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pretation, the Court has indicated that only in exceptional cases will it override the rights of the property owner who has designed and maintained his facility for a business purpose. To succeed, the claimant must prove either that the relationship between the purposes of the speech and the use of the facilities is direct or that the private property has taken on all of the attributes of a town. In making this determination the Court will weigh the equities of the parties. With the current composition of the Court, the individual seeking access to quasi-public property will find the task of convincing five Justices quite difficult. It is apparent that the *Tanner* Court has finally realized that quasi-public property is also quasi-private.<sup>94</sup>

*Ralph N. Boccarosse*

## The Comprehensive Health Manpower Training Act of 1971: Panacea or Placebo?

In 1963, the 88th Congress enacted the Health Professions Educational Assistance Act,<sup>1</sup> which established the first federal program directed to meet the critical needs for physicians, dentists, and certain other health professional manpower, providing assistance to schools for construction of facilities and assistance to students in the form of loans. The HPEA programs have undergone repeated amendment since the original enactment. The most recent of these is embodied in the Comprehensive Health Manpower Training Act of 1971.<sup>2</sup> It is the underlying need for such programs, their

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94. In an opinion dated about three weeks after *Tanner* the Rhode Island Supreme Court, in a unanimous decision, reached the same conclusion as the *Tanner* court regarding solicitation of signatures for a nominating petition inside a private mall. Refusing to expand *Marsh* and *Logan Valley* beyond their facts and concluding that the California Supreme Court's holding in *Diamond v. Bland* was an unwarranted extension of those principles, the court noted that under these circumstances there was no justification for giving the first amendment a preferred position over the fifth. Stating in a footnote that their decision had been reached prior to the decision of the Supreme Court, they nevertheless followed the same strict interpretation of footnote nine of *Logan Valley*. *Homart Development Co. v. Fein*, 293 A.2d 493 (D. R.I. 1972).

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1. Act of Sept. 24, 1963, Pub. L. No. 88-129, 77 Stat. 164 (codified at 42 U.S.C. §§ 292-293 (Supp. 1963)).

2. Act of Nov. 18, 1971, Pub. L. No. 92-157, 85 Stat. 431 (codified at 42 U.S.C. §§ 293-295h (Supp. 1973)).

legislative mutations, and their most recent formulation in the 1971 Act that are the topics of this article.

*Health Manpower Crisis in the United States*

The reasons for our present health manpower crisis are numerous, complex, and often indiscernible. Constant factors such as the increase in population, higher income, rising personal expectations, and shifting social forces are only some of the more predominant causes of our present dilemma; they are far from being the only ones. Congress, in its more recent attempts to offer better medical resources to the nation, has itself increased the problem of inadequate manpower. Senator Kennedy, in offering an amendment to the HPEA programs, identified this legislatively created ingredient in the shortage problem:

For a number of years, this body has been authorizing funds to enable Americans to purchase health care. Medicare and medicaid are two of our most successful efforts in this regard. During this period, however, we have failed to take adequate measures to increase the capacity of our health care system. We have increased the demand for health care services while doing nothing to increase the supply. This imbalance has most certainly contributed to the rapid inflation of cost and the long waiting lines . . . .<sup>3</sup>

The Carnegie Commission on Higher Education in its report on the status of health manpower points out that the shortage of all types of health manpower is "especially acute" for millions of Americans living in the rural and inner-city areas.<sup>4</sup>

The Commission's report states that in 1970, on the average, there was one physician for every 630 persons in America. Yet, in over one-third of the nation's counties there was only one physician for each 1,800 people, and in more than 130 counties (representing more than eight per cent of the nation's land area) there were no private physicians at all. Furthermore, according to the report, the number of these neglected counties is constantly growing. In the inner-city, the problem is similarly acute. Some parts of New York have one private physician for each 200 residents; while, in other areas of the city the ratio becomes a staggering one physician per 12,000 residents.<sup>5</sup>

The growth in the nation's population during the 1970's is estimated at approximately 27 million. A disproportionate amount of the population

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3. 117 CONG. REC. 10995 (daily ed. July 14, 1971).

4. The Commission's Report is entitled "Higher Education and the Nation's Health", see 117 CONG. REC. 10998 (daily ed. July 14, 1971).

5. *Id.*

increase consists of senior citizens and young children—two of the most frequent users of health services.

At present, the United States is an importer of medical manpower. In 1970, one out of every six practicing physicians was a foreign graduate. One out of every four newly licensed physicians was a foreign graduate.

In the hearings before the Senate Subcommittee on Health of the Committee on Labor and Public Welfare, Dr. Arthur M. Sackler, Chairman of the National Committee to Save Our Schools of Health,<sup>6</sup> stated that according to the U.S. Public Health Service and the various professional health associations, this nation faced a shortage in 1970 of:

- 48,000 physicians<sup>7</sup>
- 17,800 dentists<sup>8</sup>
- 150,000 nurses<sup>9</sup>
- 8,700 optometrists<sup>10</sup>
- 12,900 podiatrists<sup>11</sup>
- 9,300 veterinarians<sup>12</sup>
- 266,000 allied health professionals.<sup>13</sup>

While these figures are most astounding, the projected shortages for 1980 are even more frightening. Based on present policy trends, manpower shortages for the end of this decade are expected to number:

- 26,000 physicians<sup>14</sup>
- 56,600 dentists<sup>15</sup>
- 210,000 nurses<sup>16</sup>
- 12,000 optometrists<sup>17</sup>
- 14,100 podiatrists<sup>18</sup>
- 9,900 veterinarians<sup>19</sup>
- 432,000 allied health professionals.<sup>20</sup>

While the present situation and forecast is dismal, one positive statistic provides a degree of hope. The ratio of practicing physicians per 100,000

6. Dr. Sackler is also the international publisher of the *Medical Tribune*, and Chairman of the World Health Organization's Task Force on World Health Manpower.

