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THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT OF 1976: A NEW PRESCRIPTION?

I. Introduction

The 1976 Health Professions Educational Assistance Act (1976 Act),¹ is a new congressional effort to promote the rational development, distribution and utilization of the health professions² through financial incentives. The 1976 Act continues the federal government's extensive involvement in the education of the nation's health manpower initiated by the 1971 Comprehensive Health Manpower Training Act (CHMTA).³ Moreover, it expands and amends the National Health Service Corps (NHSC)⁴ and its scholarship program,⁵ in an attempt to provide an adequate supply of health professionals to inner-city and rural areas.

The 1976 legislation emerged after three years of extensive debate and stalemate among the House of Representatives, the Senate, and the administration.⁶ It represents a compromise solution to the issues affecting the quality, quantity and distribution of health manpower. The congressional committees responsible for health manpower legislation⁷ identified four major problems:⁸ (1) the shortage

1. Act of Oct. 12, 1976, Pub. L. No. 94-484, §§ 1-906, 90 Stat. 2243 [hereinafter cited as 1976 Act].

2. The term health professionals, as used in this Comment, includes physicians (medical doctors and osteopaths), dentists, optometrists, podiatrists, pharmacists, public health administrators, and veterinarians. Following the approach of the congressional committees, this discussion will focus on physicians and dentists, the most important providers of health care.

3. 42 U.S.C. §§ 292-95 (Supp. V, 1975), *amending* 42 U.S.C. §§ 292-95 (1970) [hereinafter cited as CHMTA]. CHMTA expired on June 30, 1974. Funding for some of its programs continued under a continuing resolution. Act of Aug. 23, 1974, Pub. L. No. 93-385, § 101, 88 Stat. 741. The new statute extends funding for CHMTA programs to September 30, 1977. Pub. L. No. 94-484, § 101, 90 Stat. 2244 (1976).

4. 42 U.S.C. § 254b (Supp. V, 1975).

5. *Id.* § 234.

6. In 1974 both the House and Senate passed health manpower bills. H.R. 17084, 93d Cong., 2d Sess. (1974); S. 3585, 93d Cong., 2d Sess. (1974). However, Congress failed to enact a law because of the inability of a House-Senate conference to resolve differences between the two bills. On July 11, 1975, the House passed H.R. 5546. 121 CONG. REC. 6659 (daily ed. July 11, 1975). In 1976 the Senate passed H.R. 5546 as amended. 122 CONG. REC. 11276 (daily ed. July 1, 1976). The House Conference Report No. 94-1612 was adopted by the House on September 27, 1976 and by the Senate on September 30, 1976.

7. The House Subcommittee on Public Health and Environment, of the Committee on Interstate and Foreign Commerce, held hearings on health manpower problems. The Com-

of health professionals; (2) the geographic maldistribution of health manpower; (3) the specialty maldistribution of physicians and dentists; and (4) the influx of foreign medical graduates into the United States. This Comment will examine the effectiveness of past legislative responses to these issues and consider the provisions of the new law that attempt to resolve them.

II. The Shortage of Health Professionals

In 1970 the Carnegie Commission⁹ reported that the United States faced a severe shortage of competent health professionals and that health profession schools lacked the financial resources to expand their training capacity. The report recommended that the federal government increase significantly its contribution to the capital and operating costs of these schools.¹⁰ Most of the Commission's recommendations were adopted by Congress in 1971 and are contained in CHMTA.¹¹

CHMTA provided health profession schools financial aid in the form of construction assistance,¹² financial distress grants,¹³ start-up grants,¹⁴ health manpower initiative awards,¹⁵ special project grants,¹⁶ loan guarantees and interest subsidies to nonprofit private institutions.¹⁷ In order to insure that these schools would have pre-

mittee report is contained in H.R. REP. NO. 266, 94th Cong., 1st Sess. (1975) [hereinafter cited as H.R. REP. NO. 266]. The Senate Subcommittee on Health, of the Committee on Labor and Public Welfare issued the report contained in S. REP. NO. 887, 94th Cong., 2d Sess. (1976) [hereinafter cited as S. REP. NO. 887].

8. H. R. REP. NO. 266, at 11-59; [S. Rep. No. 887, at 34-91.

9. CARNEGIE COMMISSION ON HIGHER EDUCATION, HIGHER EDUCATION AND THE NATION'S HEALTH (1970) [hereinafter cited as NATION'S HEALTH]. In 1970, the estimated shortage of physicians alone was 50,000. *Id.* at 18.

10. *Id.* at 61-79.

11. For a discussion of the legislative history and principal provisions of CHMTA, see *The Comprehensive Health Manpower Act of 1971: Panacea or Placebo?* 22 CATH. U. L. REV. 829 (1973).

12. CHMTA authorized appropriations of 750 million dollars for construction assistance for fiscal years 1972 through 1974. 42 U.S.C. § 293 (Supp. V, 1975). The grants could be utilized to cover 80 percent of the cost for new schools, and for major expansion of existing schools. *Id.* § 293b(a)(1).

13. *Id.* § 295f-3.

14. *Id.* § 295f-1.

15. CHMTA appropriated 270 million dollars for grants to improve the distribution, supply, quality, utilization and efficiency of health personnel and health delivery systems. *Id.* §§ 294f-4(a)(1), 294f-4(e).

16. *Id.* § 295f-2.

17. *Id.* § 293i.

dictable financial resources of sufficient magnitude to expand enrollment, the statute authorized capitation grants¹⁸ to schools that agreed to increase their student population. These grants, which provided a fixed dollar amount per student annually, were intended to provide operational support. The schools were only required to use the money to support quality education.¹⁹

In reviewing the results of the CHMTA, Congress,²⁰ the administration,²¹ and the medical community²² agreed that the statute had provided financial stability to health professions schools and helped to increase the number of graduates. Since the enactment of CHMTA, fewer schools have required financial distress grants.²³ Six medical schools, two osteopathic schools, and seven dental schools received start-up grants in the 1972-75 period.²⁴ Medical schools increased their training capacity by adding 6,953 first year places and 5,933 hospital beds.²⁵ The size of medical school entering classes has increased from 11,348 in 1970-71 to 15,351 in 1975-76.²⁶ The output of graduates increased from 8,974 in 1970-71 to 13,561 in 1975-76.²⁷

The congressional committees considering the proposed bills debated extensively whether an increase in the aggregated number of health professionals was needed. The administration viewed existing and projected enrollment as adequate, citing maldistribution as

18. CHMTA authorized the appropriation of 763 million dollars for capitation grants for fiscal years 1972 through 1974. It provided different levels of capitation support for such type of school. Schools of medicine, osteopathy, and dentistry received \$2,500 per student. Schools of veterinary medicine received \$1,750 per student. Schools of pharmacy, optometry, and podiatry received \$800 per full-time student. Bonus payments were authorized for increasing enrollment above specified levels. *Id.* §§ 295f(a)(2)-(6).

