I will vote for it.

A number of prepared statements have been submitted and they will appear in the record at the conclusion of the hearing.

The committee is adjourned.

[Whereupon, at 11:10 a.m., the hearing in the above-entitled matter was adjourned.]

[The prepared statements referred to follow:]

STATEMENT OF
THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS
AND
THE AMERICAN DENTAL ASSOCIATION
ON
H.R. 12132
BEFORE
THE COMMITTEE ON THE DISTRICT OF COLUMBIA
UNITED STATES SENATE
APRIL 23, 1976

Mr. Chairman and Members of the Committee:

The American Association of Dental Schools and the American Dental Association appreciate the opportunity to present this statement in support of H.R. 12132, a bill to extend the D.C. Medical and Dental Manpower Act of 1970.

Mr. Chairman, our nation faces serious health care problems caused by factors which are complex and often interrelated. And while all of these problems cannot be solved solely by modifications in the educational process, health educational institutions can play an important role in their resolution. Dental schools are national resources and, as such, bear a special responsibility to help assure that an adequate number of quality trained practitioners is available to meet the dental care needs of our country now and in the future. In addition, in the process, dental schools are expected to provide important resources to the communities in which they are located. But to fulfill these national and local needs, schools must be financially

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stable. It is obvious that if a school is unable to maintain its stability, it will not be in a position to accomplish any of these objectives.

Unfortunately, the financial stability of many schools has become a serious national concern. Larger student enrollments, prompted by previous federal legislation and accompanied by a continued reduction in federal support, have created financial problems in many dental schools. This reduced support has come at a time of high inflationary rates, spiraling maintenance costs, and an ever-growing need for a sophisticated base of knowledge that a health professional must have in order to give modern, high-quality care.

However, while educational costs are rising at an alarming rate, a school's ability to meet these increases is not. A dental school's sources of income are not limitless. Most schools are faced with two alternatives: increase tuition to a level which would effectively restrict future enrollment to students from wealthy families or reduce the quality of programs, the programs themselves, the number of faculty members and, perhaps, enrollment. (We see neither of these alternatives as being in the national interest.) While most schools face these difficult choices, the situation is particularly severe for those dental schools

affiliated with private universities, and it is becoming increasingly more difficult for these latter schools to meet their responsibilities.

There is increasing recognition that dental education should receive a greater share of public support. Dental education is being viewed more and more as a public responsibility. Since 1950, fifteen dental schools have been established; but, of these, all but two have been established in the public sector. There are now thirty-five public dental schools in this country and twenty-four private. However, of these private schools, ten are classified as private-state-related, which is to say that these schools receive some form of state aid. It is safe to state that of the fifty-nine U.S. dental schools, forty-five are supported wholly or in part by state appropriations. States are recognizing the need to maintain high quality dental education programs and are providing support accordingly.

Private schools urgently need supplementary assistance to maintain the scope and quality of their educational programs. We strongly believe this assistance must be found, because, in addition to the needed graduates these schools provide, we are convinced that it is better for the nation if our educational system is rooted in both private and public universities. Seven states have already responded to this need by providing assistance to ten of

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the eleven private schools located within their jurisdictions.

With this background, we feel it is appropriate for the District schools to request support from the District of Columbia Committee.

We therefore urge approval of H.R. 12132.



AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 751 6000 • TWX 910 221-0300

PRESIDENT-ELECT

April 14, 1976

RICHARD E. PALMER, M.D.
 Alexandria Hospital
 4320 Seminary Road
 Alexandria, Virginia 22304

Hon. Thomas F. Eagleton
 Chm., Senate District Committee
 Washington, D. C. 20515

Dear Mr. Chairman:

The Medical and Dental Manpower Act is presently before the Senate District of Columbia Committee and I am writing in support of the Medical and Dental Manpower Act.

At the onset, I would like to set forth the official stance of the American Medical Association on this important proposal. We support this legislation with the stipulation that funds made available to the schools in the District of Columbia should not diminish the funds generally available to all other medical and dental schools in the United States.

On the more personal side, I am a graduate of the George Washington University School of Medicine, and received my post-doctoral specialty training at that institution.

The George Washington School of Medicine and the Georgetown School of Medicine are valuable community and national resources. These schools provide, in addition to undergraduate medical education, outstanding programs in graduate medical education, (residency and fellowship programs), in continuing medical education (ongoing education programs and courses for practicing physicians), and training programs for the allied health professions. The schools also operate emergency services on a 24-hour basis and contribute vital inpatient and outpatient facilities and services to meet the needs of the community.

It is unthinkable that these fine schools of our capital city would have to curtail, and possibly cease, their activities for lack of funds.

Mr. Chairman, it only seems proper that these schools be treated by the Federal government in the manner that the state governments treat private medical and dental schools in their respective jurisdictions.

Sincerely yours,

Richard E. Palmer, M.D.

REP:mhw



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*

April 29, 1976
Rm. 6226, Dirksen Senate Office Building

The Association of American Medical Colleges is pleased to be able to testify on P.L. 93-389 and related legislation to extend the District of Columbia Medical and Dental Manpower Act of 1970.

Now in its 100th year, the AAMC represents the constituency of institutions and organizations principally involved in the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 116 operational U.S. medical schools and their students, 400 of the major teaching hospitals and 62 learned academic societies and professional organizations whose members are engaged in medical education and research. The entire medical education community in this country, including the medical schools in the District of Columbia, have a deep and direct involvement with the legislation the committee is considering.