7. U.S. Public Health Service estimates, 1970.

8. *Id.*

9. *Id.*

10. American Optometric Association estimates, 1970.

11. American Podiatry Association estimates, 1970.

12. American Veterinary Medicine Association estimates, 1971.

13. U.S. Public Health Service estimates, 1970.

14. *Id.*

15. *Id.*

16. *Id.*

17. American Optometric Association estimates, 1970.

18. American Podiatry Association estimates, 1970.

19. American Veterinary Medicine Association estimates, 1971.

20. U.S. Public Health Service estimates, 1970.

United States residents has risen over the past two decades. In the 1950's the ratio was 141 per 100,000. In 1970, the ratio was 155 per 100,000. There were about 325,000 practicing physicians in the country in 1970, compared to 219,900 in 1950.<sup>21</sup>

Training and educational activities aimed at increasing the nation's health manpower took a definite upward surge after 1963, the date of the enactment of the HPEA programs. In 1963, there were 87 United States medical schools with 8,772 entering annually, a total number of 32,001 M.D. candidates, and 7,335 graduates. In 1970-71, eight years later, the nation had 102 medical schools—an increase of 15, with 12 more schools in development; first year classes totaling 11,660 representing an increase of 2,588; a total M.D. student body of 40,333, an increase of 8,332; and a graduating class estimated to be 8,996—an increase of 1,661.<sup>22</sup> The enactment, therefore, of the HPEA programs marked a legislative watershed in alleviating the critical manpower shortage in this area. The Comprehensive Health Manpower Training Act of 1971 extended the existing HPEA programs for three years with major modifications. To fully comprehend the importance of this Act and the objectives it sought to accomplish, an examination of the programs' legislative history and a detailed analysis of the Act and the bills on which it was formulated is essential to place the legislation in proper perspective.

#### *Legislative History of the HPEA Programs*

Federal aid designed to directly confront the health manpower crisis through institutional and scholastic support programs<sup>23</sup> was initiated by the Health Professions Educational Assistance Act of 1963.<sup>24</sup> Additions, modifications, and rescissions of health education assistance characterized the programs' succeeding eight year legislative history. These consisted in part of broadening the classes of eligible recipients,<sup>25</sup> increasing the permissible

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21. Carnegie Commission's Report, *see* 117 CONG. REC. 10998 (daily ed. July 14, 1971).

22. *Id.* at 11011.

23. The Health Profession's Educational Assistance Act of 1963 authorized two programs: (1) a construction grant program, and (2) a student loan program.

24. 42 U.S.C. §§ 292-293 (Supp. 1963), *as amended* 42 U.S.C. §§ 292, 294 (Supp. 1971).

25. Under the Health Professions Educational Assistance Act of 1963, only schools of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, public health, and professional nursing could participate under the construction program. It was not until the enactment of the Veterinary Medical Education Act of 1966 that schools of veterinary medicine were eligible recipients of the federal subsidy.

Under the 1963 Act's student loan program, the only eligible recipients were students of medicine, osteopathy, and dentistry, *see* 42 U.S.C. § 293(a) (Supp. 1963), *as amended* 42 U.S.C. § 294(a) (1970). Eligible optometry students were permitted

fiscal ceiling of the loan program,<sup>26</sup> and inaugurating programs for loan forgiveness,<sup>27</sup> scholarships,<sup>28</sup> and institutional support subsidies.<sup>29</sup>

On June 30, 1971, the legislative authorizations for the HPEA programs expired, and Congress once again assumed the task of enacting legislation responsive to the needs of the institutions and students, as well as the ever-growing requirements of the health care recipients.

While numerous bills were proposed in both congressional divisions, scrupulous categorization enumerates the three principle legislative schemes as those of the Administration,<sup>30</sup> Representative Rodgers,<sup>31</sup> and that introduced by Representative Staggers and Senator Kennedy.<sup>32</sup> The House bills were

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to participate in the program in 1964, *see* 42 U.S.C. §§ 294(a), (b)(4), 294a(b), (c) (1964), *amending* 42 U.S.C. §§ 294(a), (b)(4), 294a(b), (c) (Supp. 1963), *as amended* 42 U.S.C. §§ 294(a), (b)(4), 294a(b), (c) (1970). Students of pharmacy and podiatry became eligible participants by virtue of the HPEA amendments of 1965, *see* 42 U.S.C. §§ 294(a), (b)(4), 294a(b)(c) (Supp. 1965), *amending* 42 U.S.C. §§ 294(a), (b)(4), 294a(b)(c) (1964), *as amended* §§ 294(a), (b)(4), 294a(b), (c) (1970). Students of veterinary medicine could not participate until 1966, *see* 42 U.S.C. §§ 294(a), (b)(4), 294a(b), (c), 294b(a) (Supp. 1966), *amending* §§ 294(a), (b)(4), 294a(b), (c), 294b(a), *as amended* 42 U.S.C. §§ 294(a), (b)(4), 294a(b), (c), 294b(a) (1970).