To be eligible for grants each school must: (1) increase enrollment by 10 percent over 1971 enrollment (if enrollment was less than one hundred) or by 5 percent or ten students (if the enrollment was greater than one hundred); (2) maintain non-federal financial support; and (3) establish three programs designed to improve health care delivery. *Id.* §§ 295f(f)-(g).

19. *Id.* § 295f(a).

20. H.R. REP. NO. 266, *supra* note 7, at 14-16.

21. Letter from David Mathews, Secretary of HEW, to Nelson Rockefeller, President of the Senate, Nov. 21, 1975, reprinted in S. REP. NO. 887, *supra* note 7, at 92-97.

22. Stimmel, *The Congress and Health Manpower: A Legislative Morass*, 293 NEW ENGLAND J. MED. 68 (1972).

23. H.R. REP. NO. 266, *supra* note 7, at 14.

24. S. REP. NO. 887, *supra* note 7, at 24.

25. *Id.* at 23.

26. 236 J.A.M.A. 2961 (1976).

27. *Id.*

the reason for the unavailability of health care in rural and inner city areas.²⁸

In a report issued in September 1976, the Carnegie Council on Policy Studies for Higher Education²⁹ concurred with the administration's viewpoint. According to the Council, the shortage of physicians has been reduced since 1970.³⁰ The Council further said that only one of the thirteen medical schools presently planned is necessary.³¹ It also recommended that the federal government provide bonuses to schools that increase enrollment rather than conditioning capitation grants on increased enrollment.³² The Department of Health, Education, and Welfare (HEW) estimates physician requirements in 1980 will be between 400,000 and 450,000.³³ This compares with a supply projection of between 435,000 and 450,000.³⁴

The House Committee on Interstate and Foreign Commerce rejected the administration's position that current enrollment levels in health professions schools are sufficient to meet projected manpower needs. It questioned the validity of certain HEW assumptions with respect to the influx of foreign medical graduates and the impact of national health insurance on the demand for health professionals.³⁵ The American Medical Association (AMA), in comment-

28. See *Hearings on H.R. 2956, H.R. 1957, H.R. 2958, and H.R. 3279 (and all identical and similar bills) Before the Subcomm. on Health and Environment of the House Comm. on Interstate and Foreign Commerce, 94th Cong., 1st Sess. 308-12* [hereinafter cited as *1975 Hearings*].

29. THE CARNEGIE COUNCIL ON POLICY STUDIES IN HIGHER EDUCATION, *PROGRESS AND PROBLEMS IN MEDICAL AND DENTAL EDUCATION* (1976) [hereinafter cited as *PROGRESS AND PROBLEMS*].

30. *Id.* at 23-24.

31. *Id.* at 88-90. The report warns:

We are in serious danger of developing too many new medical schools, and decisive steps need to be taken by both federal and state governments to stop this trend.

We recommend only one new medical school in a community that now has no existing or developing school—Wilmington, Delaware.

Id. at 3. The Council concluded that one new dental school is required at this time and another may be necessary in the future. *Id.* at 93. The Council took the position that the growing demand for dental care could be met by the existing training capacity and the increasing productivity of dentists. *Id.* at 43-44.

32. *Id.* at 53.

33. *1975 Hearings, supra* note 28, at 311-12.

34. *Id.*

35. H.R. REP. NO. 266, *supra* note 7, at 19. H.R. 5546 as passed by the House would have continued the existing construction authority through 1978. H.R. 5546, 94th Cong., 1st Sess. § 301 (1975).

ing on the recent Carnegie report, agreed with the House Committee's position.³⁶ The Senate Committee on Labor and Public Welfare recommended that assistance be continued only for the construction of ambulatory primary care facilities used for the training of physicians and dentists.³⁷

The new law declares that "there is no longer an insufficient number of physicians and surgeons in the United States such that there is no further need for affording preference to alien physicians and surgeons" for immigration purposes.³⁸ CHMTA construction assistance programs are continued through fiscal 1980 with amendments.³⁹ Assistance is provided for the construction of ambulatory primary care teaching facilities. There is a stipulation that 50 percent of all funds appropriated must be allocated to the construction of the ambulatory teaching facilities.⁴⁰

In recognition of the dispute regarding the need for new health professions schools, the new statute authorizes total appropriation of 120 million dollars over a three year period, beginning in fiscal year 1978.⁴¹ This contrasts sharply with the authorized appropriation of 103 million dollars in fiscal year 1977.⁴² Moreover, the 1976 Act retains the increased enrollment requirement for capitation grants only for schools of dentistry, public health, veterinary medicine, optometry, and podiatry.⁴³ The argument that there is an impending surplus of health professionals, and that there is no need for any increase in medical training capacity, is based on the rising physician-population ratio. HEW projects a physician-population ratio between 207 and 217 per 100,000 in 1985 without any further increase in training capacity.⁴⁴ HEW argues that this ratio is sufficient to meet national needs based on past and present ratios and on the ratios in other developed countries.⁴⁵ The recent Carnegie

36. The Wall Street Journal, Sept. 3, 1976, at 4, col. 2.

37. S. REP. No. 887, *supra* note 7, at 192.

38. Pub. L. No. 94-484, § 2(c), 90 Stat. 2243 (1976).

39. *Id.* §§ 301-08, 90 Stat. 2253.

40. *Id.* § 302(b).

41. *Id.*

42. *Id.* § 101(c), 90 Stat. 2244.

43. *Id.* § 502, 90 Stat. 2293.

44. 1975 Hearings, *supra* note 28, at 311.

45. *Id.* at 311-12.

Council Report warns that only one of the thirteen presently planned medical schools is required for the following reasons:⁴⁶

(1) the increase in medical-school entrants and graduates was even more pronounced in the first half of the 1970s than had been predicted and will continue to be substantial for a number of years without the contributions of schools that have not yet enrolled any students; (2) it is a virtual certainty that the physician-population ratio will reach unprecedented levels by 1985, even if the net inflow of FMGs [foreign medical graduates] is drastically curtailed; (3) the cost of establishing a new medical school is exceedingly high; and (4) communities that lack a medical school can, in most cases, be served more effectively and at much more modest cost by an area health education center than by a full-fledged medical school.

There is considerable controversy over what constitutes a desirable physician-population ratio and over the ratio's significance as an adequate measure of either the quality of medical care available or the degree of service.⁴⁷ In declaring a shortage of physicians in 1970, the Carnegie Commission cited the following factors: "(1) exceedingly high average incomes of physicians relative to those in most other professions, (2) long waiting lines for emergency services in hospital outpatient clinics, (3) the very long work week of the typical physician (with a median work week of 60 hours reported in 1968), and (4) the rising influx of foreign medical graduates (FMGs)."⁴⁸ The Carnegie Council's 1976 recommendations against the construction of more medical schools did not indicate any change in these circumstances.

