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EMERGENCY ASSISTANCE TO NORTHEAST RAILROADS

HEARINGS

BEFORE THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

ON

H.R. 2051 and S. 281

TO AMEND THE REGIONAL RAIL REORGANIZATION ACT OF 1973 TO INCREASE THE FINANCIAL ASSISTANCE AVAILABLE UNDER SECTION 213 AND SECTION 215, AND FOR OTHER PURPOSES

FEBRUARY 4 AND 5, 1975

Serial No. 94–1

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Hahn, Richard, vice president—finance and administration.
Maxwell, Gregory W., president.
Patton, Thomas F., trustee.
Silleck, Harry G., Jr., counsel.
Tyler, Ralph S., Jr., trustee.
Interstate Commerce Commission:
Grady, John A., Director, Bureau of Accounts.
Kahn, Fritz, Chief Counsel.
Stafford, Hon. George M., Chairman.

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ORGANIZATIONS REPRESENTED AT HEARINGS—CONTINUED

Penn Central Transportation Co.:
Blanchette, Robert W., trustee.
Duke, Paul, general counsel.
Horsky, Charles A., counsel for the trustees.
Langdon, Jervis, president.
Varalli, Ernest R., assistant vice president, budget and forecast.
Transportation Department:
Barnum, Hon. John W., Acting Secretary.
Eyster, Rodney, General Counsel,
Hall, Asaph H., Acting Administrator, Federal Railroad Administration.
U.S. Railway Association:
Hillman, Jordan Jay, General Counsel.
Lewis, Arthur D., Chairman of the Board.

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EMERGENCY ASSISTANCE TO NORTHEAST RAILROADS

TUESDAY, FEBRUARY 4, 1975

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The committee met at 10 a.m., pursuant to notice, in room 2123, Rayburn House Office Building, Hon. Harley O. Staggers, chairman, presiding.

The CHAIRMAN. The committee will come to order.

Today we will open hearings on H.R. 2051 and S. 281, legislation designed to continue essential rail services in the Northeastern United States. I am sure that I speak for the committee when I say that we are all weary of going through the ritual of opening the "mortuary bill" for the Penn Central. This has happened during the last Congresses.

I am sure that I speak true that if this situation continues, there is a possibility of nationalization of railroads in this country. I would not want to see it and I don't believe any other member would want to see it. Inevitably if this continues, I believe that something of this sort will have to happen. But the emergency is such that we have to act now and that is the reason we are calling this early session here, even before we are fully organized in our committee. We are organized enough to go ahead with the full committee.

It seems as if we have had to act in a crisis on several positions, be it a strike, hurricane or bankruptcy. I was hopeful that the Reorganization Plan, a bill we passed in 1973, a landmark bill, which the Supreme Court upheld in September, would help things, but we are back here again. Both of the bills we are considering and virtually all the witnesses will ask for huge outlays of emergency cash for the Northeastern railroads.

We have been warned of the consequences of not supplying that authorization. Nevertheless, we would not be doing our duty if we did not carefully scrutinize these requests and study this very complex problem in depth.

Without objection, the text of H.R. 2051 and S. 281 shall be placed in the record at this point.

[Testimony resumes on p. 15.]

[The text of H.R. 2051 and S. 281 follows:]

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94TH CONGRESS
1ST SESSION

H. R. 2051

IN THE HOUSE OF REPRESENTATIVES

JANUARY 23, 1975

Mr. STAGGERS (for himself and Mr. DEVINE) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Regional Rail Reorganization Act of 1973 to increase the financial assistance available under section 213 and section 215, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. This Act may be cited as the "Regional Rail Reorganization Act Amendments of 1975".

SEC. 2. (a) Section 211 (a) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 721 (a)) is amended by deleting the phrase "for purposes of assisting in the implementation of the final system plan;" and inserting in its place "for purposes of achieving the goals of this Act;".

(b) Section 211 (c) of the Regional Rail Reorganiza-

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tion Act of 1973 (45 U.S.C. 721 (e) (1)) is amended by deleting the phrase "carry out the final system plan" and inserting in its place "achieve the goals of this Act".

(c) Section 211 (f) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 721 (f)) is amended by deleting the phrase "goals of the final system plan" and inserting in its place "goals of this Act".

SEC. 3. (a) Section 213 (a) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 723 (a)) is amended by adding the following at the end thereof:

"Where the Secretary and the trustees agree that funds provided pursuant to this section are to be used (together with funds provided pursuant to section 215 of this Act, if any) to perform program maintenance on designated rail properties until the date rail properties are conveyed under this Act or to improve such designated properties, such agreement shall contain the conditions set forth in section 215 (b) of this Act.".

(b) Section 213 (b) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 723 (b)) is amended by striking out "$85,000,000" and inserting in lieu thereof "$185,000,000".