It is important to make clear that the Association strongly supports the adoption of the legislation which the committee is now considering. Such legislation would provide critically needed local support for the private medical and dental schools of the District of Columbia.

It is important to present some background information concerning the broader aspects of the financing of medical education in the United States.

* Presented by the Association of American Medical Colleges before the U.S. Senate Committee on the District of Columbia, April 29, 1976.

The entire structure of medical education, as well as all of higher education in the United States today, is facing difficult and threatening financial problems. The problems of medical education are particularly acute. Medical education, as it has evolved in the United States, has always been the highest cost element of higher education because of the extensive laboratory and clinical care activities involved which require a large faculty and sophisticated facilities. These high costs have now escalated even higher because of the rise in the cost of living. The Consumer Price Index increased 7% during 1975 and 12.2% during 1974.

In addition, the rapid advance of science and technology has changed profoundly the character of medical education, as it has medical care and the entire health care delivery system. 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 obviously added to the costs of medical care, they have similarly added to the costs of medical education.

In addition, medical education now embraces a wide range of tasks and responsibilities. Once confined to the limited task of educating physicians, academic medical centers now have responsibility for major research programs, graduate education (including internships and residencies) in both the basic and clinical sciences, and a growing responsibility for patient care and community services. 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 being directed to the institutions providing medical education for the single function of research.

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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 areas of primary care, family practice and ambulatory medicine. 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 reduction in the amount of federal research funds to medical schools. Although new federal programs were initiated to expand the production of physicians, these new programs have not dealt with the growing instability of the financial base of American medical education. This is the set of problems which today confronts the entire medical education community.

The lack of financial strength has had its 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. Such is the case with both the Georgetown University School of Medicine and the George Washington School of Medicine. Both medical schools are fully accredited. In addition to their substantial contributions in undergraduate medical education, they also provide graduate training and continuing education for physicians in the District of Columbia. To let these two schools of medicine close because of insufficient funds or to force them to raise tuition to a level that only wealthy students could afford, may in the long run be more costly for both the District of

Columbia and the Federal Government because of the very high costs associated with establishing new medical schools as compared to the economies realized by supporting existing schools. The repeated deficits that they and other private institutions have faced have, in many instances, forced the use of endowment capital to cover operating costs.

The prospect of substantial cutbacks in private medical educational programs has resulted in substantial concern on the part of many state governments for the private institutions within their boundaries, because of the valuable asset which an academic medical center is to any given community.

First and foremost, academic medical centers offer the opportunity for medical education to aspiring students, and thus expand the pool of physicians available for medical care.

Secondly, academic medical centers exert an important and pervasive qualitative influence upon medical practice and health services in their communities. They serve as valuable referral centers for specialized services and provide outpatient emergency care for the local community; their educational training programs, including continuing education, assert a widespread influence on the numbers and quality of medical care personnel; and their research programs assist in solving important health problems, as well as serving as an important economic asset.

The value of the private medical school to a local community has been recognized by state governments for some time. In past years, though, many states have been legislatively prohibited from awarding funds to private institutions. Pressures, however, to increase the supply of physicians and concerns about the fiscal viability of private medical schools have resulted in a number of states offering support in the 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. Sixteen of the 27 states with private medical schools provide some form of state aid to the private schools. In fiscal year 1974, a total of \$506.8 million was provided by 45 state governments for the operation of medical schools compared with fiscal 1973's reported total of \$400.7 million. Of the fiscal year 1974 figure, \$44.1 million was made available to 29 private medical schools within the states. Additionally, funds provided through regional compacts totalled \$0.5 million for private medical schools.

These developing arrangements have been reviewed briefly to convey to the committee the growing recognition by 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 (P.L. 92-157), which is still operative under a continuing resolution, provides some institutional support for the regular operating budgets of the medical schools. The capitulation support furnished under the Act, however, is based on the assumption that substantial resources will be available 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.

The Congress of the United States, particularly the District Committee of the United States Senate, 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 therefore that the Congress continue to support the critically important private medical and dental schools of the District of Columbia at a level above and beyond what is provided from the national programs.

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. The Association strongly believes, 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 appropriation process seems to be the only equitable method for Congress to augment, as so many states do for their schools, the financial support given to the District's medical and dental schools.

To implement this additional funding mechanism, the AAMC 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 appropriations legislation of the Departments of Labor and Health, Education and Welfare. It is the Association's recommendation that the receipt of such funds by the District's private medical and dental schools through the Labor-HEW appropriations measure shall clearly

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not affect the eligibility of the District's schools to seek financial distress assistance under section 773 of the Public Health Service Act. The Association's recommendations are designed (1) to 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 maintain the availability of national funds for the District's schools to relieve, if necessary, the financial distress of its institutions of medical and dental education.

STATE ROLES IN FINANCING MEDICAL EDUCATION *

In fiscal 1974, a total of \$506.8 million was provided by 45 state governments for the operation of medical schools (Table 1), compared with fiscal 1973's reported total of \$400.7 million. Of the fiscal 1974 figure, \$462.6 million was appropriated to 67 public¹ or state-related² medical schools located in the states providing the funds. The remaining \$44.1 million was made available to 29 private³ medical schools within the states. Additionally, funds provided through regional compacts totalled nearly \$2 million for public medical schools and over \$0.5 million for private medical schools (Table 2), while other interstate arrangements accounted for an additional \$0.5 million.