The report stated:⁴⁹

A surplus of physicians is not, in fact, easy to define. There is no precise way of determining the optimum physician-population ratio, and the adequacy of any given ratio, can be adversely affected by forces (for example, the adoption of national health insurance) leading to an increase in demand, or favorably affected by other forces (for example, an increase in the supply of physicians' assistants) leading to an increase in the productivity of physicians.

The report did not conclude that there is an impending surplus of

46. PROGRESS AND PROBLEMS, *supra* note 29, at 90-92.

47. Stimmel, *supra* note 22, at 70.

48. PROGRESS AND PROBLEMS, *supra* note 29, at 22.

49. *Id.* at 32.

physicians. Moreover, it acknowledged that a "surplus" would result in some benefits:⁵⁰

A surplus of physicians would probably not manifest itself in unemployment among highly trained professionals, but rather in some decline in their average incomes relative to the incomes of those in other professions and a decline in their average hours of work, both of which are exceedingly high.

Additionally, it stated that an increase in the aggregate supply of physicians would probably ease shortages in underserved areas.⁵¹

It does not appear that the construction assistance provided by the 1976 Act will expand significantly the national health manpower training capacity. While it provides 120 million dollars over a three year period,⁵² the present cost of a new medical school is approximately 100 million dollars.⁵³ Arguably, the monetary authorization should not have been reduced in view of the benefits that would result from an increased physician-population ratio. Other factors support this position. Inflation is rapidly increasing the cost of building new schools. Many qualified students are forced to seek medical education abroad.⁵⁴ Any surplus of health professionals that eventually may emerge could be utilized to accomplish a goal recommended by the 1970 Carnegie Report: "The United States should become a net exporter of medical manpower, as part of the effort to raise the quality of medical education and medical care in underdeveloped countries."⁵⁵ Currently, physicians migrating to the United States each year "represent about one quarter of the annual output of all the medical schools of the world outside of the United States, the People's Republic of China, the U.S.S.R. and the Socialist countries of Eastern Europe."⁵⁶

50. *Id.* at 33. The report acknowledged that "the probability of a decline in the relative income of physicians under conditions of rapidly increasing supply is disputed by experts." *Id.* at 33 n.8. The experts argue that physician's income will not decline because physicians tend to have considerable control over the price and quantity of services they provide. See 1975 Hearings, *supra* note 28, at 312.

51. PROGRESS AND PROBLEMS, *supra* note 29, at 34.

52. Pub. L. No. 94-484, § 302, 90 Stat. 2253 (1976).

53. PROGRESS AND PROBLEMS, *supra* note 29, at 92. It should be noted that the construction of medical and other health profession schools are funded by the Veterans Administration Medical School Assistance and Health Manpower Training Act, 38 U.S.C. §§ 5070-74 (Supp. V, 1975).

54. PROGRESS AND PROBLEMS, *supra* note 29, at 34.

55. NATION'S HEALTH, *supra* note 9, at 36.

56. Coordinating Council on Medical Education, *Physician Manpower and Distribution*, 236 J.A.M.A. 3049 (1976).

III. The Geographic Maldistribution of Health Manpower

There has long existed a serious maldistribution of physicians and other health professionals. The Northeast and Western regions of the nation have much larger per capita supplies of health manpower than the Midwestern and Southern regions.⁵⁷ Moreover, the physician-population ratios in doctor-rich states are growing faster than in doctor-poor states.⁵⁸

Throughout the nation, including the manpower rich Northeastern and Western regions, rural and inner-city areas have significantly smaller per capita supplies of health manpower than suburban areas. In recent years, rural countries have experienced both an actual loss of physicians and decline in the physician-population ratio.⁵⁹ Although difficult to document statistically, it is generally agreed that poverty stricken areas of large cities have severe shortages of health professionals.

A study⁶⁰ of the Chicago metropolitan area illustrates the growing tendency of physicians to locate in the suburbs. Many reasons have been advanced to explain why physicians and other health professionals choose to practice in rural or inner city areas. The House Committee on Interstate and Foreign Commerce pinpointed three major factors:⁶¹ financial remuneration; life-style preferences; and the medical training environment. A recent study observed:⁶²

[T]he tendency of physicians to concentrate [in urban areas and generally in centers of knowledge and activity is natural. . . . They stay close to centers of activity not only because of the higher income they receive there, but also because of the benefits of professional interaction and the fear of obsolescence, because of the opportunities for continuing education and growth, and the accessibility of research and modern facilities and equipment. Also the availability of non-professional amenities—opportunities for recreation, education for children, cultural activities and so on—play a role.

57. S. REP. NO. 887, *supra* note 7, at 36.

58. *Id.* at 38-39.

59. PROGRESS AND PROBLEMS, *supra* note 29, at 37.

60. D. DEWEY, WHERE HAVE THE DOCTORS GONE (1973). In 1973 the suburban areas of Chicago had 123 physicians per 100,000 population compared with seventy-five for the inner-city area, not including the Loop. The ratio in the inner-city area had been 111 per 100,000 in 1950. PROGRESS AND PROBLEMS *supra* note 29, at 37 n.1, citing D. DEWEY, WHERE HAVE THE DOCTORS GONE (1973).

61. H. REP. NO. 266, *supra* note 7, at 25-26.

62. C. STEWART AND M. CORAZON, INCREASING THE SUPPLY OF MEDICAL PERSONNEL (1973), quoted in S. REP. NO. 887, *supra* note 7, at 46.

According to another study, the change in the economic status of the patient population was the single most important factor in relocation of physicians.⁶³

The federal government's first major effect to alleviate the geographic maldistribution problem was the establishment of the NHSC within the Public Health Service.⁶⁴ The purpose of the NHSC is to recruit and place health professionals in critical shortage areas.⁶⁵ Scholarships were provided for students who agreed to serve in such areas on completion of their education.⁶⁶

The Secretary of HEW has the power to designate critical shortage areas.⁶⁷ In order to qualify as a critical shortage area, an urban area must satisfy the following specific criteria:⁶⁸ (1) a primary care physician-population ratio of less than 1 to 4,000; (2) no neighborhood health center; (3) no organized hospital outpatient department within ten miles of the center of the area; and (4) a primary care physician-population ratio of less than 1 to 3,000 within the entire county in which the shortage is located.

CHMTA sought to alleviate the geographic maldistribution of health professionals by providing financial assistance to students who agreed to practice their profession in medically underserved areas. It authorized the partial cancellation of the obligation to repay for education loans if the borrower agreed to serve at least two years in an underserved area.⁶⁹ CHMTA also authorized special scholarship assistance to medical students who agreed to engage in the practice of primary care in underserved areas or to provide pri-

63. PROGRESS AND PROBLEMS, *supra* note 29, at 37 n.11.

64. 42 U.S.C. § 254b (Supp. V, 1975), amending 42 U.S.C. § 254b (1970).

