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NATIONAL HEALTH SERVICE CORPS—OVERSIGHT

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HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE
HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

SECOND SESSION

JANUARY 30, 1980

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NATIONAL HEALTH SERVICE CORPS— OVERSIGHT

WEDNESDAY, JANUARY 30, 1980

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman, chairman, presiding.

Mr. WAXMAN. The hearing will come to order.

I am sorry to have kept you waiting. We have a quorum requirement for a hearing. We wanted to wait for Dr. Carter and Mr. Dannemeyer to be here to join us.

Today the subcommittee is conducting an oversight hearing on the National Health Service Corps. This is the first of several days of hearings I expect the subcommittee to hold on the health professional education programs which must be reauthorized this year.

As the subcommittee members may know, the National Health Service Corps is divided into two programs, the scholarship program, which provides scholarships to health profession students, and the service program, which uses the scholarships recipients upon completion of their health training to improve the delivery of health services in health manpower areas.

Our witnesses today have been asked to address the strengths and weaknesses and the future of the health service program. We will have additional witnesses in subsequent subcommittee hearings who will address the many aspects of the scholarship program and the other health profession student assistance programs.

I am pleased to welcome witnesses from all over the United States, from Washington State to Illinois, to Louisiana, to Maine. I expect they will give the subcommittee new insight on the successes of the National Health Service Corps and the problems to which we must address ourselves.

Our first witness is Dr. Roger Rosenblatt of the University of Washington in Seattle.

Dr. Rosenblatt recently conducted an extensive review of the Corps and previously worked with the Corps' regional office staff in Seattle.

Before you begin, Dr. Rosenblatt, I want to call on the ranking Republican member of the subcommittee, Dr. Timothy Carter.

Mr. CARTER. I want to apologize for being late.

Certainly, I want to commend you for holding this oversight hearing on the National Health Service Corps. As I have said

before, I believe we should be doing more oversight in general on all of our health programs and I welcome this opportunity today to examine the progress of this program.

Clearly, the task of solving the problem of maldistribution of health personnel is difficult and requires continuing commitment and cooperation of public and private sectors, particularly at the community level.

I have been in the practice of medicine in rural areas of Kentucky and I know how challenging such work can be, but I also know that health care is sorely needed in those areas and in ghetto areas throughout our country.

That is why I want to continue to do all that I can to help make the Corps program as successful as possible. I look forward to hearing the witnesses.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much.

Dr. Rosenblatt, we welcome you. I note the fact you mentioned earlier you came to Washington for improvement of the weather.

STATEMENT OF ROGER ROSENBLATT, M.D., M.P.H., DIRECTOR OF RESEARCH FOR THE DEPARTMENT OF FAMILY MEDICINE, UNIVERSITY OF WASHINGTON (SEATTLE)

Dr. ROSENBLATT. It went from 11° yesterday in Seattle to 27° here today proving this really is the sunny South.

Mr. WAXMAN. We are glad that you are here, and we want to hear your testimony.

Dr. ROSENBLATT. I have prepared some formal testimony which I will submit for the record but I would rather speak informally from some notes.

I am a family physician and have been involved with the National Health Service Corps since its inception 10 years ago.

As a medical student, I sought to enlist in the program even before it was fully implemented, and 3 years later after finishing my family medicare residency training I joined the Corps as a member of the regional office staff in Seattle, and had the privilege to become director of the Corps for region X during the formative years of the program.

Working with the Corps has been one of the most exciting and rewarding experiences in my life. We were able to help dozens of communities ranging from native villages on the Alaskan tundra to affluent but isolated towns on the wheat-bearing plateau of Oregon, I feel we have had a remarkably large impact on the rural health landscape of the Northwestern States and Alaska.

The key to the success of the National Health Service Corps during that period was a unique spirit of cooperation that existed between the Corps, between the WAMI program, which is our regionalized medical education program, and between the private medical sector which helped us at every turn, and between State and local governments. It was a remarkable spirit that prevailed during most of the first decade of the Corps' existence.

We were able to take people who were trained in the WAMI setting and use the Corps as a conduit through which they could be placed in places of great need and establish viable medical and dental practices.

The Corps is now at a crossroads. The first decade is over; the first phase is over, and at this juncture there are some critical problems that are emerging for the Corps.

Conflict has emerged that threatens to undermine the program, conflict that is both avoidable and remediable.

I would like to share with you my analysis of some of these current problems. The Corps has grown very rapidly, and with the introduction of the scholarship program the need for stable long-term planning has been apparent.

The appropriation level you set this year will determine the number of scholarship students, but their impact on American communities won't be fully apparent for nearly 10 years.

Over the last couple of years there has been considerable and unpredictable oscillation in appropriation levels and personnel ceilings. It is very difficult for the communities and the assignees, the young men and women who are in this educational pipeline, to know exactly what is going to happen in the future. This uncertainty creates anxiety and frustration.

Communities who are expecting an assignee may suddenly find they will not receive one. This has a deleterious impact in the community, and threatens to destroy enthusiasm and commitment of the young people who are in the program.

A second problem has been that there has not been a clear notion of the central objectives of the Corps. It's a superb instrument for doing what it does well, for being a flexible way to put doctors, nurses, other health personnel into places where they are needed.

It cannot solve all of the health problems of America; it cannot solve the problems of teenage pregnancy or smoking. Often the Corps is treated like a Christmas tree which has new Federal ornaments put on it monthly. These initiatives may be laudable and desirable, but asking Corps assignees in small American communities to try to translate these into a coherent program overburdens the system.

The typical Corps practice is often a very small practice without great administrative strength, and many of these objectives are seen at the community level as cumbersome reporting requirements or activities that are meddlesome to the Corps' essential mission.

The Corps needs to be allowed to do what it does best, and protected from unachievable expectations from within the Federal health system.

The third issue that has just started to become a major problem is the challenge of coordination at the local level. The crux of our success in region 10 and in WAMI was the fact we worked together as a community of different programs that were interested in solving the same problem.

Medical schools, family medicine departments, medical societies, and local governments are in general quite supportive, yet there needs to be a mechanism at the local level for those people to work together, to collaborate far enough in advance so that they can solve problems jointly.

The danger is that the Corps will come in with an assignee or a project that does not dovetail with other activities in the region

and create hard feelings which percolate back to Congress and affect the general support for the program.

I would recommend three areas in which major improvements can be made in the Corps program. First the Corps needs to be administratively unified. The scholarship and the service portions of the program should be meshed so the same people can worry about the medical students during medical school, residency, and in the community. This unification will bring a great deal of clarity to the program and also boost the morale of that cohort of young professionals that is going to be going out there.

Second, I think the Corps needs to have a clear notion of what its true objectives are, and enough autonomy so it can achieve them flexibly. It cannot be the handmaiden of every other Federal program. It has to have the ability to do what it does best and that is to put health manpower, doctors, and other health professionals, in places of need.

Third, I think that the program has to be meaningfully decentralized so the staff in the regional offices can work with local groups to collaborate on Corps assignments. There needs to be a mechanism at the regional and at the local level for working together, for deciding jointly where Corps people will be placed and how they will be placed.

It is difficult to pinpoint exactly how such a mechanism might evolve. Another witness at this hearing Jim Bernstein, will discuss the way that it is being done in North Carolina. In our part of the country, it could be handled through the WAMI program.

The Corps has been a tremendously powerful program, and is emerging as a centerpiece of the central strategy for helping underserved communities. By addressing some of the issues that are now being raised, its future as a meaningful Federal initiative can be preserved.

Thank you very much.

[Dr. Rosenblatt's prepared statement follows:]

Testimony Presented Before the House Subcommittee on Health's
Oversight Hearings on the National Health Service Corps

January 30, 1980

Roger A. Rosenblatt, M.D., M.P.H.
University of Washington, Seattle, Washington

I have been associated with the National Health Service Corps since its inception. As a medical student, I sought to enlist in the program. When I finished my residency training in Family Medicine, I joined the regional office staff of the NHSC in federal Region X in Seattle, and became director of the program during its formative years. I had the privilege to work with communities ranging from native villages on the Alaskan tundra to affluent but isolated towns on the wheat-bearing plateaus in Oregon. Since joining the faculty of the Department of Family Medicine at the University of Washington in Seattle, I have continued to focus my attention on problems of health manpower. I work closely with medical students and residents who have been awarded NHSC scholarships, and have devoted my research efforts to a systematic evaluation of the NHSC program in an attempt to find ways of improving its effectiveness.

The NHSC has been a powerful mechanism for improving health services in a wide variety of American communities. In Region X, working collaboratively with the WAMI Program for regionalized medical education, with state and local governments, and with the private medical sector, the NHSC has been very effective in bringing medical care to the majority of severely underserved rural communities. But the NHSC has reached a difficult crossroad; rapid growth, the addition of the scholarship program, and changes in administrative direction have profoundly altered the way the Corps operates, and threaten to submerge it in destructive and unnecessary controversy.

I see two major problem areas confronting the NHSC as it enters into a new decade:

1. Erratic and unpredictable growth.

The introduction of the scholarship program has radically changed the relationship of the typical assignee to the NHSC, and greatly increased the need for stable, long-term program planning. Instead of a two year stint as a volunteer in an underserved rural community, today's typical assignee is more likely to be a scholarship recipient who will spend ten year's of his life affiliated with the NHSC. The appropriation levels set this year which determine the number of scholarships awarded will have their real impact on American communities ten years from now. A lack of clear consensus now on the ultimate size and role of the NHSC translates into uncertainty, dashed expectations, and disenchanting assignees at the community level years hence.

2. Confusion about the objectives of the Corps.

The NHSC is a superb instrument for flexibly deploying highly trained medical personnel to areas of need; it is a clumsy and imprecise instrument for solving the multitude of health problems--ranging from teenage pregnancies to smoking--that still afflict our nation. Over the last few years there has been a tendency to use the Corps to attack every newly identified health problem; often the effect has been to saddle some small community clinic and their Corps assignees with a spectrum of responsibilities and cumbersome reporting requirements that are at best irrelevant and at worst disruptive to their basic mission.

I would suggest the following program changes:

1. Determine the role of the NHSC in the context of an overall medical manpower strategy. The Corps cannot solve all the problems of poor health and impaired access; legislatively and administratively it should be targeted to perform that which it does best--the placement of health professionals in underserved areas.
2. Unify the scholarship and service portions of the program. One agency should have the responsibility to make sure that the scholarship and service portions mesh, and that agency should have enough

administrative autonomy and clout to chart a sure and steady course, without being buffeted by demands that are laudable but unachievable.

3. Improve communication and collaboration with state governmental entities, medical schools, residency programs, and the private medical sector. Building systems of medical care is a delicate and complex process. The NHSC is most effective when it works with local governmental entities and training institutions to jointly improve access to medical care. This can be done only if the program is meaningfully decentralized, with regional office staff having the ability and authority to make policy decisions without having to worry about sudden unexpected shifts in overall program direction.
4. Set quotas for scholarships to be awarded to students pursuing specific specialties. Currently the Corps automatically defers all students entering primary care fields. However, the majority of physicians emerging from internal medicine and pediatrics are destined for narrow specialties; they are more difficult to place, and often have been poorly prepared for the generalist role required by most underserved communities. Family physicians have shown to be highly versatile in a wide variety of settings, and to have a higher likelihood of being retained in the communities where they are placed. The Corps should set explicit numerical goals for each of the medical specialties, and then select a cohort of scholarship students who will be required to finish their training in those areas before beginning active duty. Current policy giving freshmen preference for scholarships should be changed; students who have spent a year or two in medical school have a better concept of their future career goals, and scholarships are more likely to be awarded appropriately.

The NHSC is a powerful tool to improve the provision of health services to underserved populations. Rapid growth and changing mission have created administrative and operational problems, and have introduced controversy in what has heretofore been a universally popular program. Changes in the way the Corps is structured and managed are necessary for it to continue as an integral part of an effective overall federal strategy in health.

Mr. WAXMAN. Thank you very much. Let me ask you, should HEW work with State and local governments in identifying communities in need of a physician, in developing and supporting primary health care centers in those communities, and in placing National Health Services Corps in them. If so, how?

Dr. ROSENBLATT. It is essential to do that. I have thought about this problem and I am not sure that there can be one monolithic solution for the entire Nation, because the regional patterns in the country truly vary.

Thinking about the Northwest, the most logical mechanism would be to perhaps have some sort of coordination through the WAMI program, which could act as a clearinghouse whereby everybody could work together to solve problems on a regional or a State basis.

In North Carolina, there is an office of rural health which is State supported but somewhat independent of the State health officer's role. I wouldn't be comfortable seeing the Corps submerged within State government, but there needs to be a mechanism sensitive to the needs of the different regions of the country.

Mr. WAXMAN. This is a very expensive program.

Do you think that it is realistic to expect that State and local governments, or community organizations or health institutions to assume the salary expense for the National Health Service Corps physicians while they are fulfilling their obligations?

Dr. ROSENBLATT. A portion of the salaries have always been returned to the Federal Treasury by capturing fees for service charged by the Corps assignees. More recently with the assignment of Corps personnel to grant programs that has become less so.

A portion of Federal money can be recouped, but I don't think the total amount can be repaid or else the program will lose its flexibility. I am not sure the program is all that expensive when you consider the amount of impact that it has and the benefit to the communities it serves. It is a pretty good bargain.

Mr. WAXMAN. Do you think that the National Health Service Corps is the only way we can get physicians and health professionals into these communities?

Dr. ROSENBLATT. In our region the growth of family medicine has had a major impact on the increase in the number of physicians going to underserved communities. Programs such as WAMI also work together to redistribute physicians.

The Corps is unique, because it is a conduit through which people can be placed in these communities and supported during the early years where they are building up a practice or become acclimated, particularly in risky areas that have been very difficult to fill in the past.

It's a unique component of a broader strategy.

Mr. WAXMAN. From your experience have we succeeded in getting physicians to stay in those more difficult communities after their period of time for service is over? Can we expect that those areas to be served while there is a physician assigned?

Dr. ROSENBLATT. There are really two classes of projects in my experience. There is a class of projects which have a very high capability for long-term retention. In the Northwest we are starting to see almost half of the rural assignees staying on after their

assignments, often in a private practice mode. I think particularly in rural America there is a very high likelihood of long-term success.

There is another class of programs, for example in prisons or in inner cities or very isolated communities, where you will have to expect a certain amount of turnover. Long-term retention and continuity is one important goal, and I think the program can achieve that in some cases.

Mr. WAXMAN. Thank you very much.

Dr. Carter?

Mr. CARTER. I would like to commend Dr. Rosenblatt for his testimony.

It has been very interesting, and very well presented. At first I was a little reluctant to support this program, but after seeing the need, and what it has accomplished, I have become a strong supporter of it.

For instance, in one county which I represent, Jackson County, there has been only one elderly physician, a fine man crippled with arthritis, to serve 14,000 people who need medical treatment.

Now, as a result of the National Health Service Corps, we have physicians and dentists in that area. In addition, in Estill County, another one of the counties I happen to represent, we have Corps physicians as well.

Previously, there were only one or two who were getting older and who were unable to withstand all of the demands upon their profession.

I could go on and name quite a few instances in which these Corps scholarship people have been of great assistance, not only in rural areas but also in ghetto areas. As you know, the purpose of this program is to bring health practitioners to underserved rural and ghetto areas, and I believe considerable progress is being made. I will continue to support its activities.

Doctor Rosenblatt, if you could make changes in the recruitment and selection process for Corps scholarship recipients in order to improve placements and retention rates, what changes would you make?

Dr. ROSENBLATT. I think that one of the present problems is the proviso that automatically defers any medical student who wishes to be deferred for primary care residency, including internal medicine or pediatrics. I would rather see specific limited quotas for these two fields, because people in pediatrics and internal medicine tend to go into a more narrowly defined specialty than people working in the field of family medicine.

Setting specially-specific numerical quotas would probably mean you can't give the scholarships to freshmen students. The more advanced student has a better idea of what he is going to become and is less likely to be disappointed than the assignee who finds himself in the Corps having signed up 10 years earlier not knowing what he would be getting into.

Mr. CARTER. Would you comment on the appropriateness of the statute's allocation of scholarship awards specifically: 81 percent for medical and osteopathic students; 9 percent for dental students, leaving 10 percent for all other health professions.

Do you think those guidelines really reflect the needs of the Corps?

Dr. ROSENBLATT. They are not too far off. My understanding is that in the last few years places offered to nursing students went unfilled, because there weren't that many people that wanted the scholarships. It is medical education where it is particularly burdensome to the students, and medical students are the ones who will seek those scholarships.

Mr. CARTER. With the WAMI project and the program in Kentucky, we have some excellent programs. Would you describe how the WAMI project serves the people in the areas it covers? I believe it extends from Washington to Idaho and into Montana?

Dr. ROSENBLATT. I can see that you are quite familiar with the program. WAMI operates in the States of Washington, Alaska, Montana, and Idaho.

The program has two phases. In the first phase medical students are selected from their home States of Montana, Idaho, and Alaska, and spend their first year of medical school in those States, after which they come into the University of Washington campus.

During their third and fourth years of medical school they go back out into the communities for many of their clinical experiences. Through this mechanism we have been able to increase our class size considerably without spending \$1 in new capital construction. In addition, the WAMI program has made medical education much more relevant, because a substantial amount of the education occurs in the community, in settings similar to those in which these young physicians will ultimately practice.

We are much more successfully getting people to go back to their home States. The WAMI program has been an excellent source of physicians for the National Health Service Corps, and we have worked cooperatively to get scholarship students into appropriate residency programs and communities.

Mr. CARTER. How do you deal with those patients who are acutely ill? Suppose you have a case of appendicitis in an isolated area of Alaska. How is that handled?

Dr. ROSENBLATT. I can give you a graphic example. I was in Galena, Alaska, which is a remote Athabaican village on the Yukon River, visiting one of our NTTSC nurse practitioners. A Native woman was flown in from the upper fork of the Kyokuk River; she was in shock after having lost a considerable amount of blood after a miscarriage. The Air Force brought her by helicopter to our small clinic and we stabilized her and then transported her by air ambulance to the Native Health Service Hospital in Anchorage.

In virtually all of our sites we have either a land- or an air-based network for emergency evacuation.

Mr. CARTER. I think that is tremendous, and I thank you very much.

Mr. MAGUIRE. I am pleased that we are holding these hearings on the National Health Service Corps. The establishment of a Corps in 1970, and the scholarship program in 1972, have enabled the country to make some much needed progress on the problem of increasing the health care that is delivered in certain portions of your populations.

However, there are problems remaining in these programs which I hope will be addressed by the various witnesses.

Specifically, I am concerned about three items, and I would invite our witness to respond if he chooses.

First, that the recent step increases in medical school tuition have led to some students applying for and receiving Corps scholarships when they have no genuine interest to practice in medically underserved areas. Such students either avoid the Corps completely or leave as soon as possible, and this suggests that the selection process for scholarships needs some improvements.

I know that you have suggested that the scholarship and service programs ought to be integrated, which I gather would take care of this problem to some degree. There may be some additional points in this connection.

The second issue, of course, is the longstanding problem of achieving adequate distribution of Health Service Corps personnel, and the supply to serve underserved areas still lags. I might add that this is true in rural areas, as Dr. Carter knows.

Third, there is a question of whether the National Health Service Corps in its present form should be viewed as a permanent mechanism to bring health care in underserved areas, or is it an interim solution to be used while a more permanent solution is sought, and is this mechanism which is the best means to achieve the desired goal providing adequate health care to all of our population in the future?

Hopefully, these hearings will help in developing answers to those and other questions of the importance to the program. I would invite you to comment on any or all of these questions now.

Dr. ROSENBLATT. The first problem you raised is a thorny one, and that is that some schools with high tuitions have a very high proportion of their students applying for and accepting scholarships, despite the fact that these schools have no particular interest in teaching their students to serve underserved people.

There has to be a response to that. At the University of Washington we have set up a special program for all our scholarship recipients. We work with them through their medical school years to give them knowledge of the Corps sites where they will serve in the future, and we have a counselling system set up to try to orient their medical education to prepare them for their future Corps service.

I would feel that such programs need to either be mandated or encouraged of schools that are accepting large numbers of scholarship students, and there ought to be a funding mechanism whereby schools could set up those enrichment programs for such students. Perhaps there should be a quota for schools that are not exhibiting this kind of behavior but are taking very large numbers of scholarship students. It's a real problem.

With regard to your last comment, I don't see the Corps as necessarily a permanent mechanism. My suspicion is that the program will continue to grow perhaps for another 10 years, and then will get somewhat smaller. However, there are going to be places in the United States, no matter what system of health care we devise, that will need an external organized support system.

There are some rural areas that will never independently be able to support a practitioner. Galena is a good example. It has 500 people and is very remote. Even if you had national health insurance you would never be able to support that provider without outside help. There are inner-city areas with similar characteristics. I suspect some kind of Corps will be a permanent feature, on the health scene. However, it will probably be somewhat smaller than the Corps we will see during the next few years.

Mr. MAGUIRE. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Dannemeyer.

Mr. DANNEMEYER. When these practitioners go into a community, and I have heard a salary schedule of what they are paid which is a modest salary for a physician with that number of years of training, how does the clinic where the person works operate?

Do people pay for the service?

Dr. ROSENBLATT. In almost every case a fee is charged. In the rural practices that we have set up most patients aren't even aware it's a Corps practice. They feel like they are going to a community doctor. There is a published fee scale, and they pay it. A portion of it comes back to the Federal Treasury after it covers the local expenses.

Often there is a sliding fee scale, particularly in poverty areas where the patient pays according to his ability. There is an attempt made to capture third-party reimbursement and to encourage the clinic to be as self-sufficient as possible.

Mr. DANNEMEYER. Is there any data on the financial working of the clinic for a year or two as to whether or not it was able to be self-sufficient in terms of its expenses?

Dr. ROSENBLATT. I did a study of all of the sites in region X and looked specifically at that question. What we found was that in appropriate settings, you could pretty much predict that over about a 2- to 2½-year period the clinic would become self-sufficient.

Mr. DANNEMEYER. Self-sufficient?

Dr. ROSENBLATT. It is paying its own way and paying the doctors' salaries. However, the community had to be large enough to support two or more physicians and a hospital before self-sufficiency was achieved. If the community didn't meet those criteria, some degree of subsidy was required.

Mr. DANNEMEYER. Has somebody sat down and analyzed how many of these service deficient areas we have in our country?

Dr. ROSENBLATT. There have been a number of models developed and most recently the Department did develop a model and came up with a projection for the number of people that will be needed.

Mr. DANNEMEYER. What are the ranges we are talking about?

Dr. ROSENBLATT. The projections range from a need for between 4,000 and 16,000 Corps personnel.

Mr. DANNEMEYER. Not the number of people in the Corps, but has anybody identified the areas that need to be serviced that are underserved now?

Dr. ROSENBLATT. Yes; there has been a formal designation of health manpower shortage areas throughout the country. I am not familiar with the actual number.

Mr. DANNEMEYER. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Devine?

Mr. Broyhill?

Mr. BROYHILL. No questions.

Mr. WAXMAN. I want to thank you very much. You are obviously very knowledgeable and you have had a great deal of experience. Our next witnesses are from two operating Corps centers.

From Baltimore we have Mrs. Clara Moore, president, of the board and Dr. Barton McCann, medical director of the North Central Baltimore Health Corps.

From the Russell Medical Center in North Leeds, Maine, are Gerald Michaud, president of the board and Dr. Larry Lee Catlett, medical director.

STATEMENTS OF CLARA MOORE, PRESIDENT, BOARD OF DIRECTORS, NORTH CENTRAL BALTIMORE HEALTH CORP.; BARTON McCANN, M.D., MEDICAL DIRECTOR, (NCBHC); GERALD MICHAUD, PRESIDENT, BOARD OF DIRECTORS, D. F. D. RUSSELL MEDICAL CENTER, LEEDS, MAINE; AND LARRY L. CATLETT, MEDICAL DIRECTOR (RMC)

Mrs. MOORE. I am Mrs. Clara Moore from Baltimore.

As the president of the board of directors of the North Central Baltimore Health Corp. I can speak firsthand as to the positive effect the National Health Service Corps has had on the health of the community I reside in.

Eight years ago there were no doctors, dentists, or pharmacists in my community, even though it is located in Baltimore, which has a high concentration of these health professionals.

The only method of obtaining health care that was available to us was the utilization of hospital emergency rooms for our episodic health care needs.

Recognizing the fact that this utilization did not fulfill the health care needs of the community several community organizations got together to form the North Central Baltimore Health Corp.

We submitted a grant proposal for funding to HEW and also requested that physicians from the National Health Service Corps be placed at our prospective site since the funds available from HEW could only cover the operating costs of the health facility and not the physician's salaries.

The clinic opened in 1972 and the physicians who staffed the clinic were the first National Health Service Corps physicians placed in the Baltimore area. Community response to the clinic was overwhelming, and the small clinic grew from having a total staff of 5 to its present staff of 12, and has increased its enrollment to over 7,000 active patients.

At the same time, the corporation grew and opened up additional clinical sites throughout the community serving over 17,000 enrollees with a staff of 54 employees.

What role does the National Health Service Corps play in this? Very simply, the funds that are allocated to our operation under section 330 are minimal and 60 percent of the patients we serve fall in the "gray zone area."

The gray zone area consists of those individuals who earn just enough to be ineligible for medical assistance and don't earn enough to pay for the cost of medical care, or they do not receive or cannot afford any health insurance.

The minimal grant funds received from HEW and payments from the gray zone individuals fall far short of our operating costs and it is only through the utilization of National Health Service Corps enrollees that we are able to provide our service to the community.

If the corps' individuals are withdrawn, we would not be able to provide services for the community and the health of the community would suffer as a result.

In short, without the National Health Service Corps we would again be back in 1972, without doctors, dentists, or pharmacists in our community.

Thank you for taking time to hear this consumer's viewpoint of the necessity of continuing to offer National Health Service Corps assignees to Community Health Services.

Mr. WAXMAN. Thank you very much.

Dr. McCann?

STATEMENT OF BARTON McCANN, M.D.

Dr. McCANN. My name is Barton McCann. I am a commissioned officer in the National Health Service Corps having joined the corps as a volunteer in 1975.

I am assigned to the North Central Baltimore Health Corp. In addition to my duties as pediatrician and family practitioner, I also serve as the medical director of the corporation.

In this position, I supervise the health professionals at three community health centers. The personnel under my supervision includes five physicians, four physician extenders, a dentist, dental hygienist, and social worker. Of these 12 individuals, 9 are National Health Service Corps assignees.

I would like to explain to you why I joined the corps, how our system functions, and how the National Health Service Corps personnel relate to our regional office.

In 1975, I joined the corps because I felt that it presented the opportunity for me to practice medicine in a medically underserved area with the help of existing support staff. I chose an urban area because my experience through medical school and residency had shown me that, although the cities appeared to have adequate numbers of well trained physicians, the reality of the situation was that the care was fragmented and often inaccessible and expensive.

The system by its nature discouraged such preventive type activities as routine immunizations and comprehensive physical exams. In addition those patients who were identified as needing medical care often received it through hospital specialty clinics where the physicians they saw were different at every visit and who often were limited to one specialty.

It was not and is not unusual for poor inner-city residents to attend hypertension clinics for their blood pressure, endocrine clinic for their diabetes, and orthopedic clinic for their arthritis.

In the presence of this apparent wealth of medical care many patients are unable to find someone with the time and interest to treat their colds, listen to their family problems, or complete simple school physical forms.

In regard to accessibility, the inner city residents often must travel by expensive, occasionally unreliable public transportation,

and when they finally do get to the hospital they frequently must wait 3 to 4 hours in the emergency room before they are seen by a physician.

As for the problem of affordability, I would just like to point out that the minimal charge for an emergency room visit to our local hospital is \$58.

It was in response to this lack of continuity, accessibility and affordability that Ms. Moore and her board of directors developed their first Community Health Center in 1972.

This health center and those which have since opened are funded and staffed primarily by Federal dollars in the form of section 330 funds and by personnel from the National Health Service Corps. In my opinion those dollars could not have been better spent nor the doctors assigned to a neighborhood with greater needs.

The fundamental goal of our board of directors is to deliver high quality health care in neighborhood health centers which are convenient to the patients in need. We are a fee-for-service operation and utilize a sliding fee scale which allows for a reduction in charges based on income and family size.

Our centers are open in the evenings for the convenience of those patients who are working or in school. In addition one of our doctors is on call whenever the centers are closed so that patients may receive care 24 hours a day, 7 days a week.

If a patient needs to be admitted to the hospital, he is admitted under the care of his own physician. This provides complete continuity by the same physician both in and out of the hospital.

We attempt to provide as many services as possible within our health centers. Examples of these services include nutrition counseling, dental care, health education, and social work. We arrange for specialty services to be provided on site by having the specialists come to the center as a consultant as opposed to sending the patient to the hospital. This integration of services at one site is very well received not only by the patients but also by the providers.

Finally, I would like to explain the relationship of myself and our National Health Service Corps personnel to the regional office. As I mentioned earlier, I am a commissioned officer in the National Health Service Corps. I was assigned to the North Central Baltimore Health Corp. through a formal agreement between the board of North Central and the regional office. This document is called the memorandum of agreement.

The day-to-day operation of our centers is handled by our board of directors who delegate this responsibility to an executive director. This seemingly difficult situation of corps personnel under the day-to-day supervision of community boards yet receiving their paychecks from the regional office is alleviated by a written document called the principles of practice.

The principles of practice is developed by the National Health Service Corps personnel with input from the board of directors, the executive director and the regional office. It describes the goals of the practice and outlines how those goals will be achieved. It details such items as hours of operation, job descriptions, and grievance procedures.

While it incorporates Federal guidelines, each principles of practice is a unique document in that it addresses the specific needs of the community to be served.

In conclusion, I feel that federally funded community health centers in underserved areas staffed by National Health Service Corps personnel are outstanding examples of successful Federal programs that effectively address the problems of unacceptable infant mortality rates, reduced life expectancy rates, and untold unnecessary human suffering.

I am proud to be a part of the effort that is attempting to reverse the effects of past neglect. I am also proud to be serving my country in the National Health Service Corps, and grateful for the vision and support of the Congress in establishing an organization that has so successfully responded to the needs of the people.

Thank you very much.

Mr. WAXMAN. Thank you very much.

Mr. Michaud?

STATEMENT OF GERALD MICHAUD

Mr. MICHAUD. For over 30 years Dr. D. F. D. Russell served an area in South Central Maine with what has today a population in excess of 10,000. In 1972, the community recognized the fact that Dr. Russell, because of failing health, was no longer able to serve its medical needs and an alternative had to be found.

With that in mind, a committee was formed with representatives from each of the six towns of Leeds, Green, Turner, Monmouth, Wales, and Wayne.

In 1975, the culmination of this committee's nearly 3 years of work began and was known as the regional health program. At that time the staff consisted of one full-time family nurse associate under the supervision of a physician based at the Central Maine Medical Center in Lewiston.

At the same time, the expanded child health program was already in existence and functioning with a secretary, receptionist, and full-time pediatric nurse assistant under the supervision of a pediatrician having been aided and funded through a State health organization that was soon to be abolished.