26. The ceiling under the 1963 Act was \$2,000 each year which was to be repaid within ten years, *see* 42 U.S.C. § 294a(a) (Supp. 1963), *as amended* 42 U.S.C. § 294a(a) (Supp. 1971). The maximum loan amount was increased to \$2,500 annually under the HPEA amendments of 1965, *see* 42 U.S.C. § 294a(a) (Supp. 1965), *amending* 42 U.S.C. § 294a(a) (1964), *as amended* 42 U.S.C. § 294a(a) (Supp. 1971).

27. 42 U.S.C. § 294a(f) (Supp. 1965), *as amended* 42 U.S.C. § 294a(f) (Supp. 1971).

28. 42 U.S.C. § 295g (Supp. 1965), *as amended* 42 U.S.C. § 295g (Supp. 1971). These grants were allocated on the basis of a statutory formula, *see* 42 U.S.C. § 295g(b) (Supp. 1965), *as amended* 42 U.S.C. § 295g(b) (Supp. 1971).

29. 42 U.S.C. § 295f to f-3 (Supp. 1965), *as amended* 42 U.S.C. § 295f to f-4 (Supp. 1971). The original labels given these grants were "basic" and "special." The basic improvement grants were determined on a contorted statutory formula, *see* 42 U.S.C. § 295f-1(a)(1)(2) (Supp. 1965), *as amended* 42 U.S.C. § 295f(a)(1) (1970), *repealed by* 42 U.S.C. § 295f (Supp. 1971). They were made available to schools meeting accreditation standards and fulfilling a requirement for enrollment expansion, *see* 42 U.S.C. § 295f-1(b) (Supp. 1965), *as amended* 42 U.S.C. § 295f-1(b) (1970). The special improvement grants were established to facilitate a school's accreditation and fiscal maintenance. *Compare* 42 U.S.C. § 295f-2(b) (Supp. 1965) *with* 42 U.S.C. § 295f-2(a) (Supp. 1971); priorities changed greatly with the most recent legislation. While a school's financial stability remains important in the legislative eye, the federal priorities for better health care delivery take precedence.

30. On March 4, 1971, Representative Staggers, at the request of the Administration, introduced H.R. 5614, the Health Manpower Assistance Act of 1971; a bill under the same name was introduced in the Senate for the Administration by Senator Javits and entitled S. 1183. The introduction date for the Senate bill was March 10, 1971.

31. Representative Rodgers introduced H.R. 4155, the Comprehensive Health Manpower Training Act of 1971 on February 10, 1971.

32. These bills substantively identical were introduced in the House by Representative Staggers on February 10, 1971 and entitled H.R. 4171, the Health Professions Educational Assistance Amendments of 1971, and in the Senate by Senator Kennedy on February 24, 1971 under the title of S. 934, the Health Professions Educational Assistance Amendments of 1971.

referred to the House Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce; the Senate Subcommittee on Health of the Committee on Labor and Public Welfare managed the proposed amendments of the Senate.

### *The Work Product of the 92d Congress*

These subcommittees held extensive hearings to probe into the reasons for and the reaction to the various proposals.<sup>33</sup> Legislators, agency representatives, chairmen and aides of various health commissions, educational administrators, and knowledgeable concerned individuals were called to voice their opinions as to how to improve existing programs, which in many respects had been heretofore ineffective, and to share whatever innovative ideas they had with the committee members who had the ultimate responsibility of enacting legislation that could effectively confront the multiple critical problems of the nation's health system.

Such legislative drafting necessitated an appraisal of the contemporary situation, recognition of principle objectives, and the formulation of programs that could effectively attempt to correct past deficiencies and give hope of success for achieving future goals.

The legislators were greeted with testimony statistically establishing two basic facts: the health manpower system had witnessed an encouraging increase in personnel and facilities since the inception of the HPEA programs;<sup>34</sup> nevertheless, shortage areas were proliferating and health education institutions were in many cases on the brink of financial chaos.<sup>35</sup>

Any legislation, therefore, that was to efficiently attack the health care crisis had to operate on many levels. Congress had to provide more health personnel, channel this manpower into critical areas, and accomplish these goals through incentives to the educational institutions, and at the same time establish financial stability in these schools. Examination of the manner in

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33. The hearings before the House Subcommittee took place on April 2, 3, 20, 21, 22, 23, 27, 28, and 29, 1971; the Senate Subcommittee hearings occurred on May 3, 7, and 10, 1971.

34. See the statements of Elliot L. Richardson, then Secretary of the Department of Health, Education, and Welfare; *Hearings on H.R. 703 and Related Bills Before the Subcomm. on Public Health and Environment of the House Comm. on Interstate and Foreign Commerce*, 92d Cong., 1st Sess., pt. 1, at 448 (1971) [hereinafter cited as *House Hearings*].