65. *Id.* § 254b(a).

66. *Id.* § 234. Each participating student is obligated to serve not less than one year for each academic year of scholarship support on active duty as a commissioned officer or civilian member of the NHSC. At least half the period of service must be served in an area designated as having a critical shortage of health manpower or in other specified federal programs. *Id.* § 234(e).

67. *Id.* § 254b(1).

68. 40 Fed. Reg. 8156 (1975).

69. Thirty percent of the loan would be cancelled for each of the first two years of such service and 20 percent for a third year of service. Students of health profession schools are eligible to receive loans not exceeding \$3,500 for each academic year. The loans are repayable over a ten year period beginning one year after completion of training. A borrower who fails to fulfill the agreement is liable to reimburse the Secretary of HEW for any payments made on his behalf. 42 U.S.C. § 294a(a)-(f) (Supp. V, 1975).

mary care for migrant families.⁷⁰

In order to encourage educational institutions to serve shortage areas more effectively, CHMTA authorized special project grants⁷¹ and health manpower education initiative awards (HMEIA)⁷² to those schools which established special programs. Under the HMEIA program, Congress established Area Health Education Centers (AHECs)⁷³ to provide clinical training programs for health professionals in underserved areas. Their purpose is both to improve the quality of health care available to residents and to train local personnel in the health professions. Hopefully, the individuals would remain in the area after the completion of training.

These programs have had very limited success in resolving the maldistribution problem. A study of prior loan forgiveness programs for medical students, conducted by the Congressional Accounting Office,⁷⁴ found that less than 1 percent of students eligible for forgiveness chose to participate in the program. Moreover, due to the amount of funds appropriated, the impact on rural areas was minimal.⁷⁵ While the eleven AHEC centers have had some success in training area residents in rural shortage areas, no center has been established in inner-city areas.⁷⁶ The effectiveness of the NHSC program has been severely restricted by the definition of critical manpower shortage areas. The Senate Committee on Labor and Public Welfare report recognized that:⁷⁷

Under the existing definition, many urban neighborhoods which undoubtedly have a shortage of health manpower are unable to qualify for health manpower assistance. Most urban neighborhoods are located within a reasonable

70. The scholarships were paid directly to the student and the maximum limit was \$5,000. For each year of scholarship assistance, the student was obligated to serve for one year. Failure to fulfill this obligation resulted in the borrower being liable to HEW for the amount of assistance received and interest, payable within three years. Priority was given to students with low income backgrounds who resided in underserved areas. *Id.* § 295g-21.

71. *Id.* § 295f-2.

72. *Id.* § 295f-4.

73. The report recommended the development of 126 AHECs. NATION'S HEALTH, *supra* note 9, at 59.

74. S. REP. NO. 877, *supra* note 7, at 47.

75. In 1975, 1,128 communities were designated as eligible to be classified as medically underserved areas. Of this group, 445 were approved by HEW. PROGRESS AND PROBLEMS, *supra* note 29, at 77.

76. H.R. REP. NO. 266, *supra* note 7, at 38.

77. S. REP. NO. 877, *supra* note 7, at 196.

distance of a medical facility. Unfortunately, these medical facilities, which include some of the Nation's great medical centers, are often oriented toward the provision of subspecialty services for populations residing in a region, rather than the provision of primary care to residents of the immediate area.

The new legislation seeks to alleviate the geographic maldistribution of health manpower by amending the student loan program, expanding the NHSC and its scholarship program, changing capitation grant requirements, and enlarging the AHEC program.

A. Student Assistance

The 1976 Act amends the direct federal loan program for students in health profession schools for the fiscal years 1978-80.⁷⁸ It increases the maximum annual amount from the present limit of \$3,500 to the cost of tuition plus \$2,500, and changes the interest on such loans from three percent to seven percent.⁷⁹ It retains the existing provision authorizing the Secretary of HEW to repay the loan according to a prescribed schedule if the student agrees with HEW to practice his profession in a medically underserved area.⁸⁰ The statute also establishes a new program authorizing HEW to insure private loans to students in health professions.⁸¹ The insured loan may not exceed \$10,000 annually (\$7,500 for pharmacy students) and the Secretary of HEW may assume repayment of the loan under an agreement similar to that authorized for direct loans.⁸²

The statute also initiates a new scholarship program for exceptionally needy first year students at health profession schools.⁸³ It abolishes the general scholarship program,⁸⁴ and authorizes at least ten scholarships a year (known as Lester Hill Scholarships) to students who agree to enter family medicine practice in medically underserved areas.⁸⁵

Programs which have relied on financial incentives to influence

78. Pub. L. No. 94-484, §§ 402-06, 90 Stat. 2266 (1976).

79. *Id.* §§ 402-03.

80. See note 69 *supra* and accompanying text.

81. Pub. L. No. 94-484, § 401(b), 90 Stat. 2257 (1976). To be an eligible lender under this program, schools must be eligible for capitation grants. *Id.*

82. *Id.* HEW may repay up to \$10,000 for each year a student fulfills the agreement.

83. *Id.* § 408(a), 90 Stat. 2279. The statute gives priority to medical, osteopathic, and dental students and limits the amount of scholarship to the cost of tuition, and other educational expenses, plus a stipend of \$4,800 annually. There is no service requirement. *Id.*

84. *Id.* § 409(a), 90 Stat. 2290.

85. *Id.* § 408(a), 90 Stat. 2289.

physician location have not been very successful. In state loan forgiveness programs, nearly 45 percent of physician participants chose to either buy out or default on their practice commitments.⁸⁶ Federal programs have had a similar history.⁸⁷ There is nothing in the new programs to indicate that they will be more successful.

Loan forgiveness programs are based on the hypothesis that physicians tend to locate their practice in urban areas (but not inner-city areas) rather than rural areas because of the greater income potential in urban areas. A recent study concludes that there is little empirical evidence which focuses directly on this issue and that existing evidence is contradictory.⁸⁸ Another study⁸⁹ found that financial considerations ranked seventh⁹⁰ as a motivating factor in influencing the practice location choice of physicians.

B. The National Health Service Corps

Many legislators consider the NHSC program, coupled with its scholarship program, as the most effective mechanism for solving the geographic maldistribution problem.⁹¹ The 1976 Act enlarges and amends both programs to achieve greater impact on the nation's health manpower shortage areas (HMSAs). The new law defines an HMSA to mean:⁹²

- (A) An area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a health manpower shortage, (B) a population group which the Secretary determines has such a shortage, or (C) a public or nonprofit private medical facility or other public facility which the Secretary determines has a shortage.