In 1976, the decision was made by the board of directors of the regional health program to merge with expanded child health and to form the new D. F. D. Russell Medical Center located in rented space in the rear of a local church. Both the FNA and the PNA joined forces and along with the secretary/receptionist provided medical services to the already defined six town area.

It soon became obvious because of growing patient visits that a new site had to be found. A building committee of the board of directors was formed and in January 1977 a newly built medical facility was opened. This was made possible only through town support as the town of Leeds was able to secure a loan from the Farmers Home Administration to build this facility with the medical center leasing it from the town.

At the present time we are still in the lease arrangement although thought has been given to the possibility of someday soon assuming the mortgage as we have now accumulated sufficient stability and credit.

Now that we had adequate facilities, our next goal was to apply to the National Health Service, and we began our search for an onsite physician. In September 1977, Dr. Larry Catlett joined our staff as medical director.

By this time we also had on staff a community services coordinator and soon added a medical technologist. In July 1979 our PNA left the center and in November we added an office manager.

Also in November of last year we were able to reach an agreement with a dentist which made it possible for him to start a dental practice in the medical center. The board of directors has actively supported this new service that meets a critical need in our community.

Because of the overwhelming support for the dental practice shown by our service area, we are now in the process of looking into expanding the space available by converting the center's basement into more adequate dental facilities.

This is all only 3 short months after this service began. The board of directors, many of whom have served since the beginning, are very proud of these accomplishments. In 1976, with the services of the two midlevel practitioners, the center had 3,500 patient visits. This year we expect to see in excess of 10,000.

As proud as we are of this tremendous growth and success, we fully realize that it has only been made possible because of five primary factors, without any one of which would have spelled stagnation and/or failure.

First, Medical Career Development, Inc. Since our beginning with the formation of the committee, MCD has provided us with immeasurable technical assistance, moral support, and guidance. Since the merger and the formation of the D. F. D. Russell Medical Center in 1976 we have also received a total of \$55,800 in the form of direct funding; \$23,000 in 1977; \$22,200 in 1978; \$6,270 in 1979, and we project to need only \$3,500 in 1980.

Second, National Health Service Corps. We would not have been able to add Dr. Catlett to our staff without this program. We hope to some day see the center in the position of assuming this cost. However, we are at this date uncertain as to when that will be. Between both Medical Care Development and National Health Service this financial support amounts to 33 percent of our total operating budget for 1980.

Third, town financial support. Each year an article is placed in each of the six town warrants for the annual town meetings. A yearly average of \$8,000 has been generated because of this effort.

Fourth, supervising physicians at the beginning both our family nurse associate and pediatric nurse associate needed supervision and guidance from the medical community based in the city of Lewiston, some 20 miles away. Without their help midlevel practitioners would have been impossible.

Fifth, the dedication of our entire staff. They have seen the center develop through both hardship and glory and have had a great deal to do with our growth.

In summary, all five of the before-mentioned factors have placed the D. F. D. Russell Medical Center where it is today. We envision the day when financial support may no longer be necessary. However, in the case of MCD, I cannot see where we will no longer

need their technical assistance in order to maintain an active community board, respond to increasing Federal and State requirements, continue health center development, and expand the scope of services.

Thank you.

I have with me, we have arrived a little late, copies of an annual report to the town served by the medical center that contains an awful lot of what I have mentioned here, and more.

Mr. WAXMAN. Thank you. We are pleased to receive it.

[Testimony resumes on p. 25.]

[The annual report referred to follows:]

D.F.D. RUSSELL MEDICAL CENTERANNUAL REPORTBACKGROUND AND STAFFING

The D.F.D. Russell Medical Center (DFDR) was chartered to provide a broad range of primary health care services at an affordable cost to the citizens of Greene, Leeds, Monmouth, Turner, Wayne, and Wales. The medical center program resulted from the merger of two community health programs and much community and town support in July 1976.

Shortly after the merger new construction began on a new facility. In March of 1977 pediatric nurse associate Joyce Kirkley and family nurse associate William Flewelling began working together out of this building under the supervision of Dr. Steve Sokol and Dr. Russell Morrisette. In September of 1977 Dr. Larry Catlett, a graduate of Central Maine Family Practice Residency in Augusta, joined the staff as medical director.

There have been some changes in the medical center staff since March of 1977. The current staff includes:

Larry Catlett, M.D.	Medical Director
William Flewelling, FNA	Nurse Practitioner/ Assistant Administrator
Kevin Carey, Jr., D.M.D.	Dentist
Annette Grace	Medical Assistant
Jill Rogers	Office Manager
	Secretary/Receptionist

ORGANIZATIONAL STRUCTURE

The medical center is a community-based, not-for-profit corporation which is governed by 15 directors chosen from the towns served by the medical center. The Board of Directors meets monthly to review progress towards the program goals and objectives, to formulate operational policies, and to discuss new ways the medical center can become a self-sufficient resource that provides a full range of medical services that are needed by the community. The current Board of Directors includes:

<u>Directors</u>	<u>Town of Residence</u>
Gerald Michaud, President	Turner
Charles Woodward, President-Elect	North Leeds
Ellen Albert, Secretary	Greene
Gretchen Bubier, Treasurer	Greene
Kathy Additon	Greene
Elinor Ault	Wayne
Mary Briggs	Turner
Molly Fredericks	Leeds
Jassie Garrow	Greene
Robert C. Jones	Wales
Gerald McNear	North Leeds

Michelle Perry
Jameson Reynolds

Monmouth
Greene

SERVICES PROVIDED

The medical center is open from 8:30 a.m. - 5:00 p.m. on Monday, Tuesday, Wednesday, and Friday. Thursdays there are also evening hours from 6:00 - 8:00 p.m. Twenty-four hour emergency coverage is provided through a professional answering service and beeper system. Call is shared by Dr. Catlett, Mr. Flewelling, and Drs. Claxton and Elias of Lewiston. When Mr. Flewelling is on call he is backed up by a physician. In the past there have been technical problems with the beepers which have prevented the on-call provider from responding in a timely manner. If you call the answering service and are informed that you will be contacted by the on-call provider but are not contacted, please do not hesitate to recall the answering service. Chances are quite likely that the beepers have malfunctioned.

The following services are available at the medical center:

- Comprehensive family care
- Emergency care
- Prenatal and obstetrical care
- Preventive services including physical examinations, a broad range of laboratory services, immunizations, Pap smears, and other screening tests
- Dental care
- Family planning and cancer screening
- WIC services (Women, Infants, and Children's Food Supplement Program)
- Focused patient education classes for diabetic patients
- Pharmacy services

An important goal of the D.F.D. Russell Medical Center is to assure that medical services are coordinated within the service area. Therefore, the medical center maintains linkage agreements with other organizations to assure that medical center facilities and staff are used to their fullest capacity and that services are provided locally wherever possible. Formerly, the residents may have had difficulty knowing who to call for specific services. Now the medical center refers citizens to the special health and social services when requested or needed. The following is a list of all cooperative arrangements which the medical center has developed:

<u>Provider/Institution</u>	<u>Services Provided</u>
Androscoggin Home Health Agency	Home nursing services referrals; Early Periodic Screening, Diagnosis, and Treatment Program referrals
Buckfield School System	Athletic and school physicals
Central Maine Medical Center	Inpatient care; lab, x-ray and other diagnostic services; patient education for diabetics
County Extension Service	Homemaker and nutrition services

Division of Public Health Nursing	Referrals for women with high risk pregnancies
Kevin Carey, D.M.D.	Dental services
Leeds Improvement Association	Transportation for elderly citizens to the medical center
Rural Christian Action Ministry	Referrals for counseling service
Southern Kennebec Women, Infants, and Children's Program (WIC)	Food supplement assistance to eligible mothers and children
Tri County Family Planning	Family planning and cancer screening services
Task Force on Human Needs	Outreach services
Winthrop Pharmacy	Pharmacy services available at the medical center

PROGRESS REPORT

Utilization and Financial Indicators

The D.F.D. Russell Medical Center continues to strive for self-sufficient operations and shows a dramatic increase between 1978 and 1979 performances.

The total number of patient visits in fiscal year 1979 was up 25.9% over 1978. Total charges in the same period increased from \$59,385 to \$87,785, an increase of 47.8%. The amount received from patient charges was also on the rise from \$39,788 to \$77,227.

The table below reveals the progress over the last three years, relating total revenues to expenses. Based on the first six months of FY80 operations, patient visits and patient charges are expected to exceed projections for FY1980. In fact, visits are likely to reach 10,000.

	FY77	FY78	FY79
Total patient visits	4,185	6,814	8,579
Total patient charges	33,324	59,385	87,785
Total patient receipts	20,660	39,788	77,227
Total operating expenses*	N/A	109,126	118,561
Patient charges as a percentage of operating expenses	N/A	54.42%	74.04%

(*Includes allowance for total National Health Service Corps cost.)

In addition to managing the business functions of the medical center, the Board of Directors has worked hard during 1979 to expand its services to meet the special needs of the community. The board and staff still support the provision of services regardless of one's ability to pay. During the last year special cancer screening clinics were offered, a special recall system was set up to assure that the medical center's patients would be adequately immunized against childhood diseases and screened for anemia. Physical

examinations were provided at area schools; the WIC Program's intake and follow-up services were available at the center; and the Androscoggin Home Health Agency used the facility to provide screening clinics for the elderly. In addition, the center continues to serve as an access point for complete family planning services through cooperative arrangements with Tri County Family Planning. The medical center also manages a special fund which is available to eligible patients needing funds to pay for special diagnostic testing, i.e. ultrasound or x-rays, or for medications.

This past year several new developments have occurred which greatly enhance the medical center program. These developments include starting of on-site pharmacy services, expanded laboratory services, part-time dental services, and a special patient education program for diabetics.

Early in the year an agreement was arranged with a Winthrop pharmacy making prepackaged pharmaceuticals available at the health center. The Board of Directors recognized the need to make prescription drugs more readily available to its patients within the community. Currently, most of the drugs that the medical center staff commonly prescribe are available on site.

The medical center has purchased several new pieces of laboratory equipment which has greatly expanded the number of laboratory tests that can be performed on site. This new service will be most helpful to patients with chronic health problems and will cut down on patient travel to Central Maine Medical Center to have blood tests done.

This past fall, Dr. Kevin Carey approached the Board of Directors with a proposal to begin a dental practice in Leeds. An agreement was drawn up which has made it possible for Dr. Carey to start a dental practice in the medical center. Dr. Carey began providing services in November. The Board of Directors has actively supported this new service that meets a critical community need. Dr. Carey is currently available at the center by appointment weekdays, evenings, and Saturdays. Dr. Carey's wife, Kathy, also works in the office assisting during this early stage of development. The board hopes to work closely with Dr. Carey and the area schools to develop a dental education program for school age children and to help support the development of a broad range of dental services for the area.

A special education program has also been implemented for patients with diabetes. The medical center staff with assistance from Medical Care Development developed an education program with the medical education staff of Central Maine Medical Center. The program is offered at the medical center in Leeds. Diabetic patients and their spouses referred by the medical center providers are enrolled in a five-session program to teach them about their disease and give them the skills and reinforcement to keep their problem under control. There will be three to four sessions in the upcoming year. The program is available at no cost to the patient.

The Androscoggin County Bureau of Civil Emergency Preparedness has donated a porta-pac defibrillator to the medical center for use in the event of a cardiac emergency. This donation is greatly appreciated by the medical center giving the staff greater capability to care for a patient suffering a cardiac arrest.

The medical center is utilized by residents from throughout the entire service area. A breakdown of the number of patients enrolled with the medical center is provided below:

<u>Percent of Patients Served</u> <u>By Town of Residence</u>	
Leeds	24%
Greene	22%
Turner	21%
Monmouth	14%
Wales	4%
Wayne	4%
other	11%
	<u>100%</u>

Since its opening, the medical center has experienced a consistent growth in utilization from outlying communities. The staff and board members are reviewing new methods for reaching further into all communities served. A special newsletter is now produced and mailed to residents throughout the area. The newsletter provides information about services and offers educational material about special health problems. It is hoped that efforts such as this will continue to help expand community utilization and support.

FINANCIAL AND TECHNICAL SUPPORT

Over the years the medical center has received and greatly appreciated financial support from all the towns it serves. These funds help to assure the operating expenses can be met and special services such as those described above can be expanded while the medical center continues to grow. Such support is necessary in part to help keep fees for services affordable and allow services not reimbursable by Blue Cross and Medicare to be continued.

In addition to this support the medical center continues to receive funds and technical assistance from Medical Care Development of Augusta. MCD was instrumental in providing funds to make building improvements including repairs to the parking lot, a ramp for the handicapped, insulation, and ventilation changes. MCD has assisted with the development of a number of rural community health centers such as the D.F.D. Russell Medical Center with the objective of providing seed money to help establish comprehensive self-supporting programs. The Board of Directors also receives some assistance from the National Health Service Corps to pay the medical director's salary. These programs are designed to encourage as much local involvement and financial support as possible. The medical center has shown marked gains not only in its utilization and progress towards self-sufficiency but also in its ability to provide a comprehensive community program that is responsive to community needs. The board is optimistic that it will be able to continue to expand its services while becoming less dependent on revenues from Federal sources.

The budget for FY 1980 is provided below giving expenses categories and projected sources of financial support. The budget has been developed by the Finance Committee of the board and has been approved by the board, staff, and MCD.

D.F.D. RUSSELL MEDICAL CENTER
OPERATING BUDGET
FY 1979-80

PERSONNEL	\$102,567
EQUIPMENT	1,750
SUPPLIES	16,700
FACILITY/SPACE	11,500
CONSULTANTS	4,500
TRAVEL	3,000
OTHER	<u>1,800</u>
TOTAL	\$141,817

PROJECTED SOURCES OF REVENUES

PATIENT CARE REVENUES AND SPECIAL SERVICE CONTRACTS	61%
FEDERAL FINANCIAL SUPPORT THROUGH MEDICAL CARE DEVELOPMENT, INC., AND NATIONAL HEALTH SERVICE CORPS	33%
LOCAL TOWN SUPPORT	<u>6%</u>
TOTAL	100%

Mr. WAXMAN. Dr. Catlett?

STATEMENT OF LARRY L. CATLETT, M.D.

Dr. CATLETT. I also apologize for the lack of a prepared statement.

Short notice and a busy practice have kept me from doing same.

I am Larry Catlett, trained through Emory Medical School in Atlanta, Ga., and arrived at the Russell Medical Center in September 1977 to fulfill what was a co-step obligation, a now defunct program of the National Health Service Corps which was not nearly as extensive as the scholarship program now existing.

What I paid back for my 2 years was a \$1,500 debt. At any rate, in September 1979 I fulfilled my obligation with the National Health Service Corps, and reinstituted a working relationship with the Corps to allow my continued presence at the center.

As I understand it, today my purpose is to basically convey what my role is at the center, and I think it is more important the enthusiasms I have for the practice at the center which is made possible by the National Health Service Corps.

First of all, Leeds is a very small almost nontown. There really is no center of business activity. The office is essentially in a cornfield this year. Last year it was hay.

There is no particular attraction to Leeds, except that it seems to be the center of a geographical area which people have for years moved up and down through. There are no major population centers with the possible exception of Turner where Gerry lives which is some 15 miles distant from the center.

One of the problems we had in our establishment was to get people who were in small population cluster circles to come away from their previous modes of travel into our practice area. I won't go into all of that, but obviously it has worked quite well and we are very busy now.

The practice itself is a family practice. The beauty of it so far, and I say that because I function day to day with some concern about what will be the policy passed down to me as to how I am supposed to practice at a later date, is that the patients perceive it as purely a family practice, not as a clinic or Government organization as such. We do pediatrics, obstetrics, some 40 deliveries a year in the hospital in Lewiston. Our specialty cases and referrals go to that hospital through specialists I suggest.

Again the beauty of the practice, as I see it now, is that we, meaning myself and a family nurse associate who was mentioned in the preceding report, are able to provide care to people who fall in an interesting income group in that they don't quite make enough to qualify for any privately funded insurance programs but are a little too well off or stubborn, et cetera, to involve themselves in any Government programs.

Our fee schedule is quite low and is much below that of the surrounding areas. I might mention here that this I see as a potential difficulty, not at this point, but a potential difficulty perceived as competition with other physicians, and I am not sure how that is going to be worked out.

At this point I am so far removed from the overpopulation of physicians 20 miles distant in Lewiston, and nobody seems to care

about that one way or the other. It does allow us to charge \$10 for an office visit, and \$5 to recheck on people who can't afford to pay even that, and yet I still make what I consider adequate, though, as you mentioned, perhaps less than the current going salary for the amount of hours I put in.

I also feel that the practice as it exists now with the help of the Corps paying my salary but the center itself supporting itself is the inspiration that I feel is lacking in a lot of Corps positions. In private practice, you get paid for what you do. In the Corps you get paid a salary.

When you are on call 7 days a week you can get a little tired of that pretty fast and it is one of the major difficulties that we deal with in rural centers. One way to keep initiative up is that the money I generate is all put back into the center and pays everybody else's salary. We cannot support ourselves without me, and I have to be there to generate the money to make everybody else's payments go.

The other problems that I see, aside from all of the good parts we have talked about are, as I have mentioned, is "on call." It's a real problem, and one way we had hoped to solve it was that we were currently talking about getting another physician in who had done a month of his residency with me.

We had a lot of medical students in residency rotating through our center. This places great stress on the center, especially at present, and we are in an interesting position of trying to decide how we want to go in the next several years.

We are now a very busy functioning, viable private practice. Part of what the board has designated as its goal is to have a little bit better than that, that is, provide preventive care, educational resources, both for the community and medical students, residents, in the hopes of bringing them into the area.

It is difficult for me, seeing 20 to 30 patients today, to pull time away to do teaching and, again, night calls are a constant burden. Coverage is through a totally non-Corps center arrangement with me arranging through family physicians in Lewiston to cover me.

We were informed that there is a moratorium on money for volunteers in the National Health Service Corps at this point and here we had, as I see it, an opportunity to really reinforce the structure of this center as somebody who is finishing his residency and knew what he wanted to do and wanted to get into the Corps system but could not. At this point I am very reluctant to deal with scholarship people for much of the same reasons you heard here today.

I, basically, if I could say in summary, think this is a really good site and I would welcome all of you to come up and look at it and see how a National Health Corps site really functions well.

Mr. WAXMAN. I want to thank all of the members of this panel for testifying today about the different types of organizations that use the National Health Service Corps.

Dr. Catlett and Dr. McMann, how did the National Health Service Corps match you with the two communities you now live in?

Dr. McMANN. I was a volunteer, so I looked at several different sites and chose the Baltimore site. I volunteered in 1975.

Mr. WAXMAN. How about you, Doctor?

Dr. CATLETT. I was signed up with an obligation to the Corps to the Indian Health Service, but due to a serious family illness, being a resident in Augusta, switched to the National Health Service to serve in Leeds.

Mr. WAXMAN. Are you presently serving out your obligation?

Dr. CATLETT. I am finished with that and now re-signed up for 3 years at this point. A point I might bring up, when I tried to do this, nobody was really sure what to do with me because I wanted to stay on, and I wanted some sort of long term guarantee about this point.

Mr. WAXMAN. Was that after you had served a period of time?

Dr. CATLETT. I will sign up again after 3 years and perhaps eventually transfer into a long-term career obligation.

Mr. WAXMAN. We have a program that awards scholarships to medical students and then assigns these people to a needy service area with the hope that they will be retained in that area, yet a volunteer has an obstacle placed before him and a person who wants to continue on also has difficulty.

Dr. CATLETT. The root of that problem began with the fact that the original intent of the Corps, as the board and I understood it, was to get me self-sufficient in 2 years. The Corps, the board, and myself changed our minds about that simultaneously, and nobody has really to my knowledge formulated a policy that can deal with that particular situation long term.

Mr. WAXMAN. Has the National Health Service Corps representative ever come to visit you since you began practicing in your center?

Dr. CATLETT. They have been there. They have invited me to come away, which is very difficult, and I have not at this point.

Mr. WAXMAN. Were they helpful?

Dr. CATLETT. Yes. Danny Lassiter came to visit us in Bangor to help with problems and try to inform us about what current Corps policies were. They learned a lot about me, not really knowing how I got there, and I learned a lot about what they are trying to do for us, too.

Mr. WAXMAN. How about you?

Dr. McCANN. We have fairly close cooperation and direct contact. They have been very helpful.

Mr. WAXMAN. Mr. Michaud, is your health center is self-sustaining except for Dr. Catlett's salary?

Mr. MICHAUD. That is right. We are looking to being funded to the tune of \$3,500 this year. Along with that, we are talking about approximately another \$8,000 of town support.

Now other than those two amounts, roughly \$11,000, we are self-sufficient, excluding Dr. Catlett's salary.

Mr. WAXMAN. In your testimony, you state that there is a fee schedule that you use to charge patients when they come into the center. Do the fees go to the center and not for the physician?

Mr. MICHAUD. That is correct.

Mr. WAXMAN. Are some of those people insured or are most patients uninsured?

Mr. MICHAUD. Some are, maybe one third are insured, and two-thirds are not.

Mr. WAXMAN. Are you fairly successful in getting the fees paid by the insurance or by the individuals if they are not insured?

Mr. MICHAUD. Our collection rate has increased dramatically over the past couple of years. Back in 1976 we were at a 50- to 55-percent collection rate and now we are rapidly approaching 85 to 90 percent. Part of the problem there is that there is town support. I think the opinion of some townspeople back in our early days was that because of this town support they could come to the medical center free and they were not expected to pay.

Mr. WAXMAN. Was the Federal Government paying for it?

Mr. MICHAUD. Yes, or the town, whatever.

Mr. WAXMAN. If say the Federal Government decided to stop paying the physician's salary at the center, do you think the community would come to the center's aid and pay for the salaries and other services?

Mr. MICHAUD. That is a difficult question. I think that it is possible that that would happen. We have gone to the town in past years for financial support. We have not gone to them for that sort of sum that you are referring to. But it could happen.

Mr. WAXMAN. Mrs. Moore, what was your experience prior to the National Health Service's program? Did you have physicians in your area before Dr. McCann came to practice?

Mrs. MOORE. Before, in 1963 and 1964, the community that I live in was 90 percent white. In 1965 to 1968 it was 90 percent black. After the change the doctors left and the transition left us without any doctors or dentists or facilities or pharmacies. We had to use the closest hospital for emergency services, as I stated.

Then the community, who did not realize at the time that there were needs and who primarily used these emergency rooms because they didn't know that there was anything else available, organized and through the efforts of community groups we sought another arrangement. Because of the expenses of the emergency rooms in the hospital which the community could not afford we had to seek other means. It took us quite awhile to do that. We had go into Hopkins and other places to seek doctors and some help, but it was not available because we could not afford it.

Mr. WAXMAN. Did the National Health Service Corps help you start the center or in obtaining the physician?

Mrs. MOORE. The community centers, with the help of a lot of people, and then the National Health Service Corps came in and they were very helpful from the beginning. We could not have done it without them. You did not ask me but I would like to tell you how important the National Health Service Corps is to our community.

We have people in our community who are not eligible for Medicaid and Medicare, who cannot afford the expenses of some insurances who need our health centers, and who cannot, without the National Health Service Corps, get the health services they need.

We have a sliding scale fee of \$2 to \$12 for our patients who, most of them, can fall within that area.

Mr. WAXMAN. What is your collection rate? Are you successful in having people pay sliding scale fee?

Mrs. MOORE. I will send you that information to the exact figure, but we are pretty successful because those who can afford it—we

usually have a social worker talk to those and to see what the circumstances are, and those who can afford it usually pay.

But we would not be able to be self-sufficient for a long time, in a very long time, not in the community that I live in.

Ms. MIKULSKI. Will the chairman yield for further amplification of a point I think he was making about the role that Mrs. Moore and the community played?

Mr. WAXMAN. Yes.

Ms. MIKULSKI. Mrs. Moore, I am familiar with your effort. Your project falls in the area where Congressman Mitchell's district and mine are contiguous. I am familiar with what happened in the sixties.

My question to you, and I think it follows from what the chairman was getting at, concerns what you stated on page 1 of your testimony: "We submitted a grant proposal," and then you go on and cite the number of things "we" did.

The chairman is interested, as am I, No. 1, who is the "we"? and No. 2, how did you do it? No. 3, how did you know how to do it? and No. 4, concerning the role of the U.S. Government, were we of any help whatsoever or was it once again the ingenuity, resourcefulness, and guerrilla warfare of the grassroots community organizations?

Mr. WAXMAN. Could I ask you to hold that question for your time. I want to hear the answer but my time has expired and I want to ask Dr. Carter next. But that is the question I was trying to get at.

Ms. MIKULSKI. I will ask it in a few minutes.

Mr. WAXMAN. Dr. Carter?

Mr. CARTER. How many MD's are there, Dr. Catlett, in your operation?

Dr. CATLETT. One.

Mr. CARTER. How many nurses?

Dr. CATLETT. Mr. Flewelling is a family nurse associate, a trained RN and a midlevel practitioner. So we have just that one.

Mr. CARTER. Do you have any paraprofessionals?

Dr. CATLETT. We have someone who does some lab work, blood pressures, hematoritis, blood chemistry, et cetera.

Mr. CARTER. Do you have X-ray equipment?

Dr. CATLETT. No.

Mr. CARTER. Just laboratory equipment?

Dr. CATLETT. We just recently acquired that.

Mr. CARTER. Do you do blood counts?

Dr. CATLETT. We do not do white blood counts now. The laboratory equipment has been in place only 1 month.

Mr. CARTER. In a case like this, doesn't the Public Health Service Corps help to set up your facility?

Dr. CATLETT. They did not help to set this facility up. I am unable to remark on the reasons for all of that.

Mr. CARTER. How do you diagnose patients?

Dr. CATLETT. I have X-ray facilities within 21 miles.

Mr. CARTER. Have you had to do these with a stethoscope?

Dr. CATLETT. Yes, sir.

Mr. CARTER. How many people are involved in your facility?

Dr. CATLETT. People in general? There are three office staff and two practitioners.

Mr. CARTER. That is a nurse and a physician. Do you do deliveries or do you refer them?

Dr. CATLETT. I mentioned that I do 40 deliveries a year—and 1 in the office.

Mr. CARTER. Do you take any of them to Lewiston?

Dr. CATLETT. That is where they all go.

Mr. CARTER. Do you do home deliveries?

Dr. CATLETT. No. I cannot get backup from the physicians in the hospitals if I do that. If there are complications, they don't want to get involved.

Mr. CARTER. You are on 7 days a week?

Dr. CATLETT. I am off 7 to 8 nights a month, depending on circumstances.

Mr. CARTER. You are paid by the National Health Service Corps I take it?

Dr. CATLETT. Yes, directly.

Mr. CARTER. Your salary is supposed to be comparable to that of physicians in communities such as yours; is that correct?

Dr. CATLETT. To my knowledge there is not a community adjustment.

Mr. CARTER. I believe that is part of the law.

Dr. CATLETT. I am not aware of that.

Mr. CARTER. In your operation, Dr. McCann, how many physicians do you have?

Dr. McCANN. We have five.

Mr. CARTER. How many nurses?

Dr. McCANN. Four nurses.

Mr. CARTER. Are they specially trained?

Dr. McCANN. One is RN, one is LPN, and two are health aides from the community.

Mr. CARTER. One RN, one LPN and two aides? And did you say five physicians?

Dr. McCANN. Yes, sir.

Mr. CARTER. And you have a patient load of 7,000; is that correct?

Dr. McCANN. That is at one of the centers. We operate three of them. One is a geriatric center and the other two are community health centers. The total is 17,000, not 7,000.

Mr. CARTER. I though your testimony stated 7,000. Maybe I misread it.

Mrs. MOORE. I was stating the total that we had in all three. It is 17,000.

Mr. CARTER. What are your facilities like? For example what equipment do you have in your clinic?

Dr. McCANN. Our equipment is for minor laboratory procedures, urinalysis, et cetera. We don't have major laboratory equipment. We use the neighborhood hospital.

Mr. CARTER. You don't do blood sugars, cholestrols or BUN's?

Dr. McCANN. No, sir. We have a contract with an independent laboratory that picks up our blood.

Mr. CARTER. It takes a little time to send them out, doesn't it?

Dr. McCANN. Twenty-four hours, but in emergencies we can have them sooner. In emergency care we can utilize the hospital STAT laboratory.

Mr. CARTER. That seems to be rather difficult, as I see it. I assure you, I have been in places just as rural as yours, Dr. Catlett, we practiced good medicine. You almost have to have a lab to do it. That doesn't require too large an expenditure, as I see it.

What about transport? Does the emergency medical service system help you transport very sick people?

Dr. McCANN. Yes. The Baltimore City Fire Department transports patients in need of emergency medical care.

Mr. CARTER. Are they funded, too?

Dr. McCANN. They are not associated with us.

Mr. CARTER. How do you transport your patients, Dr. Catlett.

Dr. CATLETT. Through county-sponsored ambulances stationed in various points of the county, and they have EMT's in the ambulance.

Mr. CARTER. Is it very helpful to you?

Dr. CATLETT. It certainly is because of the increased ability of getting care to the patient instantly through the EMT, even if it is as simple as basic CPR.

Mr. CARTER. How would you like to have a good lab up there where you are?

Dr. CATLETT. I could comment on that at length, if you would like.

Mr. CARTER. Well, a short comment.

Dr. CATLETT. Basically, we are going to have all that a community health center should have. We can do blood sugars. We can do blood counts when they are necessary on an emergency basis. There are not too many times when a blood count is an emergency procedure. They are helpful diagnostically, but as you inferred previously, a lot of that can be done clinically. So I think it is nice to have some. Too much is cumbersome and costly.

Mr. CARTER. But you have to have enough, as I see it, not too much. Otherwise you cannot practice good medicine as I see it. I want to see that you have the capability of doing it. I believe you are doing a good job.

Thank you.

Mr. WAXMAN. Mr. Preyer.

Mr. PREYER. Thank you, Mr. Chairman.

I was interested in Mrs. Moore's and Dr. McCann's testimony about the operation of the National Health Service Corps in Baltimore. I met with some mayors from large cities last week and they told me how medical care was being stripped from the central city and was being moved to the suburbs. They were demanding that we do something. I could not think of anything very much better than the National Health Service Corps. I congratulate you on what you are doing there.

Ms. Mikulski is our authority on this and I know she has more sweeping and probing questions than I would have, so when she returns I will yield my time back to her. At this time perhaps we can go through the other questioners. I think she will be back.

Mr. WAXMAN. Thank you very much.

Mr. Dannemeyer?

Mr. DANNEMEYER. How do you handle malpractice insurance? Do you have any?

Dr. CATLETT. My personal malpractice is through the Federal Government.

Mr. DANNEMEYER. The Federal Government pays the premium on your malpractice insurance, is that right?

Dr. CATLETT. Right. In fact, the way I understand it, if I were to be sued, my name is erased from the docket and the Federal Government is put in. So the bills do not carry liability. It has been discussed.

Mr. DANNEMEYER. The clinic itself doesn't have it?

Dr. CATLETT. And the board itself does not have it. It has been advised by legal counsel that it is probably not necessary in Maine at this point.

Mr. DANNEMEYER. What would you be paying if you were in private practice, other than national health insurance?