35. See statement of Frank Gentry, the Executive Director of the Kansas Hospital Association, who pointed out to the House Subcommittee that the nursing schools in his state were closing on the average of one a year over the past ten years, *House Hearings*; for the financial plight of the nation's medical schools refer to the comments by Dr. William G. Anlyan, Chairman of the Association of American Medical Colleges, *House Hearings* 539.

which this was attempted demands investigation of each topical area.

### *Construction Grants*

The authorization level for federal share of construction costs at the time of the hearings was 50 per cent, which under unusual circumstances (*i.e.* an individual school's financial situation) could be increased to, but not exceed, 66 2/3 per cent.<sup>36</sup> Dr. William G. Anlyan, Chairman of the Association of American Colleges, voiced his opinion that these authorization levels were inadequate based on the fact that the other half or third of the funds that were needed to match the federal share was impossible to obtain in many situations. Schools already on the brink of financial disaster would be asked to secure financing that would entrench them in an intolerable state of debt.<sup>37</sup> He further pointed out that some state laws do not allow a medical school to go into debt.<sup>38</sup> Those which are not restricted by law are often restricted by the fact that they have already extended their credit to the limit because of past financial needs. The only solution to this problem in his opinion, would be an authorization of the highest possible federal share.

Under the recommended House bill, H.R. 8629, the federal share was not to exceed 75 per cent on projects for new schools, for new facilities for existing schools providing a major expansion of training capacity and for schools of public health. The share was not to exceed 67 per cent for any other project except in the case of unusual circumstances in which case the federal share could not exceed 75 per cent.<sup>39</sup> S. 934, which was reported out by the Senate subcommittee with the recommendation for adoption as legislation, provided that the share could not exceed 75 per cent for any project; except that in the case of unusual circumstances, the maximum authorized share was 85 per cent.<sup>40</sup> The report issued by the Committee of Conference, which was subsequently enacted as the Comprehensive Health Manpower Training Act of 1971, signed into law by President Nixon on November 8, 1971, was, as may be expected, a compromise of the two positions. Under the new Act, the federal share may not exceed 80 per cent on projects for new schools, or for new facilities for existing schools providing a major expansion of training capacity; such share shall not exceed 70 per

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36. 42 U.S.C. §§ 294, 294a (1970), *as amended*, 42 U.S.C. §§ 294, 294a (Supp. 1971).

37. *House Hearings* 535-36.

38. *Hearings on S. 934 and Related Bills Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare*, 92d Cong., 1st Sess. 248 (1971) [hereinafter cited as *Senate Hearings*].

39. H.R. 8629, 92d Cong., 1st Sess. § 103 (1971).

40. S. 934, 92d Cong., 1st Sess. § 101 (1971).



cent for any other project, except in the case of unusual circumstances, and the 80 per cent is the maximum authorization.<sup>41</sup>

Perhaps from their own awareness or in acknowledgement of Dr. Anlyan's statement, Congress provided a further means to lessen the burden of the schools in accomplishing the federal priority of increased health education facilities. The Act authorizes a new program of loan guarantees and interest subsidies. Under this novel three year program, the government guarantees loans made by non-federal lenders to assist non-profit private eligible entities to carry out approved construction projects. Such guarantee, however, cannot apply to any amount which, when added to any other federal grant for construction, would exceed 90 per cent of the cost, nor can it apply to more than 90 per cent of the loss of principal and interest.<sup>42</sup>

Furthermore, the new section adds authority for three years of payment of interest subsidies on behalf of non-profit private entities which are eligible for construction grants and have loans to construct teaching facilities. Such subsidies may be paid to the lender in amounts sufficient to reduce, by not more than three per cent per year, the net effective interest rate otherwise payable on such loans.<sup>43</sup>

This loan guarantee and interest subsidy program was proposed in the Administration bills and met violent opposition from some quarters. The basic objection was that such a program failed to realize the fact that educational facilities of their very nature are not the type of structures which generate income with which to pay off the principal and interest.<sup>44</sup> Schools would of necessity be most hesitant to secure such loans for fear that they would be unable to make repayment. So as to minimize the possible disincentive of such loans, the Act provides that while the United States is entitled to recover from the applicant the amount of any payment made pursuant to such guarantee, the Secretary may for good cause waive such right of recovery thereby subrogating the United States to all the rights of the recipient of the payments.<sup>45</sup>

One further consideration of this program consists of recognizing that in 1971, there was a critical backlog of approved but unfunded construction grants of research and library facilities of one billion dollars. For medical education construction alone there was a backlog of \$614 million.<sup>46</sup> The representatives of the Association of American Medical Colleges suggested

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41. 42 U.S.C. § 293 (Supp. 1971), amending 42 U.S.C. § 293 (1970).

42. 42 U.S.C. § 293(h) (Supp. 1971), amending 42 U.S.C. § 293(h) (1970).

43. *Id.*

44. *House Hearings* 535-36.

45. 42 U.S.C. § 293(h) (Supp. 1971), amending 42 U.S.C. § 293(h) (1970).