The new law also specifies the criteria which must be considered in

86. PROGRESS AND PROBLEMS, *supra* note 29, at 81.

87. H.R. REP. NO. 266, *supra* note 7, at 22-24.

88. Eisenberg and Cantwell, *Policies to Influence the Spatial Distribution of Physicians: A Conceptual Review of Selected Programs and Empirical Evidence*, 14 MED. CARE 455, 464 (1976).

89. Schwartz and Cantwell, *Weiskotten Survey, Class of 1960: A Profile of Physician Location and Specialty Choice*, 51 J. MED. EDUC. 533 (1976).

90. Motivating factors were ranked in the following order: (1) best opening; (2) family and friends; (3) military service; (4) modern facilities; (5) geographic and climatic; (6) cultural and educational; (7) financial advantages; (8) internship and residency location; (9) grew up in area; and (10) medical school. *Id.* at 537.

91. H.R. REP. NO. 266, *supra* note 7, at 29.

92. Pub. L. No. 94-484, § 407(b), 90 Stat. 2268 (1976).

the designation of HMSAs. These include “[i]ndicators of a need, notwithstanding the supply of health manpower, for health services for the individuals in an area, or population group, served by a medical facility . . . with special consideration to indicators of (A) infant mortality, (B) access to health services, and (C) health status.”⁹³ Under the new criteria, mental institutions, prisons and urban hospitals serving the needy may be designated as HMSAs and therefore can be assigned health professionals.⁹⁴

The 1976 Act has substantially increased the authorized funding for the NHSC.⁹⁵ This will enable the NHSC to aid the increasing number of communities that will be eligible for assistance. In 1975, 1,128 communities were designated as eligible and 445 were approved.⁹⁶ To make NHSC more attractive to participants, the new legislation authorizes monthly bonuses to health professionals serving in health manpower shortage areas as members of NHSC.⁹⁷

NHSC’s recruitment program will be strengthened by the amended NHSC scholarship provisions. Authorized appropriations have been increased from forty million dollars in 1977 to seventy-five million dollars in 1978, to 140 million dollars in 1979, and to two hundred million dollars in 1980.⁹⁸ The minimum service obligation has been increased from one year to two years.⁹⁹ Moreover, students who default on their service requirement are required to repay the federal government three times the amount of their scholarship support plus interest within one year from the breach of the contract.¹⁰⁰

The 1976 Carnegie Council report suggested that increasing the minimum service obligation and the default penalty might deter students from accepting scholarships.¹⁰¹ However, the increasing

93. *Id.* (emphasis added).

94. S. REP. No. 887, *supra* note 7, at 196.

95. The statute authorized the appropriation of 151 million dollars in fiscal years 1978 through 1980. Pub. L. No. 94-484, § 407(b), 90 Stat. 2268 (1976).

96. PROGRESS AND PROBLEMS, *supra* note 29, at 77.

97. Pub. L. No. 94-484, § 407(b), 90 Stat. 2268 (1976).

98. *Id.* § 408(b), 90 Stat. 2281.

99. *Id.*

100. *Id.* Under the new law, a defaulting student would be obliged to repay the federal government approximately \$150,000 (assuming four years of scholarship support) plus interest within one year. Under this loan forgiveness program, there is a ten year repayment period. 42 U.S.C. § 294a(c) (Supp. V, 1975). Considering that the maximum loan is \$40,000, this constitutes a much smaller repayment burden and in most cases will not represent a sizable portion of salary.

101. PROGRESS AND PROBLEMS, *supra* note 29, at 82.

costs of attending health professions schools should lessen this reaction. In addition, the service obligation under the new law is now more flexible. The Secretary of HEW may release an individual from service in the NHSC on the basis of a written agreement to enter private practice in a manpower shortage area.¹⁰²

In recent years, the percentage of physicians electing to continue their NHSC service beyond their initial obligation has increased.¹⁰³ The 1976 Act seeks to encourage NHSC members, who have completed their obligation, to remain in the area they have served. It does so by providing grants to assist such individuals in establishing a private practice in the area.¹⁰⁴ If this program is successful, underserved areas will have an adequate and stable supply of experienced health professionals.¹⁰⁵

C. Requirements for Capitation Support

The 1976 Act requires schools of optometry, podiatry and veterinary medicine to reserve a percentage of their first year places for students from states which do not have any such schools.¹⁰⁶ Dental and osteopathic schools are required to establish a six week clinical training program in areas geographically remote from the main site of the school's teaching facility or in a health manpower shortage area in order to retain eligibility for capitation grants.¹⁰⁷ The statute does not define the term "geographically remote." The House Committee stated that it:¹⁰⁸

102. Pub. L. No. 94-484, § 408(b), 90 Stat. 2281 (1976). The individual must agree to charge the prevailing fees for services in the area, provide services at reduced fees or no fees for such persons unable to pay the prevailing charges, and not to discriminate against medicare and medicaid recipients. *Id.*

103. PROGRESS AND PROBLEMS, *supra* note 29, at 75-76.

104. Pub. L. No. 94-484, § 408(b), 90 Stat. 2281 (1976).

105. The House-Senate conferences refused to include in the final legislation a provision of S.3239 which would have required schools to reserve an increasing percentage of their first year places for NHSC scholarship students in order to continue to receive capitation grants. S.3239, 94th Cong., 2d Sess. §§ 802-03 (1976). Before imposing the quotas on individual schools, the bill provided an opportunity for schools to meet the required goals on a national basis. *Id.* One objection to the concept of a quota for NHSC students is that it would interfere with normal admissions policy based on the quality of applicants. Stimmel, *supra* note 22, at 70.

106. Pub. L. No. 94-484, § 502, 90 Stat. 2293 (1976).

107. *Id.* See text accompanying notes 18-19 *supra*.

108. H.R. REP. No. 266, *supra* note 7, at 33.

intentionally did not define the term "remote site" in the legislation in order to allow schools flexibility to select remote sites based on the geographical characteristics of the areas in which schools are located and the special needs of those areas. The committee would expect that the remote training site would, to the maximum extent feasible, be conducted in rural or urban areas in which medically underserved populations reside in order to provide students with exposure to the needs of such populations.

Because of the ambiguity concerning the meaning of "geographically remote," it is unclear how the provision will benefit inner-city populations who live close to large medical schools. Presently, the students of urban medical schools usually participate in clinical programs operated by affiliated hospitals for nearby residents who do not have any other access to medical care. Despite the expectations expressed by the House Committee, such programs apparently would not meet the geographically remote requirement. The committee report states "if a medical school is located in an area in which a medically underserved population resides, a continuation of hospital-based clinical training by that school would not satisfy the requirement."¹⁰⁹

The remote training site concept has had some success in alleviating the shortage of health professionals in rural areas.¹¹⁰ There is little evidence, however, that current clinical programs in urban areas have influenced participants to locate their practices in inner-city areas. It might be argued that exposure to the harsh realities of ghetto practice only strengthens the resolve of students not to practice there.