SEC. 4. Section 215 of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 725) is amended to read as follows:

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"INTERIM AGREEMENTS

"SEC. 215. (a) PURPOSES.—Prior to the date upon which rail properties are conveyed to the Corporation under this Act, the Secretary, with the approval of the Association, is authorized to enter into agreements with the trustees of the railroads in reorganization in the region (or railroads leased, operated, or controlled by railroads in reorganization)—

"(1) to perform the program maintenance on designated rail properties of such railroads until the date rail properties are conveyed under this Act;

"(2) to improve railroad facilities and equipment of such railroads; and

"(3) to acquire railroad facilities or equipment for lease or loan to any such railroads until the date rail properties are conveyed under this Act, and subsequently for conveyance pursuant to the final system plan, or to acquire interests in such facilities or equipment owned by or leased to any such railroads or in purchase money obligations therefor.

"(b) CONDITIONS.—Agreements pursuant to subsection (a) of this section shall contain such reasonable terms and conditions as the Secretary may prescribe. In addition, agreements under paragraphs (1) and (2) of subsection (a) of this section shall provide that—

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"(1) the Corporation shall not be required under title III of this Act to compensate a railroad in reorganization for any portion of the value of the properties subject to the agreement and designated under the final system plan for transfer to the Corporation which is in excess of the value of such properties determined on the basis of their physical condition as of the effective date of the agreement; and

"(2) in the event that property subject to the agreement is sold, leased, or transferred to an entity other than the Corporation, the trustees or railroad shall pay or assign to the Secretary that portion of the proceeds of such sale, lease, or transfer which reflects value attributable to the maintenance and improvement provided pursuant to the agreements.

"(c) OBLIGATIONS.—Notwithstanding section 210 (b) of this title, the Association shall issue obligations under section 210 (a) of this title in an amount sufficient to finance such agreements and shall require the Corporation to assume any such obligations. The aggregate amount of obligations issued under this section and outstanding at any one time shall not exceed $300,000,000. The Association, with the approval of the Secretary, shall designate in the final system plan that portion of such obligations issued or to be issued which shall be refinanced and the terms thereof, and that

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portion from which the Corporation shall be released of its obligations.

"(d) CONVEYANCE.—The Secretary may convey to the Corporation, with or without receipt of consideration, any property or interests acquired by, transferred to, or otherwise held by the Secretary pursuant to this section or section 213 of this Act.".

SEC. 5. Section 303(c)(1) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 745(c)(1)) is amended by deleting the last word of paragraph (A); by deleting the period at the end of paragraph (B) and inserting "; and" in its place; and by inserting after paragraph (B) the following new paragraph:

"(C) what portion of the proceeds received by a railroad in reorganization from an entity other than the Corporation for the sale, lease, or transfer of property subject to an agreement under section 213 or section 215(a)(1) or (2) of this Act reflects value attributable to the maintenance or improvement provided pursuant to the agreement.".

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portion from which the Corporation shall be released of its obligations.

"(d) CONVEYANCE.—The Secretary may convey to the Corporation, with or without receipt of consideration, any property or interests acquired by, transferred to, or otherwise held by the Secretary pursuant to this section or section 213 of this Act.".

SEC. 5. Section 303(c)(1) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 745(c)(1)) is amended by deleting the last word of paragraph (A); by deleting the period at the end of paragraph (B) and inserting "; and" in its place; and by inserting after paragraph (B) the following new paragraph:

"(C) what portion of the proceeds received by a railroad in reorganization from an entity other than the Corporation for the sale, lease, or transfer of property subject to an agreement under section 213 or section 215 (a)(1) or (2) of this Act reflects value attributable to the maintenance or improvement provided pursuant to the agreement.".

94TH CONGRESS
1ST SESSION

S. 281

IN THE HOUSE OF REPRESENTATIVES

JANUARY 30, 1975

Referred to the Committee on Interstate and Foreign Commerce

AN ACT

To amend the Regional Rail Reorganization Act of 1973 to increase the financial assistance available under section 213 and section 215, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Regional Rail Reorganization Act Amendments of 1975".

SEC. 2. (a) Section 211(a) of the Regional Rail Re-

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organization Act of 1973 (45 U.S.C. 721(a)) is amended by deleting the phrase "for purposes of assisting in the implementation of the final system plan;" and inserting in its place "for purposes of achieving the goals of this Act;".

(b) Section 211(e)(1) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 721(e)(1)) is amended by deleting the phrase "carry out the final system plan" and inserting in its place "achieve the goals of this Act".

(c) Section 211(f) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 721(f)) is amended by deleting the phrase "goals of the final system plan" and inserting in its place "goals of this Act".

SEC. 3. (a) Section 213(a) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 723(a)) is amended by adding the following at the end thereof: "Where the Secretary and the trustees agree that funds provided pursuant to this section are to be used (together with funds provided pursuant to section 215 of this Act, if any) to perform program maintenance on designated rail properties until the date such rail properties are conveyed under this Act or to improve such designated properties, such agreement shall contain the conditions set forth in section 215(b) of this Act.".

(b) Section 213(b) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 723(b)) is amended by

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striking out "$85,000,000" and inserting in lieu thereof "$210,000,000".