Dr. CATLETT. With obstetrics and minor surgery, close to \$3,500 a year.

Mr. DANNEMEYER. What if the operation of your clinic in Maine, somebody said, friends, you are going to have to make it push come to shove and the income has to match the outgo. You would have to adjust your fees in order to pay your physician. You would not like to do that, but if somebody said you have to do it, can you give me an idea how you would make out?

Mr. MICHAUD. I think the end result of that would be that a lot of people would be going without medical care because of our having to raise our fees. I am not sure in the end that we would still be able to support the physician by ourselves. We have already discussed the possibility of the towns coming in with more financial support for the physician. That is a possibility, although, again, our six-town area with a total population of 10,000, that would be quite a chunk out of each town's budget.

Mr. DANNEMEYER. You mentioned that there was some doctor that retired recently that was servicing your area. How long ago did that physician retire?

Mr. MICHAUD. He passed away 4 or 5 years ago. He had served the area for over 30 years.

Mr. DANNEMEYER. Was there a period of time when you were without the services of a physician after that gentleman passed away?

Mr. MICHAUD. Yes. There was a period of time when we had two midlevel practitioners.

Mr. DANNEMEYER. How long was that?

Mr. MICHAUD. From the time Dr. Russell was unable to practice, I would say 3 or 4 years where we were without it.

Mr. DANNEMEYER. I would like to ask the gentlemen and lady from Baltimore, how do you handle malpractice insurance?

Dr. McCANN. As a National Health Service Corps commissioned officer I am covered by the Federal Tort Claims Act. Our board also has malpractice insurance that covers the other employees as well as the operation of the center and is paid for out of the operation of the grant.

Mr. DANNEMEYER. What would happen in your facility if the Federal Government would say they are going to have to raise your fees to finance the outgo, what would be the impact?

Dr. McCANN. We would be back where we were in the sixties with no care for the patients.

Mr. DANNEMEYER. How do you say that?

Dr. McCANN. Because we cannot support the practice and pay the physicians on the incomes the people have.

Mr. DANNEMEYER. Then the people would go without medical care?

Dr. McCANN. And some would go to emergency rooms.

Mr. DANNEMEYER. There are some maxims throughout life and one is that services will be utilized to the extent of somebody else paying the bill. There is a matter of judgment involved in terms of us sitting in a policy position of spending other people's money to in effect subsidize health care in Baltimore and Maine. Taxpayers in this country are expressing a sense of frustration at the level of taxation. There has to be a meeting of the minds of the willingness of the taxpayers at large to support medical services in Baltimore, Maine, or what have you?

Dr. McCANN. I would think of all the things that money is being spent on by the taxpayers, that surely they would not want to take it away from people in the inner cities. It seems to me it is one of the most worthwhile projects that taxes go for.

Mr. DANNEMEYER. Is there an effort on the part of the clinic that every person has to pay something for their services?

Dr. McCANN. Every person receives a bill. There are no free services. They are all charged.

Mr. DANNEMEYER. What is your collection effort results?

Dr. McCANN. I would presume over 50 percent.

Mr. DANNEMEYER. What happens if people don't pay the bill?

Dr. McCANN. If they don't pay the bill?

Mr. DANNEMEYER. They come back for more services and they have not paid the bill, what do you do?

Dr. McCANN. We ask them if they are able to pay the bill. If they are not, we provide them the service. It is difficult for me to describe just how poor some of these people are. Perhaps I should turn it over to Mrs. Moore who lived in the community.

Mr. DANNEMEYER. You are looking at a Member of the House who saw a doctor once before I began playing school athletics. We cannot afford it. Those were tough years.

Mrs. MOORE. You are also looking at a member of the board of directors from the North Central who could not afford to see a doctor for a number of years. That is not what we are talking about. We are talking about people in the community who are unable to pay for health services. That is why I have spent 10 to 12 years of my life to see that people who do not have the money will know money alone does not enable them to get services.

I think if I as a taxpayer can give up so much of my life, we can face the taxpayers of this country and tell them how important health care is to people who cannot afford it, I think they would change their mind.

Are we interested in more dollars or more lives? I thought the people of the United States of America were interested in saving

lives and not money. I am a citizen and a taxpayer. I do not get paid to do what I do. I do it voluntarily. I think you, as a committee, can look at it as I do and look on people as human beings, not as a money sign.

Thank you.

Mr. DANNEMEYER. I have no further questions.

Mr. WAXMAN. I want to tell you that I think you put that well. I appreciate you saying that. We always have the debate in the Congress of the United States as to all the various programs that we are asked to fund, including bailout of corporations that want our subsidies for big business.

While we have philosophical disagreement—and that is important because we represent various different areas geographically and politically in this country—I agree with you, I think the American people and their representatives want to see poor people get health care, otherwise they are going to end up paying more for sick people who become criminals and have to be on the dole for the rest of their life.

Under those circumstances, the people who keep that strict a record will realize health care is cost effective.

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

The purpose of this, as I stated before, is to provide help in underserved rural and ghetto areas, people who cannot otherwise get medical assistance. Really, I think it is a very necessary compassionate program.

If the chairman will permit, I remember when I came back to a rural area years ago. There was an old physician there who gave me this advice: Make the fat fry the lean. In other words, he meant that I should charge those who had money according to what they had and thereby take care of the poor as well.

I am thankful that even though I live in Appalachia we were able to build a hospital and a clinic which has a laboratory with a licensed technician and also X-ray equipment. We did it all without Federal aid.

But I realize that there are cases where it is impossible to do. For that reason, I support this program.

How many patients, by the way, Dr. Catlett, do you see a day?

Dr. CATLETT. Between 20 and 30, depending on a multitude of things.

Mr. CARTER. On an average, how many do your five physicians see a day?

Dr. McCANN. Approximately 20.

Mr. CARTER. In the last days I was in practice, I saw 50 of them on a regular basis.

Thank you very kindly, Mr. Chairman.

Mr. WAXMAN. Ms. Mikulski?

Ms. MIKULSKI. Thank you, Mr. Chairman.

I thank the indulgence of the committee in being patient to wait for my return to the room. I left to accept a phone call from Bangkok, Thailand. As many of you know, the Congresswomen made a special trip to that area on the issue of refugees. That was a followup phone call about the situation becoming increasingly desperate. Thank you for waiting.

If I could pick up, Mrs. Moore, on the question that I asked earlier where you talk about the fact that several community organizations got together, formed the North Center Baltimore Health Corporation, and then applied for a HEW grant, and for National Health Service Corps personnel, all of which require a great deal of, I think, sophistication and expertise, I just wonder, how did that occur?

Mrs. MOORE. The community submitted the grant to HEW.

Ms. MIKULSKI. How did the community know, one, to submit a grant to HEW, how to draw up a grant for HEW, and who did it?

Mrs. MOORE. We had go to several people in the community who knew about grants and had expertise.

First, we organized three communities, the Mund area, Homestead-Montibello, and Waverly. We came together to form a community group. Out of that group I think we first started with 72 people who wanted to handle everything and everybody wanted a part of the turf. You know how the ball game goes.

We got together with a few people and started in the church on Alameda and 29th Street. We got a few people together with some community expertise who knew about writing proposals—we did not, the ones who started the process—and we submitted a proposal to HEW. The community organized the center and the National Health Service Corps furnished the physicians.

Ms. MIKULSKI. Mrs. Moore, I think that is tremendous. I am familiar with the community and therefore know that there are a lot of folks around who are social workers who have some of this knowledge.

The reason I asked this question is that communities, for example, in rural areas like our friends here from Maine or communities that don't quite have the neighbors, the community people themselves don't have some of this background.

The reason I ask that is that if we are going to be effective, there should be some way that community people who organize on the basis of need should be able to follow those processes. Therefore, you did it because you knew community contacts that could help you.

By the way, did city, State, or Federal Government provide any kind of one-stop shop in order for you to have the information to pursue solving your own problems?

Mrs. MOORE. The city government was helpful because we needed statistics and different kinds of forms. You, at the time, were councilwoman and you were very helpful.

Ms. MIKULSKI. I was one of those community leaders with expertise.

Mr. WAXMAN. I think that question was a setup.

Ms. MIKULSKI. Thanks, Mrs. Moore. We rehearsed this rather well.

Mrs. MOORE. You were very helpful to us and other people in the city government were helpful too. That is how we got started. You provided us with a lot of help in setting up and what to do and where to go.

Ms. MIKULSKI. As we go to refashion the program, would you recommend some type of one-stop shop in terms of a clearinghouse,

like something at HEW where somebody is in a rural area or small town where they don't have the expertise?

Mrs. MOORE. Yes, I do, because we, as a model for the whole thing, were stumbling around. To save a lot of time from a whole lot of stumbling and a whole lot of running around and a lot of years, if a model was set up in HEW that someone could go to and be told this is step one, two, and three and this is what works for you,

If there are several models that one could utilize, it would be helpful. If we had a model when we started, it would have been helpful. It would have saved a couple of years of running around and bumping heads.

Ms. MIKULSKI. Thank you very much. I think we should make a note of that.

Dr. McCann, I have a few questions for you, if I may.

First of all, I understand you have been cited as one of the best National Health Service doctors in the country, is that right?

Dr. McCANN. That may be an exaggeration.

Ms. MIKULSKI. Well, as Mrs. Moore says, she knew me when I was a councilwoman. I have made a career of that, so don't you feel funny.

My question to you, doctor, in looking at your staffing pattern, and at page three where you talk about your interest in public health services like nutritional counseling, social work and so on, I would like to know, one, do you utilize allied health professionals, and I would like to know who they are, what it is they do, and who pays their bill?

Dr. McCANN. By allied health professions, do you mean within the center?

Ms. MIKULSKI. Yes.

Dr. McCANN. Yes, we do. Their salaries are paid from the grant we receive which is primarily out of section 330 funds. It includes people that we call health advocates, who help the patients with processing of medical assistance papers, enrolling for such programs as food supplements, et cetera.

So we do have allied health personal at the site and their salary comes from the grant which is primarily section 330 funds.

Ms. MIKULSKI. What about the social workers and the health aides that you mentioned? Do you have nurse practitioners or physician assistants? In other words, National Health Service Corps right now is targeted to physicians, dentists and pharmacists as I understand the program. I am wondering what it is that you use and if they are paid for out of the National Health Service Corps?

Dr. McCANN. Out of 12 people, 9 are National Health Service Corps, that is the group I listed in our statement.

Ms. MIKULSKI. Then the other would be considered advocacy services or community education services from out of the section 330 funds; is that right?

Dr. McCANN. That is right.

Ms. MIKULSKI. In your opinion or Mrs. Moore's opinion, are those services provided by the nonphysician personnel essential to the primary care, and should we consider a greater expansion in those areas as well?

Dr. McCANN. I would say they are absolutely essential. As a physician working in the inner city I could not function without the assistance of these people.

Ms. MIKULSKI. Could you elaborate on that?

Dr. McCANN. In trying to see 20 patients a day where finances is one of the problems and people have no transportation or not enough money for food, I would be spending so much time on the telephone contacting different agencies making referrals that I would not be able to perform my primary role which is delivery of health care. So it frees me to provide more health care to more patients by having more support staff in the community health center.

Ms. MIKULSKI. So this is important as a health care delivery team?

Dr. McCANN. Absolutely. We think it is crucial.

Ms. MIKULSKI. When your service time is up, and perhaps with the other physicians, are you planning to stay on? Is this a sufficient enough practice for someone like yourself and how would you be paid if you decided to stay there?

Dr. McCANN. I have signed and rejoined the National Health Service Corps three times already as my time has come up. I began in 1975. I plan to stay.

Ms. MIKULSKI. You have 2-year terms, too?

Dr. McCANN. I was a volunteer in the beginning. I would like to stay. I am happy with the work that I am doing and the patients that I take care of and would hope to have the opportunity to stay in the National Health Service Corps.

Ms. MIKULSKI. As a career?

Dr. McCANN. Yes, ma'am.

Ms. MIKULSKI. When you re-enlist, what is your salary as a National Health Service Corps physician?

Dr. McCANN. As a volunteer eligible for the bonus, the VIP pay, my salary is approximately \$35,000.

Ms. MIKULSKI. Thank you very much Mr. Chairman. I have no further questions.

Mr. WAXMAN. I would like to ask you if you have had other National Health Service Corps members assigned to you, either physicians or other health professionals? Have you had others assigned to you that were serving out their obligation?

Dr. McCANN. Yes. We have some scholarship people right now, sir.

Mr. WAXMAN. How would you rate their dedication and their work?

Dr. McCANN. This is a very small sample, but I would say that they are dedicated and they work equally as hard. We have had good success with the people that have been assigned to us.

Mr. WAXMAN. Have you had volunteers who have tried to be placed with you and then found there were difficulties in doing so?

Dr. McCANN. It has been more of a problem in the last year than it was in the past. When I came into the corps in 1975 it was easier to recruit volunteers. Now, with the growth of the scholarship programs, it is more difficult to pick up volunteers. Similar problems were expressed for the rural areas.

Mr. WAXMAN. That is why I asked, I wondered if it was the same situation in urban areas. Do you see differences between scholarship physicians and volunteers?

Dr. McCANN. I think the potential exists for the scholarship people to have less dedication. We have not seen it at this point.

Mr. DANNEMEYER. May I ask a question?

Mr. WAXMAN. Surely.

Mr. DANNEMEYER. I would like to ask the gentlemen from Baltimore, has your board considered the operation of a thrift shop style business as a means of raising revenue, to assist in the raising of revenue? In the northern part of my district there is an operation of that type and the community people use it for all kinds of needs of people who are not on welfare at all. It is a wonderful community effort. I wondered if you considered it as a means of meeting this need?

Dr. McCANN. The community organizations around the health center have things like that. They organize parking around the center for Baltimore Orioles and Colts games. The community does make every effort to raise money.

Mr. DANNEMEYER. How about a thrift shop, do you know what that is?

Dr. McCANN. You are talking about a place to sell clothes?

Mr. DANNEMEYER. Yes. People donate clothes and they sell them. It is a moneymaker in small quantities if you have volunteers to work in it. Have you done that?

Dr. McCANN. Not that I know of.

Mrs. MOORE. No, we have not sold old clothes.

Mr. DANNEMEYER. It is not limited to old clothes.

Mrs. MOORE. There is a Goodwill five blocks away which does that for the city. It would not be feasible for us to do that. But we have other ways to raise funds. We do a lot of other things, even Saturday night fish fries. Any way we can help, we help.

But it does not produce enough money to carry on a big operation because if you don't have the money for medical care, you don't have the money to buy shoes from the thrift shops either. The money you have, if your rent is \$200-and-some a month, you cannot even afford a thrift shop. We do what we can. Your idea may work for you, but we have different ways of trying to do that.

Mr. DANNEMEYER. I don't know about the rural areas of Maine, have you folks considered that at all?

Dr. CATLETT. No.

Mr. MICHAUD. We have had bake sales, talent shows, and parades.

Mr. DANNEMEYER. You have political primaries also in Maine.

Dr. CATLETT. I feel compelled to say one final thing since the question was raised earlier about what would happen to the center if the funds were cut off and we closed the door.

Mr. DANNEMEYER. I didn't say cut off. I postulated that maybe the Congress would say you have to match income with outgo.

Dr. CATLETT. Basically, should it come down to the point where that kind of stipulation would change the character of the practice, I think regardless of what sort of funds were available and raised and where they came from, I think that I personally would have to do some considering myself as to whether or not I would stay at

the practice at that time because I think it is important that all of you recognize that there is a reason we stay at these places other than our \$35,000 a year salaries. If that were taken away, given the workload, whether it is 30 or 50 patients, if that reason were taken away, I might reconsider and look for a more lucrative life.

Mr. WAXMAN. Do any of the physicians in the National Health Service Corps supplement their income with other outside activities?

Dr. McCANN. We have a policy of not moonlighting.

Dr. CATLETT. The National Health Service Corps has that policy.

Mr. MICHAUD. I would like to add to what Dr. Catlett was saying. I think if the National Health Service funds were cut back or eliminated, at this point it would have the effect of pulling the rug out from our feet.

Unlike Baltimore, as I understand it, we are looking toward some day in the very near future being self-sufficient. I think we can do that. Based on the growth that we have had over the past 4 years, if you project that out to the next four, I think that during that time we will be and possibly be able to meet Dr. Catlett's salary and have a home.

Mr. WAXMAN. I guess the problem for us to figure out is, at what point does an area become self-sufficient when it can, and why should it try to if it has the advantage of the Government paying for the physician's salary and whatever other Government programs in effect subsidize the community.

Obviously, if there is a need, the Government should be involved in helping it out by subsidization, but when that need is no longer there, how do we break it? I don't quite know how we do that, but I think that is on our mind as we look at these programs so that we can reorient on these to help those areas that need it most that cannot be self-sufficient.

I wonder how many of your people there think, and I say this only because you mentioned it in your testimony, that they feel too proud to sign up for public health programs, feel that they are not getting any advantage from Government-funded programs, and probably have some distain for those people in maybe Baltimore who do have Government-funded programs that are a lot more visible.

I say that for no other reason except to put that on the table for consideration.

Mr. MICHAUD. I think we are very stubborn up in Maine and if there is any way of becoming self-sufficient, we are going to do it. That is the bottom line.

Ms. MIKULSKI. Could I just comment on this idea of self-sufficiency because in other hearings, whether it was health planning or HMO legislation, I continually raised the question, who competes for who in the health care delivery system.

In communities like Baltimore, as Mrs. Moore eloquently stated in her testimony, she and her neighbors live in the shadow of some of the major medical institutions and also several hospitals. The fact is that no one competes for the population served by the North Central program because these are people who live on the margin. Their medical bills are not taken care of by any third-party reim-

bursement system and their own means are limited. They tend to be retail clerks or a variety of other low-paying jobs.

The point that I am making is that North Central cannot expand its population base to include a more affluent population that could pay full fee for service. Therefore, without that patient mix they assume the burden that no one else will compete for in whatever the current little mechanisms that are buzz words for competition.

I just wonder if that is your observation. Isn't that the limitation of your constituency?

Mrs. MOORE. That is very true. They are the bunch that nobody wants but North Central.

Mr. WAXMAN. Let me thank each of you again for coming here. You have been a very good panel and you have been very helpful to us. We look forward to digesting and thinking about some of the comments that you have made.

We are now going to break until 1:30 p.m. and we will reconvene at that time.

[Whereupon, at 12:07 p.m. the subcommittee recessed, to reconvene at 1:30 p.m. the same day.]

AFTER RECESS

[The subcommittee reconvened at 1:30 p.m., Hon. Henry A. Waxman, chairman, presiding.]

Mr. WAXMAN. We will reconvene. Our meeting will please come to order.

Our next panel will be Mr. James Bernstein, of the North Carolina Office of Rural Services, and Mr. John Kessler, executive director, West Central Alliance Health Systems Agency. These gentlemen are engaged in the supply of physicians to rural areas. They are here to discuss the role that States can play in assisting the National Health Services Corp.

But before I call on Mr. Bernstein, who will lead off for this panel, I want to recognize Congressman Richard Preyer.

Mr. PREYER. I am proud Dr. Bernstein is from North Carolina, and I am speaking on behalf of Congressman Broyhill, who wanted to be here, too. He asked me to express to you his appreciation for what you have done. He is the director of 25 rural health centers which he was instrumental in setting up. He has placed close to 800 physicians in underserved areas, not all from the National Health Service Corps, but many are. He also has some six recommendations to offer.

Mr. Broyhill and I want to commend the committee's attention to those recommendations and express our pleasure in having Mr. Bernstein here.

Also Dr. Madison from the University of North Carolina will be on later today. We are glad to have him here, too. If Mr. Broyhill and I should happen to miss your testimony, we want to express our appreciation for your being here.

Mr. WAXMAN. I want to join you in welcoming Dr. Bernstein and Dr. Madison for coming to our hearing today. We would be pleased to hear the suggestions you might have to offer us.

STATEMENTS OF JIM BERNSTEIN, CHIEF, OFFICE OF RURAL HEALTH SERVICES, DEPARTMENT OF HUMAN RESOURCES, STATE OF NORTH CAROLINA; AND JOHN KESSLER, EXECUTIVE DIRECTOR, WEST CENTRAL ILLINOIS HEALTH SYSTEMS AGENCY

Mr. BERNSTEIN. Thank you, Mr. Waxman and Mr. Preyer.

I appreciate your invitation to present my thoughts on the National Health Service Corps today. I have followed the Corps since its inception, having written one of the first applications for North Carolina to the National Health Service Corps in 1971. Presently, I am chief of the North Carolina Office of Rural Health Services, which has a mission similar to the Corps. Prior to coming to North Carolina, I served as director of the Indian Health Service programs for northern New Mexico and Colorado whose medical and dental components were staffed by young Public Health Service Corps commissioned officers stationed at rural reservation sites.

The North Carolina Office of Rural Health Services was established by the North Carolina State Legislature to address the medical maldistribution problem in our State. Our approach has been to assist rural communities to develop new primary care programs or augment existing ones. Having this flexibility, we are able to respond appropriately to the strengths and weaknesses of each specific situation. The basic principle underlying our concept is to make available to rural communities and providers competent comprehensive technical assistance in demand and need assessment, community organization, personnel and financial management, medical records development, data management, laboratory design, communications, graphics and architectural assistance, personnel training, and physician recruitment.

In addition to our technical assistance staff we employ three types of resources to assist us to carry out our goal.

First, our legislature has provided our office with grant funds for program development, including initial operational funding and capital funding for equipment and construction. We feel that local community participation and involvement is important to the future success of a project. As part of the community input the community shares the cost of the capital project on a 5-to-1 State to community matching formula. We also request that at least 750 families contribute to the local match. In all our projects, the communities have collected more than the required match from far more than 750 families. Our grant budget has remained constant since 1974 under a unique understanding with our legislature. In lieu of our going to the legislature each biennium to request funds for a proposed number of new projects, they have agreed to hold constant the budget permitting us to initiate as many new projects as needed provided we not obligate the State to more money in future years than our present budget. This provides us with a great incentive to make our existing projects as efficient as possible.

Second, we have organized a sophisticated physician placement service. Through this activity we attempt to identify all family physicians in the United States interested in rural practice and carefully match them to communities. By investing considerable time and effort with both the communities and the physicians we

hope to retain the great majority of the physicians on a permanent basis.

The third resource, and the one very important to us today, is the National Health Service Corps. We provide the State liaison for the National Health Service Corps for region IV. The Federal-State representative is assigned to our office, where he works with us to optimize the National Health Service Corps objectives, using our field personnel to the extent that his regulations permit. Mr. Herb Bateman, the DHEW region IV representative assigned to North Carolina, has done an exemplary job of making this fairly complicated organizational effort work.

The results of these combined efforts in North Carolina are significant. We have built and developed 25 rural health centers. The majority of these are in small, physicianless communities and are staffed by family nurse practitioners or physician assistants. We have assisted in placing 190 physicians in rural communities, of which about 34 were National Health Service Corps physicians. The expenditures for our total effort last year were \$1,347,137. This included our staff salaries, physician recruitment expense, and all capital and operating grants. Our efforts, along with those of the North Carolina Area Health Education Centers program, the four medical schools, our health departments, and the RHI and HURA programs have improved the distribution of medical services tremendously in North Carolina in a relatively short period of time. In 1974 we had 42 counties out of 100 with a ratio of more than 4,000 people to each primary care physician. By 1978, there were only 22 counties with a ratio greater than 4,000-to-1. At the other end of the spectrum, we had only 19 counties in 1974 with one physician to 2,500 or less people. By 1978 we had 45 counties in this most favorable category.

Given North Carolina's efforts to make primary health services more accessible to our underserved rural areas, the future direction of the National Health Service Corps with its significant projected expansion is of real concern to all of us. I feel the National Health Service Corps conceptually is a tremendously exciting program. Being relatively new, the National Health Service Corps has and will continue to experience growing pains and at the same time require creative programming to realize its potential to the country. Originally the National Health Service Corps was a manpower program to get primary care physicians to locate in underserved rural areas with the intention of staying permanently and moving into their own practices which would be financially independent of Government. It was a strategy to effect a better distribution of physicians.

It appears to me that over the last few years the Corps has taken on additional objectives such as reducing the cost of other Federal grant programs by providing free manpower or attempting to address the financial barriers affecting access to care by the poor who are not eligible for medicare and/or medicaid. Given the economic condition of our Nation and its impact upon the poor, I believe it imperative that Congress proceed with consideration of a national health insurance program that extends primary care coverage to all the poor, combined with a total program of effective cost containment.

However, I believe the first issue which this committee needs to address for the public is a clear statement of the intent of the National Health Service Corps. What priority should be placed on the Corps as a distribution strategy? To what extent should the Corps be employed to reduce grant funds to federally funded sites and discourage recruitment of physicians from outside the Corps? What priority should be placed on reducing the cost of the National Health Service Corps program through the development of sites that can return all or a part of the physician cost to the Federal Government? What priority should be placed on having National Health Service Corps assignees establish private practices in critical manpower shortage areas? I believe these are fundamental policy questions which this committee needs to answer in order to help assure a successful National Health Service Corps program in the future.

Of special concern to many of us in North Carolina is an unanticipated problem which will occur in other States that have tried to address their physician availability problems by investing State funds in medical education. Over the past 7 years, our State has added a fourth medical school and funded a statewide area health education centers program. The State invests \$16 million into the AHEC program each year, which is 93 percent of the total AHEC budget. A large part of this program supports the training of primary care residents. We have almost doubled the number of primary care residency positions since 1974, going from 368 to 668. Our hope is that a significant percentage of the AHEC-trained physicians will settle in rural North Carolina.

Since an increasing number of medical students are obligated to the National Health Service Corps and can be assigned anywhere in the United States, there is potential for an understandable conflict of objectives. The National Health Service Corps program must and should see its role as addressing all the underserved areas of the country. North Carolina needs to be concerned for those underserved communities within her borders.

I know that both National Health Service Corps and State officials are aware of this problem and are working to find an equitable, workable solution for both interests. The AHEC and National Health Service Corps programs are fundamentally complementary; I bring this to your attention because it demonstrates how important it is to the State and the Federal Government to coordinate their efforts.

Finally I would like to make six recommendations for the National Health Service Corps of the eighties. These recommendations are made under the assumption that the Corps scholarship program will be expanding dramatically, and that it is very likely there will not be sufficient funds to cover all Corps salaries. It, therefore, makes sense to deploy as cost effectively as possible a significant number of Corps assignees to reserve sufficient salary funds to target those areas which are the most deprived and in need of physician services. These might be federally funded projects, poor health departments, or freestanding National Health Service Corps sites in very poor and/or sparsely populated areas.

It is my belief that even within many health shortage areas medical programs can be developed which require little or no Fed-

eral support. Based on my experiences, I would suggest the following ideas to improve the Corps.

First, review and restate for the public and those who implement the Corps legislation your objectives. To what degree do you intend that the National Health Service Corps be used as a grant program to reduce funding costs of other grant programs through salary waiver? Is it your intention that freestanding Corps sites providing only primary care be discouraged or encouraged? Have you targets to put forward regarding economic feasibility and efficiency? How would you define the balance between the objective of providing primary care resources to a community and utilizing Corps personnel to implement specific department program goals?

Second, because the primary care scene is changing so rapidly as a result of private sector care activity, mandate regular updating of health manpower shortage areas. In this fashion you will prevent destructive competition between new private providers and Federal efforts. Also, since your scholarship program is involved in making commitments 7 years prior to provider availability, mandate careful projection of future manpower needs and limit scholarships accordingly so that program requirements will not have to be relaxed to provide physicians opportunity to work out their obligations.

Third, review the process of site selection in keeping with your objectives for the Corps. If permanence through some Corps sites becoming private practices is desirable, place emphasis on using Corps manpower as a part of a rational delivery network. Such sites should be coordinated carefully with the private medical community where possible. You may also wish to consider local cost sharing as an indicator of local demand for services.

Fourth, if efficiency is your objective, assure that quality technical assistance is readily available to Corps sites from the beginning of the process of site development. I am referring here to freestanding sites, since integrated sites employ administrators who should basically possess the required technical skills. Contract consultant services, provided by national firms, as they are today, at least in our region are usually limited and late. Through cooperative agreements, States could assume the responsibility of providing quality technical assistance.

Fifth, I believe success may be increased and problems reduced by more selectivity in the recruitment or scholarship granting process. A reasonably sophisticated process needs to be initiated which will identify those physicians best equipped mentally and emotionally to serve in rural or urban medically underserved areas. Encourage every effort to make clear the conditions of service at the time of initial commitment. When possible, grant candidates first option on sites in States where they have trained and where States have invested heavily in that training. I would encourage the initiation of the matching process as early in the second year of residency as possible to provide maximum opportunity for the physician to find the site most suited to his needs.

Finally, general personnel and program policies should be reviewed to see if changes might produce additional incentives to successful practice development. Consideration might be given to rewards for productivity and efficiency and to funding local com-

munities to employ scholarship recipients. The private practice option to serve in some health manpower shortage areas will work at little cost to the Federal Government. I would encourage the expansion of that option.

Thank you again for granting me the opportunity to express these thoughts. The National Health Service Corps has been of great assistance to our State. The cooperative arrangement the Corps and our office have developed has helped both the Corps achieve its objectives and our State meet its needs for primary care. I believe the National Health Service Corps is one of the finest health programs to come from the Federal Government, and I wholeheartedly support its continuation. Our office of rural health services looks forward to continued cooperation with the National Health Service Corps in meeting the primary care needs of North Carolina's medically underserved areas.

Mr. WAXMAN. Thank you very much. I want to commend you for that testimony. We appreciate the suggestions you have made. After Mr. Kessler's testimony, we will have questions from the subcommittee to both of you.

Mr. Kessler, we are pleased to have you with us.

STATEMENT OF JOHN KESSLER

Mr. KESSLER. My name is John Kessler. I am the executive director of the West Central Illinois Health Systems Agency located in Springfield, Ill.

Thank you, Mr. Chairman, for inviting me to appear before this committee. As a member of the health planning community, I welcome the opportunity to share insights gained from our agency's experience in recruiting primary care physicians, dentists, and other health personnel to west central Illinois.

Our health systems agency serves a population of approximately 600,000 in 18 counties located between the Mississippi River and Springfield, the State capital. Seventy-three percent of the population reside in rural counties. Of the 18 counties we serve, 8 are designated as physician shortage counties; of these 8, 6 are also dental shortage areas. Generally, these designated counties have an older population, a high proportion of agricultural workers, and residents who are often 20 to 30 miles from primary health care services.

The elimination of these primary care and dental shortage counties has been a priority in the development of our long- and short-range plans—health systems plan and annual implementation plan. Without the elimination of these shortage areas, 30 percent of our population will continue to have inadequate medical and dental care.

As a result of this priority, our agency over the past 18 months has worked with approximately 20 communities to recruit physicians and dentists. To date, our efforts have produced considerable success. Our successes include the funding of a rural health initiative program and placement of one physician in Brown County; second, the recruitment of a family practice physician together with three nurse practitioners in Cass and Scott Counties; third, the recruitment of four additional physicians for another four counties; and fourth, the approval of two additional rural health

initiatives and a National Health Service Corps site pending funding and physician placement by the Department of Health, Education, and Welfare.