Information on the direct state support for fiscal 1974 was reported by medical schools in the Annual Medical School Questionnaire on Financing of the Liaison Committee on Medical Education, administered jointly by the American Medical Association and the Association of American Medical Colleges. Only those funds earmarked for the operation of the medical school were reported, funds for the support of teaching hospitals and special clinics were excluded.

Ranking highest on total support for the public schools was Texas with \$61.7 million reported. Nevada, with only one two-year institution, reported the lowest figure, \$567,000. For states with public medical schools, the mean level of the total direct state support income for public schools was \$10.8 million.

* Journal of Medical Education, Vol. 51, No. 3, March 1976, p. 206 (DATAGRAM)

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Based upon the state support to public medical schools per full-time equivalent (FTE) student, the figures ranged from a high of \$23,687 per FTE student for Massachusetts, to a low of \$1,626 for Virginia. Nine states reported spending more than \$10,000 per FTE student while 17 states spent less than \$5,000 per student. The average support level was \$6,973. Because the medical schools are involved in many activities besides education, the use of funds at the various schools may not be comparable. Generally, the state expenditures exceeding \$11,000 per FTE student indicate new and developing medical schools that require substantial initial operational and facility resources for a limited number of students.

Considerable variation is shown in state support per state resident and per \$1,000 of personal income. This ranged from a high of \$6.68 per state resident in Vermont to a low of \$0.34 in New Hampshire. The mean support per state resident was \$2.37. The expenditures per \$1,000 of personal income again showed Vermont and New Hampshire as having the highest and lowest figures, with Vermont paying \$1.44 and New Hampshire \$0.06. The mean support was \$.48. Vermont's high per capita and per \$1,000 of personal income support levels are a reflection of the state's low population, while for New Hampshire, the low per resident and per \$1,000 income support levels reflect the absence of a public medical school.

Support of Private Medical Schools

In past years, many states have been legislatively prohibited from awarding funds to private institutions. 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 state and District of Columbia programs for the support of private medical schools for years subsequent to fiscal 1974.

California - The state is authorized to contract with its private medical schools to expand class size over the base year 1970-71. For each additional student enrolled, up to \$12,000 will be paid, less the amount of federal capitation. The program is limited to 100 students, with no provision restricting it to state residents. The contract period runs through fiscal 1977.

Delaware: The state contracts with Jefferson Medical College in Philadelphia to accept up to 20 Delaware residents per year. A provision stipulates that a "portion" of the medical students serve their clinical clerkships in the Wilmington Medical Center. The level of support is based upon the cost of educating a medical student at the private medical school, less tuition paid by the student, capitation from the federal government, and the amount of a special appropriation by Delaware to the Wilmington Medical

Center for the support of undergraduate medical education there. At present, the amount of capitation is \$8,000. Legislation increasing the level of support to \$10,000 per student is now pending before the Delaware State Legislature.

District of Columbia: In fiscal 1975, Congress approved legislation extending the authorizations of support on a capitation-like basis to the two private medical schools in the District of Columbia. In the current fiscal year, the authorizations have again been approved for the two private medical schools. The law authorizes a capitation support level of up to \$5,000 for each medical student. Authorizations are in addition to those in any other federal capitation program.

Florida: Final legislation has been enacted in Florida which authorizes capitation levels at \$7,680 in 1975-76. For those students who complete their education in less than four years, \$9,600 per student is awarded. Because of cutbacks in the state budget during the current fiscal year, the capitation amounts were reduced from a previous level of \$8,000 per four-year student and \$10,000 per two or three-year student.

Georgia: The state contracts with the Southern Regional Education Board to provide subsidies to its private school on a capitation basis. Entitlement is earned by increasing the number of students enrolled during previous base years. \$6,500 is awarded for each additional Georgia resident.

Illinois: The private institutions of Illinois continue to receive support provided under the Health Services Education

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Grants Act, enacted in 1969 to increase enrollments in medical, dental, nursing and allied health education programs.

The medical schools are allowed \$6,000 annually for each additional Illinois resident they enroll in the four-year program and \$8,000 for each additional 3-year student they enroll. At least 20 additional Illinois residents must 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 1971, is to be awarded. This grant was contingent upon a commitment by the school to the minimum expansion of 20 Illinois resident students.

A one-time 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 was awarded each year for each enrollee projected above the initial increment of 20 such students.

Louisiana: This state's contract with its private medical school provides a per capita grant of \$5,000 per enrollee, after reaching a base level of 24 students. The awards are limited to a maximum of 50 per year. In fiscal 1975, capitation support totalled \$505,000. An estimate of \$750,000 is expected to be

received in fiscal 1976, pending final action in the state legislature.

Maryland: Legislation was passed in fiscal 1976 to provide \$211,000 for the state's private medical school. On a per capita basis, the school will be awarded \$233. Included in the capitation payments are all registered students: M.D.'s, Ph.D.'s and post-doctoral students. The program is not limited to state residents.

Minnesota: Continuing legislation was approved for fiscal 1975 and 1976 awarding \$8,000 per Minnesota resident enrolled in the state's private medical school. The expansion contract has set a ceiling of 40 students.