SEC. 4. Section 215 of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 725) is amended to read as follows:

"INTERIM AGREEMENTS

"SEC. 215. (a) PURPOSES.—Prior to the date upon which rail properties are conveyed to the Corporation under this Act, the Secretary, with the approval of the Association, is authorized to enter into agreements with the trustees of the railroads in reorganization in the region (or railroads leased, operated, or controlled by railroads in reorganization)—

"(1) to perform the program maintenance on designated rail properties of such railroads until the date such rail properties are conveyed under this Act;

"(2) to improve rail properties of such railroads; and

"(3) to acquire rail properties for lease or loan to any such railroads until the date such rail properties are conveyed under this Act, and subsequently for conveyance pursuant to the final system plan, or to acquire interests in such rail properties owned by or leased to any such railroads or in purchase money obligations therefor.

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"(b) CONDITIONS.—Agreements pursuant to subsection (a) of this section shall contain such reasonable terms and conditions as the Secretary may prescribe. In addition, agreements under paragraphs (1) and (2) of subsection (a) of this section shall provide that—

"(1) the Corporation shall not be required under title III of this Act to compensate a railroad in reorganization for any portion of the value of the properties subject to the agreement and designated under the final system plan for transfer to the Corporation which is attributable to the maintenance or improvement performed pursuant to the agreement. The Association and the special court shall, in determining value pursuant to section 303 of this Act, take into account the physical condition as of the effective date of the agreement; and

"(2) in the event that property subject to the agreement is sold, leased, or transferred to an entity other than the Corporation, the trustees or railroad shall pay or assign to the Secretary that portion of the proceeds of such sale, lease, or transfer which reflects value attributable to the maintenance and improvement provided pursuant to the agreement.

"(c) OBLIGATIONS.—Notwithstanding section 210(b) of this title, the Association shall issue obligations under section 210(a) of this title in an amount sufficient to finance

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such agreements and shall require the Corporation to assume any such obligations. The aggregate amount of obligations issued under this section and outstanding at any one time shall not exceed $300,000,000. The Association, with the approval of the Secretary, shall designate in the final system plan that portion of such obligations issued or to be issued which shall be refinanced and the terms thereof, and that portion from which the Corporation shall be released of its obligations.

"(d) CONVEYANCE.—The Secretary may convey to the Corporation, with or without receipt of consideration, any property or interests acquired by, transferred to, or otherwise held by the Secretary pursuant to this section or section 213 of this Act.".

SEC. 5. Section 303(c)(1) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 745(c)(1)) is amended by deleting the last word of paragraph (A); by deleting the period at the end of paragraph (B) and inserting "; and" in its place; and by inserting after paragraph (B) the following new paragraph:

"(C) what portion of the proceeds received by a railroad in reorganization from an entity other than the Corporation for the sale, lease, or transfer of property subject to an agreement under section 213 or section

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215(a) (1) or (2) of this Act reflects value attributable to the maintenance or improvement provided pursuant to the agreement.".

SEC. 6. Section 303(d) of the Rail Passenger Service Act (45 U.S.C. 543(d)) is amended by inserting immediately after the third sentence the following: "This limitation upon compensation shall not apply, however, in the event the Board determines with respect to one position that a higher level of compensation is necessary and is consistent with the general level of compensation paid officers of railroads in positions of comparable responsibilities, but in no event shall such compensation exceed $90,000 per annum.".

SEC. 7. (a) Section 207(b) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 717(b)) is amended (1) by inserting "(1)" immediately before the first sentence thereof, and (2) by adding at the end thereof the following new paragraph:

"(2) Whenever it has been finally determined, pursuant to the procedures of paragraph (1) of this subsection, that the reorganization of a railroad subject to reorganization under section 77 of the Bankruptcy Act (11 U.S.C. 205) shall not be proceeded with pursuant to this Act, the court having jurisdiction over such railroad may, upon a petition which is filed within 10 days after the date of enactment of this subsection by the trustees of such railroad, reconsider such

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order. Such reorganization court shall (i) affirm its previous order or (ii) issue an order that the reorganization of such railroad be proceeded with pursuant to this Act unless it finds that this Act does not provide a process which would be fair and equitable. The provisions of paragraph (1) of this subsection are applicable in such reconsideration, except that (A) such reorganization court shall make its decision within 30 days after such petition is filed, and (B) any decision by the special court on appeal from such a decision shall be rendered within 30 days after such reorganization court decision is made. There shall be no review of the decision of the special court. The Association shall take any steps it finds necessary, consistent with time limitations and other provisions of this Act, to effectuate the consequences of such a revised order, including the preparation and submission of any necessary or appropriate supplements to the preliminary system plan.".

(b) Section 207 (a) (2) is amended to read:

"(3) The Office is authorized to hold public hearings on the preliminary system plan and to make available to the Association a summary and analysis of the evidence received in the course of such proceedings, together with its critique and evaluation of the preliminary system plan, not later than 60 days after the date of release of such plan. The Office is authorized to hold public hearings on any supplement to the

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preliminary system plan and to make available to the Association a summary and analysis of the evidence received in the course of such proceedings, together with its critique and evaluation of such supplement, not later than 30 days after the date of release of such supplement.".