The success which we have enjoyed has been made possible by combining private initiatives and public programs to meet the health needs of our underserved populations.

There are, however, problems inherent within any primary care recruitment program. First, rural communities are generally not well organized and lack the expertise to effectively recruit personnel and develop health care services. It is common for communities to assume the solution to their perceived problems to be merely the addition of more physicians. Discussions often focus on the location of a health clinic rather than the types of health services which need to be provided. Communities also begin recruiting without adequate thought given to community needs and resources, marketing of the community, and the development of a recruitment incentive package. These problems often limit the success of a rural community to attract primary care physicians.

The second problem common to rural communities concerns the application for Federal programs. Often the program guidelines are rigid and prohibit a positive response to a community's needs, expectations, and resources. In one of our NHSC sites it was suggested the building be expanded because one of the rooms lacked 20 square feet. Usually, if a second physician comes to the rural health program, they add approximately 2,000 square feet to this particular type building. This is a cost that the community will have to assume by going out and getting a loan which will certainly be an additional burden for them.

A third problem involves the communication between the local agencies and the regional office of the Bureau of Community Health Services. Over the past year and one-half, our staff has faced: Changing application submission deadlines—which lead to short time frames for application development; an understaffed regional office—which often results in 2 or 3 day delays in responding to telephone inquiries; and finally, changing administrative priorities—this year for example, the priority is the health of migrant workers, certainly a medically underserved group, but also an extremely small percentage of the west central Illinois population. Due to the lack of migrant workers in our area, we were discouraged by both the National Health Service Corps and rural health initiative program from submitting additional applications. These changing priorities are obviously confusing and frustrating to rural communities.

All of these problems are, of course, solvable. At the local level, health systems agencies should continue to increase their assistance to communities, to organize and develop comprehensive primary care services, which will often include physician and dentist recruitment. In addition, health systems agencies should annually assess health manpower shortage areas (HMSA) and could, using a technique currently under development at our agency, forecast potential shortage areas which will result due to physician retirement. This annual assessment by HSA's should be mandated in the renewal legislation. At the program level, health systems agencies and the Bureau of Community Health Services should refer com-

munity inquiries about primary care programs to the local health systems agency for assistance. Health systems agencies should also inform communities about available Bureau of Community Health Services programs. Also, additional program flexibility could enhance the effectiveness of the rural health initiatives and National Health Service Corps programs at the local level. I also feel this flexibility should be built into any renewal legislation.

Additional personnel in the regional office would help to ease the present communications problem. If the number of National Health Service Corps physicians increases as dramatically in the next decade as predicted, failure to increase the staff proportionately would undoubtedly cause increasingly severe problems.

In conclusion, I believe that the National Health Service Corps and rural health initiative programs are certainly important alternatives for alleviating the current physician and dentist maldistribution. In west central Illinois, however, I believe we will need a combination of private as well as public initiatives to eliminate all shortage areas and provide timely access to medical and dental care to all our residents.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Kessler, your HSA is looking at the shortage areas for physicians. Do you know whether other HSA's are similarly engaged?

Mr. KESSLER. I know the majority, at least six of the HSA's in Illinois do annually assess the health manpower areas including the inner city of Chicago and downstate, southern Illinois.

Mr. WAXMAN. Does the National Health Service Corps use your office to assist them in placing NHSC physicians?

Mr. KESSLER. Our working relationship is improving on a month-to-month basis. A conference was held which brought the Bureau of Community Health Services and the regional staff and the region five HSA's, where we discussed some of the perceived problems which are in the process of being resolved. We are beginning to work together, but more can be done.

Mr. WAXMAN. You referred to shifting priorities, particularly the fact that migrant programs were the ones being urged on local communities. How would that affect a maldistribution problem if there was a rural area not without a migrant population and they were underserved?

Mr. KESSLER. This year, because migrant persons are the priority, no applications to the National Health Service Corps will be accepted. We have been strongly urged not to submit additional applications.

Mr. WAXMAN. Mr. Bernstein, along these lines, I understand the National Health Service Corps has put a priority on certain types of communities for the placement of National Health Service Corps physicians and that most of the physicians will be placed in federally supported sites. Do you agree with this approach, and what are the implications in a State like North Carolina?

Mr. BERNSTEIN. Federal project funds are best suited for targeting of extreme poverty and sparse population. There are many other sites within HMSA's that could benefit by the Corps. Since the Corps is expanding so rapidly, I assume there will be sufficient

physicians to help underserved areas that might not have or want Federal program funds.

Most communities are willing to cover some of the cost. In some cases the State is willing to help out, as in North Carolina. In many instances, the intent and outcome of the project might be the same, but the resources not nearly as available. So, my answer is, the Corps should be available to be used by other sites depending on the area of need rather than whether or not it has another Federal grant.

Mr. WAXMAN. If this were priority of the West Central Illinois Health Systems Agency, what would be the effect in Illinois?

Mr. KESSLER. At the present time, there is only one federally supported site. We do have four sites, however, that are federally approved, but the match has not been made between the physician and the community.

So I think if they are currently a federally supported facility, that would have no impact on helping our HSA to alleviate the manpower shortage.

Mr. WAXMAN. Mr. Bernstein, has the NHSC used your office to assist them in placing National Health Service Corps physicians?

Mr. BERNSTEIN. Yes. We work pretty much as a team, and I think it is effective. It could work much better with more flexibility and delegation of authority and responsibility by the Federal Government to the State.

Instead of one person, we have like 12 people covering the State, and we have more National Service Corps people in North Carolina than in any other State in the South region.

So I think the Corps could use offices like ours to increase not only the quality but quantity of practices tremendously.

Mr. WAXMAN. Mr. Bernstein, have you developed any methodology to assist you in identifying the best location for a primary care center or in predicting its financial self-sufficiency or the percentage of a community which will use the primary care center? If so, can that methodology be used in the NHSC program?

Mr. BERNSTEIN. There is no set formula that could be plugged into a computer that would do this. We do have an analytical methodology based on historical experience that gives us a realistic idea of who would use the service, and it is lower than most people would expect.

What we have learned is that you have to be close to the scene to figure out the best location and you have to spend a lot of time with the community and surrounding communities to develop the project. If that development work is done properly, your success is more assured. It is more difficult to develop a project from Washington, or Atlanta, or a regional office. It takes more than one type skill and more than one person.

The initial input of time pays off in the end.

Mr. WAXMAN. In your testimony, you talked about the primary care scene changing rapidly as a result of private sector activity. Would you elaborate on that?

Mr. BERNSTEIN. Well, I can speak for North Carolina. We have increased the medical residents in the last 4 years so we will have more doctors training and coming out. Most want to stay in North

Carolina. They are filtering out into smaller communities. We have that activity going on, and to some degree, that activity is going on in other States. We are increasing the supply. They will move out somewhat on their own causing some, competition between areas. There is increasing competition in some areas between State and Federal programs and the private sector. With increasing concern for hospital cost containment, larger primary care, service areas are required to support a bed creating competition between hospital service areas for primary care patients. It is a fascinating question that requires careful monitoring.

Mr. WAXMAN. Do we need such as large a service corps as we project for the 1980's, if we are successful in our manpower programs to encourage more primary care family physicians to go into some of these underserved areas?

Mr. BERNSTEIN. I do not know enough about the total country's needs to say how big the expansion should be. I do not believe all of it has to be underwritten.

Mr. WAXMAN. You think more can be raised on the local level?

Mr. BERNSTEIN. Yes; and I think many of the physicians would be willing to go into areas to set up practices, areas designated by the Federal Government as underserved, and practice on their own or with a small amount of support. That does not hit upon the real hardcore populations that you want to target and subsidize the people through the provider system.

Mr. WAXMAN. Do you think if gave some other kind of encouragement, the less hard-hit areas would be served by physicians who want to be there rather than scholarship recipients?

Mr. BERNSTEIN. Yes. I do not know how many, but I know I have talked to several who would be willing to do that. To make it work the Government must make the program flexible.

Mr. WAXMAN. Have you run into a problem with people wanting to volunteer and not being placed because there is no need for them?

Mr. BERNSTEIN. I think the freeze is off now, but there was a freeze on volunteers in the Corps, so only scholarship recipients were being taken in. There were people at that time who wanted to volunteer for the Corps. I believe there will always be volunteers. Volunteers are important to the success of the Corps, and I would hate to see them cut out completely.

Mr. WAXMAN. Thank you very much.

Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. Bernstein, North Carolina offers us a unique model to address the health manpower needs of rural areas. As you may know, there has been a proposal in the Senate to phase down the National Scholarship program but to provide funds to States to conduct a similar program. In fact, your State already has such a program, and is financing it to a certain degree.

Would you comment on the major advantages and disadvantages of an expanded State role and a decreased Federal role in the scholarship program?

Mr. BERNSTEIN. I have not read the bill, but can comment on that question. I think States could assume a much larger role, and there are significant advantages to it. State government is closer to

the problem. It is more accountable for dealing with the problems that arise in the practices and in the communities than government further away. I think it can deploy technical assistance, at least in our situation, better. I believe it can stay on top of problems that come up better, and integrate Corps sites with the existing system to make things go smoother. I believe we have demonstrated this.

It might have some disadvantages. Possibly the Federal Government can bring more equity. I do not necessarily believe this anymore. I do not feel that is true for North Carolina. It might be true in other places. I think it is becoming less of a reason to have service programs centralized than it was 5 or 10 years ago. That is a possible disadvantage.

Another disadvantage to Federal Government that comes to mind is that I think it is good for the State department to pay part of the technical assistance, to be invested in a portion of the activity, and the community, too. We ask our communities to contribute and even the poorest communities are willing to put up something for their health programs. I think by different groups investing in the goal, you get a better product.

Mr. CARTER. You stated in your paper, I believe, that you had a passover problem. Apparently, some patients do not use the local center but travel further to go to a hospital instead. Would you elaborate?

Mr. BERNSTEIN. I think there is a problem, not just in Federal Government and State, it is for private practitioners, too. You set up an office and patients use it at night and for something minor that comes up, but when they get sick or have a physical they drive right on by and go to the big city to a specialist. That poses a problem for any community using a physician.

Mr. CARTER. Before a physician locates in North Carolina do you have a program whereby your State builds the clinic, should one be needed?

Mr. BERNSTEIN. We make grants to communities to build them. We might pay for 75 percent of the building.

Mr. CARTER. What does that include? Any equipment?

Mr. BERNSTEIN. Equipment—and we are talking about facilities anywhere from 2,000 to 3,500 square feet.

Mr. CARTER. What would it include in addition to the building?

Mr. BERNSTEIN. Laboratory equipment—not usually X-ray. Communities can get that themselves later on. Many of these decisions depend on how isolated the sites are and what other resources are available.

Mr. CARTER. How many of these facilities have you built in the State of North Carolina?

Mr. BERNSTEIN. Twenty-five.

Mr. CARTER. Do you have many problem areas where there is 1 physician per 4,000 or more?

Mr. BERNSTEIN. We have 22 counties in that situation, and pockets of other places that I would say have that kind of a market.

Mr. CARTER. With regard to the physicians in the 25 facilities that you built, do they charge regular fees? Do you regulate their charges?

Mr. BERNSTEIN. No, most of them are run by nurse practitioners or physician assistants. Only a few have full-time physicians. In the majority of instances, the fees are basically the fees in the region that the other physicians are charging.

Mr. CARTER. Do you have physician assistants in these areas and nurses with clinical training?

Mr. BERNSTEIN. Yes.

Mr. CARTER. You do have a supervising physician over the region?

Mr. BERNSTEIN. A private physician who contracts with each project to provide this supervision.

Mr. CARTER. Do you feel that a physician in such an area who is serving a population of 4,000 can become independent after a bit and go on his own?

Mr. BERNSTEIN. Yes; most of them do.

Mr. CARTER. Do you think that is the consummation to be wished in the case of National Health Service scholarship programs, also? Is that correct?

Mr. BERNSTEIN. I think a certain portion of the medically underserved areas could support physicians moving in and staying on a private basis or in a community practice on a self-sufficient basis without subsidy or very small subsidy.

There are numerous areas in North Carolina and other States where the people are too poor or the areas are too sparsely populated to support a program.

Mr. CARTER. These people need to have assistance either from the State or the Federal Government; is that correct?

Mr. BERNSTEIN. Right.

Mr. CARTER. Well, you also state the following in your testimony:

The private practice option to serve in some health manpower shortage areas will work at little cost to the Federal Government. I would encourage the expansion of that option.

I would too. I think it is something we should encourage.

Mr. BERNSTEIN. Right now, it is almost nonexistent. The present rules for the private practice option are not workable. Unless they are changed to become more flexible it will not be an effective part of the NHSC.

Mr. CARTER. Our problem is mainly one of distribution, as I see it. The purpose of the corps is to provide physicians and other personnel to poor areas, where it is difficult to attract them.

Mr. Kessler, in what ways can health systems agencies participate in improving health care delivery in medically underserved areas?

Mr. KESSLER. I think the activities which our agency and some of the others in southern Illinois have of getting out and helping the communities determine what type of health care service they need, and then outlining and helping them either through the seeking of public, National Health Service Corps physicians or through the actual private recruitment of physicians to their areas. This is a very viable activity in which the HSA should be involved.

We have helped people figure out the kind of needs they have. We have actually helped them write NHS applications. We have helped them work through the channels and provided other support to get a recruitment committee up and going.

Mr. CARTER. I would like to ask each of you the same final question: Has the National Health Service Corps been of help to your area of Illinois or to the State of North Carolina, and what changes, if any, would you make?

Mr. KESSLER. Would we make changes with the NHS Corps?

Mr. CARTER. Yes.

Mr. KESSLER. It certainly has been of help to our particular area, and to the whole of southern Illinois. I think right now there are three or four National Health Service Corps sites in Illinois, which includes three health service areas.

The changes that I would make would be to make the application guidelines with respect to the clinic site more flexible so that the community can utilize the resources that are already existing in the community rather than going out and expanding, adding to or building a whole new clinic site. I think that is a much cheaper and more efficient use of very limited and scarce community resources.

Also, I would urge more cooperation between the regional office and the HSA's so that we know what types of personnel are available from the National Health Service Corps and how many we might be able to expect in the Midwest and the Chicago regional office.

Thank you.

Mr. CARTER. What is your response, Mr. Bernstein?

Mr. BERNSTEIN. First of all, I would say the Corps has been helpful to our State and has been successful. I would make it more flexible. I would allow a certain percent of physicians to use the private practice option. I would delegate to the State the responsibility of providing full technical assistance to the freestanding Corps sites; I would give some kind of priority to physicians who are trained in North Carolina to practice in North Carolina at approved sites. I think this is going to be a problem in the future for States like North Carolina who are producers of physicians where the Federal Government has put a lot of money into the training end of it, then the physician is pulled out and sent somewhere else.

I think there should be the option of having medical residents trained in the State having first option.

Mr. CARTER. If we consider Duke University, do more of its graduates stay in North Carolina or go to other States?

Mr. BERNSTEIN. Duke University produces for the country, but in the family medicine program at Duke, a larger percentage of its graduates stay in North Carolina and are practicing in rural and underserved areas, but the rest of the school is basically tertiary-care oriented. It is not just a State university.

Mr. CARTER. Duke University is really a type of national asset. I would like to see the percentages on those who remain and those who go.

Thank you.

Mr. WAXMAN. Mr. Preyer.

Mr. PREYER. This committee has been interested in the AHEC program as it relates to the manpower bill. Would you comment on the relations of the AHEC program and the NHS and whether there are any conflicting objectives to these two programs?

Mr. BERNSTEIN. Basically, the AHEC program and the NHS Corps should be and are in most situations very complementary. They support and work together very effectively. There is one situation I do not think anyone foresaw. AHEC in North Carolina costs the legislature about \$16 million a year, and a lot of that goes to family physician training. The problem is that if the AHEC invests say \$90,000 into training a family resident in Asheville, N.C., and that resident also has a national health service corps scholarship from medical school, he or she is at risk to be put in any other State. I think this could create a problem, because the legislature says to AHEC, we are evaluating you on how well you get physicians to stay in rural North Carolina, and some of the recipients of AHEC are asked to go to other States.

It is a complicated problem, because the NHS Corps has to look at the whole country and cannot really give preference to North Carolina. On the other hand, it might be able to give priority to those residents for approval sites. That is what we are trying to do. I believe the people in the NHSC, the AHEC program, and our office will work it out without too much problem, but there is a conflict now.

Mr. PREYER. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Bernstein, let me ask you a question similar to that of Dr. Carter, of possibly changing the program to a State-run program. The State of North Carolina is quite advanced; has done a great deal on its own. Are you familiar with other States and how long it would take them to gear up to run a program to deal with the underserved in certain States?

Mr. BERNSTEIN. I am familiar with a few, and I think it would take a while to gear up. There are some States gearing up very fast to do that sort of thing, but it takes time, because if you do not do it carefully, you will lose some portion of the power structure you need to work with you, whether it be the university or professional associations. There are States that can do it.

I would base it on performance requirements. States that can meet realistic performance criteria would have the option of having more responsibility and authority. The Federal Government must be more realistic about what is possible. For example, a smooth functioning delivery infrastructure needs to be developed. To do this, competent technical assistance has to be available. Other States that are not interested, but who have populations that need to be served would be under the traditional Federal Government rules. I am not sure you have to treat every State the same.

Mr. CARTER. What do you think of the WAMI program?

Mr. BERNSTEIN. From what I know it is an excellent program.

Mr. CARTER. I feel it is a tremendously exciting program.

Thank you very much.

Mr. WAXMAN. Thank you both for your testimony.

Ms. MIKULSKI. Mr. Chairman, I had the opportunity to review the written testimony of both panelists and I only have one question for Mr. Kessler.

Mr. Kessler, I would like to talk about some of the points that you made on page 3 of your submitted testimony.

You raise three issues on that particular page. One is the problem in applying for Federal programs; second, is the communication between local and regional offices and, third, you indicate that HSA's should increase their assistance to communities to organize and develop comprehensive primary care programs.

They seem to be quite in keeping with the issues raised and that were discussed in the colloquy that I had with Mrs. Moore from Baltimore, which deals with how do community people get their act together to apply for health service initiatives in underserved areas.

You seemed to indicate that you had somewhat of the same problems, and that rather than having one-stop shops at HEW, you talk about the role of HSA's.

Do you see yourself as being a resource to community people and a health planning agency as being a resource as well as an advocate?

Mr. KESSLER. Exactly. I think that is a very appropriate role for health systems agencies. We have worked with a number of communities not only in recruiting primary care physicians in outlining the types of resources that are available in both the public and private sector, but we have also worked with communities to seek Department of Transportation funds for emergency medical services vehicles, for WIC programs, and other public assistance and housing programs.

For those HSA's that do have the community acceptance and credibility, especially in the rural areas, then I think they can serve as the initial stopping point or the initial contact with the other Federal agencies, principally the Department of Health and Human Services. HSA's can assist in determining what kind of grant funds are available and the HSA's can also go the next step, which is assisting those communities who do not have the expertise in actually filling out the applications, getting the data, and helping them work through the State and Federal channels to get their applications approved.

Finally, HSA's should be the advocate, if a community does indeed need the services, and it is outlined in its long and short range plans, then I think it is most important for the HSA to be that advocate.

Ms. MIKULSKI. Your concept is not merely to review certificates of need for either capital additions or expansions but truly to do health planning in a community in terms of identifying underserved areas, working with the community, and so on, and as you see that, health planning is also in helping to meet those needs.

Mr. KESSLER. Exactly.

Ms. MIKULSKI. You have got the resources to do it.

Mr. KESSLER. I would say rather than call it health planning it would certainly be rural health resources development.

That would be the implementation phase of the planning program. Yes, because we are rural and have few hospitals and few physicians, I would say an equal proportion of our activity goes into our regulatory activities, certificate of need and proposed use of Federal funds as well as the development in the assisting of communities.

Ms. MIKULSKI. Thank you very much.

That answers my question.

Mr. WAXMAN. We appreciate your being with us.

Our next panel is from the HEW and includes Dr. Julius Richmond, Dr. George I. Lythcott, Dr. Henry Foley, Dr. Daniel Whiteside, Dr. Edward Martin, and Mr. Fred Little, of the Philadelphia Regional Office.

We are pleased that you could be with us today to discuss the operation of the Corps.

The committee is interested in the Corps, and we have many questions to ask of you.

Dr. Richmond, I would like you to summarize your testimony for us, if you would. We have a complete text which will be made part of the record.

STATEMENT OF JULIUS B. RICHMOND, M.D., ASSISTANT SECRETARY FOR HEALTH AND SURGEON GENERAL; PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY GEORGE I. LYTHCOTT, M.D., ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION; HENRY A. FOLEY, PH. D. ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION; DANIEL F. WHITESIDE, M.D., DIRECTOR OF BUREAU OF HEALTH MANPOWER, HEALTH RESOURCES ADMINISTRATION; EDWARD D. MARTIN, M.D., DIRECTOR, BUREAU OF COMMUNITY HEALTH SERVICES, HEALTH SERVICES ADMINISTRATION; AND FRED LITTLE, CHIEF, PROGRAM CONSULTATION BRANCH, DIVISION OF HEALTH SERVICES DELIVERY, PUBLIC SERVICE, REGION 3 (PHS)

Dr. RICHMOND. Thank you very much, Mr. Chairman.

I very much appreciate this opportunity, and my colleagues do as well, to review with you what we regard as rather considerable progress which has been made in administering the National Health Service Corps program and its scholarship components.

I believe, as you have indicated, that you have had the opportunity today of hearing a good deal about the program and its background, and the committee has had a longstanding interest in it. Perhaps it would be well in the interest of time for me to abbreviate the testimony considerably.

I think you all recognize that this program is a relatively recent one, as health programs in the Nation go.

It is today serving some 746,000 people through its Corps placements, serving those people who prior to 1972 had no services virtually at all in terms of primary care.

The Corps, in order to serve people, has now grown to some 2,000 personnel on duty. I would like, Mr. Chairman, to emphasize that the major aspect of our program is health service to people who are living in areas which are designated, as the statute directed us to so designate areas of the country, in terms of the degree to which they had adequate services. We have developed a design for designating health manpower shortage areas.

In this designation we utilize a variety of indicators to arrive at that determination. We consider particularly the number of practitioners who are available for the population—usually more than

3,500 people to be served by one practitioner—health statistics indicators such as infant mortality, and access to health services.

As a consequence, we categorize manpower shortage areas into groups; the most needy groups, of which there are 640 in group 1 and 425 such areas in group 2 these have the greatest priority as a consequence of those shortages.

We think, Mr. Chairman, if we do our job properly, that we would have a minimum of competition with those practitioners or organized clinic groups that already exist in communities for those two categories are categories which are indeed very needy, and we are targeting those as our highest priority.

We, of course, are in the process of placing not only physicians but dentists and other health professionals in these areas of great need. I would, as a person who has been in the field of health for all of his career, which now is a long time, like to point out that by and large the Corps people whom we place are relatively young people who have recently been students, relatively recently out of their training, and they are being asked to go into some of the most difficult to serve areas of the country, often in the communities where illness and all morbidity and mortality rates are higher than we would like to see them. I think it is a tribute to these young people that they not only have been going into these areas but have been performing very well.

I should mention that inasmuch as they are relatively inexperienced as professionals, we can anticipate that there will from time to time arise some problems, but I think my colleagues would join me in saying that we have been impressed at how few significant problems we have encountered in the performance of those individuals.

I would like to comment that as we have gained more and more experience with this program, we have moved in the direction of combining the placement of our individual Corps persons into organized settings which can give some degree of permanence or continuity to these underserved communities.

I am thinking particularly of community health centers, migrant health centers, community mental health centers, hospital-affiliated primary care centers, maternal and child health and crippled children's services operating in the States along with the solo sites. I think we are also seeing a reciprocal development. It is not uncommon when Corps people are placed in a difficult to serve community, they recognize they need nursing services, often mental services, pharmacy services. As a consequence, what we have begun to see is the development of organized sites or what amounts to a community health center as a consequence of the placement of these people in such communities.

I would comment briefly on the recruitment of such personnel for work in these difficult-to-serve, difficult-to-reach communities. We started out with a volunteer program. That program continues. We think it has served the Nation very well, but Congress, I think very properly, in 1972 began to anticipate meeting the needs of these health manpower shortage areas by developing a scholarship program for students in the health professions and this is what complements the service program in communities.

That program has grown, we think, very well. For the 1979-80 academic year the awards total 6,408, which included 2,379 awards to new recipients, and 4,029 continuation awards to recipients from previous years.

Of those awards 5,374 went to students of allopathic and osteopathic medicine; 568 to dental students and the remaining 466 to selected other occupations.

We must constantly gear our planning to a recognition of the length of the training program and the need to defer students to complete their specialty training, and we have begun to do this. There are a number of students who have completed their educational programs but who are in some stage of postgraduate training and who will be coming into service in order to discharge their obligations.

We, in summary, Mr. Chairman, feel that this program is working very effectively in meeting the needs of a significant segment of our population, generally poor, not uncommonly remote or else in concentrated central-city areas where it has been difficult for them to obtain services. They are not uncommonly from a minority group background and not uncommonly have a high concentration of elderly persons.

We think that, along with our community health center programs, our migrant center programs, and our health education programs, of which you have already heard somewhat briefly today, we are developing a matrix of services for those difficult-to-reach communities which are being better served now. We anticipate they will continue to be better served in the future.

I would close with an emphasis on the fact that the numbers of health professionals we are talking about, Mr. Chairman, are really relatively small. We are talking ultimately, of a physician output of the scholarship program coming into service of just a little more than 1 percent of the total pool of practicing physicians.

We think that in these United States there will be populations in pockets which will be difficult to serve, and we think that it is an extremely wise and modest investment to have just a little bit more than 1 percent of our medical profession available to fill in in those difficult areas where it is not likely we are going to be able to provide services through conventional means.

Thank you very much, Mr. Chairman, and I am sure my colleagues and I will be pleased to answer any questions.

[Testimony resumes on p. 80.]

[Dr. Richmond's prepared statement follows:]

STATEMENT

BY

JULIUS B. RICHMOND, M.D.

ASSISTANT SECRETARY FOR HEALTH AND SURGEON GENERAL
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OVERSIGHT HEARING-NATIONAL HEALTH SERVICE CORPS

I appreciate this opportunity to review with you the progress we have made in administering the National Health Service Corps program and its scholarship components, and the problems which this program addresses.

At the outset, I would commend the Congress for providing to the Administration and to the Nation a very valuable tool to assist in assuring competent health care to several millions of people who otherwise would be hard pressed to secure care or would go without all but the most critical attention. I would add that this Administration is committed to making the National Health Service Corps an effective program. We are very gratified by the great progress we have made in the nine years since the program was conceived. Think what it means to the 746,000 people who today rely on Corps personnel for their continuing health care, people who nine years ago had no regular doctor. Visualize with me the Corps of 330 practitioners two years after the program was enacted, and a Corps today grown to 1,400 personnel on duty in remote rural areas, in small cities, and in poor urban communities where doctors have not chosen to serve voluntarily. We are continually seeking ways to improve the program, to use it in

tandem with other related programs, and to cooperate with the States and local areas in their efforts to meet unmet health care needs. We are currently examining the level of field strength we should plan in future years, and the associated scholarship awards which would be required. Naturally, moving the program into action in a substantial way has not been without problems, and I will discuss these with you. But we are proud of the advances made to bring quality health care to underserved populations.

I would also like to stress with you, at the outset, what I believe to be the key words in the program—"health service." We have adopted, as I think the Congress intended, as the underlying concept of this program—providing health services for populations who lack them. After enacting the initial National Health Service Corps legislation in 1970, Congress wisely added provisions in 1972 for scholarships to help recruit needed personnel. We are using these scholarship arrangements, but as Congress mandated, they are used primarily to meet the service requirements of the Corps.

Let me now carry you briefly through the links which make up the National Health Service Corps program.

Extent of Need and Area Designation

What is the basic need which the Corps seeks to meet? It is the presence in this Nation, which is generally served with a high quality of health care, of substantial geographic and population segments which lack a sufficient number of health care providers to meet reasonable standards of service. As we measure, in each county or health service area, the ratio of population-to-primary care physicians, we first identify those with more than 3,500 persons per primary care physician. This gives us the initial indication of need. But before a community can obtain the services of National Health Service Corps personnel, it must first be designated a Health Manpower Shortage Area—a HMSA. By law, the criteria used for shortage area designation take into account not only full-time-equivalent primary care practitioner-to-population ratios but also indicators of need for health services. Special consideration is given to indicators of infant mortality, access to health services, and health status of the population. Thus, we are identifying areas where the need is great as measured by data on health conditions, and at the same time the providers of care are lacking, as measured by personnel resources located in the area.

In the designation process, information and recommendations from Health Systems Agencies, State Health Planning and Development Agencies, and Governors' offices are considered. Resources available in contiguous areas also are taken into account.

Under amendments to the law adopted in 1976, the term "shortage area" has been expanded to include urban and rural geographic areas, population groups, and facilities with shortages of health manpower. Separate designations are made for different categories of health professionals.

According to the most recent data from the health manpower shortage area analysis and designation program, by the end of the calendar year 1979 over 1,700 areas had been identified as having a shortage of primary medical care personnel. These areas had a total population of 37 million persons. This does not mean, of course, that all of these persons are underserved. The primary medical care shortage areas, those on which we place the greatest concentration, have been classified into four groups according to degree of shortage. There are 640 areas in Group 1 and 425 in Group 2, areas which have the greatest shortages, giving them the highest priority for

assignment of Corps personnel. Those areas have not only fewer health personnel, but they have high infant mortality rates, other indicators of poor health status, and often low family income. We are placing the greatest stress on first meeting the primary care health needs of underserved families in these areas. In staffing the areas, we are giving priority to the assignment of physicians, dentists, and nurses primary care providers.

Validity of Need

Some concern has been expressed about the validity of HMSA designations, and about allegations that we are unduly competing with existing practitioners in areas without a real need. The process for designation of a HMSA has been set out in regulations in exacting detail, with opportunity for comment. The initial criterion is a physician-to-population ratio of 3,500 to 1. As I stated, the process for designation also includes reviews by State Governors, Health Systems Agencies, the State Health Planning and Development Agencies, and professional societies.

Notwithstanding all the procedural safeguards and the reasonableness of the standards, we recognize that there are

arbitrary elements to designation and that a particular area might be inappropriately designated. Although we recognize that the system is not foolproof, we stress that it is reasonable. We constantly strive to improve the process of designations, and the Department immediately investigates charges that designated areas are not truly shortage areas.

Our placement policy also recognizes the limitations of the designations, and we therefore attempt to confine placements to areas in the upper two quartiles of the indicator of need. It should, of course, be borne in mind that just as some areas not in need may be listed, some truly needy areas may not qualify for designation. The data show that shortage areas generally are characterized by high poverty levels, a high percentage of elderly, and high infant mortality rates. In order to improve the designation system, we now have under way a review of the criteria and data currently used, and will consider modifications if they prove desirable and feasible.

We are very alert to controversy or allegations of unfair competition associated with particular placements. In order to avoid these difficulties, we have issued a policy directive to our Regional Offices that medical and other professional societies, including minority societies, be notified of impending placements, and that efforts be made to contact other practitioners in the proposed service areas. This procedure not only alerts us to problems, but has been a source of assistance to us as many practitioners in these areas know of the need and can provide valuable guidance and cooperation.