46. *House Hearings* 535.

that the backlog could be broken by making the grant payments as they become needed according to the stage of construction.<sup>47</sup> The "lump sum" payment method depletes the authorized appropriations; therefore, a system which could "free-up" funds would permit greater use of federal monies on a much broader scale. This proposal was made part of the recommended Senate bill, S. 934,<sup>48</sup> but the Committee of Conference deferred to the objections of the Appropriations Committees that such an amendment would commit the federal government to expenditure of funds in future years which Congress would then be obligated to appropriate in those years.<sup>49</sup>

The amendments to the construction program were made with the primary objective of providing a means whereby health education institutions could increase or extend their facilities so as to accommodate increased enrollments. The joint effort of the House and Senate was in direct response to the various positions of the parties testifying before them, to the extent that such recommendations were feasible. Conscious of the financial peril of many such institutions, yet constant in their desire to maintain an enrollment increase, Congress further authorized that eligible applicants for construction grants would include combinations of schools.<sup>50</sup> Each segment of the construction program was designed to keep intact the primary federal objectives while at the same time not making it impractical or impossible for schools to participate.

### *Capitation Grants*

As the name "capitation" denotes, these grants are based on a "head count" of students. The capitation grant's principle purpose is to aid schools in stabilizing their financial situation. The value of the capitation system, according to the President's Message to Congress, is that the schools would know in advance the amount of federal money that could be anticipated. It would allow an institution to make its own long-range plans as to how it could best utilize these funds. Furthermore, it would mean that the emergency assistance programs could be gradually phased out.<sup>51</sup>

Opposition to the capitation scheme was premised on the belief that it would be a definite shortcoming to request schools which are already in financial distress and who are in dire need of the financial stability provided by such grants to further extend themselves by taking in more students, thus

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47. *Senate Hearings* 253.

48. H.R. 8629, 92d Cong., 1st Sess. § 102 (1971).

49. CONFERENCE REPORT, S. REP. No. 398, 92d Cong., 1st Sess. 41 (1971); H.R. Rep. No. 578, 92d Cong., 1st Sess. 41 (1971).

50. 42 U.S.C. § 293(a) (Supp. 1971), *amending* 42 U.S.C. § 293 (1970).

51. President's Message to Congress, Feb. 18, 1971.

aggravating their critical situation.<sup>52</sup> The response to this was voiced by Secretary Richardson who pointed out that such schools could request aid in the form of special project grants specifically designated as financial distress grants.<sup>53</sup>

The major conflict, however, as to a capitation system was the manner in which such awards would be given. The Administration's proposal was to grant these subsidies on the basis of out-put or graduates, rather than subsidizing input or enrollments. The design of the Administration's proposal was to encourage the maximum feasible production of health personnel through such means as advanced placement of persons with prior training in the sciences related to health care, shortened curricula and special programs for admitting United States students who have received part of their training in foreign schools. It was the Administration's position that if the expansion enrollment requirement could be met solely by first year enrollment, those schools which were trying to accelerate their production of graduates by advanced placement and other mechanisms for admitting students into the upper year classes would be penalized.<sup>54</sup>

Opposition to the "graduate" theory of capitation was quickly forthcoming on the part of the Association of American Medical Colleges in the person of Dr. Anlyan. He stated that such a system does not take into account the number of drop-outs on whom a great deal of money is expended. Furthermore, he noted that medical schools are not a clean-cut four year bundle. There is a diffusion into college and residency years with special programs such as the M.D.-Ph.D programs.<sup>55</sup>

A further provision of the Administration's bills was that there should be different levels of capitation for schools of medicine, dentistry, and osteopathy than there would be for schools of optometry, podiatry, veterinary medicine, and pharmacy. Secretary Richardson, quelling any fears that this was intended to deny the latter group operational support, stated that they would not be without federal assistance. He pointed out to the subcommittee members the raw fact that there is a great variation in the national needs for the services of the professionals these schools train. To provide capitation on the same level for all seven disciplines would create serious inequities. A capitation formula assumes a demonstrated need for financial assistance for the discipline as a whole and a clearly established national need for the health services of the professional in such discipline.<sup>56</sup>

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52. The only major proposed bills which would have deleted the enrollment expansion requirement were H.R. 4171 and its Senate counterpart S. 934.

53. *Senate Hearings* 191.

54. *House Hearings* 450-51.

55. *Senate Hearings* 227.

56. *House Hearings* 451.

The conscientiousness with which the congressional committees responded to the testimony in their formulation of the 1971 amendment to this program is evident in the formula ultimately devised. Under the present law, the capitation levels vary according to the particular disciplines. The formula takes into account the number of students in each year with the highest capitation level directed at the number of students who will graduate in no more than three years.<sup>57</sup> Once again, federal subsidy is offered to aid a school's operational costs and at the same time offers each school the possibility to obtain a greater amount of support if it will conform to those goals designed to alleviate the health manpower crisis. This observation is evidenced moreover by the fact that applications for capitation grants must also be in accord with the "Plan Requirement."<sup>58</sup> This facet of the program is designed specifically to engraft federal priorities upon the tendered subsidy. These range from the effecting of significant curriculum improvement to the enrollment and retention of financially or educationally disadvantaged individuals.

Under this section of the Act, the Secretary is authorized to make "on-site inspections" of any school or require such school to supply the necessary data so as to determine if the school is complying with the special projects under the "Plan Requirement."<sup>59</sup> The Secretary is also directed to submit to the respective Senate and House committees two complete reports estab-

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57. See 42 U.S.C. § 295(f) (Supp. 1971), amending 42 U.S.C. § 295(f) (1970).