The 1976 Act omits a controversial provision contained in H.R. 5546. This provision would have required that all health profession schools, in order to be eligible for capitation grants, enter into a legally enforceable agreement with each student¹¹¹ wherein, the student would promise to repay the federal government the amount the school received in capitation support for his education. The bill provided that the federal government would waive the payment of one annual installment if the student serves for one year in the NHSC or as a private practitioner in an area with a designated underserved population.¹¹² The experience with loan forgiveness pro-

109. *Id.* at 29.

110. *Id.* at 31-34.

111. H.R. 5546, 94th Cong., 2d Sess. § 802 (1975).

112. *Id.*

grams suggests that this provision would have had only a minor effect on geographic maldistribution of health professionals.

The payback provision of H.R. 5546 was the subject of much controversy.¹¹³ The House Committee recommended the provision as a counter-argument to the administration's position that capitation grants should be eliminated because the high earning potential of health professionals allows them to finance a greater share of their education costs.¹¹⁴ In the committee's opinion, withdrawal of capitation support would necessitate increased tuition. This would increase the financial burden on students when they are least able to bear it and would deny educational opportunities to the poor. Repayment of the capitation grant after the recipient had started to practice seemed preferable. The House Committee also viewed the payback provision as recognition that health professions schools receive more direct federal aid than other schools.¹¹⁵ Finally, the forgiveness provision would encourage health professionals to locate their practices in critical shortage areas.¹¹⁶

Opponents of the backpay provision raised legal and policy arguments against it. Among the legal objections were force and duress in obtaining a contract, failure of consideration, absence of privity, governmental interference with the right of an individual to pursue a legitimate profession, and the unconstitutional imposition of a tax on a specific type of citizen.¹¹⁷ In the opinion of the Congressional Research Service,¹¹⁸ such a contract is enforceable by the federal government as a third party beneficiary, since there is freedom of contract and valid consideration.

Congressional opponents to the payback provision also argued that its adoption would be contrary to sound public policy. Since all health profession schools have altered their financial structures in reliance on capitation grants, they would be obliged to demand that all applicants execute a payback contract. Therefore, all stu-

113. H.R. REP. NO. 266, *supra* note 7, at 21-22.

114. *Id.*

115. *Id.*

116. *Id.*

117. *See generally* 121 CONG. REC. H6605 (daily ed. July 11, 1975).

118. *Id.* at H6615-16. Furthermore, the service concluded that the provision was constitutional since the government may attach reasonable conditions on its grants of financial assistance. *Id.*

dents seeking a medical education in the United States would have no alternative but to sign the contract. Opponents argued that the provision is unfair because the student did not have any voice in the school's decision with respect to enlarging its enrollment or applying for the grant.¹¹⁹

Representative David Satterfield criticized the payback provision as unnecessary because pending legislation would be sufficient to alleviate the maldistribution problem.¹²⁰ Moreover, he contended that it would create a dangerous precedent since the government provides financial assistance in many career fields.¹²¹ Others argued that the requirement would be counterproductive since the capitation repayment would increase the already burdensome financial obligations of new graduates. Thus it would increase the pressure on the graduate to develop a lucrative specialty and locate his practice in an affluent suburb.¹²² Also, the new graduate would pass the repayment cost on to his patients.¹²³

D. Area Health Education Centers

Despite the absence of research data demonstrating that a residency in an AHEC strongly influences an individual's decision to practice in the community it serves,¹²⁴ the 1976 Act enlarges the existing AHEC program.¹²⁵ The statute specifically authorizes funding for AHECs which previously had been funded under the Health Manpower Initiative Awards Program. It also requires that each center be affiliated with a medical or osteopathic school and that no less than 10 percent of all undergraduate clinical training be

119. *Id.* at H6643.

120. *Id.* at H6613. Specifically he referred to the provision increasing the funding of the NHSC program. In 1973 the NHSC scholarship program received 1,000 applicants for the available 345 scholarships. *Id.* at H6618.

121. *Id.* at H6644.

122. *Id.* at H6644-45. Representative Paul G. Carter estimated that on graduation the average medical school graduate would owe \$42,000, including the repayment of the capitation grant. *Id.* at H6611.

123. *Id.* at H6614.

124. PROGRESS AND PROBLEMS, *supra* note 29, at 98. The report states that, "The experience with area health education centers is too recent to yield hard statistical data on this point, but there is a good deal of anecdotal evidence indicating that development of a high-quality residency program in a community hospital has been of substantial assistance in attracting physicians to communities suffering from shortages." *Id.* The Council recommended the development of several additional AHECs. *Id.* at 107.

125. Pub. L. No. 94-484, § 801(a), 90 Stat. 2311 (1976).

conducted in the center.¹²⁶ However, the statute contains no provision requiring the establishment of AHECs in inner-city areas.

The continuing federal support for AHECs and clinical training programs may help alleviate the related problem of specialty maldistribution of physicians and dentists. These programs are situated in medically underserved areas and are oriented towards training in family medicine rather than specialties.¹²⁷

IV. Specialty Maldistribution of Physicians and Dentists

Another major issue addressed in the new legislation is the growing specialty maldistribution within the medical profession. During the last decade, a decreasing percentage of physicians have entered the primary care specialties of family practice, general internal medicine, general pediatrics, obstetrics and gynecology.¹²⁸ This has resulted in a shortage of primary care specialties and a surplus in medical subspecialties, surgery, and non-patient care specialties. The shortage of family practice practitioners, the basic primary care specialist, is the most severe. Only three states meet the American Academy of Family Physicians recommended ratio of general practitioners to population.¹²⁹ Moreover, specialty maldistribution is growing worse. In 1960, 59 percent of all physicians were in primary care. In 1970 the percentage was 44 percent. In 1976, only 37 percent of trainees were in primary care specialties.¹³⁰

There is also a trend towards overspecialization in dentistry. The proportion of specialists has risen from approximately 5 percent in 1960 to over 11 percent in 1974.¹³¹ The number of dental students

126. *Id.*

127. The interrelationship between specialty choice and locality of practice is not completely understood. Earlier studies had arrived at contradictory conclusions regarding the existence of a causal relationship between the two choices. Presser, *Factors Affecting the Geographic Maldistribution of Physicians*, 3 J. LEGAL MED. 12, 13 (1975).

128. In 1949, 50 percent of all physicians considered themselves as general practitioners. S. REP. NO. 887, *supra* note 7, at 48. It is estimated that the nation requires 133 primary care physicians per 100,000 population. *Id.* at 54.

In 1970, 1,210 family practice-general practice residencies were offered. Forty-three percent were filled, the lowest percentage for any approved residency program. S. REP. NO. 887, *supra* note 7, at 50.