The Corps Placement and Service Program

The role of the Corps in the health care delivery system has grown dramatically. In 1973, the NHSC had 330 assignees staffing 183 sites and serving 209,000 people. On January 1, 1979, there were 1,406 NHSC professionals staffing 727 sites and serving more than 746,000 people. The service appropriation has increased from \$12 million in 1972 to \$70 million in 1980, and an additional \$10.8 million is pending in supplemental requests. The 1981 Budget requests \$134 million to support a field strength of 4,528 NHSC personnel.

As we look to the Corps program to aid in placing health care providers where they are lacking, we can more clearly see how this program balances the Administration's National Health Plan designed to provide the financial underpinning—the reimbursement for care. Clearly we need both the payment system and the providers of care. In fact, it is important to point out that much of the cost in financing the services provided by Corps personnel will come from payments under the National Health Plan. The reimbursements do not come to the Corps program directly, but the payment for services will be made to a greater degree under the National Health Plan.

The absolute numbers cited above are not simply abstract figures. They represent physicians, dentists, and other health professionals actually providing compassionate and quality health care to people in

need. The program directly affects people's lives and is part of their lives. Herein lies the potential of the Corps and its opportunities, but the human element also carries with it sources of conflict and difficulty. We must bear in mind that NHSC providers are generally young, inexperienced, socially conscious professionals; that scholarship recipients are students, and that users of NHSC services are individuals who are ill and often poor and members of minority groups. One cannot comprehend the Corps program, its mission, or its problems without an appreciation of its human elements.

We have continually reviewed our experience with Corps assignees in an effort to develop the most effective modes of practice. We have studied the results of placement in solo practice and in organized and integrated settings. Currently about 35 percent of Corps providers are located in freestanding sites, and we generally expect this level to be maintained in the near future. There are benefits and handicaps in each arrangement. For the Corps assignee in solo practice, demands of night and weekend calls and coverage at local hospitals lead to constant overwork and family pressures. Little opportunity is available for professional education. Replication of the

high volume, low per-unit cost, fee-for-service model of delivering medical care is not attractive to many new physicians. Study findings indicate that settings with the greatest general social and economic deprivation are the most difficult in which to create a successful NHSC site.

Because of beneficial experience, we have utilized the integrated approach to services in many shortage areas. Under this arrangement, we make the best use possible of all of the resources available to fill the needs of these areas where practitioners do not voluntarily locate. We have had the most success using the combined resources of Community Health and Migrant Health Centers, Community Mental Health Centers, Hospital-Affiliated Primary Care Centers, and Maternal and Child Health and Crippled Children's Services, together with the National Health Service Corps. The initial legislation mandated that NHSC services be provided in connection with other health care programs of the Public Health Service. Now community health centers, migrant health centers, Indian Health Service facilities, and prisons are set forth specifically in the law as potential NHSC sites, and NHSC personnel explicitly may be assigned to Federal facilities. While we have found this integrated use of Federal programs to be effective, this

does not rule out assignment of NHSC staff in non-Federally supported health care settings in underserved areas. The overriding concern of the Department is to address the Nation's need in a coherent, integrated manner that assures quality services to the greatest number.

The Corps physician as a member of a health care team in an organized setting in a shortage area has an opportunity for professional associations, for continuing education, for consultation, for time off for recreation and family, and an all-around sense of professional growth and fulfillment.

It is enlightening to note that the association of a Corps physician with a health center can occur in either of two ways. Obviously we can assign Corps doctors to existing health centers which are unable to recruit physicians successfully. In many cases we do. But in a significant percent of the instances where a Corps physician is serving in a health center, the Corps physician came first. A shortage area needed a doctor and the Corps assigned a physician to the community. With the doctor's help, the community came to realize that it needed more than just a doctor and his receptionist. It needed a nurse, a pharmacist, attention to environmental problems, outreach services, help with financial problems. Soon the organizing effort crystallizes and a health center is born.

Rural/Urban Areas

The NHSC will continue its placement strategy on rural/urban distribution in accordance with the distribution of the population in need. The present composition of our NHSC assignees is 70 percent rural and 30 percent urban. This distribution should remain constant in the next 5 years.

Productivity

There are those who contend that NHSC physicians have lower productivity rates than those of private practitioners. The differences in the nature of the services between NHSC physicians and private physicians must be realized in making any such analysis. The NHSC consists primarily of new and inexperienced practitioners in the process of building practices. They provide outreach, and environmental and other health services not normally provided by private practitioners. Nationally, the NHSC is seeing proportionately more of the poor, underprivileged individuals who usually have more extensive health needs. Thus it is important to consider these genuine differences in comparing productivity data.

Placement Strategy

As noted, the NHSC strategy is to place health professionals where they are most needed. We have limited placements basically to areas that are in the two highest quartiles of the indicator of need or that have large migrant populations. There are, however, limitations to this policy. We are mandated by law, and driven by a desire for retention, to match personnel to area. Matching is an extensive process that examines prospective NHSC personal characteristics and those of their spouses in reference to possible placement areas. We must also be mindful of "buy-outs," —those who repay their scholarships and do not serve. Obligees are now subject to a triple penalty which, of course, should reduce buy-outs; but, in the meantime, we must strive to reduce losses through careful attention to the matching process.

Recruitment of Personnel

Given the designated areas, and the decision on which of those areas can be provided with personnel within the funds available, how do we secure the health professionals required? We have two essential sources: those who volunteer, and those

who enter into a commitment to serve. The commitments are made as a result of acceptance of scholarship aid for their education or acceptance of repayment of their loan by the Federal government in return for service. In order to help assure an adequate supply of physicians and other primary care personnel, Congress enacted the National Health Service Corps scholarship authority in 1972, two years after the service program was authorized. As specified in the law, priority for scholarships is given to those categories of professionals that are most needed in shortage areas. Corps scholarship assignees also help to meet the staffing requirements of other Public Health Service programs, such as those of the Indian Health Service. Volunteers represent an important supplemental recruitment source which generates about 300 new physicians annually and bring continuity and long-term commitment to service delivery.

The Scholarship Program

The first NHSC scholarships were awarded in fiscal year 1974 to 372 medical and osteopathic students enrolled in academic year 1973-74. From the outset the program was designed to improve the geographical distribution of health professionals. Applicants were

not required to be in financial need. Assistance to needy students was provided under separate non-service-conditional health professions and nursing scholarship and student loan programs. Awardees were selected on the basis of relative promise for continued service in a health manpower shortage area. The types of disciplines for which scholarship awards were made were determined according to the needs of the Public Health Service and the National Health Service Corps for individuals who were trained in those disciplines and who were unavailable through voluntary recruiting mechanisms. In the first two years of the program, awards were made only to students of medicine and osteopathy. Other disciplines were added in subsequent years, to a limited extent, based on the needs of the Corps. As specified in the statute, the scholarships are strictly service-conditional. Recipients are required to commit themselves to serve in a shortage area one year for each year of scholarship aid received, with a minimum service obligation of two years. The original law simply required individuals who defaulted on their service obligation to repay the scholarship aid with interest within 3 years. Amendments adopted in 1976 increased the penalty for default to repayment of three times the scholarship aid plus interest at the maximum prevailing rate, within one year.

The 1976 amendments gave scholarship recipients in fiscal year 1978 and after the option of performing their obligatory service in the private clinical practice of their profession in a health manpower shortage area. The area was required to have priority for the assignment of Corps members and a sufficient financial base to provide the individual with an income not less than the income of Corps members.

Under the 1976 amendments, at least 81 percent of the scholarship funds in any year must be awarded to students of medicine and osteopathy and 9 percent to dental students. Depending on the projected needs of the Corps program, the proportion of funds used for awards in these disciplines may be higher.

Over the years the scholarship program has expanded until, for the 1979-80 academic year, awards totaled 6,408, including 2,379 awards made to new recipients and 4,029 continuation awards to recipients from previous years. Of these awards, 5,374 went to students of allopathic and osteopathic medicine, 568 to dental students, and the remaining 466 to selected other occupations.

We must constantly gear our planning to a recognition of the length of the training program and the need to defer students to complete specialty training before they begin to practice. Thus, over the seven years experience, a total of 2,694 persons had been assigned to the field through FY 1979. By the end of 1979, 238 scholarship recipients had actually completed their service obligation. During the 1979 fiscal year, 605 scholarship recipients entered obligated service of 2 to 4 years. Eight thousand nine hundred and ten (8,910) scholarship recipients are still in training, either in basic professional schools or in advanced clinical training. These individuals will enter service obligations during fiscal years 1980 through 1986. First year medical students supported by the FY 1981 budget request will generally be available for assignment in 1989 and 1990.

For the 1979-80 academic year, each scholarship award consisted of the following benefits:

1. Payment to the school of the full amount of tuition and required fees that would otherwise be billed to the student.

2. A monthly stipend of \$453 for a total of \$5,436 for the year.
3. An additional amount paid directly to the student to cover all other reasonable educational expenses, such as books, equipment, and supplies.

The average amount obligated on behalf of the 6,408 students receiving new and continuation awards for the academic year 1979-80 was about \$11,700.

Later this year, an estimated 6,657 new and continuation awards will be made for academic year 1980-81. These awards will be funded from the fiscal year 1980 appropriation of \$85.5 million. The average award, allowing for increased cost related primarily to inflation, will be about \$12,700.

For fiscal year 1981, the President's budget request of \$93.5 million would fund a further increase in the total number of scholarships to about 6,700, of which about 5,577 will be for physicians. The average cost of these scholarships will be about \$13,800.

If the Corps scholarship program is to be fully effective in providing individuals for shortage area service over the coming years, we see a need for a few changes in the legislative authorities for the program. We would remove the requirement that at least 90 percent of scholarship funds go to medical, osteopathic, and dental students. The Secretary should have the flexibility to adapt the distribution of scholarships to the changing Corps program needs on a year-to-year basis. At the same time, the Department should be able to limit private practice agreements to ensure physician location in the highest priority shortage areas. We believe, finally, that the Secretary should be allowed, on a demonstration basis, to enter into cooperative agreements with States regarding the assignment of Corps obligees in those States. Under these agreements, a State would assist in defraying the costs of Corps scholarships and costs associated with establishing and maintaining a Corps site. In return, the Secretary would agree to assign certain individuals to health manpower shortage areas in the State in accordance with a State plan approved by the Secretary.

Other Recruitment and Professional Development Programs

Although the Corps scholarship program in recent years has become HEW's major means of recruitment of personnel for overcoming shortages of health professionals in urban and rural areas, it must be viewed as one of a number of Department programs directed toward this end. Programs for repayment of a portion of student loans of individuals who agree to serve in health underserved areas date back to the early 1970s and before. Currently such repayment is authorized for Health Profession Student Loans, for federally insured Health Education Assistance Loans, and for any nursing educational loans. We would continue these programs. Another means of meeting the needs of health manpower shortage areas is to train larger numbers of family medicine and other primary care specialists of the type required in those areas. The Administration favors continued targeted support for primary care physician training (family medicine, general internal medicine, and general pediatrics), nurse practitioner and physician assistant training. There is some evidence that these types of practitioners more frequently locate in rural areas. We will also continue training in dental team practice to promote increases in the supply of primary care professionals.

The Area Health Education Center (AHEC) program has provided for the enhancement of health professions training opportunities in areas remote from existing education centers. The 21 AHEC programs receiving Federal support in fiscal year 1979 were operating or developing 30 regional centers serving over 433 counties in 22 States. Our initial evaluation indicates that the AHEC program is effective in stimulating better geographic distribution of primary care physicians. We seek continued support for it.

Private Versus Federal

The contention has been put forth that the goals of the NHSC would be better served by permitting scholarship obligees to fulfill their obligations through private practice in shortage areas. This is a perplexing problem. Obviously, loss of direction and control, and possibly service to the needy, could result from such a policy. We must avoid such an outcome. In some cases, the private practice option may be more economical and more enduring. We must retain the requirement for service only in the areas of highest priority need. The greater the need, usually the less able the area is to support a physician at the NHSC salary—especially a beginning practitioner. This

is the dilemma. We are actively considering an amendment to the private practice option to modify the requirement for determining in advance that there is a sufficient financial base. We have also succeeded in devising a private practice option for individuals who did not receive scholarship support under the new law. This private practice initiative is being implemented this year, and we have made needed revisions in the Corps' informational materials and the service contract in order to foster the private practice alternative. We support increased but cautious use of private practice to address the Nation's needs.

Outlook

This Administration has a commitment to meet the primary health care needs of the people of the Nation. We rely, of course, on the market forces which influence the predominant number of physicians in choosing a practice location. We feel a special obligation to those who will not be adequately served without intervention. We believe that the National Health Service Corps is a cornerstone of a successful effort to meet needs. While we are mindful that the rate at which we can expect Federal and non-Federal resources to meet the need, and the manner in which we can work through State and local cooperative efforts, are questions for continual review, the Administration is dedicated to make progress to meet this need.

Thank you for this opportunity to present our views. We will try to respond to your questions.

Mr. WAXMAN. Thank you very much. We appreciate it.

Let me address some questions to you and if you wish to have other of your colleagues answer them, that is fine.

Is the purpose of the National Health Service Corps to provide student assistance or to secure primary care physicians for communities that are without those services?

Dr. RICHMOND. I think, Mr. Chairman, we certainly started out in this program wanting to deliver services to groups that are underserved.

It seemed to be a good match to provide scholarships for students in order to provide them with assistance in return for which they would help in the provision of such services. I think it is fair to say that we have a kind of dual-purpose program.

I think it is a good match.

Mr. WAXMAN. What are our expectations for the need for physicians to serve in these underserved areas over the next decade? We have recently heard that physicians are now voluntarily locating in some of these communities. Is that true?

How do you see the need for the Corps?

Dr. RICHMOND. Well, in making our studies, Mr. Chairman, we identify some of those health manpower shortage areas, medically underserved areas, as having populations that will be large enough to require somewhere between, about 5,000 primary care physicians and some 8,000 to 9,000 a decade hence.

We are not absolutely certain of what that number will be, but again I come back to the fact that we are talking about a very modest number of primary care providers, around 1¼ percent.

It seems to me it is a wise investment for us to make, since this program provides us with an opportunity to redistribute physicians into communities of need. I think as a nation we ought to make that investment of about 1 percent of our manpower in providing help to very difficult-to-serve communities.

Mr. WAXMAN. Specifically, what total number of physicians will be available to the National Health Service Corps for placement during each of the fiscal years 1981 through 1983?

Dr. RICHMOND. I think some of my colleagues could provide you with that very precise number. My recollection is we will be soon approaching the 5,000 figure.

Drs. Lythcott and Martin could give us that.

Dr. LYTHCOTT. What years did you say, sir? In 1981, 4,528; in 1982, 5,114; in 1983, 5,541. That is total.

Dr. RICHMOND. I rounded that out to 5,000.

Mr. WAXMAN. What is the cost in each fiscal year of having that many physicians?

Dr. LYTHCOTT. The cost is \$133 million in 1981.

Mr. WAXMAN. What was that figure?

Dr. LYTHCOTT. That figure is \$133 million in 1981; \$195 million in 1982; and \$230 million in 1983.

That does not, Dr. Martin reminds me, account for the amount of money that is returned to the Treasury. This is what it costs to run the program, so it is not pure numbers.

Mr. WAXMAN. Is this what it costs to run the Corps part of the program, not the scholarship part?

Dr. LYTHCOTT. That is correct, but I also added it does not account for money the Treasury will be reimbursed as a result of the services.

Mr. WAXMAN. What percentage of the total amount that is spent now is returned to the Treasury?

Dr. LYTHCOTT. It is between 14 and 18 percent, but we are increasing our ability to seek third-party funding for reimbursement, and it is at 14 to 18 percent now with the figure going up.

Mr. WAXMAN. Tell us in what ways you are seeking to increase the amount of reimbursements the Federal Government will receive?

Dr. LYTHCOTT. We are working with the Health Care Financing Administration to make certain that those services which we provide are reimbursed, and that they are reimbursed to the level somewhere in the area of what it costs us to render the service.

We also are involved in better management systems which would add to that number.

Dr. RICHMOND. I think it is appropriate, Mr. Chairman, to remember that medicaid operates through the States. We have a good deal of work to do with the States to try to get their reimbursement schedules up to levels which would be more comparable to what it costs us to deliver the services.

Mr. WAXMAN. Looking at physicians alone for 1983, what percentage of all United States physicians will that represent?

Dr. RICHMOND. Which year?

Mr. WAXMAN. For 1983. I assume the figures you gave me—

Dr. RICHMOND. Slightly less than 1 percent.

Mr. WAXMAN [continuing]. I assume the figures you gave me are the total physicians.

Dr. RICHMOND. Yes.

Mr. WAXMAN. I understand that HEW's current policy is to place physicians in urban and rural communities which have the greatest need for health services. Would you explain this strategy?

Dr. RICHMOND. I might ask either Dr. Lythcott or Dr. Martin who work with them to respond.

Dr. LYTHCOTT. As you know, sir, we have health manpower shortage areas which are defined by a program in HRA and published in the Federal Register. We know where those areas are and look at them carefully, as to their relative need. We put them in quartiles and select out the two quartiles which have the greatest priority.

Mr. WAXMAN. Approximately what portion of communities defined as an underserved areas are put in a higher priority category resulting in assignment of Corps physicians?

Dr. LYTHCOTT. It is a larger number.

Dr. MARTIN. It is a little more than half, but 83 percent of the assignees are in that worse half. Those populations predictably are characterized by poverty, high numbers of migrants, and isolated rural areas. You are talking about a system which takes one-tenth of the population and describes it as the shortage area, divides that by two and within that two divides it again so you are talking about a priority mechanism really focusing intensely on a much smaller population.

Mr. WAXMAN. What sort of areas are being left out even though they fit into the category of an underserved area?

Dr. MARTIN. As an example, it took us almost 3 years to get MUA designations in the District of Columbia. If you look at the ratio of physicians in the city as a whole, or some parts of New York City, it looks like there are plenty of physicians, but when you go down into Anacostia and talk to people, and ask do those physicians accept medicaid, or will they accept as patients minorities or people who speak different languages, you find the answer is often no. For populations sometimes of a very substantial size there may be doctors in and around the community, but for those people they are certainly not accessible.

After 4 years we finally were able to designate some of the worst, parts of the District. We had a great deal of difficulty in parts of New York where it looks like there are doctors there. Rural areas are generally easier to designate than urban areas because it is easier to determine the availability of physicians.

The patients who are trying to get care in urban emergency rooms and the like keep reminding us that you may think doctors are there but they are not.

Mr. WAXMAN. Is it fair to say when you are finished with your targeting that the innercity areas are generally a lower priority than the isolated rural areas?

Dr. MARTIN. In the proportion of designations, yes, sir, it is about 55 to 60 percent rural high-priority designations versus about 40 percent urban, but the key innercity areas where there is unquestionably great need are accorded the same priority; for example, in Harlem, the south Bronx, and many other urban areas.

You had testimony from someone about parts of Baltimore. Many other urban areas do not fall within that highest priority area.

Mr. WAXMAN. What impact does this targeting have on repayment to the Federal Government for the cost of physicians?

Dr. MARTIN. Generally the more we target those resources to the population with the worst health care and the greatest needs, the lower the reimbursement is.

Mr. WAXMAN. What impact does this targeting system have on retention of physicians in those communities after they have served out their obligation for the scholarships?

Dr. LYTHCOTT. There is a direct relationship, certainly. The answer is, the more difficult the site, the more difficult it is to have a high retention rate.

Dr. RICHMOND. Mr. Chairman, I think that is one of the reasons why we are focusing on the development of centers in some of these very difficult areas. We would like to have continuity. We can't always keep professionals in these remote areas or very poor communities, and if we have developed a center, we can then rotate people through that center so that the population there has continuity of care, even though some of the providers may change.

Dr. MARTIN. It is also important to emphasize recruitment because it is very difficult to get physicians trained today to accept a particular mode of practice, either in a facility or with support systems which are alien to their training.

There is a good case example in fact in an important part of Kentucky. About 4 or 5 years ago Congressman Carter pushed on us very hard, to get Corpsmen into this part of Kentucky. We must have traveled dozens of doctors through those communities. They would visit the communities and say there is community interest, and we have got a good feeling about coming here, but we simply are going to have difficulty.

After we started rural health initiatives and got outreach staff, we made a grant which links those doctors to the University of Kentucky. After 4 years with Dr. Carter's support, we now have 17 National Health Service Corps assignees, and the key element there has to do with how the local communities, and how elected officials participate.

A great deal of the opposition we faced when we did that was dealt with by Congressman Carter and without that kind of assistance we wouldn't have 17 physicians in there today.

Mr. CARTER. It is true, Mr. Chairman; they have been very helpful to my district. Many of those physicians have gone into Jackson County, which is the strongest Republican county in the United States.

Dr. RICHMOND. They deserve good medical care, too.

Mr. CARTER. We appreciate that too.

Mr. WAXMAN. In 1976 some people expected that National Health Service Corps physicians would elect to use the private practice option after their obligation was fulfilled, and they would stay in the same underserved areas.

I gather what we are being told today is because of the targeting for some of the highest priority areas, and for other reasons, this has not been the case.

Is that a fair statement?

Dr. RICHMOND. Well, to an extent, and Drs. Lythcott and Martin may want to make some additional comments.

I would say if we are targeting toward the highest priority areas, the notion of the private practice option is a very difficult one in many of these communities.

Reimbursement rates are insufficient, as we have indicated, particularly from some of the public programs. I think that it is easier in communities that are more affluent; as you know, there are some remote communities that can be relatively affluent and yet difficult to serve. It is easier for a person to exercise a private practice option in communities that are in better economic circumstances, so I would say if we are really doing the job that we want to do it should not be difficult for a significant number of people to exercise that option under the reimbursement system that now exists.

Mr. WAXMAN. What is HEW doing to encourage people to stay in underserved areas after fulfilling the obligation?

Dr. LYTHCOTT. Could I add to Dr. Richmond's very excellent point, the fact that only the assignees who have gotten their training under the new law are eligible for this kind of buy-out and the numbers are so small at this time that we really have not had a chance to look at it.

I think what I hear you saying is, Is it a good idea? It is a good idea, but we need more time, I think, to offset the problems that

Dr. Richmond mentioned of some of the areas which need the most not being able to support them.

The law says the area must be able to support a physician from the point of salary, and so on. It will be several years before we really get to where that becomes a very viable option.

Mr. WAXMAN. What is HEW doing to encourage physicians to stay on in those areas?

Dr. LYTHCOTT. All of those who are eligible get letters from us encouraging them to do it. When they begin looking is when they have problems.

Mr. WAXMAN. If a physician wanted to stay on as a volunteer beyond the period which he is fulfilling his obligation, does he receive the same salary that he received before?

Dr. LYTHCOTT. If he stays on as a volunteer, or as a Federal employee, sir?

Mr. WAXMAN. As part of the Corps but not because of an obligation to be fulfilled, because he wants to be there.

Dr. MARTIN. Under the previous law until Congress made modifications in November or October, there was a pay differential of about \$11,000 or \$12,000, so the scholarship obligee made about \$11,000 less than his colleague who did not have an obligation.

What most young physicians discovered is that if they joined the Civil Service, there was no pay differential. So they did that and many of our scholarship obligees got the same amount of money.

Congress rectified that in the fall with the pay bill modifications for scholarship recipients, and now there is a bonus that goes also to scholarship recipients which will equalize the pay of a scholarship obligee or a volunteer.

It's a crucial distinction to point out that the private practice option under the present statute is only an option which is available to new scholarship people and under the present law can only be in an area where we have to by law guarantee in the first year of practice that they will make as much money as if they were a Federal employee.

That is very hard to do, to say to a physician in a high-priority area, we guarantee you that your income is going to be equivalent to \$33,000 or \$34,000 a year. That is what the private practice option requires us to implement.

The other question is how many people are retained. As we have moved to more organized settings, our retention rate in the communities has grown from 3 to 15 percent. We think that will continue to grow.

Mr. WAXMAN. Let me discuss the retention rate; once a Corps member has completed his obligation, would you prefer him to move on so that new people can come into the Corps?

Dr. MARTIN. Absolutely not. We would prefer to have the continuity of care and in fact about one out of every two or three professionals in the NHSC desires to stay on at least an additional year, and we anticipate that that percentage will continue.

Mr. WAXMAN. What incentives do you give them to remain?

Dr. MARTIN. The kind of clinical support activities, improving the kind of practice in the sites, a lot of the benefits to an individual staying in a community coming from the community itself.

An important factors in why practitioners stay in communities has to do with the work the community does to make them feel at home and welcome.

Mr. WAXMAN. Psychological play?

Dr. MARTIN. Absolutely.

Mr. WAXMAN. What about financial?

Dr. MARTIN. Most assignees, doctors in the National Health Service Corps, are not in it for the financial aspects.

Mr. WAXMAN. As I understand what you are telling me, there is no increase for those who are dedicated and want to stay on in terms of their salary from those who come there just to fulfill their obligation?

Dr. MARTIN. Your salary goes up as you spend 2, 3, or 4 years.

Mr. WAXMAN. Do they get the other benefits of the Civil Service?

Dr. MARTIN. Yes; they are fulltime Federal employees.

Mr. WAXMAN. Are there problems in placing physicians who want to volunteer to be part of the Corps but who are not there as fulfilling their obligation for the scholarship?

We heard some testimony to that effect this morning.

Dr. LYTHCOTT. I believe you are referring to what has been a fairly recent problem which had to do with whether or not the supplement that the Department requested is forthcoming.

If we do not get that supplement, we would be in the position of having more scholarship students than we could use and, therefore, have more volunteers than we could use. We began by holding back on the volunteers and negotiating with the scholarship assignees.

We now are looking at both from the point of view of who is most likely to stay in the area after the period of obligation is over.

What you are talking about is a temporary thing that has to do with funding at the moment that we hope will be alleviated by the supplemental.

Mr. WAXMAN. Are you having trouble paying for the whole Corps?

Dr. LYTHCOTT. We will have this year if the supplemental does not come through. We will have trouble maintaining the Corps that we had planned on for this year and had worked with community health centers to achieve.

Mr. WAXMAN. You say a supplement? Where is that supplement?

Dr. MARTIN. The House Appropriations Committee has a hearing tomorrow and the Senate committee on Friday. The technical problem last year was the key to this.

The committees were prepared to vote on the level of the Corps but the authorization level was limited to \$70 million. The President's request was for \$82.8 million, so the President's request could not be acted on by the Appropriations Committee until after October or November.

The administration has submitted a supplemental request for that \$12.8 million in the hearings that are imminent, and we are optimistic. That means there are 1,000 practitioners that cannot be placed without that supplemental.

Mr. WAXMAN. In fiscal year 1980 how many scholarships will be awarded, and how many applications do you expect for those scholarships?

Dr. RICHMOND. We might ask Dr. Foley and Dr. Whiteside.

Dr. FOLEY. In 1980 we project we will make 6,657 scholarship awards with an appropriation figure of \$85.5 million. Would you like us to submit to you a table which includes the scholarship figures from fiscal year 1978 through fiscal year 1981?

Mr. WAXMAN. Yes; that would be helpful. Let's have that for the record.

[The following information was received for the record:]

NHSC SCHOLARSHIP DATA

Fiscal year	Applicants for new awards	New awards made	Total number of all awards made	Total (millions)
1978	5,400	3,347	5,254	\$60.0
1979	7,400	2,379	6,408	75.0
1980	(¹)	1,624	6,657	85.5
1981 ²	(¹)	1,891	6,701	93.5

¹ Unknown.

² Based on President's budget for fiscal year 1981.

Mr. WAXMAN. What criteria do you use to select scholarship recipients and do you believe that those criteria will identify students who will remain in health manpower shortage areas?

Dr. RICHMOND. I would like to ask—

Mr. MAGUIRE. They didn't say how many applicants they were having for those scholarships. You asked that. You said how much do they get but they didn't tell you.

Dr. WHITESIDE. In fiscal year 1979, we had 2.8 applicants per new scholarship award overall.

Mr. MAGUIRE. Thank you.

Mr. WAXMAN. What are the criteria for making this decision?

Dr. WHITESIDE. We look at the career goals of the individuals who are applying. We look at their work experience and the areas from which they came. We are particularly interested in identifying people who are interested in delivering primary care and people who have come from small towns and people who have had experience working with underserved populations.

Mr. WAXMAN. Would NHSC physicians be better prepared to provide service in underserved areas if the NHSC scholarships are only awarded to students attending schools with strong commitments to primary care and to preparing students to serve in underserved areas?

Dr. RICHMOND. We would not want to take the position that students attending any of the schools throughout this country wouldn't or couldn't have the motivation and the desire to serve in these underserved areas. I think we have felt that the competition ought to be a rather open one. The development of institutions which by policy say they are interested in primary care has been a fairly recent development.

We don't know whether their graduates are truly going to be more committed than graduates of other schools to working in underserved areas. I think that we would prefer to see it remain on a relatively open process and open competition.

Mr. WAXMAN. In other words, in awarding the scholarships you are looking at potential physicians, not just physicians to serve in the underserved areas, is that correct?

Dr. RICHMOND. Well, I think it is a combination. We are looking for motivation to serve in underserved areas.

Mr. WAXMAN. How many students in their second year of medical school would be on a scholarship?

Dr. RICHMOND. Well, I think I can comment on the total pool. We are at about 8 percent. Could you give us that, Dan?

Dr. WHITESIDE. We don't know the number that are in second year but we can provide you the breakdown.

[The following information was received for the record:]

Recipient of National Health Service Corps Scholarships in schools of medicine and osteopathy, as of September 30, 1979, by class, are as follows: senior, 1,110; junior, 1,562; sophomore, 1,844; and freshman, 933.

Mr. WAXMAN. I would like to have the breakdown for each of the years.

Are we talking about most students going to medical school that are supported by these scholarships?

Dr. RICHMOND. As of now we are close to 8 percent. We are not destined to go significantly higher. We may get as high as 10 percent.

Mr. WAXMAN. Is this the only program available for medical school students who are in need of financial aid?

Dr. RICHMOND. No; there are loan programs which Dr. Foley and Dr. Whiteside administer.

Dr. FOLEY. We have the health professionals student loan program which is a revolving fund in the medical schools themselves. That provides loan money.

We also have the exceptional financial need scholarship for students for their first year, particularly targeted toward minority and low-income students so they can get past their first year and make a choice on what type of support structure they might obtain using either private financing, military financing, or NHSC scholarship support.

We also have the health education assistance loans, which basically is a loan program at commercial interest rates for the students to get through medical school.

We do have in fact a range of loans and it reflects back to what Dr. Carter has asked in other sessions, of which schools are receiving scholarships. While the average is low for all students in medical schools, some schools do have a significant portion of their student body on scholarship.

It is a major source of support for those specific medical schools, a couple of them not too far distant from this particular room, in fact.

Mr. WAXMAN. I have heard from a number of different professional associations including podiatrists and psychiatrists that NHSC scholarships are not being given in proportion to the need for those professionals.

Do you agree with that? If not, why not?

Dr. FOLEY. In terms of the medical students or all other professionals?