58. The authorized projects under this Plan are those

- (1) effecting significant curriculum improvement;
- (2) for enrolling, increasing and retaining financially or educationally deprived or disadvantaged individuals;
- (3) for training of primary health care personnel particularly in the field of family medicine;
- (4) training for new roles, types, or levels of health personnel;
- (5) to establish cooperative interdisciplinary training among schools of the seven disciplines, and nursing, and public health, including projects for training in the use of the team approach to the provision of health services;
- (6) to assist in significantly increasing the supply of adequately trained personnel in the health professions;
- (7) to establish, in schools of medicine, osteopathy, or dentistry, increased emphasis on, and training in, the science of clinical pharmacology; diagnosis, treatment, and prevention of drug and alcohol use and abuse; the assessment of the efficacy of various therapeutic regimens, and; in the case of schools of medicine and osteopathy, the science of nutrition;
- (8) to provide, at schools of pharmacy, for increased emphasis on, and training in, clinical pharmacy, drug use and abuse, and where appropriate clinical pharmacology.

The Act provides that any application for a grant under this program after fiscal year beginning June 30, 1971, must be accompanied by a plan to carry out or establish and carry out at least three of the categorized projects commencing on the first day of the fiscal year after the fiscal year in which the grant is given.

59. 42 U.S.C. § 295(f) (Supp. 1971).

lishing the extent to which schools receiving capitation grants are carrying out such projects.<sup>60</sup>

### *Special Project Grants*

This type of institutional operational support is mainly designed to meet federal priorities for the distribution of health manpower into the nation's shortage areas. They were first made available in 1968 and were known by the title of special improvement grants. In fiscal years 1968 and 1969, special improvement grants were funded on the basis of review committee and National Advisory Council appraisals of the relative financial need of the applicants—priority being given to schools whose accreditation was in jeopardy. In fiscal years 1970 and 1971, the funds appropriated were sufficient only to support the continuation of the costs of the original awards, and new projects to expand enrollment, shorten the training period, and alleviate serious financial need.<sup>61</sup>

The \$412 million authorized appropriations may be channeled only into specific projects. The categorized projects reflect the extensive investigation and testimony concerning the plight of health care shortage areas.

Dr. Burkett pinpointed a crucial factor when he stated that all these elements including scholarships, loan forgiveness, and all other programs designed to bring health manpower to shortage areas will be useless unless there are good training programs to prepare professionals to practice in these areas. Such programs, he noted, are rarely found in health educational institutions, and even those that are in existence suffer because they are relegated to a minor role in the curriculum.<sup>62</sup>

From a very pragmatic viewpoint, one recognizes that a major difficulty in attracting personnel to these areas is that the locations themselves do not offer much incentive to the professional since they are usually lacking in the social, educational, and cultural qualities which are most available in the suburban sectors of the country. Suggestions as to methods of overcoming these obstacles took on the guise of emphasizing the need for the team approach to health care<sup>63</sup> so as to minimize the isolationist feeling characterized by rural practice; utilization of preceptor programs where students could have a structured, sustained familiarization with shortage area practice<sup>64</sup> thus diminishing the latent fear of inability to cope with the problems of such practice; and utilization of non-physician allied health personnel who could

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60. *Id.*

61. See H.R. REP. NO. 258, 92d Cong., 1st Sess. 22 (1971).

62. *House Hearings* 215.

63. See, e.g., *Id.* at 208.

64. See, e.g., *Id.* at 157.

most adequately handle the myriad primary health care functions<sup>65</sup> thereby opening a new frontier for those individuals willing to dedicate their skills but heretofore denied the opportunity to offer their talents.

When viewed in light of these statements, the list of authorized projects bespeaks the comprehensive schema: curriculum improvement; cooperative inter-disciplinary training programs; training new kinds of health personnel; training students likely to practice in shortage areas; planning experimental teaching programs or facilities; increasing the enrollment of low-income or minority students; establishing traineeships for students training under a preceptor in family medicine, pediatrics, internal medicine, or other health fields, or in rural or other shortage areas; utilizing the team approach to the organization and delivery of health services; and utilizing health personnel more efficiently through computer technology.<sup>66</sup>

Under this program there is also authorized a total of \$45 million for financial distress grants. These financial assistance emergency grants are available to schools to meet the costs of operation or to meet accreditation requirements. These appropriations are available for the special projects if the Secretary determines that they will not be needed for distress purposes.<sup>67</sup>

#### *Health Manpower Education Initiative Awards*

The stated uses in the act for the \$270 million appropriated for such grants are to improve the distribution, supply, quality, utilization, and efficacy of health personnel and health services delivery systems.<sup>68</sup> This program was referred to by Secretary Richardson as "probably the most far-reaching proposal" the subcommittees had before them. This is a new authority for enhancing some of the most critical health manpower efforts. They are given to schools to help develop and/or operate health manpower organizations and for the training of health manpower personnel.

As the Carnegie Commission pointed out, area health education centers are potentially means of improving the distribution of health personnel and relating health manpower more directly to the changing patterns of life. This is due to the fact that they provide training programs in educational activities directly associated with a community hospital, clinic, or health manpower organization and with one or more educational institutions located in areas too sparsely populated to support a medical school.

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65. See *supra* note 63.

66. 42 U.S.C. § 295 (Supp. 1971).