SEC. 8. Section 205 (d) (2) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 715 (d) (2)) is amended to read as follows:

"(2) employ and utilize the services of attorneys and such other personnel as may be required in order to properly protect the interests of those communities and users of rail service which, for whatever reason, such as their size or location, might not otherwise be adequately represented in the course of the reorganization process as provided by this Act.".

Passed the Senate January 29, 1975.

Attest: FRANCIS R. VALEO,

Secretary.

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Mr. CHAIRMAN. The first witness this morning is the Honorable John Barnum, Acting Secretary of Transportation. Mr. Barnum, would you identify yourself and your position and the gentlemen with you, and you may proceed as you see fit. We hope if you have a large statement, you will insert it in the record and summarize.

STATEMENT OF HON. JOHN W. BARNUM, ACTING SECRETARY, DEPARTMENT OF TRANSPORTATION, ACCOMPANIED BY RODNEY EYSTER, GENERAL COUNSEL, AND ASAPH H. HALL, ACTING ADMINISTRATOR, FEDERAL RAILROAD ADMINISTRATION

Mr. BARNUM. Thank you very much, Mr. Chairman, and members of the committee.

I have with me this morning on my left Ace Hall, Acting Administrator of the Federal Railroad Administration, and on my right, the General Counsel of the Department of Transportation, Rodney Eyster.

With your permission I have a brief statement which I would prefer to present to the committee.

We appreciate this opportunity to appear before you today in support of the Department's proposed legislation entitled "The Regional Rail Reorganization Act Amendments of 1975" (H.R. 2051). We are particularly pleased that your committee has scheduled this hearing, for the problem addressed in this bill merits immediate attention. Indeed, I sincerely hope that we are in time.

We are presently confronted by a serious financial crisis among the bankrupt railroads of the Midwest and Northeast. This crisis is a result of a number of factors which have had a negative impact on both revenues and costs of those railroads. The initial factor was the November-December coal strike, which had a $5 million per week adverse impact on Penn Central revenues. Also, sharp declines in traffic in automobiles and metal products have accelerated the revenue loss. The Penn Central and Ann Arbor, in particular, have been victims of this downturn.

At the same time the bankrupt railroads are experiencing greatly increased operating costs. Penn Central paid 100 percent more for fuel and 30 percent more for maintenance of way materials in the first 9 months of 1974 than in the same period of 1973. Had Penn Central not been able to obtain approval of freight rate increases of approximately 18 percent during 1974, the 1974 deficit would have been considerably worse.

In late November the Department was informed of the critical nature of the railroads' financial posture. We examined the amount of authorized funds available to meet the coming cash crisis and allocated those funds on the basis of need as shown by projections available at that time. The Department also began consideration of, first, what cost-cutting items could be undertaken by the railroads, and second, what were the alternatives to additional direct cash assistance under section 213.

During the course of December we entered into agreements to provide assistance under section 213 with Penn Central for $30 million, with Lehigh Valley for $1.4 million, and with Ann Arbor for $250,000. The Central Railroad of New Jersey had already received a commit-

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ment of funds for the first half of 1975. In addition, the agreement with the Lehigh and Hudson River was extended for the first half of 1975.

Concurrently, in December, the trustees of the Penn Central proposed that if additional assistance was not available to meet their 1975 cash needs, they would implement a "three-point" program consisting of (1) not paying wage increases due in 1975, (2) reducing its labor force by 4,500, and (3) reducing material purchases by $92 million. This program would have resulted in substantial reduction of their maintenance of way and maintenance of equipment programs. We found this unacceptable since it would result in the ultimate shutdown of the railroad due to unsafe operating conditions and unreliable service.

While the Department was conducting its evaluation of Penn Central's cash needs, Secretary Brinegar on December 30 asked the trustees to consider what other cost-cutting measures might be taken. The trustees replied the following day that the "three point" program was the only program within management's control which would produce the necessary cash savings, and that all other available measures had been taken.

On January 10, I responded to the trustees that the Department was concerned that the "three point" program not be implemented, that we would present a legislative proposal, and that we wanted to explore with them what other cost-cutting measures might be available. The trustees replied that they would not implement the program, but in the event aid were not forthcoming, traffic would be embargoed in the middle of this month in contemplation of a complete shutdown. I would like to submit copies of this correspondence for the record [see p. 21].

I should also report that in December we requested appropriation of the remaining $10.2 million authorized under section 213. Recognizing the critical need, Congress responded within 1 week of the request. Last month we agreed to amend the Penn Central grant agreement to provide an additional $12 million. We also agreed in January to provide an additional $750,000 to the Ann Arbor and an additional $595,000 to the Lehigh Valley. As of today there remains less than $4 million of the original authorization which has not been committed I should mention here that the entire amount authorized has been appropriated.

Attached to my statement is a current summary of the obligations and outlays of section 213 funds to date [see p. 24].

At this point, then, it seems clear that, unless additional funds are promptly made available, several of these railroads, particularly Penn Central, will be forced to cease operations as early as February 25. It is likewise clear that this cannot be permitted to happen until the planning process contemplated by the Regional Rail Reorganization Act of 1973 is completed. In addition, and of more immediate importance, the termination of rail service by these roads would have a crippling effect on the overall economy of the region and, indeed, the Nation.