Mr. WAXMAN. In terms of different professional groups, and the ones I specifically heard from were podiatrists and psychiatrists.

Dr. FOLEY. We have continued those awards that were awarded prior to this coming fiscal year for those professions in response not only to the committee but also to the Appropriations Committee.

The administration has made a decision not to award new awards to those particular professions, the veterinary, optometry, podiatry, and pharmacy, and that information was to be communicated to the chairmen of the Appropriations Committees.

The reason for the decision is that in terms of priority areas for the delivery of health care services themselves, as Drs. Lythcott and Martin referred to, the basic decision was that these other types of health professionals could be recruited through the normal market mechanism in those particular underserved areas. The people's primary need in those areas were for physicians and nurse practitioners.

The answer is that we are giving no new awards.

Mr. WAXMAN. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I am interested in knowing the average annual cost to the Federal Government of a National Health Service Corps dental practice, and also for a National Health Service Corps medical practice.

In other words, if you add up all of the expenses to the Government for the years of scholarship and plus the cost of the stipend, supplies, and support personnel, could you give us a rough estimate of the cost to establish and operate a dental site or a medical site?

Dr. LYTHCOTT. I think we would have to get that kind of detailed information to you for the record. We feel it costs us about \$45,000 a year to support a National Health Service Corps assignee in terms of salary and scholarship costs. We will get that information for you for the record.

Mr. CARTER. Yes; that will be fine.

[The following information was received for the record:]

AVERAGE ANNUAL COST OF MEDICAL AND DENTAL PRACTICE FOR NATIONAL
HEALTH SERVICE CORPS

The estimated total annual cost of a medical NHSC practice—including the physician's salary and bonus, plus scholarship, support, and start-up assistance costs—is approximately \$115,000.

Medical practice

Salary, scholarship, and bonus	\$50,000
Support costs	45,000
First-year start-up assistance	20,000
Total	115,000

The comparable estimated total annual cost of a dental NHSC practice is approximately \$110,000.

Dental practice

Salary, scholarship, and bonus	\$40,000
Support costs	35,000
First-year start-up assistance	35,000
Total	110,000

Mr. CARTER. What is the cost to the Corps for a student going to Georgetown University?

Dr. FOLEY. Dr. Carter, I would be glad to get you the exact figures, but as I recall it is approximately \$16,000 a year. We do have those figures and can provide them for you.

Mr. CARTER. I didn't think it was that much. I thought it was \$13,500.

Dr. FOLEY. \$13,500 is the tuition. We are also looking at stipend support and also books.

Mr. CARTER. I would like to know everything that the Corps would pay for a student going there with one of your scholarships.

Dr. FOLEY. We would like to get you that total figure, Dr. Carter, and we will do so.

[The following information was received for the record:]

TUITION FOR GEORGETOWN MEDICAL SCHOOL

Tuition for students entering in academic years 1980-81, 1981-82, and 1982-83 will be \$13,500, subject to change. Fees will be \$105. Other expenses (textbooks, room and board, etc.) are estimated at \$5,995 per year.

Mr. CARTER. I wonder if there is any particular reason why Georgetown has the second largest number of Corps scholarship students of any medical school in the United States?

Dr. RICHMOND. Was your question why?

Mr. CARTER. My question was why does Georgetown Medical School have the second largest number of NHSC scholarship recipients in the United States? Is there any particular reason for that? Do you believe that these students are most likely to go to rural areas?

Dr. FOLEY. Dr. Carter, as we mentioned earlier, in terms of decision roles for awards of scholarships, a lot clearly has to do with the financial incentives of the students and their needs. Also, the history of the school itself and the part the financial aid officer plays in relationship to the medical students, in making them aware of the National Health Service Corps scholarship program.

Georgetown is blessed in that it is in our city. It is close to the Capitol and sees how we interact in the Congress and the executive branch and how the bureaucracy acts. I suspect that has some influence on why Georgetown has proceeded for the awards.

Also, as I indicated, when you have an expensive tuition there is a tendency to use not only the National Health Service scholarship program but also the VA program and the Department of Defense. I think we should expect that.

Dr. RICHMOND. I would like to add this observation in connection with the costs of medical education and education for people in other health professions. A number of years ago I had the opportunity to sit on a committee of the Institute of Medicine that studied these costs very carefully. I think what we see in institutions like

Georgetown and George Washington is a tendency for the universities to begin to charge the true costs.

What we found in the Institute of Medicine studies was that tuition in general was about one-third of the actual costs to the universities. Private institutions that do not have public support of any kind, and certainly no counterpart of State capitation, if they are to remain viable as institutions, have to come closer to charging their true costs.

I would certainly be willing to make the guess that we are seeing more and more institutions moving in the direction of charging students more of the true cost of the educational process rather than a relatively small fraction of it. I am not saying that by way of justification, but it is an observation that I think should be on the record.

Mr. CARTER. In this case for Georgetown, your costs for the scholarship for 1 year for tuition, books and so on would be much above the \$11,700 average which you mentioned earlier that also included tuition, stipend and books. Is that correct?

Dr. RICHMOND. That is correct. It is somewhat above.

Mr. CARTER. Georgetown has no State support, as you mentioned. Of course, in times past we have provided through legislation, grants to Georgetown and George Washington. Don't misunderstand my views; I go to Georgetown sometimes on occasion and I like the school very much. However, I think it is unbalanced to have so many awards going to a school that doesn't have any special leaning toward rural practice, or underserved areas. In addition, George Washington University has 208 scholarships. I can understand Meharry's large number of awards and I agree with that because there is a need there. I understand Meharry's condition is not too stable and these scholarships are needed.

When there is a need, you have to try to match the need with the number of students there. They go into areas where the medical need is great. I can see that. But it is still just a little bit difficult to justify the large concentration of scholarships here in Washington. Why not provide some out at the University of California at Los Angeles? I wonder why you don't have that school listed. Is the number of scholarships not significant enough to mention?

Mr. WAXMAN. I will probably have to wait for Republicans to come in and take care of Los Angeles.

Mr. CARTER. You know, I'd like to say something about that. Health is not a political consideration to my mind and it never has been. I don't bring up politics here, even though I come from Lincoln County and I don't deny it.

How many scholarships do you have out at the University of California at Los Angeles?

Dr. FOLEY. We certainly can get you that exact number.

[The following information was received for the record:]

There are currently 26 NHSC Scholarship recipients at the University of California at Los Angeles, including 14 at the School of Medicine, 11 at the School of Dentistry and 1 at the School of Nursing.

Dr. FOLEY. To return to Dr. Richmond's point for a moment, again, the University of California at Los Angeles which is a distinguished medical school also has great State support. Now whether

or not that will continue because of other tax measures out there is a real question. But you don't have the real cost incurred on the student in the California system.

As Dr. Richmond was pointing out clearly, the real costs are shown rather dramatically in the private education system. We have the same phenomena in Texas where the capitation is very high for students with residency within the State of Texas and you will see few scholarships within that State because of the adequate State support for their training.

Mr. CARTER. I have also noted that when you award scholarships people, you say that you try to match them. In other words, you select a physician who has been reared in a rural area who later will go to a similiar area. But the way you allocate scholarships seems to be contrary to your objectives. Instead you are providing essentially school support, with the exception of one or two schools. Really you are providing school support rather than supplying funds to students who are most likely to go to rural or ghetto areas.

Dr. FOLEY. Well, I think we should clarify one area, Congressman. As you know from your own medical training, students oftentimes given their first preference when they enter the first year of medical school but have changed their mind when they enter the third or fourth year, especially if they are specializing.

We find the same phenomena among students who have gotten a scholarship such as the DOD scholarships. As they become aware of their responsibilities, they take on those responsibilities and go into the areas that they are supposed to.

In fact, with the expansion of the number of medical schools in the country and the number of physicians that we have been producing, and as we produce more board-certified specialists, we see a net increase of 14 percent in the number of physicians moving into populations below 50,000 in the nonmetropolitan areas of this country from 1960 to 1977.

The students themselves, as they go through medical school and see role models and get encouragement from personnel of the department who explain to them what rural practices are about, are better prepared psychologically to go to those areas.

Also, in those communities in which there are area health education center programs there is adequate psychological preparation and ongoing continuing education support not only for that physician but other physicians. For nurse practitioners, as in the North Carolina experience, we find it likely that they will stay in the area.

Mr. CARTER. How many students in North Carolina medical schools do you have in the Corps scholarship program? Down in North Carolina with their AHEC program they are really producing physicians for rural areas, or ghetto areas for that matter. In my view it would be preferable to focus support on this area.

Could you tell me about how many scholarship students you have at the University of North Carolina and at the other four schools in that State?

Dr. FOLEY. Dr. Carter, we will supply you a listing of each school in the country and the number of scholarships for each school. We do have it. I just don't happen to have those figures on hand.

[Testimony resumes on p. 99.]

[The following list of schools was received for the record:]

NHSC SCHOLARSHIPS, BY MEDICAL SCHOOL
ACADEMIC YEAR 1979-80

TOTAL	6,619*		
ALBANY MEDICAL COLL OF UNION	69	129	LOMA LINDA UNIV SCH OF MEDICI
ALBERT EINSTEIN COLL OF MED O	33	22	LOUISIANA STATE UNIV SCH OF M
BAYLOR COLL OF MEDICINE	21	12	LOUISIANA STATE UNIV SCH OF M
BOSTON UNIV SCH OF MEDICINE	86	42	LOYOLA UNIV OF CHICAGO STRITC
BOWMAN GRAY SCH OF MED OF WAK	31	11	MAYO MEDICAL SCH
BROWN UNIV PROGRAM IN MEDICAL	43	35	MED UNIV OF SOUTH CAROLINA CO
CASE WESTERN RESERVE UNIV SCH	61	21	MEDICAL COLL OF GEORGIA SCH O
COLL OF MED AND DENT OF NJ NJ	44	41	MEDICAL COLL OF OHIO AT TOLED
COLL OF MED AND DENT OF NJ RU	70	72	MEDICAL COLL OF PENNSYLVANIA
COLUMBIA UNIV COLL OF PHYSICI	37	75	MEDICAL COLL OF WISCONSIN
CORNELL UNIV MEDICAL COLL	17	214	MEHARRY MED COLL SCH OF MEDIC
CREIGHTON UNIV SCH OF MEDICIN	40	84	MICHIGAN STATE UNIV COLL OF H
DARTMOUTH MEDICAL SCH	45	24	MOUNT SINAI SCH OF MEDICINE O
DUKE UNIV SCH OF MEDICINE	32	76	NEW YORK MEDICAL COLL
EASTERN VIRGINIA MEDICAL SCH	40	38	NEW YORK UNIV SCH OF MEDICINE
EMORY UNIV SCH OF MEDICINE	37	27	NORTHWESTERN UNIV MEDICAL SCH
GEORGE WASHINGTON UNIV SCH OF	152	36	OHIO STATE UNIV COLL OF MEDIC
GEORGETOWN UNIV SCH OF MEDICI	180	37	PENNSYLVANIA STATE UNIV COLL
HAHNEMANN MED COLL OF PHILADE	82	60	RUSH MEDICAL COLL
HARVARD MEDICAL SCH	46	4	SOUTHERN ILLINOIS UNIV SCH OF
HOWARD UNIV COLL OF MEDICINE	132	59	ST. LOUIS UNIV SCH OF MEDICIN
INDIANA UNIV SCH OF MEDICINE	31	20	STANFORD UNIV SCH OF MEDICINE
JEFFERSON MED COLL OF THOMAS	136	23	SUNY AT BUFFALO SCH OF MEDICI
JOHNS HOPKINS UNIV SCH OF MED	8	17	SUNY AT STONY BROOK SCH OF ME
		32	SUNY DOWNSTATE MEDICAL CTR CO
		48	SUNY UPSTATE MEDICAL CTR COLL
		89	TEMPLE UNIV SCH OF MEDICINE
		17	TEXAS TECH UNIV SCH OF MEDICI
		156	TUFTS UNIV SCH OF MEDICINE
		54	TULANE UNIV SCH OF MEDICINE

*This total includes 209 NHSC recipients who are in inactive status. The number of awardees for FY 1979 (academic year 1979-80) is 6,408.

UNIV OF ALABAMA SCH OF MEDICI	30	UNIV OF NEVADA SCH OF MEDICAL	8
UNIV OF ARIZONA COLL OF MEDIC	5	UNIV OF NEW MEXICO SCH OF MED	27
UNIV OF ARKANSAS SCH OF MEDIC	29	UNIV OF NORTH CAROLINA SCH OF	26
UNIV OF CAL LOS ANGELES SCH O	14	UNIV OF NORTH DAKOTA SCH OF M	12
UNIV OF CAL SAN DIEGO SCH OF	3	UNIV OF OKLAHOMA COLL OF MEDI	17
UNIV OF CAL SAN FRANCISCO SCH	29	UNIV OF OREGON MEDICAL SCH	46
UNIV OF CAL DAVIS SCH OF MEDI	26	UNIV OF PENNSYLVANIA SCH OF M	65
UNIV OF CAL IRVINE COL OF MED	15	UNIV OF PITTSBURGH SCH OF MED	64
UNIV OF CHICAGO PRITZKER SCH	23	UNIV OF PUERTO RICO SCH OF ME	91
UNIV OF CINCINNATI COLL OF ME	73	UNIV OF ROCHESTER SCH OF MEDI	23
UNIV OF COLORADO SCH OF MEDIC	59	UNIV OF SOUTH ALABAMA COLL OF	27
UNIV OF CONNECTICUT SCH OF ME	23	UNIV OF SOUTH DAKOTA SCH OF M	15
UNIV OF FLORIDA COLL OF MEDIC	23	UNIV OF SOUTH FLORIDA COLL OF	7
UNIV OF HAWAII SCH OF MEDICIN	18	UNIV OF SOUTHERN CAL SCH OF M	52
UNIV OF HEALTH SCIENCES CHICA	36	UNIV OF TENNESSEE COLL OF MED	30
UNIV OF ILLINOIS COLL OF MEDI	48	UNIV OF TEXAS MED BRANCH AT G	23
UNIV OF IOWA COLL OF MEDICINE	31	UNIV OF TEXAS MED SCH AT HOUS	16
UNIV OF KANSAS SCH OF MEDICIN	17	UNIV OF TEXAS MED SCH AT SAN	25
UNIV OF KENTUCKY COLL OF MEDI	27	UNIV OF TEXAS SOUTHWESTERN ME	14
UNIV OF LOUISVILLE SCH OF MED	12	UNIV OF UTAH COLL OF MEDICINE	26
UNIV OF MARYLAND SCH OF MEDIC	72	UNIV OF VERMONT COLL OF MEDIC	27
UNIV OF MASSACHUSETTS MEDICAL	22	UNIV OF VIRGINIA SCH OF MEDIC	56
UNIV OF MIAMI SCH OF MEDICINE	40	UNIV OF WASHINGTON SCH OF MED	32
UNIV OF MICHIGAN MEDICAL SCH	30	UNIV OF WISCONSIN MEDICAL SCH	30
UNIV OF MINNESOTA DULUTH MEDI	2	VANDERBILT UNIV SCH OF MEDICI	17
UNIV OF MINNESOTA MINNEAPOLIS	47	VIRGINIA COMMONWEALTH UNIV ME	84
UNIV OF MISSISSIPPI SCH OF ME	36	WASHINGTON UNIV SCH OF MEDICI	38
UNIV OF MISSOURI COLUMBIA SCH	14	WAYNE STATE UNIV SCH OF MEDIC	49
UNIV OF MISSOURI KANSAS CITY	19	WEST VIRGINIA UNIV SCH OF MED	12
UNIV OF NEBRASKA COLL OF MEDI	10	YALE UNIV SCH OF MEDICINE	32

CHICAGO COLL OF OSTEOPATHIC M	32	CREIGHTON UNIV DENTAL SCH	7
COLL OF OSTEOPATHIC MEDICINE	78	EMORY UNIV DENTAL SCH	16
WEST VIRGINIA COLL OF OSTEOPA	27	FAIRLEIGH DICKINSON UNIV DENT	3
KANSAS CITY COLL OF OSTEOPATH	113	GEORGETOWN UNIV DENTAL SCH	30
KIRKSVILLE COLL OF OSTEOPATHI	93	HARVARD UNIV DENTAL SCH	5
MICHIGAN STATE UNIV COLL OF O	49	HOWARD UNIV DENTAL SCH	33
OKLAHOMA COLL OF OSTEOPATHIC	20	INDIANA UNIV DENTAL SCH	3
PHILADELPHIA COLL OF OSTEOPAT	97	LOMA LINDA UNIV DENTAL SCH	11
TEXAS COLL OF OSTEOPATHIC MED	23	LOUISIANA STATE UNIV DENTAL S	4
OHIO UNIV COLL OF OSTEOPATHIC	16	LOYOLA UNIV DENTAL SCH	4
WRIGHT STATE UNIV SCH OF MEDI	19	MARQUETTE UNIV DENTAL SCH	1
NORTHEASTERN OHIO UNIV COLL O	1	MEDICAL COLL OF GEORGIA DENTA	6
UNIV OF SOUTH CAROLINA SCH OF	3	MED UNIV OF SOUTH CAROLINA DE	3
TEXAS A & M UNIV SCH OF MEDIC	6	MEHARRY MED COLL DENTAL SCH	38
MARSHALL UNIV SCH OF MEDICINE	4	NEW YORK UNIV DENTAL SCH	15
NJ COLL OF OSTEOPATHIC MEDICI	11	NORTHWESTERN UNIV DENTAL SCH	9
NEW YORK INST OF TECH (NY COL	33	OHIO STATE UNIV DENTAL SCH	4
MOREHOUSE COLL SCH OF MED	30	SUNY AT BUFFALO DENTAL SCH	5
EAST CAROLINA UNIV	2	SUNY AT STONY BROOK DENTAL SC	2
EAST TENNESSEE STATE UNIV	4	TEMPLE UNIV DENTAL SCH	13
CATHOLIC UNIV IN PONCE	34	TUFTS UNIV DENTAL SCH	33
NEW ENGLAND SCH OF OSTEOPATHI	32	UNIV OF ALABAMA-DENTAL SCH	6
COLL OF OSTEOPATHIC MEDICINE	19	UNIV OF CALIF LOS ANGELES DEN	11
UNIV OF ILLINOIS URBANA MEDIC	2	UNIV OF CALIF SAN FRANCISCO D	6
SCH OF MEDICINE OF CAYEY	4	UNIV OF COLORADO DENTAL SCH	5
BAYLOR UNIV DENTAL SCH	5	UNIV OF CONNECTICUT SCH OF DE	5
BOSTON UNIV DENTAL SCH	9	UNIV OF DETROIT DENTAL SCH	6
CASE WESTERN RESERVE DENTAL S	6	UNIV OF FLORIDA COLL OF DENTI	6
COLL OF MED AND DENT OF NJ DE	3	UNIV OF ILLINOIS DENTAL SCH	1
COLUMBIA UNIV DENTAL SCH	7	UNIV OF IOWA DENTAL SCH	5

UNIV OF KENTUCKY DENTAL SCH	9	BIOLA COLL	1
UNIV OF MARYLAND DENTAL SCH	29	CAL STATE UNIV FRESNO	1
UNIV OF MICHIGAN DENTAL SCH	7	CAL STATE UNIV SACRAMENTO	1
UNIV OF MINNESOTA DENTAL SCH	4	LOMA LINDA UNIV	3
UNIV OF MISSISSIPPI DENTAL SC	3	UNIV OF CAL SAN FRANCISCO	1
UNIV OF MISSOURI DENTAL SCH	4	UNIV OF SAN DIEGO	1
UNIV OF NEBRASKA DENTAL SCH	2	UNIV OF SAN FRANCISCO	2
UNIV OF NORTH CAROLINA DENTAL	12	LORETTO HEIGHTS COLL	5
UNIV OF OKLAHOMA DENTAL SCH	10	UNIV OF COLORADO SCH OF NURSI	2
UNIV OF OREGON DENTAL SCH	11	UNIV OF NORTHERN COLORADO	1
UNIV OF PENNSYLVANIA DENTAL S	35	UNIV OF BRIDGEPORT	1
UNIV OF PITTSBURGH DENTAL SCH	12	WESTERN CONNECTICUT STATE COL	1
UNIV OF PUERTO RICO DENTAL SC	10	AMERICAN UNIV	1
UNIV OF SOUTHERN CAL DENTAL S	13	CATHOLIC UNIV OF AMERICA	1
UNIV OF TENNESSEE DENTAL SCH	8	GEORGETOWN UNIV	4
UNIV OF TEXAS HOUSTON DENTAL	5	HOWARD UNIV	4
UNIV OF TEXAS SAN ANTONIO DEN	6	FLORIDA STATE UNIV SCH OF NUR	1
UNIV OF THE PACIFIC DENTAL SC	16	UNIV OF FLORIDA GAINESVILLE	1
UNIV OF WASHINGTON DENTAL SCH	14	EMORY UNIV	1
VIRGINIA COMMONWEALTH UNIV DE	19	VALDOSTA STATE COLL	1
WASHINGTON UNIV DENTAL SCH	7	RUSH UNIV	1
WEST VIRGINIA UNIV DENTAL SCH	4	ST. XAVIER COLL	2
ORAL ROBERTS UNIV DENTAL SCH	1	UNIV OF ILLINOIS MEDICAL CENT	1
SAMFORD UNIV	1	MARION COLL	1
TROY STATE UNIV TROY	1	GRACELAND COLL	2
UNIV OF ALABAMA IN BIRMINGHAM	2	MARYCREST COLL, DIV OF NURSIN	1
UNIV OF SOUTH ALABAMA	1	SPALDING COLL	1
UNIV OF ARIZONA	2	DILLARD UNIV	1
UNIV OF ARKANSAS PINE BLUFF	1	COLUMBIA UNION COLL	3
UNIV OF CENTRAL ARKANSAS	1	COPPIN STATE COLL, HELENE FUL	1

TOMSON STATE COLL	1	CAPITAL UNIV	2
UNIV OF MARYLAND SCH OF NURSI	1	CASE WESTERN RESERVE UNIV	1
BOSTON COLL SCH OF NURSING	1	OHIO STATE UNIV	3
BOSTON UNIV SCH OF NURSING	3	UNIV OF CINCINNATI	1
MICHIGAN STATE UNIV	1	WRIGHT STATE UNIV	1
NAZARETH COLL	1	CENTRAL STATE UNIV	1
COLL OF ST. SCHOLASTICA	1	EAST CENTRAL OKLAHOMA STATE U	1
UNIV OF MINNESOTA	1	UNIV OF OKLAHOMA HEALTH SCI C	4
UNIV OF MISSISSIPPI SCH OF NU	1	UNIV OF TULSA	2
UNIV OF SOUTHERN MISSISSIPPI	2	UNIV OF OREGON HEALTH SCI CTR	1
UNIV OF MISSOURI-COLUMBIA SCH	1	UNIV OF PORTLAND	1
CARROLL COLL DEPT OF NURSING	1	ALLEN TOWN COLL OF ST. FRANCIS	1
MONTANA STATE UNIV SCH OF NUR	3	UNIV OF PENNSYLVANIA	1
UNION COLL	1	VILLA MARIA COLL	1
ST. ANSELM'S COLL	1	WIDENER COLL	1
RUTGERS UNIV NEWARK	1	CATHOLIC UNIV OF PUERTO RICO	2
RUTGERS UNIV CAMDEN	1	UNIV OF SOUTH CAROLINA	1
UNIV OF NEW MEXICO	5	MOUNT MARTY COLL	1
COLUMBIA UNIV	2	SOUTH DAKOTA STATE UNIV	1
LONG ISLAND UNIV BROOKLYN CTR	1	UNIV OF TENNESSEE KNOXVILLE	1
MOLLOY COLL	1	VANDERBILT UNIV	2
NEW YORK UNIV	2	BAYLOR UNIV MEDICAL CTR	1
NIAGARA UNIV	1	INCARNATE WORD COLL	1
PACE UNIV WESTCHESTER	6	MARY HARDIN-BAYLOR COLL	2
SUNY AT BUFFALO	1	PRAIRIE VIEW AGRI & MECH UNIV	2
SYRACUSE UNIV	5	UNIV OF TEXAS AT EL PASO	2
DUKE UNIV	2	UNIV OF UTAH	2
EAST CAROLINA UNIV	2	UNIV OF VERMONT SCH OF NURSIN	1
NORTH CAROLINA CENTRAL UNIV	3	HAMPTON INSTITUTE	2
UNIV OF NORTH CAROLINA CHARLO	1	OLD DOMINION UNIV	1

UNIV OF VIRGINIA	3	UNIV OF ILLINOIS COLL OF NURS	1
PACIFIC LUTHERAN UNIV	2	JOHNS HOPKINS UNIV SCH OF PUB	3
SEATTLE UNIV	1	COLUMBIA UNIV SCH OF NURSING	2
UNIV OF WASHINGTON	4	UNIV OF UTAH COLL OF NURSING	1
WALLA WALLA COLL	1	ARIZONA STATE UNIV COLL OF NU	5
WEST VIRGINIA UNIV	1	UNIV OF CAL LOS ANGELES NURSI	1
ALVERNO COLL	2	UNIV OF COLORADO MED CTR NURS	1
UNIV OF WISCONSIN MADISON	1	YALE UNIV SCH OF NURSING	9
UNIV OF WISCONSIN MILWAUKEE	1	EMORY UNIV WOODRUFF SCH OF NU	2
UNIV OF WYOMING	1	RUSH UNIV COLL OF NURSING	1
SIMMONS COLL	1	UNIV OF KENTUCKY COLL OF NURS	1
ST JOHN COLL-URSULINE COLL	1	BOSTON COLL SCH OF NURSING	2
CUNY CITY COLL SCH OF NURSING	2	BOSTON UNIV SCH OF NURSING	1
CUNY HUNTER COLL-BELLEVUE SCH	2	COLUMBIA UNIV SCH OF NURSING	3
MARYMOUNT COLL OF VIRGINIA	1	NEW YORK UNIV DIV OF NURSING	1
UNIV OF ALABAMA IN BIRMINGHAM	1	SUNY AT STONY BROOK SCH OF NU	1
UNIV OF ARIZONA COLL OF NURSI	1	UNIV OF ROCHESTER SCH OF NURS	1
YALE UNIV SCH OF NURSING	1	UNIV OF NORTH CAROLINA SCHOOL	3
UNIV OF HAWAII	1	UNIV OF PENNSYLVANIA SCH OF N	1
RUSH UNIV COLL OF NURSING	1	UNIV OF SOUTH CAROLINA COLUMB	4
UNIV OF ILLINOIS COLL OF NURS	3	UNIV OF UTAH COLL OF NURSING	1
BOSTON COLL SCH OF NURSING	1	UNIV OF VIRGINIA SCH OF NURSI	1
BOSTON UNIV SCH OF NURSING	1	VIRGINIA COMMONWEALTH UNIV SC	4
UNIV OF MINNESOTA SCH OF PUB	1	UNIV OF WASHINGTON SCH OF NUR	3
ADELPHI UNIV SCH OF NURSING	1	UNIV OF WISCONSIN MADISON SCH	1
NEW YORK UNIV DIV OF NURSING	1	LOMA LINDA UNIV PUBLIC HEALTH	2
UNIV OF ROCHESTER SCH OF NURS	1	UNIV OF CAL BERKELEY PUB HEAL	3
CASE WESTERN RESERVE UNIV SCH	1	UNIV OF HAWAII PUBLIC HEALTH	1
UNIV OF PENNSYLVANIA SCH OF N	1	UNIV OF MICHIGAN DEPT CMTY HE	6
YALE UNIV SCH OF NURSING	9	UNIV OF MINNESOTA SCH OF PUB	4

COLUMBIA UNIV TEACHERS COLL	6
CORNELL UNIV DIV OF NUTR SCI	1
UNIV OF NORTH CAROLINA	6
CASE WESTERN RESERVE UNIV DEP	1
PENNSYLVANIA STATE UNIV NUTR	2
UNIV OF TENNESSEE KNOXVILLE	2
CAL STATE UNIV SACRAMENTO SOC	1
CATHOLIC UNIV OF AMERICA SOCI	1
HOWARD UNIV SCH OF SOC WORK	1
UNIV OF MARYLAND BALTIMORE SO	1
UNIV OF MINNESOTA MPLS SCH OF	1
UNIV OF SOUTH CAROLINA COLL O	1
UNIV OF WISCONSIN MADISON SCH	1
UNIV OF COLORADO BOULDER DEPT	1
UNIV OF MARYLAND SPEECH & HEA	1
MICHIGAN STATE UNIV AUDIOLOGY	1
CASE WESTERN RESERVE UNIV SPE	1
TEMPLE UNIV SPEECH & HEARING	4
UNIV OF PITTSBURGH SPEECH & T	1
UNIV OF WASHINGTON SPEECH/AUD	1
VOPP Participants	119

Mr. CARTER. By the way, I do appreciate your good work. I think you have done an excellent job. But I am afraid you are going to have trouble assigning many of your people. In fact, I understand that you have a few serious difficulties in retaining placements.

Dr. RICHMOND. I would be glad to have Drs. Lythcott and Martin comment also. I think, Mr. Congressman, we have had really quite remarkable results in making those matches and people staying functional.

Mr. CARTER. I am pleased with the assignees in Kentucky, but I realize there are some who have had difficulties.

Dr. RICHMOND. Doctor Lythcott and I have talked about this extensively and this is why in my opening comments I indicated that we are dealing with young people who are going into very difficult areas, often isolated, certainly difficult medical problems, as you can appreciate, Dr. Carter, very well. I think we have all seen, even in optimal circumstances, young professionals who in their first few years have a very difficult time. So I think the fact that we have occasional difficulties is not surprising.

Mr. CARTER. Perhaps these problems could be remedied by wiser choices at the time the scholarships are awarded. Well, anyway, I do support you and I appreciate everything you have done. Thank you very much. I can say that truthfully as a dedicated Republican.

Mr. WAXMAN. You are lucky this is not partisan.

Ms. Mikulski?

Ms. MIKULSKI. Thank you, Mr. Chairman.

Members of the panel, Dr. Richmond, first of all, I would like to compliment you on providing us what really is a profile of what is needed to deliver health services in underserved areas. I think one of the benefits we get from this oversight hearing is not only to determine how more effectively to use the National Health Service Corps, but really I think you provide very valuable insights on how we must have a national policy and what our national policy should be in future health care activity.

I found particularly of interest the physician profile that you raised on pages 9 and 10 of your report of your testimony in which you talk about the problems the physician would have in solo practice as compared to the problems or benefits of being involved in a community team approach.

The reason I say that is that it is obvious from what you have found by the administration of this program that, we are talking about people who are poor, who tend to get sicker quicker, stay sicker longer, that their problems are multiple, chronic and often progressive with all kinds of other additional problems than medical problems.

A physician in a freestanding or solo practice has not so much the problem of emotional breakdown as the problem of burn out. Therefore, one of the things that emerges is the need to provide the type of team approach.

So I thank you for really furnishing that because I think if we are going to be serious about helping poor people in this country, we have to keep that in mind when we talk about who we are going to help, who we are going to help train, and the reimbursement models as Dr. Martin suggested.