New Hampshire: The state provides support to its private medical school on a contract basis by awarding \$5,000 for each student. The school must enroll at least five resident students in each year. The program began in fiscal 1974 with five first-year students and will expand each year until fiscal 1976 when a grant is to be made for a total of 15 New Hampshire residents in each of the three years of the three-year curriculum.

New York: The state of New York through the State Education Department has three types of contractual arrangements with each private medical school in the state: (a) The Expansion Contract awards \$6,000 for every student enrolled over the average of those enrolled during previous base years, 1961-65, with a limit of 25 students per class and a maximum payment of \$600,000. (b) For each student enrolled in the pre-clinical science years, \$1,500 is paid on a per capita (over)

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basis while \$2,500 is awarded for each student in the clinical years. However, when funds from the Expansion Contract are awarded, the capitation payments are not received. Additionally, one-third more capitation aid is made available for three-year curriculum students. (c) The Bundy Plan provides \$3,000 for each M.D. and Ph.D. graduate, and \$600 for each Master's candidate, providing that no assistance was received through the Expansion Contract.

North Carolina: The state contracts with its private medical schools to provide between \$5,000 and \$8,000 for each North Carolina resident enrolled. Five hundred dollars of this \$5,000 per capita awarded must be held in a special scholarship fund for North Carolina residents, leaving \$4,500 for unrestricted use.

Ohio: The state's private medical school received a \$7,997,000 grant for the 1975-77 biennium. The state provides the same level of support to both its private and public medical schools. The private school's net capitation figure is calculated to be the difference between the public and private school's tuition.

Pennsylvania: The amount of the awards measured on a capitation basis for the state's four private medical colleges has been \$4,400 since 1971. Although the state legislature has not yet approved an extension of the appropriations in the current fiscal year, the funding level is anticipated to remain the same.

Rhode Island: Grants provided under the state's medical assistance program have been increased to \$700,000 in the current fiscal

year for its private medical school. This figure compares with previous appropriation levels of \$200,000, \$400,000, and \$600,000 in the fiscal years 1973-75.

No restrictions on the use of this award are made, nor is the grant conditioned upon increased enrollment or the residency of an enrolled student. However, the school is working informally to increase the number of Rhode Island residents to one-third of its total enrollment. At present, one-fourth of the enrollees are state residents.

Tennessee: The state contracts with the Southern Regional Education Board to provide subsidies for one of its two private medical schools. Funds totalling \$45,000 were channelled through the Board in fiscal 1975. Direct subsidies, totalling \$32,750, were made available to the state's other private medical school. Capitation amounts of \$6,500 were awarded for five Tennessee medical students. Legislation to continue the funding program is expected to be renewed in the current fiscal year.

Texas: Enabling legislation was passed to provide \$9,763,538 for fiscal year 1976 to support the private medical school in the state. An informal agreement provides that at least 70 percent of each entering class will be Texas residents. The funds are channeled through a coordinating board which contracts directly with the private medical school.

Virginia: The Virginia state legislature has authorized a capitation support level of \$4,032 for the 1974-76 biennium, with a maximum payment of \$1,000,000. Due to state cutbacks in the budget, however, the capitation payments have been reduced by 5% in the current fiscal year.

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Wisconsin: State appropriations for support of the private medical school in Wisconsin totalled \$2,353,800 in fiscal 1976. An award of \$7,846 per Wisconsin student will be granted provided that a base level of 81 resident students is enrolled. In the succeeding fiscal years, 90 Wisconsin enrollees will be the base figure.

Regional Compacts

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 medical schools. Funds flowing through the boards for contract programs in medicine totalled nearly \$2.5 million for fiscal 1974. Slightly over \$2.5 million was made available for fiscal 1975 (Table 2).

Other Interstate Arrangements

Because North Dakota's medical school is a two-year institution, the state of North Dakota contracts with the University of Minnesota to accept up to 35 North Dakota medical students for completion of the last two years of their medical education. The contract, which was initiated in fiscal year 1975, is not contingent upon the North Dakota students returning to practice medicine in the state. On a per capita basis, the amount of funding for fiscal 1976 is \$14,500.

¹ State owned and supported medical school.

² Private medical school that receives partial state aid. State-appointed officials represent a portion of the medical school's governing board.

³ Privately owned medical school.

TABLE I

STATE FUNDS FOR PUBLIC AND PRIVATE MEDICAL SCHOOLS FOR EDUCATIONAL AND GENERAL PURPOSE PROGRAMS

(Fiscal 1974)

State	Public Medical Schools			Private Medical Schools (Thousands of Dollars)	State Residents	
	Total (Thousands of Dollars)	Per FTE Student (Dollars)	Per FTE Student (Dollars)		Per Resident (Dollars)	Per \$1,000 Income (Dollars)
ALABAMA	11,324	8,850			3.30	.75
ALASKA	3,993	14,899			4.37	.84
ARIZONA	3,235	4,225			1.62	.37
ARIZONA	42,341	6,097		578	2.14	.35
ARIZONA	5,335	5,034			2.73	.50
ARIZONA	5,913	13,744			2.23	.35
ARIZONA	11,610	10,394		3,370	1.95	.35
ARIZONA	12,229	10,353			2.14	.45
ARIZONA	2,531	13,353			2.15	.35
ARIZONA	2,531	13,353		4,837	2.64	.35
ARIZONA	13,332	4,650			2.51	.43
ARIZONA	6,823	3,291			2.10	.45
ARIZONA	1,530	1,153			4.34	.30
ARIZONA	10,222	5,152			3.03	.57
ARIZONA	8,090	6,335		265	2.22	.52
ARIZONA	5,033	7,152		56	1.26	.71
ARIZONA	3,432	23,587			.94	.16
ARIZONA	32,752	6,055			3.62	.61
ARIZONA	6,555	3,419		523	1.92	.33
ARIZONA	5,125	6,728			2.15	.52
ARIZONA	7,453	5,845			1.37	.71
ARIZONA	4,223	3,961			2.55	.58
ARIZONA	567	6,097			1.03	.16