In addition to section 213 of the act, section 215 authorizes the Secretary of Transportation, with the approval of USRA, to provide $150 million for the acquisition, maintenance or improvement of prop-

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erties that will be in the final system plan. This was intended to enable DOT and USRA to get a head start on the substantial maintenance and rehabilitation task ConRail will face. Considerable difficulites have been encountered in implementing the section 215 program, particularly those caused by the uncertainties created by the constitutional litigation and the changing Penn Central maintenance program. To date we have guaranteed $3.4 million of obligations issued under section 215 for the acquisition of 12 locomotives by ConRail which have been leased to the Lehigh Valley.

The Department and the United States Railway Association have jointly developed a program based on applications submitted by the railroads for expenditure of the balance of the $150 million presently authorized under section 215. This program was approved on January 17 by the USRA Board of Directors, and the Department is now able to enter into the appropriate agreements. There has also been substantial agreement between the Department and USRA as to the use of the additional $150 million we are requesting for section 215.

The legislation we have proposed recognizes the close relationship between the need for cash assistance and the need for maintenance and improvement of rail properties. We anticipate that if the bankrupct railroads are to continue to provide service substantially at the level provided through 1974, and if extensive furloughs of personnel and sharp cutbacks in maintenance and improvements are to be avoided, there will be a need for additional assistance of approximately $300 million. This amount has been estimated for the period through the first quarter of 1976 and is based on the current revenue projections and cost estimates for that period.

The purposes of the proposed legislation are several. First, we propose to provide in section 213 and section 215 sufficient assistance to enable bankrupt railroads to continue to provide service. Second, it would enable the Department and the association to commence work on an expedited basis on the maintenance and rehabilitation of the properties destined for inclusion in the final system plan. Third, it would assure that to the extent such assistance adds any value to the properties maintained or improved with those funds, that increase in value will benefit ConRail or will be returned to the Government, and will not accrue to the estates of the railroads. Fourth, approximately $25 million of this assistance is intended to be utilized in performing deferred maintenance on the Northeast Corridor between Boston and Washington, for which there is not presently any other source of funds.

Finally, this legislation will make clear that loans may be made under section 211 prior to the effective date of the final system plan where such loans would assist in carrying out the goals of the act. This would allow ConRail to order materials in 1975 which will be needed once the final system plan is approved.

The new section 215 would increase the authorization from $150 to $300 million and would expand the purposes for which section 215 can be used in two significant areas. First, it will permit the Department and USRA to take over, in whole or in part, the regular track and roadway maintenance programed by a railroad in reorganization. The Department and USRA will be assuming expenses that the railroad would otherwise have to make to carry out its existing maintenance program, thereby reducing its forecasted cash needs.

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Second, it will permit the Department and USRA to acquire for ConRail railroad facilities or equipment that a railroad likewise has planned to acquire, and thereby both reduce the railroad's cash needs and provide an asset for ConRail. In addition, the Department and USRA can acquire an interest in capital items, such as rolling stock subject to a conditional sale agreement or equipment trust certificate, by paying an installment on such agreement or certificate that the trustees would otherwise have to pay and acquiring a pro rata interest in the underlying equipment. Such action would directly reduce the railroad's projected cash needs, and also would provide equity for ConRail. A chart depicting the section 215 program is attached to my statement [see p. 25].

The proposed amendment to section 215 will assure that any value added to the properties as a result of such work will not be paid by ConRail. The existing provision was intended to make this assurance, but it presents difficult questions as to the valuation of properties maintained or improved under that section because it requires a determination of the value attributable to the improvements. It is very difficult to devise an analytical formula which would fairly measure what portion of the land of given rail property is attributable to the effectuation of given improvements in its physical condition. Thus, the present section 215 would proliferate litigation and there would be too much uncertainty as to whether it would result in adequate protection for the Government.

Our proposed amendment would obviate those problems by having the value of the properties which are subject to a section 215 agreement and transferred to ConRail determined in the final system plan on the basis of their physical condition prior to the maintenance or improvement brought about by the agreement.

It is important to note, since there has been some misunderstanding on the point, that our proposed amendment does not change the valuation process undertaken by the Association in any way other than by establishing that the physical condition used as the basis for the valuation of properties covered by section 215 agreements and transferred to ConRail is the physical condition of the properties on the effective date of the section 215 agreements. In all other respects value would be determined as of the date for the valuation of property transfered under the final system plan. We note that the Senate-passed bill, S. 281, requires a determination of the value attributable to maintenance or improvements performed under a section 215 agreement and, therefore, we recommend against adoption of the Senate language.

An additional deficiency in the existing language of section 215 is that it does not make any provision for recovering the value of maintenance or improvements to properties transferred under the final system plan to railroads other than ConRail. Therefore, our proposed amendment provides that, in the event the final system plan designates the conveyance of properties to such railroads, the trustees will be obligated to return to the Government the value added to those properties by maintenance and improvement financed under section 215.