This takes me to my questions in terms of how best to use the health services scholarship program. A great deal of the conversation today has focused on physicians. Yet it seems to me that the other key components of this team approach are other allied health professionals. We talked specifically about the nurse practitioners. I assume implicit in that is nurse midwives. Yet indicated, also, I think, would be other service people such as nutritionists, social workers, people who might provide what I guess would be called health but nonmedical services.

Therefore, my question is that, assuming that they are an integral part of the team as a physician, what then should our public policy be in providing group scholarships because I understand that we really have a 10-percent cap on that and I just wondered what we should do.

I think you allude to some recommendations on pages 19 and 20 and I wonder how you think we should address that, if at all, if you think those areas should be expanded, and if so, how best to do that?

You have to know I am an old National Institutes of Mental Health scholarship person myself in social work.

Dr. RICHMOND. Yes, I know your background in social work. I think you have put your finger on the heart of the problem in terms of serving people of low income backgrounds. This has been a very high priority of this administration—to close the gap. We think that we have come a long way from the days of the development of community health centers in the sixties to the present in bringing services to all of our population in need.

We have been moving in the directions which you suggest. As I indicated in some of my testimony, it has been rather interesting to see that even when some of our National Health Service Corps people move out into communities where there are relatively few services, often they begin to develop a community health center rather than a solo site because they recognize the need for the nurse practitioner, the midwife, the nutritionist, the social worker, the sanitarian. Many communities that they go into do not even have good hygienic resources. We have seen that development taking place.

The reason, Congresswoman Mikulski, that we have not moved in the direction of expanding the scholarship program for those groups is that we seem to have no significant problems in recruitment of such personnel. We are able to recruit them essentially on the open market. They are available, as the Corps sites develop their programs, and we have tended to husband the resources of the scholarship program in the direction of those professions which up to now have been very, very difficult to redistribute, the physicians, the dentists and the nurse practitioners in particular.

Ms. MIKULSKI. So that you are not recommending an expansion in this particular area?

Dr. RICHMOND. Not at the moment.

Ms. MIKULSKI. I have just one other question. Well, I have several. Should we break for a minute and go vote?

Mr. WAXMAN. If you wish. This is a motion to go into the Committee as a Whole. If you want to vote on that, we will break.

Ms. MIKULSKI. Dr. Richmond, I will tell you what I am going to ask. On page 11 of your testimony you talk about the way the doctor comes and the site develops. One of the questions I will talk about is what role does HEW play in helping communities develop their programs?

We heard impressive testimony today about how people organized, got themselves together to apply for National Health Service physicians and so on, but it was really hit and miss. There was some uncertainty about where at HEW information was, kind of a one-stop shop and clearinghouse.

Dr. RICHMOND. Thank you.

Mr. WAXMAN. All right, we will take a short break to vote. [Brief recess.]

Mr. WAXMAN. We will resume.

What is your answer to that question?

Dr. RICHMOND. Well, Mr. Chairman, first, I would like to say that it is a very good question. What we have been trying to do is to get this matching process down to an effective one, one that works smoothly and to the satisfaction of the scholarship recipients as well as to the communities. Dr. Martin and Mr. Little who comes from our regional office in region 2 and has responsibility for doing just what Ms. Mikulski asked about is here. Since it is her region fortuitously—

Ms. MIKULSKI. I am region 3.

Dr. RICHMOND. It is region 3, I am sorry, I misspoke. But he is from your regional office. So I would like to ask them to make some comments.

Dr. MARTIN. I think that it is very important to point out that the idea of a single, simple way of carrying out the activity of community development, technical assistance, and the like was in part very well responded to by very divergent perspectives of the people this morning and afternoon.

I think the strength of the program is the fact that there is great heterogeneity because there is great heterogeneity in the communities. I hope the HSA concern is clearly stated in the record. Much of the concern articulated about regional offices is articulated because they are the ones on the firing lines. When I ran an OEO project I had to deal with the central office and I had the same concerns.

So where communities and doctors interface is where you hear those concerns. For us that is the regional offices. So the question of is that a unique kind of problem—

Ms. MIKULSKI. I didn't ask that.

Dr. MARTIN. I wanted to make sure that we understood that for the regions.

Mr. LITTLE. I will try to respond to the question that was asked.

I think each region responds in different sorts of ways to the problems that they have to address.

Ms. MIKULSKI. You mean there is no clear policy of working with community groups?

Mr. LITTLE. Yes, there is clear policy, but responding to the needs of Maryland is different from responding to the State of West Virginia just as it is to responding to different assignees in the matching process.

There are two key people in the region generally that work, on these needs one with the site and the other with the individual. That is the recruiter and the project officer. The recruiter is talking with the individual applicant, scholarship or volunteer and the spouse concerning their needs, practice considerations and other types of factors. What are their personal interests, hobbies, geography——

Ms. MIKULSKI. I think you misunderstood my question. Let me rephrase it. I am not talking about placement and matching of physician to an appropriate community. My concern is how do people who live in underserved areas know how to apply for help to get physicians, to get the designation and so on.

Dr. Martin, you heard the questions I asked Mrs. Moore this morning. She said we lived near Johns Hopkins Hospital. And when you talked about the complications where there are lots of doctors in an area but that doesn't mean that the total area is adequately served, there are clusters in certain parts of the community, Mrs. Moore and her community got together as part of a church group. They wanted to get doctors in their community. They had a heck of a time trying to figure out who to go to for what to get personnel in there.

My question, therefore, is that where there are two or more gathered now in a little church trying to figure that out in West Virginia or Texas, where could they go in HEW to find out what is it they could apply for and how could they apply and a variety of things like that? It is the bottom up type of thing.

Mr. LITTLE. We have an individual assigned geographically. That person has responsibility for keeping in contact with HSA's, other kinds of community organizations, and it would seem to me that in a situation such as that they would probably hear through the regional advisory committee to the HSA of a particular concern in a particular area and respond in that fashion through the HSA to that particular community group. That is one methodology.

The project officer, working in a particular geographic area, maybe a city, would have various contacts with various social agencies from time to time, in keeping his ear to the wall would also hear of inquiries, concerns and so forth to respond to. But it is that person assigned geographically that is going to pick up on the information that is being requested and funnel that information into the regional office for a response.

Ms. MIKULSKI. What would the response be?

Mr. LITTLE. In the case of community group interested in applying to the National Health Service Corps for the placement of people, it would be to go down and meet with that community group, the project officer himself, and explain the process for doing that. Probably along with that person, probably an HSA rep would go along because the process also requires designation.

So between those two people they could be responsive to a group such as that.

Ms. MIKULSKI. I see.

Dr. Martin?

Dr. MARTIN. I think, importantly, the policy is that the responsibility of the staff involved in that kind of activity is to help the community make an assessment of a whole set of resources that

are available, not just the National Health Service Corps or section 330 and the like. That function, I think, is best measured by the success in the development of the numbers of those kinds of groups in the country and the participation of consumers and community groups in the programs across the entire agency.

It is very considerable. There is a lot of effort placed on the development of materials for those kinds of communities. There is wide dissemination of information. We have specific technical assistance contracts which are developed with local activity groups that know how to do that.

So at least with the HSA programs there is a huge amount of effort in developing that assistance to the community groups. There are a lot of those such groups.

The fact that we have in excess of 3,000 organized community groups within our respective programs is a measure of success. That was about 300 or 400 only 4 or 5 years ago. There has been a huge expansion of that. I think that is a reflection of the increased commitment of resources to do that kind of community development with technical assistance resources, States, HSA's, and our regional office staff.

Ms. MIKULSKI. Let me ask it from another direction. I think you have classified for me the role of the HSA. But let's just say the Martin Luther King Memorial Church writes a letter in South Carolina or West Virginia, writes a letter to Secretary Harris and says, we are in trouble, we don't have any doctors, and roughly, in community language, we have the problem of being underserved. What would happen in that situation?

Dr. LYTHCOTT. That has happened more times than I can count actually.

Ms. MIKULSKI. They might write to Jimmy Carter. I think that is the way desperate people would start. I don't think they know about HSA and SMSA's, et cetera.

Dr. LYTHCOTT. That letter would be referred from the Secretary's office to Dr. Richmond's office. It would in return be referred to me. I would refer it to the Bureau of Community Health Services and they would get a letter back over my signature, probably, which would outline in detail, giving names of people and telephone numbers in their area, et cetera, that they should contact.

Ms. MIKULSKI. So it is best to write to the President.

Dr. LYTHCOTT. If, on the other hand, you are saying something else, and I think you are, that we could improve these communications, you are absolutely right and we are working on it every way.

Ms. MIKULSKI. We are in the process of figuring that out, but that certainly answers that question.

Mr. Chairman, I just have one other question relating to the scholarship person and the volunteer person. I understand we could support a medical student—I would like to go back now to the figures—we give the physician anywhere from \$15,000 to \$20,000 a year in a benefit. That person then will come to an underserved area. No doubt they are extremely dedicated—and all those I have met are of extremely high quality. I did not understand the whole business of what they get paid compared to someone who volunteers for health corps service, who has paid his or her own way through medical school. Is there a differential? In

other words, do the scholarship folks get less during their 2 years than the straight volunteer?

Dr. MARTIN. Their pay would be essentially comparable.

Ms. MIKULSKI. What do we get?

Dr. MARTIN. 800 physicians this year, with obligated service, three-quarters to 80 percent of whom will serve. If we had gone the volunteer route, we would have 200, each of whom would be highly selective of where they went. The ability to respond to national needs with a pool of 800 practitioners is a great deal different than trying to match individual volunteer interests. If a volunteer chooses not to go, our options for assignment are gone. There are a lot of places where volunteers simply do not and will not go without the scholarships. In many of those places we simply will not get practitioners in there. There is a limit to volunteers. The limit we have been able to reach is 250 volunteers a year, whereas the need is 900 to 1,000.

Ms. MIKULSKI. So if the taxpayers say, what do we get when we invest as much as \$80,000 in a physician's training, in effect, what you get is the fact that the area will be served. You will not necessarily get a cost saving, but you do have a better opportunity to meet underserved areas, and that is it. So if we think of that in any way a scholarship is an opportunity for future salary waiver or whatever, that is just not going to be so; is that right?

Dr. RICHMOND. I think, Ms. Mikulski, the matter is these people will be delivering very significant service, which has a value. We cannot always recover the full amount of that value because of reimbursement schedules, medicaid reimbursement, for example, being relatively inadequate in most of the States. So what they deliver is indeed of value. We cannot necessarily recover the dollar, but we do get it in service to their communities.

Ms. MIKULSKI. What types of good guy or good gal bonuses do you think we ought to have to encourage people to reenlist?

One of the things I think important to health care delivery is the continuity of practice and relationship with the health provider. I know the limitations of a 2-year term, and wonder if there are not some opportunities for either the 2-year term, would there be bonuses that perhaps we could provide for a 5-year term and have a few opportunities for reenlistment? One might be for 2 years, one might be for 5 years, and if I enlist for 5 years, you might get something or other? How does that strike you as a possibility?

Dr. RICHMOND. We do have longer payback for many coming out in the future, and many will have received not 2 but 4 years of support, so they pay back year for year and will serve in communities on a year-for-year basis.

If those communities provide potentialities for people to get fees or reimbursement, then it might be quite likely that some of those people would stay in those communities, but we feel the establishment of centers, the kinds of programs you described earlier of a cluster of professionals based in a site to provide services for that community is important, because even if some of those providers come and go, we can rotate people in.

A number of countries throughout the world, particularly for remote rural areas, have taken that route. They have given up on

the notion that in remote areas physicians will remain for years. Scandinavian countries have done this for many years.

Ms. MIKULSKI. So the continuity would last. Would the quality of the site, itself?

Dr. RICHMOND. Particularly in the difficult-to-serve areas, and that is what I suggested to the chairman earlier. The private practice kinds of options are easier to accomplish where there is more affluence and where circumstances may be more desirable.

Ms. MIKULSKI. I have no further questions.

Mr. WAXMAN. Mr. Little, how does your staff identify a community in need of a health services corps physician in that area?

Mr. LITTLE. Staff is assigned geographically. In relating to this particular geographic section of the State or in some cases a particular city and working with the HSA, we attempt to identify areas where the population profile is such that the area appears to be in need.

Taking the proactive stance on that, we would attempt through probably the HSA and other groups to organize a community group for the purpose of delivering health care. In responding to that it is just the organization and preparation of the application and so forth. Then begin the review and approval of the application and placement of people proceeds.

Now in that process, we talk to the professional society, too, in terms of what the need appears to be to them. We ask for their comments and participation in the designation process as well as the review of the application.

Mr. WAXMAN. How does your office work with the State and local governments in identifying these areas and assisting in developing a program?

Mr. LITTLE. I will cite the State of West Virginia, where right now the regional office is working very, very closely with the State Health Department in the potential deployment of resources, those of a public health nature as well as those we can provide through the Bureau of Community Health Services.

Another example would be working with an AHEC on continuing education for health personnel and others which is being undertaken in the State of West Virginia.

Nationally as we progress, we have a need to relate to the A-95 agencies for the purpose of review so they understand what we are looking at and they understand what we are looking at in the process.

Mr. WAXMAN. How many people on your staff work on that program?

Mr. LITTLE. Nine people, broken down in predominantly support staff. There are five professionals who monitor the program's activity as well as perform the recruitment activities in this region.

Mr. WAXMAN. What percent of their time is spent on NHSC?

Mr. LITTLE. One hundred percent of their time. There are other people in the office, people assigned geographically, that spend varying degrees of time on HSC's.

Mr. WAXMAN. How many National Health Service Corps regions are in your jurisdiction?

Mr. LITTLE. 103; the physicians' complement being 70 percent.

Mr. WAXMAN. How often does your staff travel to a community before an NHS Corps physician is placed in that community?

Mr. LITTLE. That project officer would probably travel there three or four times. After the placement of the individual he would probably be back in there on a quarterly basis.

Mr. WAXMAN. How many placements have been made in your region for the future?

Mr. LITTLE. Something near double that in 1981. The figure would go up 60 percent in 1980, 100 percent or more in 1981.

Mr. WAXMAN. Dr. Martin, how does the NHSC work with local governments to identify communities in need of physicians, in developing and supporting primary care centers and placing National Health Services Corps physicians in them?

Dr. MARTIN. There is a mechanism established over the last year and a half as to local and State governments, and local and State professional societies. The designation process itself involves the State government, the State planning agency, the HSA's which include local governments in the A-95 and the council of local governments. As you go through the developmental process, generally the health systems agency requirements of public notification very quickly get us involved with elected local and county officials.

Interestingly enough, in rural America about 60 to 70 percent of the rural health initiatives are sponsored by local elected groups trying to develop capabilities for their groups. Through the HSA, the elected officials, particularly the mayors, are kept involved in the whole process. Oftentimes they are the driving force to get it developed. That has improved substantially 5 or 6 years ago.

Mr. WAXMAN. What would be the impact on most States if we turn the program primarily over to them?

Dr. MARTIN. More importantly what would be the impact on the communities we serve? There is a request of \$5 million in the President's budget under section 340A providing for cooperative contracts, as Mr. Bernstein discussed.

Frankly, there are other States where there is lack of interest or appreciation or commitment on the part of a State government. The population is at high risk and at this time we would be reluctant to turn over a program of this sensitivity to some States where it simply is not a high priority, or if the elected State officials feel antithetic toward the program. It is difficult if the State officials have a strong feeling there should be no program. The result is a negative impact on the community at risk.

There are a number of States rather aggressively increasing their involvement. For example, the States of Michigan, West Virginia, et cetera. We feel that in those States we can develop technical assistance contracts for a substantial portion of the State, hopefully on a shared-cost basis, presuming the State would be willing to put up some resources, too.

Mr. WAXMAN. What would you think about the suggestion of Mr. Bernstein to have performance standards?

Dr. MARTIN. Without that kind of clear understanding it could be a serious problem for the communities we have to serve. I think they would have to be explicit and objective and not simply how many gadgets or gadgets get done. The whole set of issues having to

do with the political and social development at the community level have to be considered.

Dr. RICHMOND. Mr. Chairman, because we do place a good deal of emphasis on gaining the cooperation of the States aggressively redistributing their resources to improve the health of their community, I have been meeting with the Association of State and Territorial Health Officers quarterly. We have been trying to review how State health officers can help to move their governments and communities more effectively toward redistribution. We are interested, because if we get these programs going, the health of the States and the Nation will be better, and we are concentrating very heavily where infant mortality rates are higher so we can target these efforts and put the resources into areas of greater need. We have been moving rather aggressively to consummate that type of relationship. I can only say that there are some States which are becoming really effective in redistribution.

Mr. WAXMAN. Have you developed any methodology to assist you in identifying the best location for a primary care center or in predicting its financial self-sufficiency or the percentage of a community which will use the primary care center? If so, can that methodology be used in the NHSC program?

Dr. MARTIN. No. that model, as Jim Bernstein even talked about, is an evolving model. There is no computer algorithm. There has been over the years considerable improvement in some places such as Tennessee, and North Carolina. When we look back at what we did, it is clear to see, that if we had applied a different kind of assessment technique we would have improved our utilization of those resources. When we placed many of them we did not have the knowledge or expertise. We have learned; we are constantly modifying that ability. There are new things that will make it much more effective.

Mr. WAXMAN. Is it realistic to expect health institutions, State and local governments to assume the salary expense of NHSC physicians while they are fulfilling their obligations?

Mr. LITTLE. I think there are some areas in the country that can do that now. There are about 7 million people we consider underserved who are not necessarily poor but who are underserved by virtue of geographic isolation. We will look at those with a different perspective. As time goes by, it is something we will look forward to, and investigate; as a matter of fact we are doing it in some areas already.

Mr. WAXMAN. We want to thank you very much. Your testimony has been very helpful. We will look forward to the administration's recommendations.

Our final panel today will focus on the National Health Service Corps scholarship program. Dr. Donald Madison of the University of North Carolina is a nationally recognized expert on rural health care and has recently written on the use of the scholarship program to improve care in underserved areas. Miss Pittman and Mr. Mallory are medical students with scholarships, and Mr. Clements is president of the American Medical Student Association.

STATEMENTS OF DONALD L. MADISON, ASSOCIATE PROFESSOR, DEPARTMENT OF SOCIAL AND ADMINISTRATIVE MEDICINE, UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE (CHAPEL HILL); CHARLIE CLEMENTS, PRESIDENT, AMERICAN MEDICAL STUDENT ASSOCIATION; VINCENT D. MALLORY, MEDICAL STUDENT, MEHARRY MEDICAL SCHOOL (NASHVILLE); AND DIANE PITTMAN, MEDICAL STUDENT, TULANE UNIVERSITY SCHOOL OF MEDICINE (NEW ORLEANS)

Dr. MADISON. Mr. Chairman, members of the committee. I am pleased to respond to this committee's request to discuss the National Health Service Corps.

Most of my professional career has been spent in efforts to bring health care to underserved communities, both urban and rural. For the past 5 years I was the director of the rural practice project, a national demonstration based at the University of North Carolina at Chapel Hill and sponsored by the Robert Wood Johnson Foundation. In this capacity I have been in communication with hundreds of rural communities in need of medical services and have had opportunity to visit many which are served by NHSC members.

There is a 50-year history of programs—by Government and private initiative—designed to solve the rural doctor shortage. A long list of theories and strategies have been advanced as solutions for that chronic problem. Most have used an indirect approach; that is, if the goal was to place doctors in rural locations, the most favored courses of action were those which put in place some condition thought to predispose physicians toward choosing rural practice careers. This indirect rationale has been used to justify construction of rural hospitals, financial guarantees for private practitioners, educational loans in return for a promise of subsequent service, preceptorships during training, preferential selection into medical school of applicants from rural areas, a new medical school in a rural region of a State, and so on. Not until the 1970's, with the emergence of the National Health Service Corps and associated Federal grants for developing community practice settings, was there any substantial direct action to deal with the rural physician shortage. Now, with the approaching maturity of the NHSC, all of the necessary strategic elements are in place, and we might reasonably expect in the future to see a marked decrease in the size of this problem, which heretofore has not responded measurably to any other corrective actions. What remains, however, is the all-important, continuing question of implementation.

In 1976, based on the favorable experience of the NHSC's early years and the indisputable effectiveness of the direct approach to geographic distribution which the Corps represents, Congress amended the authorizing law in ways that placed the NHSC at the center of a Federal strategy to serve the medically underserved. As a result of the Health Professions Educational Assistance Act of 1976, the size of the Corps increased. And it will soon increase much more rapidly as more and more students who received scholarships authorized by that law begin to serve their obligations. I believe that the magnitude and difficulty of the problem the Corps is addressing justifies the increase in its size. But I believe, too, that a strong NHSC is even more essential than a large one; and

for the program to have strength, improvements need to be made. I should like to suggest two.

First, the Corps' in-service training programs should be vastly expanded and liberalized to meet the needs of its increasing membership. At the time of their entry into the NHSC the physicians and others have no on-the-line experience delivering service to a community. The shift from full-time trainee to full-time, but as yet unseasoned, professional is a critical transition—for all health practitioners, not just those entering the NHSC. But it may be unusually difficult for Corps members—because of the greater than usual cultural distance between the majority of their clients and themselves, the tendency for the Corpsperson to be practicing as one of a company of equally inexperienced colleagues, and the probability that this first full-time work assignment will be in an organizational setting that is still fairly new and in need of some administrative fixing before a program of quality care is assured.

The potential strength of the NHSC is in the resource and resourcefulness of its members at the periphery, not in the control that can be exerted from its center. In order to strengthen the abilities of the members and to see to it that the important transition from training to community practice goes well, the NHSC needs to expand its own in-service training and clinical supervisory capacity and to enlist the help of a greater number of academic medical centers. It should also be authorized to offer special part-time, supervised training experiences that could qualify certain of its members for greater responsibilities—within their own practice settings and within the NHSC organization.

Finally, a comment about what I believe is the most important challenge now facing the Corps. Nearly 12,000 future NHSC members are at this moment either studying for professional degrees or pursuing postgraduate training. Most are medical students and resident physicians. All of them received NHSC scholarships and are, therefore, obligated to a term of service to the underserved. They know who they are and the Corps knows who they are. But too little is being done to take advantage of the opportunity this situation affords to prepare these students for the important tasks they are to face later on. Moreover, because of the combined effect of the early timing of their agreed-upon commitments, the mandatory nature of the future obligations, and the normal results of the professional socialization that all medical students go through, failure to place a great deal more attention on these students could leave them to form attitudes that are potentially destructive to morale and, ultimately, to the Corp's effectiveness. Similarly, failure to intervene while they are in medical school and residency training leaves these future physicians to the underserved with only the usual knowledge and skill that medical training provides. To be sure, these are the *sine qua non* for a physician; but they are by themselves insufficient preparation for the responsible role that an NHSC physician ought to fill in an underserved community, rural or urban.

It is unreasonable to think that the same preparation that suffices in preparing students for the most common current career pattern—specialty practice in private offices and hospitals in cities and suburbs—will do for serving the greater and more complex

health needs of medically disadvantaged communities. Additional skills and sensitivities are needed. Special preparation is called for. And because of the long leadtime between the awarding of a scholarship and service—a time in which the scholarship recipients can know with some specificity the types of roles they will be assuming in the not-too-distant future—such preparation is feasible.

This issue of preparing the scholarship students for their future service is beginning to receive some attention, but it has not so far received a priority equal to its importance. And the fact that the scholarship program is lodged in one agency and the NHSC in another tends to hamper any initiative that might emerge from within the Department of HEW. I believe, therefore, that the concern and push to assure the future strength of the NHSC needs to come from Congress, its originator. In a sense, the Congress is responsible for a policy gap left by the 1976 law: There are provisions to assure that more primary care physicians are produced and to see to it that they are distributed where they are most needed, but no provision assures that these physicians will be prepared with the skills and sensitivities they need to carry out their responsibilities in these kinds of communities. The legislation which extends the authority needs to contain a provision which speaks to this need for special preparation of these future NHSC physicians while they are in medical school and residency training. Responsibility for this training should be placed jointly on the medical schools and on the Corps.

A more detailed discussion and recommendations regarding this last point are contained in two documents—one is a 1978 report, "Leadership for Community-Responsive Practice—Preparing Physicians to Serve the Underserved," which was prepared for the Bureau of Health Manpower as a problem analysis with recommendations; the other is a special symposium on the subject, "Health Professions Education and the Underserved." This symposium appears in the current issue of Public Health Reports which, I am told, is due from the printer tomorrow. (January-February 1980, vol. 95 No. 1.) I submit both of these documents for the committee's consideration.

Mr. WAXMAN. Thank you very much. We will be pleased to receive those documents.

[The report and symposium referred to may be found in the subcommittee files.]

[Testimony resumes on p. 117.]

[Dr. Madison's prepared statement follows:]

STATEMENT
TO THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
U.S. HOUSE OF REPRESENTATIVES

January 30, 1980

Donald L. Madison, M.D.
(Associate Professor, Department of Community Medicine
and Hospital Administration,
University of North Carolina at Chapel Hill)

Mr. Chairman, Members of the Committee, I am pleased to respond to this Committee's request to discuss the National Health Service Corps.

Most of my professional career has been spent in efforts to bring health care to underserved communities, both urban and rural. For the past five years I was the director of the Rural Practice Project, a national demonstration based at the University of North Carolina at Chapel Hill and sponsored by the Robert Wood Johnson Foundation. In this capacity I have been in communication with hundreds of rural communities in need of medical services. I also had opportunity to visit many which are served by NHSC members.

There is a fifty year history of programs - by government and private initiative - designed to solve the rural doctor shortage. A long list of theories and strategies have been advanced as solutions for that chronic problem. Most have used an indirect approach; that is, if the goal was to place doctors in rural locations, the most favored courses of action were those which put in place some condition thought to predispose physicians toward choosing rural practice careers. The indirect rationale has been used to justify construction of rural hospitals, financial guarantees for private

practitioners, educational loans in return for a promise of subsequent service, preceptorships during training, preferential selection into medical school of applicants from rural areas, a new medical school in a rural region of a state, and so on. Not until the 1970's, with the emergence of the National Health Service Corps and associated federal grants for developing community practice settings, was there any substantial direct action to deal with the rural physician shortage. Now, with the approaching maturity of these programs, all of the necessary strategic elements are in place, and we might reasonably expect in the future to see a marked decrease in the size of this problem, which heretofore has not responded measurably to any corrective actions. What remains, however, is the all important, continuing question of implementation.

In 1976, based on the favorable experience of the NHSC's early years and the indisputable effectiveness of the direct approach to geographic distribution which the Corps represents, Congress amended the authorizing law in ways that placed the NHSC at the center of a federal strategy to serve the medically underserved. As a result of the Health Professions Educational Assistance Act of 1976, the size of the Corps increased. And it will soon increase much more rapidly as more and more students who have received the scholarships that were authorized by that law begin to serve their obligations. I believe that the magnitude of the problem the Corps is addressing justifies the increase in

in its size. However, I believe, too, that a strong NHSC is even more essential than a large one; and for the program to have strength, improvements need to be made. I should like to suggest three:

(1) First, I am supportive of the strategy of using project grants through the Rural and Urban Health Initiatives in concert with placement of NHSC personnel. This helps provide a stronger organizational environment from which these personnel can do a much better job of service to their communities. However, this strategy should not result in a de facto merger of separate programs. I do not believe it is in the best interest - of the local projects themselves, the individual NHSC members, or the Corps as a national program - for government officials to urge grant-assisted health centers to fill vacant slots with NHSC assignees, or to give assurances that NHSC personnel will be available to solve the staffing problems of these programs, thereby absolving them of their normal recruiting responsibilities. This much dependence on the federal government leads to an excessive degree of federal control, which can compromise local self-determination as well as any incentives that may exist toward achieving ultimate financial self-sufficiency in places where this is a reasonable expectation. It would be better, I believe, if federally-assisted health centers in need of staff were to compete on a no more than equal basis with other local health programs - that are otherwise eligible for NHSC personnel,

but that have elected to operate independent of federal grant support.

(2) Second, I believe that the Corps' in-service training programs must be vastly expanded and liberalized to meet the needs of its increasing membership. At the time of their entry into the NHSC the physicians and others have had no on-the-line experience delivering service to a community. The shift from full-time trainee to full-time - but as yet unseasoned - professional is a critical transition for all health practitioners, not just those entering the NHSC. But it may be unusually difficult for Corps members for a number of reasons: the greater than usual cultural distance between the majority of their clients and themselves, the tendency for the Corpsperson to be practicing as one of a company of equally inexperienced colleagues, and the probability that this first full-time work assignment will be in an organizational setting that is still fairly new and likely to need some administrative fixing before a program of quality care is assured.

The potential strength of the NHSC is in the resource and resourcefulness of its members at the periphery, rather than the control that can be exerted from its center. In order to strengthen the abilities of the members and to see to it that the important transition from training to community practice goes well, the NHSC needs the resources and flexibility that can enable it to expand its own in-service training and clinical supervisory capacity and

to enlist the help of a greater number of academic medical centers. It should also be able to offer special part-time, supervised training experiences that could qualify certain of its members for greater responsibilities within their own practice settings and within the NHSC organization.

(3) Finally, a comment about what I believe is the most important challenge now facing the Corps. Nearly twelve thousand future NHSC members are at this moment either studying for professional degrees or pursuing post-graduate training. Most are medical students and resident physicians. All of them received NHSC Scholarships and are, therefore, obligated to a term of service to the underserved. They know who they are and the Corps knows who they are. But too little is being done to take advantage of the opportunity this situation affords to prepare these students for the important tasks they are to face later on. Moreover, because of the combined effect of the early timing of their agreed upon commitments, the mandatory nature of the future obligations, and the normal results of the professional socialization that all medical students go through, failure to place a great deal more attention on these students could leave them to form attitudes that are potentially destructive to morale and, ultimately, to the Corps' effectiveness. Similarly, failure to intervene while they are in medical school and residency training leaves these future physicians to the underserved with only the usual knowledge and skill that medical training provides. To be sure, these are the sine qua non for a physician; but they are by themselves insufficient preparation for the responsible role that an NHSC physician ought to fill in an underserved community, rural or urban.

It is unreasonable to think that the same preparation that suffices in preparing students for the most common current

career pattern - specialty practice in private offices and hospitals in cities and suburbs - will do for serving the greater and more complex health needs of medically disadvantaged communities. Additional skills and sensitivities are needed. Special preparation is called for. And because of the long lead time between the awarding of a scholarship and service - a time in which the scholarship recipients can know with some specificity the types of roles they will be assuming in the not too distant future - such preparation is feasible.

This issue of preparing the scholarship students for their future service is beginning to receive attention, but it has not so far received a priority equal to its importance. And the fact that the Scholarship Program is lodged in one agency and the NHSC in another tends to hamper any initiative that might emerge from within the Department of HEW. I believe, therefore, that the concern and push to assure the future strength of the NHSC may need to come from Congress, its originator. In a sense, the Congress is responsible for a policy gap left by the 1976 law: there are provisions to assure that more primary care physicians are produced and to see to it that they are distributed where they are most needed, but no provision assures that these physicians will be prepared with the skills and sensitivities they need to carry out their responsibilities in these kinds of communities.

A more detailed discussion and recommendations regarding this last point are contained in a 1978 report, "Leadership for Community-Responsive Practice - Preparing Physicians to Serve the Underserved," which was prepared for the Bureau of Health Manpower as a problem analysis with recommendations. I am submitting this report for the Committee's consideration.