TABLE I
STATE FUNDS FOR PUBLIC AND PRIVATE MEDICAL SCHOOLS FOR EDUCATIONAL AND
GENERAL PURPOSE PROGRAMS*
(Fiscal 1974)

State	Public Medical Schools		Private Medical Schools (Thousands of Dollars)	State Residents For Education (Dollars) (Millions)
	Total (Thousands of Dollars)	Per SZ Student (Dollars)		
New Hampshire			263	.34
New Jersey	19,239	13,520		.32
New Mexico	2,375	7,634		.49
New York	31,779	6,127	10,842	.39
North Carolina	10,411	6,589	860	.56
North Dakota	1,240	3,653		.33
Ohio	17,839	5,532	2,950	.35
California	3,093	3,253		.12
Oregon	7,777	6,722		.35
Pennsylvania	12,495	4,375	10,644***	.65
Puerto Rico	2,943	4,096		.38
Rhode Island			430	.36
South Carolina	9,282	7,859		.41
South Dakota	843	3,619		.32
Tennessee	5,196	4,153	24	.23
Texas	53,561	16,873	6,118	1.07
Utah	3,021	3,230		.32
Virginia	2,636	1,626	96	.14
Vermont	3,098	4,264		.62
Washington	10,278	3,651		.52
West Virginia	5,550	7,554		.71
Wisconsin	7,137	3,768	2,228	.39
TOTAL	\$462,647		44,119	
MEAN	10,759	6,973	2,757	.43

FOOTNOTES FOR TABLE I

- * The data relate to funds provided directly by the state to medical schools located within the state. They exclude funds provided to medical schools through regional compacts or other interstate arrangements. The fiscal 1974 state support data are derived from the 1974 Annual Medical School Questionnaire of the Liaison Committee on Medical Education, supplemented or amended by information provided directly by the medical school. Funds per resident of the state are based on 1973 population data taken from the Statistical Abstract of the United States, 1974, 95th Annual Edition, page 12. Personal income data are preliminary 1974 figures from the Survey of Current Business, April 1975, Vol. 55, No. 4, page 19. FTE student data are taken from the Journal of the American Medical Association, January 1975, Vol. 231, pages 108-110. Population and personal income data for Puerto Rico were obtained from the Washington, D.C. office of the government of Puerto Rico.
- ** FTE students include all full-time medical students, master's and Ph.D. candidates, interns, residents, postdoctoral students, fellows, and a calculated full-time student equivalent for all other students educated by the medical school.
- *** Does not include funds from the state of Delaware which totalled \$656,000.

TABLE 2
REGIONAL EDUCATION PROGRAMS IN MEDICINE, FISCAL 1975

Regional Board	Participating States	Contracting Institutions	No. of Students in Program	Per Capita Award	Total Funds to:	
					Public Schools	Private Schools
New England Board of Higher Education	Maine, Mass. & Rhode Island	Public	163	\$5,000*	\$815,000	-
		Private				
Southern Regional Educational Board	Ala, Fla, Georgia, La., Md., Miss., N.C., Tenn., & Va.	Public	126	\$3,250	-	\$409,500
		Private				
Western Interstate Commission for Higher Education	Alaska, Arizona, Idaho, Montana, Nevada, & Wyoming	Public	250	\$6,000**	\$1,165,668	\$134,668
		Private		\$5,000***		
TOTAL			539		\$1,980,668	\$544,168

* Maine pays the full \$5,000 capitation award only for those students from Maine who, because of financial need, do not pay the full out-of-state tuition at the contracting medical school.

** For first-year students, 1975-76 Academic Year

*** For second, third, and fourth-year students, 1975-76 Academic Year



DISTRICT OF
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DENTAL
SOCIETY

CONSTITUENT OF THE AMERICAN DENTAL ASSOCIATION

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STATEMENT TO THE
COMMITTEE ON THE DISTRICT OF COLUMBIA
UNITED STATES SENATE
BY FRANK L. SHUFORD, JR., D.D.S.
PRESIDENT OF THE DISTRICT OF COLUMBIA DENTAL SOCIETY
APRIL 29, 1976

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I AM
DR. FRANK L. SHUFORD, JR., PRESIDENT OF THE DISTRICT OF
COLUMBIA DENTAL SOCIETY. I AM REPRESENTING THE VOICE OF THE
MORE THAN 550 PRACTICING DENTISTS IN THE DISTRICT, MANY OF
WHOM ARE GRADUATES FROM GEORGETOWN UNIVERSITY SCHOOL OF
DENTISTRY. IN FACT WHEN WE TESTIFIED IN SUPPORT OF THE
D. C. MEDICAL AND DENTAL MANPOWER BILL IN 1972 WE REPORTED
THAT FIFTY PERCENT OF THE PRACTICING DENTISTS IN THE
WASHINGTON METROPOLITAN AREA WERE ALUMNI OF THIS SCHOOL.
GEORGETOWN UNIVERSITY CONTINUES TO PROVIDE A LARGE NUMBER
OF DENTAL GRADUATES TO THE WASHINGTON COMMUNITY.