As you know, funds provided under section 215 ultimately constitute obligations which must be assumed by ConRail. However, a

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portion of the obligations to be issued under the amended section 215 will be for purposes which are not normally carried as capital debt, such as deferred maintenance. Therefore, we propose that USRA, with the approval of the Secretary of Transportation, indicate in the final system plan what portion of the debt should be carried by ConRail, considering its projected overall debt structure, and what portion should be canceled, resulting in effect in a grant. In our view if ConRail can bear such a debt, it should do so rather than have the taxpayer do so.

With respect to operating assistance, on the basis of projections developed by the Department and forecasts of the railroads now classified under the 1973 Act as railroads in reorganization we concluded last month that additional grant authority in the amount of $75 million was necessary for those railroads, plus $25 million for needed repairs on the Northeast Corridor. Therefore, the bill we submitted on January 17, H.R. 2051, proposed that the authorization contained in section 213 of the act be increased from $85 million to $185 million. In addition, that bill proposed that where such assistance is used to perform program maintenance or improvements on designated rail properties, it should be provided on the same terms and conditions as are required under section 215. Those terms and conditions are designed to assure that any value added by such maintenance and improvements goes to ConRail or back to the Government and not to the estates of the railroads in reorganization.

Since we submitted that bill to the Congress on January 17, we have concluded that two significant changes should be made to the bill to ensure that the bankrupt railroads will have sufficient operating assistance to continue to provide service. Amendments effecting these changes are attached to my statement [see p. 25].

The first change entails an increase of $30 million in the authorization under section 213. In projecting the need of the bankrupt railroads for financial assistance, we had assumed that an application pending before the ICC for a 7-percent rate increase would go into effect tomorrow. Just last Thursday, however, the ICC issued an order suspending that proposed increase. We are hopeful that the additional $30 million we propose will be adequate to compensate for the revenues that the bankrupt railroads would have derived from that increase had it gone into effect this month.

If the railroads are not successful soon in obtaining approval of such an increase, however, the additional funding we propose will not be sufficient. For example, if the bankrupt railroads fail to obtain approval of a 7-percent increase during the maximum 7-month period for the suspension of rates, we estimate that our proposed funding increase of $30 million will fall short of making up lost revenue by nearly $45 million.

The second major change to our bill entails the adoption of an amendment to section 213 containing a separate $25 million authorization for railroads not reorganizing under the 1973 act which operate rail properties that are likely to be transferred to ConRail or other railroads under the final system plan. The basic purpose of this amendment is to insure that the Erie Lackawanna can be afforded sufficient financial assistance to avoid a shutdown of its operations prior to implementation of the final system plan. Reversing the posi-

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tion they took last year in court proceedings under section 207(b) of the 1973 act, the trustees of the Erie recently announced that the railroad cannot be organized independently under section 77 of the Bankruptcy Act within a reasonable time. In addition to seeking financial assistance under section 213, the trustees have proposed that the 1973 act be amended to permit the railroad to be reorganized under the 1973 act.

We agree that financial assistance should be made available to the Erie. We also believe that provision should be made for including employees of the Erie under the labor protection provisions of title V of the act and have drafted amendments to accomplish that. We do object, however, to the adoption of an amendment, such as the one contained in the Senate-passed bill, which would permit the Erie to become a "railroad in reorganization" for all purposes of the 1973 act.

First, we believe that such a provision is unnecessary for the Erie can and will be included in the planning process, and the final system plan can provide for the conveyance of its properties on a voluntary basis.

Second, we believe that such a provision would have two serious drawbacks. If the assets of the Erie Lackawanna become subject to mandatory conveyance under the final system plan, the possibility exists that the Government could become liable to the Erie's estate under the Tucker Act for both interim erosion of the estate pending implementation of the final system plan and for any court-determined shortfall in the adequacy of the compensation the Erie receives for its rail assets conveyed under the final system plan.

Also, such a provision might lead to time-consuming litigation by creditors or trustees of railroads already reorganizing under the act which could delay or impede the implementation of the final system plan and thereby seriously aggravate the need of these railroads for interim financial aid.

In addition to searching for ways to get the most effective results from the financial assistance provisions of the act, we have considered possible actions the ICC might take to prevent a cessation of the service provided by railroads in organization under the 1973 act. For example, we have looked into the possibility of the Commission's invoking its powers under section 601(e) of the 1973 act. Under that provision the Commission is empowered, on an emergency basis, to direct a carrier to move the traffic of another carrier over the other carrier's lines. There are important requirements associated with the issuance of such directions, however. These include the provision of compensation to the directed carrier to cover the difference between the costs and revenues associated with such operations. In this regard it should be noted that costs are defined in the statute to include a reasonable profit.

Another important requirement that must be satisfied under Section 601(e) is that there not be any substantial impairment of the ability of the directed carrier to serve adequately its own patrons or to meet its own outstanding common carrier obligations. Given (1) the immense scope of the rail service that would be discontinued if the Penn Central and other bankrupt railroads were to go into liquidation; (2)

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the high costs that would be involved in directing other carriers to continue such service; and (3) the limited resources of neighboring carriers which might be directed to provide the service, we do not believe that it would be feasible to look to section 601(e) to provide the answer to a large-scale shutdown. In fact, in our judgment there is not any reasonable alternative to seeking additional authority to provide financial assistance for the continuation of services by the existing bankrupt carriers.