129. The recommended goal is a family physician to population ratio of 1 to 2500. Arizona, Iowa and Maine have reached that goal. *Id.* at 55.

130. H.R. REP. NO. 266, *supra* note 7, at 43.

131. S. REP. NO. 887, *supra* note 7, at 216.

applying for specialty training has also risen dramatically.¹³²

The Coordinating Council on Medical Education has defined a primary care physician as: "one who establishes a relationship with an individual or a family for which he provides continuing surveillance of their health needs, comprehensive care for the acute and chronic disorders he is qualified to care for, and access to the health care delivery system for those disorders requiring the services of other specialists."¹³³ A primary care physician is the first contact for a person seeking medical attention or advice and he is able to provide more effective service than a crowded emergency room or an unfamiliar specialist. Reliance on either of the latter sources of medical care is both inefficient and uneconomical.¹³⁴

The specialty of a physician is determined by the post-graduate training the student received. Thus, the availability of post-graduate physician training programs affects the specialty mix of physicians in the nation. Today these programs are supervised by various specialty boards which control accreditation.

Four major factors contribute to the present irrationality in the distribution of residencies by specialty. First, large training programs provide institutions with a source of cheap labor and prestige.¹³⁵ Second, primary care specialties provide ambulatory care which is not as financially remunerative as inpatient or institutionally based non-primary specialties.¹³⁶ Third, training programs are approved exclusively on the basis of quality rather than of need.¹³⁷ Fourth, various boards operate independently. They do not attempt to coordinate the number of residencies with the number of graduates available to fill these positions or to allocate the residencies to the various specialties in such proportion that would insure an adequate number of specialists in each specialty.¹³⁸

132. *Id.*

133. 49 J.A.M.A. 911 (1974).

134. Canfield, *Family Medicine: An Historical Perspective*, 51 J. MED. EDUC. 904, 906 (1976).

135. Institutions have strong incentives to establish training programs and to increase the number of physicians within such programs because of two factors: the need to provide services, and prestige. Since trainees often work more than sixty hours a week, they represent a source of inexpensive medical service, service which is otherwise very costly to obtain. Very large training programs thus appeal to hospital administrators. H.R. REP. No. 266, *supra* note 7, at 41.

136. *Id.*

137. *Id.*

138. *Id.* at 41-42.

Family practice became a recognized specialty in 1969.¹³⁹ Two years later, CHMTA authorized special project grants for hospitals to operate approved residency programs in family medicine and to provide stipends to students in such programs.¹⁴⁰ These programs have increased the number of available residencies in family practice.¹⁴¹ The percentage of filled residencies has also risen.¹⁴²

The 1976 Act requires medical schools, in order to retain eligibility for capitation support to insure that an increasing percentage of first-year residencies in affiliated hospitals are reserved for primary care training.¹⁴³ The AMA opposed this provision on the grounds that it represents direct federal intervention into the educational process, a state responsibility.¹⁴⁴ It described the requirement as "unwise" and "unnecessary" as the number of filled residencies in primary care specialties had increased significantly without federal regulation.¹⁴⁵ It also continues special project grants for family practice specialties and establishes a new program providing similar support for approved programs in the general practice of dentistry.¹⁴⁶

The most controversial provision that emerged from both congressional committees was the proposal to regulate post-graduate physician training.¹⁴⁷ This proposal would have authorized the Secretary of HEW to commence an annual certification program in 1978. After consultation with an advisory council, he would establish the total number of post-graduate physician training positions for the following twelve months. The number of such available residencies would be allocated to the various specialties and distributed throughout

139. S. REP. No. 887, *supra* note 7, at 50.

140. 42 U.S.C. § 295f-2 (Supp. V, 1975).

141. S. REP. No. 887, *supra* note 7, at 53.

142. *Id.*

143. Pub. L. No. 94-484, § 502, 90 Stat. 2293 (1976). Unless the number of filled first year positions in primary care residencies is at least 35 percent of all filled first year residencies (nationwide) on July 15, 1977, no individual school of medicine will be eligible to receive capitation grants the following year unless it meets the required percentage by July 15, 1978. *Id.* The required percentage rises to 40 percent in 1978 and 50 percent in 1979. *Id.*

144. 236 J.A.M.A. 3041 (1976).

145. *Id.*

146. Pub. L. No. 94-484, § 801, 90 Stat. 2311 (1976).

147. S. 3239, 94th Cong., 2d Sess. § 501 (1975) (as reported by the Committee on Labor and Public Welfare); H.R. 5546, 94th Cong., 2d Sess. § 1701 (1975) (as reported by the Committee on Interstate and Foreign Commerce).

the country. Any entity maintaining uncertified positions would lose federal funds and be liable for civil penalties. Floor amendments in both Houses deleted the provision.¹⁴⁸ The proposal was opposed vigorously by the administration,¹⁴⁹ and the AMA.¹⁵⁰ Representative Broyhill, summarizing the arguments of the AAMC and others, criticized the provision as unnecessary because positive incentives to increase the number of primary care physicians had worked.¹⁵¹ To support his position, he presented data showing that family practice was the fastest growing medical specialty and that several medical specialties were considering the possibility of placing or had already placed, restrictions on their field.¹⁵² He also pointed to the acknowledged lack of generally accepted distribution standards for specialists and urged the adoption of a more effective method of increasing the number of primary care physicians.¹⁵³

In recent years, the programs established under CHMTA have resulted in more graduate medical students accepting residencies in primary care fields.¹⁵⁴ This trend should continue under the 1976 Act. Thus, it is improbable that federal controls over residencies will be required. Financial incentives alone should be sufficient to halt the trend towards specialty maldistribution.

V. Influx of Foreign Medical Graduates

The fourth important health manpower issue considered by the congressional committees is the growing reliance on graduates from foreign medical schools (FMGs).¹⁵⁵ In 1973, 21 percent of all licensed physicians in the United States were FMGs. Recent HEW projections indicate that by 1990 FMGs will constitute 30 percent of the licensed physicians in the United States.¹⁵⁶ FMGs are seriously maldistributed geographically and by specialty. In 1970, 91 percent of

148. 121 CONG. REC. H6659 (daily ed. July 11, 1975); 122 CONG. REC. S11276 (daily ed. July 1, 1976).

149. 1975 *Hearings*, *supra* note 28, at 314.

150. 236 J.A.M.A. 3041 (1976).

151. H.R. REP. No. 266, *supra* note 7, at 265.

152. *Id.*

153. *Id.*

154. Recent data indicates that in the academic year 1976-1977, 69 percent of first year graduate training is in primary care residencies. *PROGRESS AND PROBLEMS*, *supra* note 29, at 41.