IN ADDITION TO SUPPLYING A MAJOR PORTION OF THE DENTAL
MANPOWER NEEDS OF THE CITY, GEORGETOWN'S SCHOOL OF
DENTISTRY INTERACTS WITH THE COMMUNITY AND THE D. C. DENTAL
SOCIETY IN A NUMBER OF IMPORTANT WAYS. THESE LINKAGES
ARE A VITAL PART OF THE TOTAL PICTURE OF GOOD DENTAL CARE
DELIVERY IN THIS AREA.

FIRST, GEORGETOWN UNIVERSITY PROVIDES AREA DENTISTS WITH A SOURCE OF HIGH QUALITY CONTINUING EDUCATION COURSES. ADVANCES IN DENTAL TECHNOLOGY AND TREATMENT ARE APPEARING SO RAPIDLY THAT PRACTITIONERS NATURALLY TURN TO THEIR INSTITUTIONS TO KEEP THEIR SKILLS UP-TO-DATE.

SECONDLY, NUMEROUS MEMBERS OF THE D. C. DENTAL SOCIETY PROVIDE THEIR SERVICES TO THE UNIVERSITY AS CLINICAL TEACHING STAFF OF THE DENTAL SCHOOL CLINIC. GEORGETOWN UNIVERSITY HAS ALWAYS FELT THAT THE ASSISTANCE PROVIDED BY A STRONG CORE OF PROFICIENT AND INTERESTED PRACTICING DENTISTS WAS OF VALUE TO THE CLINICAL TEACHING PROGRAM.

BECAUSE OF THESE IMPORTANT LINKS BETWEEN THE DENTAL SCHOOL, THE PRACTICING DENTAL COMMUNITY, AND THE COMMUNITY AS A WHOLE, THE D. C. DENTAL SOCIETY IS CONCERNED THAT THE UNIVERSITY MAY NOT BE ABLE TO CONTINUE ITS PRESENT LEVEL OF PROGRAMS UNLESS IT CONTINUES TO RECEIVE THE FINANCIAL ASSISTANCE DERIVED FROM THE DISTRICT OF COLUMBIA MEDICAL AND DENTAL MANPOWER ACT. COSTS ARE INCREASING AT AN ALARMING RATE, FORCING THE PRIVATE SCHOOLS TO RAISE TUITION TO A NON-COMPETITIVELY HIGH LEVEL. AT THE PRESENT RATE, FEWER AND FEWER STUDENTS CAN EVEN CONSIDER APPLYING TO GEORGETOWN UNIVERSITY. IF THE UNIVERSITY LOSES ITS SUPPORT FROM THE MANPOWER ACT, GREATER TUITION HIKES OR SERIOUS PROGRAM CUTS WILL ALTER THE SCHOOL TO AN UNRECOGNIZABLE ACCUMULATION OF EMPTY BUILDINGS.

ALTHOUGH THE SOCIETY FAVORS QUICK CONSIDERATION OF A SIMPLE EXTENSION OF THE AUTHORITY, WE NOTE WITH DISFAVOR THE DISTINCTION BETWEEN THE AUTHORIZED LEVEL OF SUPPORT FOR MEDICAL AS OPPOSED TO DENTAL SCHOOLS. WE BELIEVE THAT THE ACTUAL COSTS OF EDUCATING A SINGLE MEDICAL STUDENT OR A SINGLE DENTAL STUDENT, EXCLUSIVE OF RESEARCH-RELATED EXPENSE, ARE ALMOST EXACTLY THE SAME.

WE ARE AWARE OF THE EFFORTS BY THE UNIVERSITY'S DENTAL SCHOOL ADMINISTRATORS TO CONTROL OPERATING COSTS AND TO GAIN HIGHER LEVELS OF PRIVATE FUNDING. THEY ARE DOING THEIR PART.

THE D. C. DENTAL SOCIETY IMPORES THE COMMITTEE TO FAVORABLY REPORT AN EXTENSION OF THE D. C. MEDICAL AND DENTAL MANPOWER ACT, SO THE CITY AND THE FEDERAL GOVERNMENT CAN DO ITS PART TOWARD SUSTAINING THIS LOCAL AND NATIONAL HEALTH EDUCATION RESOURCE.

THANK YOU FOR THE OPPORTUNITY TO EXPRESS OUR THOUGHTS TO THIS COMMITTEE.

STATEMENT OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

on H.R. 12132, The Medical and Dental Manpower Act of D.C.

before the United States Senate
Committee on the District of Columbia
The Hon. Thomas F. Eagleton, Chairman, presiding
April 29, 1976

Mr. Chairman and Members of the Committee:

I am Dr. Raymond Scalettar, President-Elect of the Medical Society of The District of Columbia. With me is Dr. William Cooper, Chairman of the Executive Board of our Medical Society. Our Society, chartered by the U.S. Congress, represents a membership of over 3,000 physicians who practice in this metropolitan area.

We are here today to enlist your support for the extension of the District of Columbia Medical and Dental Manpower Act of 1970. It is our contention that failure to do so will represent a tragedy for the institutions - The George Washington University School of Medicine and The Georgetown University School of Medicine and Dentistry, and the numerous students who will be unable to continue their education because of the huge increases in tuition.