In conclusion, our proposed bill, amended as I have described, should enable the department and the association to deal flexibly and effectively with the two most pressing needs pending completion of the planning process—assuring continuation of rail service, and commencing an integrated maintenance and improvement program for properties that will be in the final system plan. These needs will be met in a manner which will maximize the benefit to ConRail and will not allow unjust enrichment of the estates.

Mr. Chairman, that concludes my prepared statement. I will be pleased to answer any questions the committee may have.

Thank you.

[Testimony resumes on p. 29.]

[The documents referred to follow:]

DEPARTMENT OF TRANSPORTATION,
OFFICE OF THE SECRETARY,
Washington, D.C., December 30, 1974.

Messrs. ROBERT W. BLANCHETTE,
RICHARD C. BOND, and
JOHN H. MCARTHUR,
Trustees of the Property
Penn Central Transportation Co.
Six Penn Center Plaza
Philadelphia, Pa.

GENTLEMEN: On November 20 your representatives informed me that the current cash flow forecast of the management of Penn Central Transportation Company is as follows: if the amount of maintenance performed on the railroad and the number of personnel employed are held at 1974 levels, the company will suffer a net cash outflow of some $280 million during the period which includes calendar year 1975 *and* the first quarter of 1976 ($157 million during calendar year 1975). I understand that the significant increase in the forecasted cash outflows over those of prior years is primarily due to an expected 7% overall decline in traffic as a consequence of the current slowdown in the economy.

Your representatives also informed me that management has presented a program which would contribute to a net cash inflow of some $53 million during 1975, and would decrease the net cash outflow for the entire period which includes calendar year 1975 *and* the first quarter of 1976 to some $78 million. I am told that the program depends to a large extent upon a significant reduction in maintenance expenses, both through a $92 million decrease in material purchases, and through a reduction in force of maintenance of way employees.

I am very concerned by the cash outflows forecast by Penn Central management. I have instructed my staff to conduct an independent evaluation of the situation and to present their cash forecasts to me as soon as possible. They have been in continual communication with management, and are prepared to give your representatives a preliminary analysis of management's forecast.

I am very troubled, however, that the only program which Penn Central management has so far presented for offsetting the revenue effects of the expected traffic decline appears to depend largely on short term measures which might in the long term prove detrimental to the ability of the Penn Central (or of ConRail) to provide necessary transportation services. Nowhere in the information provided to us is there any mention of cutbacks in the scope of non-maintenance operations, other than a reduction in force of 1,000 headquarters and yard non-operating transportation personnel, and the "possibility" of either not paying wage increases or of funding them through rate increases. Are there

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not a wide range of other cost cutting measures which should be employed by a railroad faced with such a significant decline in its traffic?

We would be remiss in our obligation to the taxpayers if we do not ensure that every possible cost cutting measure either has been taken, or has been fully planned for implementation when the opportunity arises. Accordingly, I would appreciate receiving from you, and I am requesting by this letter, a detailed explanation of the program of cost cutting alternatives available to Penn Central, other than the three point program already provided, in view of the current and expected downturn in traffic. Further, I would appreciate knowing in detail what contingency plans have been made or what alternatives are available for further cost cutting should the traffic downturn be even worse than is now forecast. In this regard, I should note that members of my staff believe that recent developments in the automobile and steel industries indicate that a greater than 7% decline in Penn Central's 1975 traffic is indeed possible.

It would be of great assistance in completing our evaluation of the situation, and in formulating our recommendations to the President and the Congress, if we could receive your response as soon as possible, but not later than January 10, 1975.

Sincerely,

CLAUDE S. BRINEGAR.

* * *

PENN CENTRAL TRANSPORTATION CO.,
Philadelphia, Pa., December 31, 1974.

Hon. CLAUDE S. BRINEGAR,
Secretary, Department of Transportation,
Washington, D.C.

DEAR MR. SECRETARY: Your letter of December 30 notes the Trustees' cash flow forecasts which were provided to you on November 20 and indicates an awareness of the extremely serious cash problem which the Penn Central will face in the first quarter of 1975 and throughout the balance of the year. As you will recall when we visited you on November 20, you advised us not to institute certain cutbacks in programmed maintenance for 1975 and indicated that the Department would have a series of proposals to alleviate the serious cash shortages which are impending.

You state that you are troubled by the fact that you believe the only program the Penn Central management has so far presented for offsetting the revenue loss from the present traffic decline is a program to cut back on maintenance work. You ask whether there are any other cost-cutting measures which should be employed, and request a detailed explanation of alternative programs to cut costs.

Let me assure you that the severe cutback in purchases of materials and supplies and the reduction in maintenance forces is not the only program which the Penn Central management has proposed or adopted. It is, however, the only program within management's control which will produce the substantial cash savings necessary to avoid an immediate complete cessation of operations.