155. S. REP. No. 887, *supra* note 7, at 61-69; H.R. REP. No. 266, *supra* note 7, at 46-58.

156. S. REP. No. 887, *supra* note 7, at 61.

all FMGs were located in metropolitan areas.¹⁵⁷ In 1973, less than 10 percent of FMGs were in general practice.¹⁵⁸

The large influx of FMGs has important implications for the nation's health care system and for foreign policy.¹⁵⁹ The medical community is divided as to whether FMGs provide the same quality of care as physicians graduated from United States schools.¹⁶⁰ Some tests indicate that FMGs are not as professionally competent as United States graduates.¹⁰¹ The House Committee has concluded that FMGs are less qualified than graduates from United States medical schools, and that their relatively uncontrolled entrance into this country will adversely affect the quality of health care.¹⁶²

Ninety percent of all FMGs come from developing countries which lack adequate health manpower to meet the needs of their own growing populations.¹⁶³ Some foreign countries have actively opposed the emigration of their physicians.¹⁶⁴

The majority of FMGs came to the United States to participate in internship and residency training programs. The Smith-Mundt Act of 1948¹⁶⁵ authorized a student exchange program and created the exchange visitor (J-visa) immigration category based on the premise that the students would return to their homelands upon completion of their training. In fact, many FMGs convert exchange visitor immigration status into an immigrant status.¹⁶⁶ Moreover, FMGs have become a primary source of inexpensive medical manpower for United States hospitals, long term care institutions, mental hospitals and prisons.¹⁶⁷ Two-thirds of FMG interns and resi-

157. H.R. REP. NO. 266, *supra* note 7, at 47.

158. S. REP. NO. 887, *supra* note 7, at 61.

159. *Id.* at 210.

160. A bibliography of reference materials appears in Goldblatt, Goodman, Mick, & Stevens, *Licensure, Competence and Manpower Distribution*, 292 NEW ENGLAND J. MED. 137 (1975).

161. H.R. REP. NO. 266, *supra* note 7, at 53.

162. *Id.* at 54.

163. Prior to 1965, almost 50 percent of all FMGs came from the Americas and Europe. Only 10 percent came from Asia. In 1965, the national quota system was abolished. 8 U.S.C. §§ 1151-53 (1970). In 1972, 70 percent of FMG immigrants came from Asian countries with critical shortages of health professionals. The major countries of origin are India, the Philippines, and Korea. H.R. REP. NO. 266, *supra* note 7, at 49.

164. S. REP. NO. 887, *supra* note 7, at 210. In 1957 India prohibited the further administration of the Education Council for Foreign Medical Graduates Examinations. *Id.*

165. 8 U.S.C. § 1182 (1970).

166. PROGRESS AND PROBLEMS, *supra* note 29, at 24.

167. *Id.* at 27. H.R. REP. NO. 266, *supra* note 7, at 50. It has been argued that the high

dents are in programs not affiliated with medical schools.¹⁶⁸

The Immigration and Nationality Act allows certain¹⁶⁹ categories of individuals preference for immigration into the United States. Generally, FMGs qualify for preferential admission either as individuals "who because of their exceptional ability in the sciences or arts will substantially benefit the national economy, cultural interest or welfare," or as "qualified immigrants who are capable of performing a specific skill or unskilled labor, for which a shortage of employable and willing persons exist in the United States."¹⁷⁰ Despite administration testimony that there is no further need to expand the enrollment of medical schools in the United States, the Labor Department has certified that there is a shortage of physicians in this country.¹⁷¹ For this reason, physicians are given preference for immigration. Once a physician has been admitted into the United States he is not required to practice in a medically underserved area.

The 1976 Act changes the requirements for an FMG to enter the United States under an exchange visa. The FMG must: (1) participate in a program sponsored by an accredited school of medicine or other recognized educational institutions; (2) have passed part I or II of the National Board of Medical Examiners Examination or its equivalent; (3) make a commitment to return to his country of origin upon completion of his education in the United States; and (4) demonstrate competence in English.¹⁷² These immigration law amendments will insure that FMGs coming to the United States as exchange medical students receive a quality education and that their homelands enjoy the intended benefits from the exchange program. The present delivery of health care by institutions that rely

rate of FMGs in hospital based practice results from difficulties in obtaining initial capital, racial prejudice and lack of enthusiasm for private practice. See Goldblatt, *supra* note 160, at 140. In the article, the author notes that state licensing boards frequently offer limited licenses to FMGs which restrict their practices to particular institutions (usually a state, municipal, or county hospital) with a manpower shortage. *Id.*

168. PROGRESS AND PROBLEMS, *supra* note 29, at 27.

169. 8 U.S.C. §§ 1101-1503 (1970).

170. *Id.* § 1153.

171. S. REP. NO. 887, *supra* note 7, at 211.

172. Pub. L. No. 94-484, § 601(d), 90 Stat. 2301 (1976). FMGs arriving in the United States to practice medicine will not be eligible for preferential treatment. *Id.* § 601(b), 90 Stat. 2301. Additionally FMGs seeking non-preference immigration visas must have passed parts I and II of the National Board of Medical Examiners Examination (or an equivalent examination) and demonstrate competence in English. *Id.* § 601(a), 90 Stat. 2300.

on FMGs will not be adversely affected since the amendments are not effective until December 31, 1980.¹⁷³ Moreover, many of these institutions will be eligible for NHSC assistance, and the increasing number of medical school graduates should fill the available residencies. Recognizing that many FMGs are United States citizens, the statute authorizes grants to medical and osteopathic schools which allow citizens studying abroad to transfer into their programs.¹⁷⁴

VI. Conclusion

The 1976 Act represents a compromise between the advocates of federal control of the nation's health manpower education programs and those who claim that existing institutions, with sufficient financial support from the federal government, have the capacity to solve the nation's health manpower problems, without additional federal regulation. The legislation provides existing institutions with another opportunity to respond effectively to these problems. If the nation continues to be plagued with severe geographic and specialty maldistribution of health professionals at the expiration of this statute in 1980, there will be immense pressure for extensive federal control of health manpower education, including the regulation of the health professional's choice of specialty and practice location. There is broad support in the Congress and throughout the country for the proposition that if the public finances health education, the public has "the right to ask that doctors be in the right place, and trained in the right specialty."¹⁷⁵

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173. *Id.* § 601(d), 90 Stat. 2301.

174. *Id.* § 801(a), 90 Stat. 2311. The statute also requires that each medical school, as a condition of eligibility for capitation grants, reserve positions for citizens of the United States who prior to September 15, 1976 were enrolled in foreign medical schools. *Id.* § 502, 90 Stat. 2293. To be eligible, the student is required to have completed two years of study abroad and successfully completed part I of the National Board of Medical Examiners Examination. *Id.*

In certain circumstances, the Secretary of HEW may waive this requirement for capitation grants. *Id.*

175. 122 CONG. REC. S11273 (daily ed. July 1, 1976) (remarks of Senator Schweiker).