It is not the purpose of this presentation to reiterate the numerous statistics relating to the financial difficulties of these institutions. Instead, I would like to focus on their significance as scientific institutions involved in health care delivery and the impending human hardship that may emerge if this act is not renewed.

The metropolitan Washington area represents one of the great scientific communities of the world. The George Washington University Medical School and The Georgetown University School of Medicine and Dentistry are major contributors to the excellence of this area's health care facilities which comprise this scientific community. These institutions have pioneered innovations in the field of cardiac surgery, renal dialysis, neurosurgery and health care delivery, to name but a few of their accomplishments. This nation can justly be proud of these institutions who have educated students from all over the country. Upon graduation, many have settled

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in the Washington area and contributed to the health care of this population. They have also made contributions of national and international importance. It is an irony that these institutions which are among the best in our society, must struggle for survival primarily because the state aid given to comparable institutions is not available to them. When in the past huge sums of money have been appropriated to new or expanding schools, the possible closure of these respected institutions seems incredible.

Education in the health care field and particularly in medicine and dentistry has been attacked in the past as dominated by the rich and affluent. Yet, many of the students of these institutions have already indentured their futures. For some, there are no further resources or means to pay the predicted increases in tuition if this act is not extended. Surely this is a distortion of the American dream that would enable those with ability to achieve a medical or dental degree, without interposing staggering tuition increases.

For these reasons, we urge you to extend this act and thank you for the opportunity to present the viewpoint of the Medical Society of the District of Columbia.

STATEMENT

OF

DR. VIJAYA L. MELNICK
ASSOCIATE PROFESSOR AND
PREMEDICAL ADVISOR
DEPARTMENT OF BIOLOGY
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BEFORE THE
COMMITTEE ON THE DISTRICT OF COLUMBIA
U.S. SENATE

APRIL 29, 1976

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Mr. Chairman, I appreciate your invitation and the opportunity to appear before you to testify on a bill 'To extend as an emergency measure for one year the District of Columbia Medical and Dental Manpower Act of 1970'.

I would like to put it on record, that my testimony is not being made on behalf of any institution or organization but as that of a private citizen. However, in doing so, I will freely draw upon my experience as a professor of Biology and a premedical sciences advisor at Federal City College, Wash., D.C. I have been deeply concerned with the problems and opportunities faced by my students, most of whom are District of Columbia residents, in their attempts to secure professional education and training in medicine, dentistry and related biomedical and health professions. I have also been concerned at the maldistribution of health care professionals and services within the metropolitan Washington area.

My position, Mr. Chairman, remains very much the same, as when I testified on a similar bill in 1974 (Bill to extend for 3 years the D.C. Medical and Dental Manpower Act of 1970). I urge the support of the bill, merely because, at a time of need for more health professionals in this country, we can ill afford to close down existing facilities that train them. However, my support is very much contingent upon certain public obligations and public commitments that must be required of the Georgetown Medical and Dental schools and the George Washington Medical School. For they are, through this bill, seeking public support.

This bill would authorize the Secretary of Health, Education and Welfare to assist private non-profit medical and dental schools (Georgetown Medical and Dental schools and George Washington Medical School--to be specific) in the District of Columbia in a manner similar to that in which certain States support private medical and dental schools located ⁱⁿ their specific jurisdictions. State support of such private schools is by no means universal. It is very important to note that when a State does decide to support a private medical or dental school then it does so in

consideration of specific benefits to the State and its residents. Such benefits generally involve:

- 1) providing needed trained health professionals in the areas of health care services, research and teaching;
- 2) the need for expanded opportunities in health professional and biomedical training opportunities for the residents of that state;
- 3) the need to combat specific health problems or develop better and more efficient methods of health care delivery, especially in areas of the State, where the health care services are inadequate either because of maldistribution of health personnel or unequal access.

What is most disconcerting is the fact that this bill will provide a multimillion dollar subsidy to these two private schools in the District (Georgetown and George Washington) without requiring any accountability, on the part of the schools, in the form of specific and additional benefits in services or expanded opportunities for the District residents.

In a letter to Congressman Fortney Stark (D-Calif), from Dr. Matthew McNulty (Chancellor, Georgetown Medical Center, dated Jan. 30, 1974, in answer to specific questions raised by the Congressman), regarding enrollment of District residents, health services to the District, etc. Dr. McNulty writes and I quote "... We have exercised vigorous leadership in trying to develop an enlarged pool of applicants of both D.C. students and minority students. This effort has been rewarding but on a slowly developing basis. We intend to keep emphasizing this consideration, and we believe over the years ahead both the applicant pool and those admitted to the pool will increase".

If indeed this be the intent then I wish to offer the following specific points to be incorporated into the legislative history of the bill. These points should help towards fulfilling that intent and result in some tangible benefits accruing from the bill for the District residents.

Points to be incorporated:

1) A specific number of places to be set aside in each of these schools (GT medical and dental school and GW medical school) for District residents. I would suggest that number to be not less than 20% of each entering class. The composition of District residents enrolled should reflect, as closely as possible, the demographic pattern of the District. If this number cannot be reached all at once, then a time table should be set, starting with a certain specified number, to reach the goal of 20%--say within the next 3 years.