67. *Id.*

68. *Id.*

They would be responsive to the health manpower needs of the service area in which they are located. Experience has demonstrated that when a health training center is established in a given locality, the range and quality of health centers available to the people of the community rise. Also, there is the firm possibility that they would tend to encourage such individuals who had received their training in that area to remain there.<sup>69</sup>

Under these awards, the federal government would also assist in the establishing of residency training programs for family practitioners, and other training programs for primary care personnel of the types needed in a given locale.<sup>70</sup>

### *Student Assistance Programs*

#### *Scholarships*

As noted by Earl Jackson, President of the Topeka NAACP, only two percent of all physicians as of 1971 were black.<sup>71</sup> Representation of other minority groups was equally dismal. The most obvious reason for such a situation is the fact that the cost of medical education is beyond the reach of many families having members capable of entering health education and providing that manpower this nation is in such great need of securing.

The Administration's bills offered a targeted approach of directing scholarships so as to provide the necessary incentive to schools to increase the number of enrolled disadvantaged students. According to such scheme, scholarships would only be given on the basis of the number of students from low-income or disadvantaged backgrounds.<sup>72</sup>

The Association of American Medical Colleges attacked this scheme on the basis that it would be an unnecessary constraint on the use of scholar-

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69. *Senate Hearings* 454.

70. Further authorized under this program is the conferring of authority on the Secretary to make grants to assist private health or health teaching institutions in meeting the costs for special projects to identify, enroll, and retain qualified individuals from minority or low-income groups, and in relation to this group, grants for projects designed to publicize existing sources of financial aid available to such persons. No more than a maximum of 15% of the appropriation of a given fiscal year may be used for this purpose. The vast majority of the appropriated money is to be used to combat the maldistribution of our health manpower.

Also under this program, the Secretary is authorized to grant or contract for the discovery, collection, development or confirmation of information for the planning, development, demonstration, establishment or maintenance of, or the alteration or renovation of existing facilities for the projects categorized under the principle program. See for both of the above programs 42 U.S.C. § 295 (Supp. 1971).

71. *House Hearings* 396-97 (his source of information was the Statistical Abstracts of the United States, 1968, Bureau of Census, at 23).

72. H.R. 5614, 92d Cong., 1st Sess. § 16 (1971); S. 1183, 92d Cong., 1st Sess. § 16 (1971).

ship funds which should be kept available for flexible use by the schools so that they can best meet their varying patterns of need.<sup>73</sup>

The final formulation of the scholarship program in the 1971 Act was again the product of a determination to achieve federal priorities while at the same time remaining responsive to the opinion and needs of the institutions themselves. The present program calls for a three year extension. The formula for determining the grant's amount is that sum equal to \$3,000 times one-tenth the number of full-time students enrolled, or \$3,000 times the number of students enrolled who are from low-income backgrounds (whichever is greater).<sup>74</sup>

The Act also provides a novel scholarship program which bespeaks a dual incentive—both for the individual student and the schools. Special scholarship assistance may now be granted to students who will practice in shortage areas or who will provide care for migrant workers and their families. Such scholarships are paid directly to the student and may not exceed \$5,000 for any full academic year. These scholarships are made on a one-to-one ratio—*i.e.* for each year that a student receives a scholarship there must be one year of the type of service described. Failure to fulfill the obligation demands repayment, with interest, within three years. Cognizant that this repayment clause could tend to be an initial disincentive to students, the Act provides that the Secretary is authorized to forgive repayment in unusual circumstances.<sup>75</sup>

#### *Student Loan Program*

This program is also extended under the new Act for a period of three years. As requested in both the Senate and House recommended bills, the maximum amount of the loan is \$3,500.<sup>76</sup>

A further incentive is provided under the loan cancellation program. The new provisions call for the cancellation or repayment of any program loan or any other loans for professional education if the borrower agrees to serve for at least two years in designated shortage areas (at a rate of 30 per cent for each of the first two years of such service, and 25 per cent for the third voluntary year of service). It further allows the Secretary to repay in whole, or in part, any loan made to a student of the seven disciplines for his professional education, upon a determination by the Secretary that such stu-

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73. *Senate Hearings* 247.

74. 42 U.S.C. § 295g (Supp. 1971).

75. *Id.*

76. 42 U.S.C. § 294a(a) (Supp. 1971). The former ceiling, as previously mentioned, was \$2,500, see note 26 *supra*.



dent who failed to complete studies leading to his first professional degree is from a low-income or disadvantaged background, and has not resumed, or cannot reasonably be expected to resume, his professional studies within two years after termination.<sup>77</sup> Such provisions are specifically designed to alleviate the fears of disadvantaged students that the utilizing of the loan program could place them in serious financial difficulty in the event of their failure to complete their course of study. The disincentive of utilizing such loans is therefore mitigated if not for the most part obliterated.