Summary Statement by Charlie Clements

In summary, we feel the major problems confronting the National Health Service Corps and its Scholarship Program from the viewpoint of students are:

1. A substantial percentage of those applying for a National Health Service Corps scholarship do not fully understand the program's purposes or the implications for their own professional careers.
2. An adequate application review and selection process has not been developed to insure that the most appropriate students are awarded the scholarship.
3. There are substantial problems associated with targeting a large percentage of awards each year for entering first year students.
4. After receiving the scholarship, many students have difficulty obtaining information regarding their scholarships and career options in the Public Health Service.
5. Program administrative problems and student access to information are often hampered by the very limited staffing pattern within the Health Resources Administration Scholarship Services Branch.
6. The separation of the Scholarship Services Program in Health Resources Administration and the service delivery programs in Health Services Administration creates coordination problems which ultimately affect students.
7. Many of the schools where scholarship recipients are concentrated have little or no commitment to preparation of students for the type of medical practice they will encounter.

While much of the criticism we have presented has been negative, we would like to emphasize that the National Health Service Corps is the only successful federal or state program that is delivering health care to millions of Americans who would otherwise go without. We are proud of its accomplishments and optimistic about its mission.

Mr. WAXMAN. I understand, Mr. Clements, you will be speaking for the other students.

STATEMENT OF CHARLIE CLEMENTS

Mr. CLEMENTS. They will be making statements. I just have a short statement.

I am Charlie Clements, a fourth-year medical student from the University of Washington. I have taken a year's leave of absence to represent 24,000 medical students as president of the American Medical Student Association. In June of this year, I will graduate and enter a residency in family medicine. Lest there be any confusion, AMSA is an independent organization not related to another medical group with a similar sounding name. AMSA is dedicated to improving medical education and health care. We have chapters at over 130 medical schools in the country. It is an honor to be here today because we have a special relationship to the National Health Service Corps. In 1969, students introduced a resolution in our house of delegates urging Congress to create a Federal health corps to serve in areas where physicians would not ordinarily work. We were there when the first hearings were held and we have come back since to offer our suggestions as the Corps has experienced growing pains over the years. We are as committed to the concept of the National Health Service Corps today as we were in 1969. We do not feel that the economics of health care have changed in favor of attracting physicians to serve in rural and inner-city areas, leaving millions of Americans without access to health care. Last year 25 percent of U.S. counties were designated health manpower shortage areas and over 25 million people live in those areas. And while the medical profession as a whole may not be known today for its idealism, there are still significant numbers of medical students who have chosen to enter this profession to serve people. Medical education has become an expensive proposition with some students graduating with debts of over \$80,000 merely to meet costs of living and tuition. The number of students entering medical school from low- and middle-income families has continued an alarming decline over the last 5 years. This combined with cutbacks in available financial aid have forced many students to view the National Health Service Corps as a financial assistance program, not a means of service to the underserved. The problems that have resulted from a rapid expansion of the Corps and inadequate funding to properly staff its administrative needs are complex. They require an understanding of the medical education model and its shortcomings. With me today are two students who have been participants in the Public Health Service advocacy program and the National Health Service Corps preceptorship program. Both students are scholarship recipients. I hope they can give you some insights into these problems by relating their own experiences. I am pleased to introduce Vincent Mallory, from Meharry Medical College, and Diane Pittman, from Tulane School of Medicine.

I would like to remind the subcommittee they are testifying from a personal, not an organizational point of view.

[Attachment to Mr. Clements' prepared statements follows:]

Mr. Preyer [presiding]. Thank you.
Mr. Mallory.

STATEMENT OF VINCENT MALLORY

Mr. MALLORY. I am a senior medical student currently receiving my third year of financial aid from the NHSC scholarship. I accepted the scholarship for only one reason—money. I sat in my apartment one summer not knowing how I was going to pay my bills or medical school tuition for the next 3 years, so I decided that I needed financial help from anyone. I applied to the Navy, Air Force, Army, and PHS scholarship programs. I am afraid of heights, cannot swim a lick, and I detest green khaki clothes, and I knew even less about the Public Health Service, so I decided to take their scholarship. I had no intentions of delivering primary care, I did not like cities with less than 1 million inhabitants, and most of all, I did not know the slightest thing about everyday real medicine. All I knew when I signed that dotted line was that all my tuition would be paid and I would have some spending change in my pocket for the next 3 years. Somewhere down the road I would have to give 3 years of my time to PHS, but that did not seem like much that summer day in 1977.

Two years later what was once a blessing—the PHS scholarship—turned into a dreadful mess. I had now decided to do a surgical residency, but I would not be able to get a deferment from PHS to complete my training. I was told there were only deferments for a few specialties, none of which I cared to go into. Then I was told that if I did not do one of the allowable residencies, I had to do an internship and then pay back my 3 years to PHS. In the meantime, marriage plans had cropped up, and it was difficult explaining to my better half that I was leaving medical school in Nashville to do an internship in New Orleans for 1 year, then to move to Snatchback, Miss., for 3 years to pay back PHS and then to move on to Atlanta to do the surgical residency that I intended to start 4 years earlier.

All of a sudden, the happy medical student with ample pocket change was having academic, social, and soon to be emotional problems. How I wished that I had never signed that dotted line.

The above story is true not only for me, but for several of my classmates and probably for a large number of medical students across the country. At a very early stage in our careers, we are signing contracts not knowing that they tie up the next 11 years, 12 years in the case of Ob/Gyn, of our lives.

The most important point made in the story is that, in my opinion, more than 80 percent of all students accepting NHSC scholarships accept them because they need financial aid, and not because they desire to render primary care. Most of the students are not fully aware of exactly what is expected of them when they serve their obligation. Their recruitment has been by a financial aid officer who often advises them about the "right" answers for the application. Moreover, how is it possible that during the first year of medical school a student can know if he wants to be a pediatrician or a neurosurgeon?

I do not think it is reasonable for first-year medical students to make a commitment to primary care practice after training, be-

cause they have not experienced enough of the medical specialties to make wise decisions. In the course of my 4 years, I have changed directions four times. I entered school concerned with gynecology, changed to internal medicine, then surgery and, only 2 weeks before writing this paper, I decided that anesthesiology is the one for me. By the time you finish reading this dissertation, I may be well on my way to a family practice residency.

I look back over my 4 years of medical education and I admit that I have learned a wealth of technical medical skills. However, I have yet to be a doctor in every sense of the word. I have trained in the high power medical systems of Vanderbilt, UCLA and Emory. I have taken the ominous National Board and passed. After all of that, I found something missing.

Medical students do not realize that medical institutions represent less than 10 percent of all health care delivered in the United States. Ninety percent of the health care is provided by physicians in office-based settings. As far as I am concerned, these doctors, outside of institutions, often in private practice, represent the real doctors.

After serving a 1-month preceptorship at a rural National Health Service Corps site in Tennessee, I found out that outpatient practice in a small town is a far cry from medical school and residency training programs. I can honestly say that we are trained to do one job, but actually do something altogether different when we enter practice. I am grateful that I participated in the preceptorship program because it was my first real experience at being a physician, not some kind of intern, or medical student. The people of that town were extremely grateful to have a physician. I treated colds, hypertension, diabetes, depressions, and cuts and bruises. That is everyday, real medicine. I did not see any waldenstroms macroglobulinemia, histiocytosis X or schistosomiasis, which are all things that I seemed to have been overdosed on in medical school. I have a totally different outlook on medicine, and primary care in particular.

Last but not least is the business of residency training. Study after study has shown one of the most significant factors of where doctors practice is the site of their residency training. I would like to eventually set up a private group practice somewhere in the Southeast. I was born, raised, and educated here. It would make sense for me to be able to plan my residency to receive appropriate training for where I might serve. If the National Health Service Corps is going to assign me to serve 4 years in a northeastern inner city site, it would make sense for me to select an urban setting for residency training so I could serve those people better. But I have no assurances of whether it will be urban or rural, northeastern or southwestern. It would make more sense for me to be able to do a residency in the Southeast, serve the people of the Southeast, and then settle down in the Southeast, but I may end up serving the citizens of Buffalo Breath, Mont. Approximately 40 percent of the designated shortage areas are in the Southeast, region IV, I believe, but less than 10 percent of the scholarship recipients are from there. Perhaps some preference in selection could be given to students from the geographical areas that need to be served in-

stead of so many students at high tuition, private medical schools with limited commitment to primary care.

All in all, I have had more positive experiences with the National Health Service Corps than negative ones. Its intent and goals are commendable, but I am nowhere satisfied that the system, as it is, will fulfill them.

Mr. PREYER. Thank you very much, Mr. Mallory. Perhaps you could change over to become a writer. You expressed yourself very well.

We have a vote on the floor at the moment. So the committee will stand in recess for about 10 minutes. Then we will hear from Miss Pittman.

I appreciate that Dr. Madison has to catch a plane. If you feel the need to leave, Dr. Madison, do not hesitate to go ahead. We have been expecting a snowstorm or something here; it does not look too bad at the moment, but if you are concerned we will excuse you.

The committee will stand in recess for 10 minutes.

[Brief recess.]

Ms. MIKULSKI [presiding]. Could I have your attention, please?

Mr. Preyer and Mr. Waxman will return to us shortly.

In the meantime, I will act as chairman, and we will be able to continue the testimony.

Mr. Mallory, we left rather abruptly. Had you completed your testimony?

Mr. MALLORY. Yes.

Ms. MIKULSKI. Thank you very much.

Ms. Pittman, I believe you are next on the agenda.

STATEMENT OF DIANE PITTMAN

Ms. PITTMAN. Thank you.

I am a scholarship recipient in my second year at Tulane Medical School.

I have been interested in primary care since I first elected to go into medicine. I grew up in a small town in Vermont and worked for 2 years as a volunteer on a rural rescue squad.

I spent the summer before I began medical school working on a rural health team project in southeastern Ohio. All these experiences have contributed to my intense interest in primary care and my desire to live "out in the boonies."

Signing up for the National Health Service Corps was a natural thing for me to do when the issue of financing medical education came up.

I am currently serving as a National Health Service Corps advocate for Tulane. I act as a contact point for addressing scholarship students' questions and concerns about the program. The advocacy program is the first step in establishing an active link between students and the rest of the program, but it still has a long way to go. I find my job as an advocate frustrating.

I have dialed the scholarship's 800 number continuously for an hour and gotten nothing but busy signals. On finally getting through, the person answering does not have the information needed nor does he or she know who should be contacted for it.

There are times when I have received outdated information or frank misinformation. Then there is the decision of whom to call for what questions. The Regional Scholarship Office? They won't accept collect calls.

The National Health Service Corps office? They aren't used to dealing with questions from people 4 to 7 years away from their commitment.

The scholarship program? They don't know anything about the service end of the program.

The advocacy program? They have the same trouble getting information that I do.

Students are frustrated with the lack of hard information about the NHSC. Recruiters and scholarship administrators who have spoken to us at Tulane have come without enough information or, worse yet, misinformation, creating a credibility gap.

Official communications are limited to glossy magazine type publications with anecdotal reports on assorted NHSC sites. There are no regular direct communications with recipients on matters like Federal legislation affecting Corps personnel, site development, the site selection process, residency deferments, and private practice options.

The goal of the NHSC is to bring physicians committed to primary care into underserved communities. Traditionally, it has been the State funded medical institutions who train primary care physicians while private schools groom students for the subspecialties.

But right now, most of the NHSC scholarship recipients are at private schools like Tufts, George Washington, and Tulane, where they receive very little support in pursuing primary care interests.

For example, Tulane has no Department of Family Medicine, and the Department of Community Medicine has only 1.5 faculty members. The outstanding role models in the first 2 years of school are a pathologist and a neurologist. We have yet to see a family practitioner in the causes of our education. Sometimes I wonder how I will be able to maintain my interest in primary care for the next 2½ years in the face of such nonsupport.

The reason for the disproportionate number of scholarship recipients in private school is, of course, money. Students in private schools where tuitions are approaching and sometimes exceeding the \$10,000 a year mark, need funding.

Low-interest loans are drying up; tuition is skyrocketing; and people feel forced into the NHSC to meet their educational expenses. Some of these people are already committed to primary care. Others will become committed to primary care as they advance in their training and experience.

I feel these two groups are in the minority. The majority of students will either serve their 2 to 4 years willingly, chalk it up as the price to pay for going to school and go on their way to whatever field they choose; or they will be resentful, serve unwillingly and do everything they can to get out as fast as possible.

I like to think that the latter will be far in the minority, but with the resentment and frustration many students are feeling now over the lack of communication and other problems, there will be some unhappy doctors in the Corps. And unhappy doctors are not good for shortage areas.

The students who do find themselves committed to primary care are those who have had an early positive experience with it. They are students who have worked with a doctor or in a hospital under the conditions one finds in NHSC-type areas.

I myself am very committed to rural primary care, and much of that commitment is due to the experience I had working on a health project in a rural setting the summer before I started medical school.

It is very important to channel those people who may be interested in the NHSC into early firsthand experiences in primary care. This is especially important for those of us who are going to schools where primary care is not taught.

I am grateful that the National Health Service Corps exists to help people like myself return to shortage area practices, but I have concerns about the lack of other financial aid which forces uncommitted students into this program.

Thank you.

Ms. MIKULSKI. Thank you very much.

I also appreciate the latter remarks that you made in terms of your concern about people coming into the program in terms of their commitment.

I also appreciated your remarks about thanking us for the opportunity for you to continue your education.

I will be quite frank, friends, I was disappointed with the testimony presented here, and I am one of the lefties on the committee.

I am one of the big spenders and I guess what so surprised me by this testimony from you, because what I was looking forward to hearing from the students, was that you are the first person to say thank you for the opportunity.

This is a very expensive program paid for by taxpayers, and I know if Mr. Dannemeyer were here, and some of the others, it would be quite disturbing to them.

I will be quite candid about it, because the taxpayers, and I am not going to lecture or scold or whatever, I just want you to know my reaction is that I represent a blue-collar community.

I represent many of the communities in Baltimore that are underserved, even within the shadow of the University of Maryland Medical School and Hopkins. I am familiar with the way medicine is being practiced certainly in urban areas, and the people who pay for their National Health Service Corps program are the charwomen in my community who are going to work right now to clean out toilets so we can pay the taxes to provide for some of those kinds of social programs, where there might be a cop on the beat that has not had a raise and he makes \$600 more than a CETA employee, and so I want to get more of a bang for the buck, if you will, and more services, a dollar's worth of services for a dollar's worth of taxes.

We could help students complete their very expensive education by this program, but I guess what I really expected was at least a thank you, not to me but on behalf of the people who provided that education, so I just want to say that, and I would hope that when scholarships are given that they are used, some as an investment on the part of the taxpayer for a return.

Now, when we get to your administrative problems, they are horrendous, and the advocacy problems that you have encountered are quite real.

What a sorry state of affairs, that for giving you \$80,000 you might have to give up a few years of your life. I guess I am just not sympathetic at all, and if you want to respond to that you are more than welcome, but I must say I am dismayed.

Mr. CLEMENTS. If I could respond to that, I had some summary recommendations, which I will not go through, but at the end of my statement I want to emphasize that while our comments have been critical, they have been critical because we are committed to the National Health Service Corps and have been for 10 years.

It's the only successful Federal program delivering health care to millions of Americans that otherwise wouldn't get it. There are many students who want the opportunity to serve in shortage areas. We don't always feel they are getting the scholarships, the selection criteria or preparation to do that, but there are many of them out there and we are committed to the Corps and thankful for its existence and what it does for the millions of Americans that otherwise wouldn't have any health care in their communities.

Ms. MIKULSKI. How would you improve this program in terms of the selection of the recipients and the administration of it?

Mr. CLEMENTS. I think we have alluded to some of the problems. Financial aid officers are often the points of entry for this program, and we don't feel they should be recruiting students to serve in this program.

The advocacy program needs to recruit people, not people who are trying to tell people how to finance their education. We would like the schools that are teaching people to be family practitioners to have some kind of weighted application process so that more students at those kinds of schools are getting scholarships.

There are substantial problems with targeting a large percentage of the awards for first year students. Students who enter medical school are very idealistic.

They will change their minds, because they know nothing about what being a doctor is like the first year of medical school. We think there should be opportunities for entry at the second or third or fourth year when students begin to know what they want to do to make the proper kind of commitment.

We think the administrative and information problems——

Ms. MIKULSKI. Could I just stop you there?

There is a problem, of course, with the difference between legislation and administrative directorate. We have a broad policy, but would one of those ways of dealing with that be to strongly recommend to HEW that physicians currently involved in National Health Service Corps activity with alumni links to major institutions in effect be the recruiters?

I don't want to sound corny, but in effect have some type of career day where people who have actually been in the field, whether it is urban or rural, are the ones that come and say, now here is the scoop, here is the dope. I know what it's like to be a first- or second-year medical student. I know what you are going to go through.

Would those be the kinds of practical things that would help?

Mr. CLEMENTS. I think that would be very helpful. You can imagine a financial aid officer who is worried about meeting a quota doing that recruiting versus someone who has been there. We want as realistic a picture presented as possible.

Vince was not committed to the Corps until he did a preceptorship with the Corps, and it turned around his attitudes completely.

A recruiter who has been there certainly is very effective.

Ms. MIKULSKI. What about some of the other areas, and the other two of you should feel free to answer?

Ms. PITTMAN. One thing that I would like to say is that the preceptorship experience is very important, as Charlie said.

I know it was important for me in sustaining my interest. Waiting a couple of years until students are in their third and fourth year to make that kind of commitment is important. You just don't know enough when you have gone through a premedical curriculum, biology, chemistry, et cetera, and you start a medical curriculum, to make that kind of career commitment.

Ms. MIKULSKI. Let me ask you a followup on that.

You needed your money right away so there wasn't time for you to put up the money, and I would venture to say that most people, many people don't even have the bucks there and that is one reason why they signed up, where you could then be reflective about career goals, life style, choices, et cetera.

How do you handle that problem for students who in their first and second year need financial assistance?

Ms. PITTMAN. Well, perhaps some kind of an open-ended loan program could be developed. Students are finding it difficult to get enough loans. There are loans available, but almost all of the students at our school are underfunded. We have a budget, but it is almost always less than what we really need to live on and go to school on.

The problem is the money is needed from the beginning, but most people can't make the commitment that early.

Ms. MIKULSKI. When do you feel that you could honestly make a decision or a commitment, at what point?

Ms. PITTMAN. Myself?

Ms. MIKULSKI. When you speak about you, I really mean everybody.

Ms. PITTMAN. Really almost after you get out of medical school. The first 2 years you spend almost all of your time in the classroom, especially in schools like where I am from and you don't even start getting clinical rotations until your third year. Then you get on OB-GYN, and you love it.

The next thing you know you are on surgery, and you love it and you want to be a surgeon. By the time your senior year rolls around maybe you really do have an idea, but many people don't even have a good idea when they are applying for their residencies.

Mr. MALLORY. I am a senior and in 5 months I will have my M.D. degree, and I don't know what I want to do in life at this moment, due to the fact that I have had five good experiences in five different hospitals in three different States, and I am still not married, and I still don't have any kind of—

Ms. MIKULSKI. Don't blame that on the scholarship.

Mr. MALLORY. We are humans first, and regardless of what you do, you have a personal life. Here you are getting your degree, going out to do your internship, and you don't know what you want out of life or what kind of hours you want to spend being a doctor.

For example, there is a far cry between a radiologist and a surgeon, and I just finished taking radiology 2 months ago, and I really like the lifestyle, and I have another job coming up in 3 weeks that I have never experienced yet, anesthesiology, and I think I will like that, so you are learning all the way down to the end degree.

So when you say name a time when we are ready to commit ourselves to primary care, there is no reasonable period of time within the 4 years of medical training that you can really say you want to take the scholarship. So you say, "where are we?"

I don't know where we are, but we are back to the same business of giving the scholarships out at a time when you don't even know pediatrics from OB, and maybe you should at least wait until the summer after the junior year of medical school before you commit those people to serving and give them the money in the meantime, the first 3 years and if they don't want to serve for you make them pay it back as a loan at a very high interest rate.

At least the obligation of time in the boondocks is off their backs.

Ms. MIKULSKI. Mr. Clements, is that what you feel?

Mr. CLEMENTS. I feel there are a lot of students that are able to make that commitment at many different times. I come from a school where half the graduates are going into family practice. Most of my classmates did at the University of Washington.

We all make commitments to residency at the end of our junior year, and the majority of students could make a very solid commitment at that time in their careers.

Ms. MIKULSKI. Are you suggesting the first 2 years be a loan program with an option which you could then convert into a service format if you chose?

Mr. CLEMENT. I think that would be a better option than we have now. In 1975 in health manpower hearings a decision was made by the Congress in that year to cut back student aid to force people into the Corps as an option for financial aid, and what we have seen is that that hasn't served the Corps well, and if people come in at a time when they are able to make a good commitment we will get better physicians out in those areas.

Ms. MIKULSKI. I would like to go to the administrative questions that you raised, Ms. Pittman.

Do you have any suggestions what to do about that or are you just going to bring it to our attention?

I wish you would have testified before we had the administration here.

Ms. PITTMAN. The thing that I think is a basic part of the problem is the separation of the two programs. You have the National Health Service Corps and the scholarship program being administered from two different branches of the PHS—the HRA and the HSA. So when I have a question, either for myself or as an advocate, I have to, No.1, decide—

Ms. MIKULSKI. Are you paid to be an advocate?

Ms. PITTMAN. No, I am not.

Ms. MIKULSKI. It is a student function like being on the student council?

Ms. PITTMAN. Yes. I have to decide who it is I should call, which agency I should deal with. I have had better dealings with some than others. It is difficult to find who has the information needed.

One of the disturbing things to scholarship students is that they don't get regular communications from anybody. There is an occasional form letter, an occasional magazine or booklet, but nothing that says, here, you are 2 years away from when you will have to ask for a deferment and here are some things you might want to be thinking about. There is no kind of direction at all.

In a school such as Tulane which does not provide any direction we are sort of lost. We wander around and try to get the answers as best we can, but there is no mechanism for getting the information to us.

Ms. MIKULSKI. Is it your recommendation that there should be one central place that should be in charge of both of those?

Mr. CLEMENTS. We think that would be good to have one place. The communication between those two Bureaus is significant when we are trying to get information. In addition, I think the national scholarship program is fairly understaffed and they have not expanded their staff for 2 years while the program has.

Ms. MIKULSKI. Where do you think this ought to be located? What ought to combine with what?

Mr. CLEMENTS. I think we have some opinions on that. I am not sure that we are the best qualified people to reach that decision.

Ms. MIKULSKI. Why? You are the people most affected at that point. After you go to fulfill your requirement, then it is the constituency that would evaluate you. You have every opportunity to evaluate the administration. Don't be shy.

Mr. CLEMENTS. In a way, you are asking us to say whether HRA or HSA is more competent for one role or another. It is perhaps our feeling that it should be under HSA because the scholarship recipients are going to be moving into HSA because they are administering the service program.

Ms. MIKULSKI. It would have the most—

Mr. CLEMENTS. It would be a continuity and pipeline kind of movement with HSA administering the program.

Ms. MIKULSKI. Staff tells me HEW is moving to unify these two programs by moving the scholarship component to HSA. But having been a street organizer and social worker, I like statutory mandates rather than executive directives because they can change. I am always suspicious when they say they are moving toward something. I don't know if that means in my lifetime, when I am through with menopause. I mean, I just never know.

One of the things I would like to do in the cleaning up of this program and making it more efficient to accomplish our objectives is to move it in one area.

Do you have any other comments that you would like to make? I know many of you probably have planes to catch or whatever.

Mr. CLEMENTS. We would just like to thank you again for the opportunity and say that we could have brought students here that could have given you glowing reports of their experiences and glowing reports of their commitment, but we felt our role was to

bring you the reality of what is going on out there and I hope we have done that.

Ms. MIKULSKI. Let me ask you two other questions. One doesn't really deal with this program but it deals with the issue that you brought up and it is an area of interest in my career here on the Health subcommittee. That is, the role that medical education plays in formulating your decisions and your values, your decisions as well as your technical expertise.

One, I think you have talked about medicine as taught as an unreal world until you have had those other opportunities. Miss Pittman, you talk about being able to sustain your interest in primary care. I, too, wonder about medical education, not its scientific quality. I am sure you all saw the CAT scanner maybe the first 3 days you were there.

What concerns me is values, an orientation to a humane, holistic delivery of service where you are not talking about a liver but you are talking about a human who has that liver or kidney, or needs kidney dialysis, all types of emotional reactions, emotional reactions to mastectomy or other things.

What kind of recommendations would you have to alter, without tampering with medical education in this country, if you were me?

Mr. MALLORY. Let me say one thing, that when you come through medical school, any medical school, especially schools like Georgetown, George Washington, or Johns Hopkins, you are taught high quality, expensive laboratory, hospital-based medicine. For my first 3 years of medical school, I never went to a patient who had an unknown problem. When I got there he had been examined by 3 different specialists and I had to go read and write and study about a problem that was very minute and very detached from the person. I never saw a person who came in and said, "I feel bad," and then worked him up start to finish.

When you go to these NHSC sites, people come in and say, Doc, I just don't feel good. You are not taught how to handle that in medical school. You are taught how to handle atherosclerosis but the patients out there don't come in and say that. I am not knocking high-powered medicine, I love CAT scans and I don't know how I could do without them, but the fact of the matter is I probably read one CAT scan for every 500 patients I have seen.

Ms. MIKULSKI. Mr. Mallory, other than your own intuitive ability, did you have a course in interviewing techniques or what did you learn about human behavior?

Mr. MALLORY. Let me speak about behavioral science and all that stuff, as I call it. We have a phrase, "all that stuff", psychology, patient-doctor relationship, ethics, put the word that you want to it. The course lasts about 1 month.

So in 4 years of med school I feel I have had maybe 1 month of how to be a humanistic doctor.

Ms. MIKULSKI. Based on our experience, you feel that that 1 month was very important to you and that it should be expanded?

Mr. MALLORY. After my first week at the NHC site I had to dig out those notes from that course which I took in my sophomore year. I found those few scanty notes, I could read them all in 5 minutes, and there was not enough meat there to use the course.

Ms. MIKULSKI. Who taught you that, another physician?

Mr. MALLORY. Ph. D's. The first 2 years of medical school are taught by Ph. D's. All behavioral sciences are taught by psychologists and social workers. I am not knocking them, but it is just that I was not taught by MD's until the third year and the ones I encountered were not at the community sites, they are very high-powered specialists. When you go out to the sites you are dealing with family practitioners.

One thing I would like to say here is "attitude." I have come through 4 years of school now and I know that at 5:30 in the morning on surgery rounds, when you looked tired and sleepy, the surgeons had a tendency to look at you and say, "If you can't take it, go into family practice." Family practice is on the bottom. They are the low-class doctors.

Ms. MIKULSKI. At least they tell you to go into family practice. They probably tell Miss Pittman to get married. Maybe you are married.

Mr. MALLORY. So the attitude is poor to begin with.

Ms. MIKULSKI. What are students doing to change this and do you think it is appropriate for Congress to consider activities of changing the course of medical education?

As I understand it, there is a basic format established for medical education, approximately 70 or 80 years ago, I forget the methodology, but that format was established and it has been that ever since only it has gotten more scientific in its orientation and less with "all that stuff".

Mr. CLEMENTS. The reason I hesitated to answer your question the first time was that I was afraid that I would open a floodgate. The essence of our association is to attend to that problem. The reason we are here is because we understand the carrots that the schools pay attention to is the Federal grants. The fact that 60 percent of them are saying they teach significant nutrition now is as a result of Federal dollars. The fact that 4 years ago there was not a school in the country that had a geriatrics curriculum and almost all of them do now is as a result of Federal dollars. That is the carrot that makes the medical schools pay attention.

We have task forces. Our association is trying to supplement what goes on in medical education because we are disappointed. We have task forces in humanistic medicine and why physicians have a high suicide rate and why the people we came to serve after 2 years we are calling crooks and dump bags.

We have task forces to deal with women and their problems as patients and providers. We have task forces looking at medical education and the misuse of national boards. On the way down we were talking about it is possible to go through 2 years of medical school and never write a sentence because it is multiple-choice medicine. These are some of the things our association has been trying to address.

We will be down here to testify about nutrition education, and geriatrics and many other problems, the lack of role models, the lack of ever seeing a family practitioner, are all problems with the attitudes and socializations that take place during medical school.

Ms. MIKULSKI. Miss Pittman, did you want to add anything?

Ms. PITTMAN. I really agree with the things that are being said. We have a course in community medicine, taught by one of the 1.5

faculty members of that department. I would say average attendance was half the class. It was called things like community coffee break, comedy medicine. That is the attitude toward this type of thing.

Ms. MIKULSKI. Was that an attitude the students had when they walked through the doors the first day or was that the attitude that developed because of the subculture of medicine within these institutions?

Ms. PITTMAN. I would say it is probably some of both because the way our school works, you hear about what a course is like from the class before you so you go in with very preconceived attitudes.

Ms. MIKULSKI. No. I once took a German course like that because I was told the professor never failed anybody, but I was the first.

The time is running late. I find this information very helpful, because the latter part of this discussion goes to the heart of the concerns that I have as we try to shape a national health care system. We don't have one. That is why I talked earlier when Dr. Richmond was here about what does it take to work in a poor community. It takes a lot so you don't burn out.

Having worked as a social worker in those communities, I am very familiar with it. Unfortunately, too many people who set Federal policy never made a home visit or worked in an accident room on a Saturday night or have done in-take at shock trauma. So it is a very different kind of orientation.

I am very pleased to hear the work of your association. I would offer myself as a personal resource to your association in terms of changing some of these policies. I think to come and testify is very helpful and very enlightening. It is not often that we have the chance to have even this type of conversation.

But as you have outlined, your task forces and the goals of this organization which I just find to be quite splendid, I would like to work with you on concrete suggestions that you might have.

What happens is that in public policy we go with the authorizations that are before us. I mean, we are dealing with the scholarships now because that is up. We also deal with disease of the month. Some of us are interested in diabetes and some of us are interested in something else and we create a little institute and that institute is supposed to get out there and help and so on. So that we really don't—and then it becomes a fad. I don't mean that geriatrics is a fad, but somebody on the committee somewhere got interested and geriatrics became a Federal program and scholarships, et cetera.

So there is rather stereotypical thinking that goes on in the Federal Government as it sets up grants and aids. We always set up scholarships and training programs but not for comprehensive health care delivery for people to have a certain amount of choice. We will give a scholarship in geriatric medicine before you have made your choices. Some people might sign up for geriatrics and find that is not their thing. They would much rather be working in a migrant worker situation, or something.

So with people like me who are struggling to try to make some changes, along with an organization like yours, I think that you would find both in myself and some of the other members of the committee who could not be present today more than a willing ear

but a source of activism in this and we would look forward to working with you.

Mr. CLEMENTS. Thank you very much. We find it very heartening to find this kind of attitude here. You might have to tell us to keep away. You will hear from us so much.

Ms. MIKULSKI. Thank you.

[Whereupon, at 5:30 p.m. the hearing was adjourned.]

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