Present records indicate that the percentage of D.C. residents in both these schools is extremely low. In fact, if one ranks every medical school in the country, including both private and state medical schools--Georgetown and George Washington medical schools rank among the very lowest in their ratio of in-state to out-of-state students.

There is an added interest here. That is the fact that the population of the District is almost 80% black. It is well acknowledged that there has been, and is, a tremendous underproduction of black physicians. Experience and documentation prove that for the most part black physicians deliver medical care in areas that are predominantly black. The point has been eloquently made by Dr. Therman Evans, the newly elected President of the D.C. Board of Education, and Executive Director of the Health Manpower Development Corp. in a recent article in the Op. Ed page of the Washington Post. He correctly makes the observation and point, for the need for more medical centers that are primarily oriented towards a minority clientele, if the problem of black and other minority physician shortage is to be solved. Congressman Pepper (D-Fla.) introduced this article into the Congressional Record with a strong endorsement for the need for legislation to initiate and develop such measures. In addition, Cong. Pepper clearly states that "we still need to take steps which will enable minority students to enter and succeed in predominantly white schools".

Georgetown and George Washington school records show that the percent of

minorities in their medical school classes is also extremely low. I don't have the exact numbers for GW but GT has 35 black students out of a total of 817 medical students (The numbers for Spanish American and American Indian is 7 and 3 respectively). In the biomedical graduate program GT has 7 blacks out of a total of 170.

This clearly demonstrates a need for insisting that a certain specified no. of seats be set aside in each of the entering class for D.C. residents--reflecting the demographic pattern of the District.

2) The establishment of a program in the District of Columbia that will ensure the process of generating an adequate and qualified pool who will have longitudinal support and guaranteed access to these schools. I suggest that this program be called 'Alliance for Better Health'. Such a comprehensive program for the District of Columbia should be developed in coordination with the D.C. Public Schools and the D.C. University. The planning and development should be carried out in conjunction with the Secretary of Health, Education and Welfare. An annual progress report on the program should be submitted to the Secretary who, in turn, shall transmit the report to the appropriate Congressional Committees. A planning and development team, to draw up the blueprint for the program, should be selected with representations from each of the Universities concerned, and the District Public Schools.

The Georgetown/District of Columbia Medical and Dental Health Careers program is a program in such a direction. Even though this is only a small beginning it is a very appropriate one. The program is designed to motivate and assist District residents from disadvantaged back grounds to obtain admission to medical or dental school or other health oriented programs. Dr. Arthur Hoyte has worked hard in a leadership role in this and related endeavours along with some very able assistance, such as Mr. Ernest Middleton and Ms. Delores Askey. I have been privileged to work with this group from the formulation to the implementation (which occurred just recently) of the program. I look forward to more such cooperative and productive ventures between schools and universities in the District. The potential to identify

areas of need, where innovative and appropriate joint programs could be developed, is very high. Such endeavours, will no doubt help increase the quality of life, and opportunity for advancement, for the District residents.

3) A more vigorous implimentation of the affirmative action guidelines in the area of hiring faculty with Ph.D, M.D. and D.D.S. qualifications. The plan should focus on underrepresented minoritiles in the medical, dental and biomedical sciences.

Any educator knows that an effective and successful academic program requires not only just good facilities, and a dedicated and competent faculty, but more specificaly a faculty than can also serve as role models for students from various segments of society. Study after study has shown that this is doubly important for minority students--especially those coming from families where they (the students) are the first college graduates or first to enter professional training.

4) The health professional and para professional training programs should some way reflect and respond to the needs of the District, with special emphasis on providing for needed health manpower in underserved areas of the city. Some of these programs could be developed as co-operative programs between these private health professional schools and the public university and public schools of the District--as already mentioned in point #3.

I would like to conclude by saying that in preparing this testimony I have spoken with several colloques and many students (from Federal City College as well as outside). Their views are reflected in many of the statements I have made here. However, I do not speak as their representatives and hence take sole responsibility for what I have said. Thank You for this opportunity again, Mr. Chairman.



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May 7, 1976

The Honorable Thomas F. Eagleton
Chairman, Committee on the
District of Columbia
United States Senate
Washington, D. C. 20510

Dear Senator Eagleton:

On behalf of the American Medical Association, I would like to submit for your consideration these comments in support of H.R. 12132 which we understand is now under consideration by the Committee on the District of Columbia. This legislation would extend for one year 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 AMA has advocated continued federal financial support for our medical schools in recent testimony on manpower legislation pending in the Congress. We have 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.

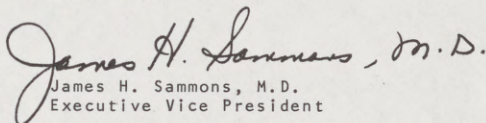
One of the important sources of funds for medical education has been those from the States. In many States privately supported as well as publicly supported medical schools receive financial support from States to assist the schools in carrying out their education of medical students. In a sense, the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

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The American Medical Association therefore supports H.R. 12132 authorizing a continuation of such assistance to the private medical schools in the District of Columbia. As we stated in our letter of support in 1974 for a previous extension of this Act and as we have recently stated to the House in its consideration of an extension, it is most important that all of the nation's medical schools continue to receive adequate financial support. Therefore, we recommend that funds made available through this Act 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 H.R. 12132.

Sincerely,


James H. Sammons, M.D.
Executive Vice President

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