#### *Administrative Changes*

Under prior law there existed two national advisory councils which were to advise the Secretary on the various aspects of the HPEA programs. The 1971 Act replaces these with a new National Advisory Council consisting of twenty-one members. This Council is to consist of four members from the general public, and two from among full-time professional students. As pointed out by the Honorable Joseph G. Minish, Representative from New Jersey, the Secretary of HEW has the power to make detailed studies of the HPEA programs, but his office has neither the time nor the personnel to devote the full attention and investigation required.<sup>78</sup> Representative Minish also provided a basis for understanding the inclusion of the public on the Council when he testified to the effect that the Council must be free of conflicts in interest in order to best evaluate the federal health programs.<sup>79</sup>

The final provision of the new Act requires the Secretary to prepare and submit a report to Congress by June 30, 1974, on the administration and impact of the amended and novel programs on the health manpower and requirements in the United States.<sup>80</sup> Congress is apparently most intent on keeping close contact with their programs and determining whether the approach chosen for this three year period was any more successful than those of the prior eight years. Many of the prior programs gave the appearance of alleviating the health crisis in the nation, yet in retrospect they are judged as inadequate, piecemeal efforts at remedying a complex, multifaceted problem.

#### *Conclusion*

While no program in and of itself will solve the health shortage crisis in the United States, it is the combination of these innovative efforts which provides the hope of future success toward this goal. Congress attempted to deal with the maldistribution and shortage problems through multiple incentives

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77. 42 U.S.C. § 294a(f) (Supp. 1971).

78. *House Hearings* 445.

79. *Id.*

80. 42 U.S.C. § 242i (Supp. 1971).

directed at all levels of the health care system. Perhaps their greatest foe is the reality of the situation. When a newly trained physician emerges from his institutional environment, the most obvious reaction to be expected is that he will choose to practice in an area that is most advantageous to himself and his family. Backward, disadvantaged rural areas or poverty and crime ridden inner-cities are hardly the type of locale which offer such attractions. Any effort to attract personnel to these areas confronts by necessity many social and psychological factors. Furthermore, the institutions themselves have not for the most part aided in the effort of making such a profession an attraction. Preceptor programs, such as at the Mayo Clinic are few and far between. Executive denial of federal funding of family health practice programs provided a further stumbling block. While ideas on how to solve the crisis are multiple and varied, they will be to no avail unless all forces work in conjunction in a well coordinated effort to make our goals a reality.

One innovative idea which has not been mentioned heretofore is that of Dr. William B. Schwartz, Endicott Professor and Chairman Elect of the Department of Medicine at Tuft's University School of Medicine in Boston, Massachusetts. It involves the very concept spoken of earlier—the extent to which the problem of health manpower shortage in critical areas can be handled provided the various proposals suggested by the Comprehensive Health Manpower Training Act of 1971 are given effect.

Dr. Schwartz emphasized that merely an increase in the number of students will not correct the maldistribution problem. We must create major changes in the health care system based on the exploitation and on a redefinition of the physician's role in the delivery service. His plan calls for the development of physician's assistants and so-called categorical technicians trained for multiple roles. Medical schools would be called on to make studies to determine what tasks now performed by doctors could be transferred to nonphysicians. Utilization of this medex type of individual would demand a change of strategy and the development of the appropriate computer software and the timesharing capability so that we can, in effect, replace, for this individual, several years of education by placing the expertise in the computer, thus affording more time for the individual to devote to his efforts in the field. There would be a complete interaction between the individual and the computer. Individuals would be chosen for their humane qualities as well as their intellectual capacity. He surmises that three years would be a sufficient training period, thus opening the door to tens of thousands who otherwise might not have the opportunity for a medical education.

He would abandon the concept of dispersing physicians into small towns and ghettos, for he feels, based on the experience of years, that such is per-

haps not an achievable goal. He would replace this with the concept of computer-aided physician's surrogates delivering high quality primary care by virtue of supervision of physicians based in regional centers—thus utilizing the Carnegie Commission's concept of 126 health education centers located no more than one hour's drive from the population each serves. There would be one physician to moderate every ten allied health specialists or primary health care specialists.

The plan in effect proffers the tableau of a health education center containing a group of primary care specialists and physicians who would make a circuit each week spending a half-day at each of their ten primary care associate offices which would contain computers linked to the central computer at the center. These centers would also contain specialists for the more serious or complex cases.<sup>81</sup>

Many of the features which have been disincentives to shortage area practice would be obliterated. Such a center, containing the number, quality and variety of health personnel would provide a stimulating environment, extremely attractive to many members of the health profession. The base city would possibly not be comparable to our suburban areas, yet it need not be in the depths of the poverty belt. A man or woman taking the initial step into his new profession would be less concerned about his ability to cope with problems. Fully-trained, qualified personnel and the omnipresent computer would be there as consoling overseers.

The depth of this imaginative scheme is unlimited. Yet, it can succumb to the same fate as did many other innovative concepts. If, however, the priorities present in the 1971 Act are given life by the joint effort of many factions, plans such as that of Dr. Schwartz or any other proposals which have the potential to heal our present plight can come to fruition.

The congressional efforts in the abstract are perhaps the most responsive legislation to date. The thoroughness and precision with which the 92d Congress attacked the shortage problem is most laudible. The programs in the Act are admittedly not the final answer but rather a "crucial first step toward providing comprehensive services for all Americans." This legislation, while perhaps not a panacea, is assuredly a definite and most needed curative catalyst in our present medical equation. Nevertheless, lack of institutional response to the programs, or legislative inattention to their development and success vel non would render this Act nothing more than a sugar-coated pill providing psychological security for the masses without really curing the malady pervading the system.

*Brian J. Nash*

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81. *Senate Hearings* 525-28.