Your letter speculates that there may be a wide range of other measures that should be used. Those which are available to us have been and are being used. For example, in light of the declining volume of traffic, the number of employees presently handling that volume has declined from 80,381 in August, 1974, to 78,752 in December. We have cut the number of freight trains operated in December by almost 11,500 as compared with October, and reduced the number of yard crews by 8,500. We will continue to make similar reductions consistent with traffic levels wherever possible.

Where traffic sources dry up, we attempt to eliminate operations at those points entirely. However, major yard facilities for the interchange of traffic must continue to be operated even in the face of serious traffic losses, and the expense reduction therefore cannot approach the revenue loss. The figures which you were provided in November included the possible expense reductions premised on the then anticipated traffic decline. These forecasts have been and are being adjusted continuously to reflect changes in traffic levels.

As I am sure you are also aware, our ability to effect major additional cost savings by reductions in force is limited by the fact that over 75% of our employees have the benefit of merger protective provisions which require that they be paid whether or not they work. More importantly, Penn Central has been operating at minimum employment levels, and further major cuts in transportation or other expenses are simply not available, without seriously affecting

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service. When the Penn Central entered reorganization in June, 1970, it had a total of 95,772 employees. As of the middle of this month, we have only 78,752, a reduction of almost 18% of our total employment.

Unlike major manufacturing concerns, we cannot build up a backlog of our product and shut down entire production lines. Consistent with our common carrier obligations and safe operation of the property, we can only make major short-term cost reduction in the one area we control—our maintenance program. Expenditures for the plant improvement or equipment acquisition have already been eliminated.

In short, every cost-cutting measure which we believe can reasonably be adopted and still operate either has been taken or is being implemented in light of our declining traffic.

Your letter also notes that your staff have made an independent evaluation of our forecasts and are prepared to give our representatives a preliminary analysis of those forecasts. Upon receipt of your letter last evening, I instructed our representatives to contact responsible officials of the Department and the Federal Railroad Administration to obtain that analysis and whatever suggestions are contained therein. I understand that that was done immediately.

Finally, I cannot emphasize too strongly the need for an immediate action program by the Department to alleviate the impending cash shortfall. Since we met on November 20, the cash situation on the railroad has worsened and the absence of external sources of cash will require even deeper cuts in maintenance expenses than were then contemplated. To avoid a complete cessation of operations by late February-early March the Trustees will have to implement management's program within the next ten days. Even on that spartan basis, system operations beyond the first quarter simply cannot be presently assured.

ROBERT W. BLANCHETTE, *Trustee.*

* * *

DEPARTMENT OF TRANSPORTATION,
OFFICE OF THE SECRETARY,
Washington, D.C., January 10, 1975.

Messrs. ROBERT W. BLANCHETTE, RICHARD C. BOND, and JOHN H. MCARTHUR,
Trustees of the Property of the Penn Central Transportation Co.
Philadelphia, Pa.

GENTLEMEN: Your letter of December 31, 1974 indicates that Penn Central has implemented cost-cutting measures to meet the serious cash problem which faces Penn Central in 1975 and the first quarter of 1976. You further indicated that despite these management actions, in the absence of external sources of cash, the Trustees will be forced, within the next few days, to implement severe cuts in maintenance expenses to avoid a complete cessation of operations by late February or early March. You requested the Department to develop an action program to alleviate the impending cash shortages facing the railroad and thus enable the Trustees to continue operations without having to invoke these maintenance cutbacks.

The Department is, of course, deeply concerned that Penn Central not implement any cutbacks in its maintenance program which might prove detrimental to the ability of Penn Central (or Conrail) to provide necessary transportation services. In this connection the Administration has developed a legislative proposal which will provide the resources necessary to sustain all the railroads, including Penn Central, which are reorganizing under the Regional Rail Reorganization Act of 1973 ("Rail Act") through the first quarter of 1976. This proposal involves increasing the amount of financial assistance available under sections 213 and 215 of the Rail Act, and amending section 215 of the Rail Act to enable the Government to deal more effectively with the financial and maintenance problems of the railroads reorganizing under the Act. We intend to submit this legislative program to Congress within the next week, and we will urge that Congress act promptly on the problem.

I trust that the foregoing assurance will enable the Trustees to continue rail operations without having to implement any severe cutbacks in the railroad's maintenance program. We wish to explore further with you or your representatives alternative cost-cutting measures which the management might be able to adopt to meet the railroad's cash needs.

Sincerely,

JOHN W. BARNUM,
Acting Secretary.

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PENN CENTRAL TRANSPORTATION CO,.
Philadelphia, Pa., January 13, 1975.

Hon. JOHN W. BARNUM,
Deputy, Secretary of Transportation,
Department of Transportation,
Washington, D.C.

DEAR MR. BARNUM: The Trustees have received your letter of January 10, 1975 expressing the Department's deep concern that we not implement management's program of extensive employee furloughs and severe reductions in purchases and materials and supplies required to permit continuance of Penn Central rail operations beyond late February of this year. You indicate that the administration has developed a legislative proposal which will provide the resources necessary to sustain Penn Central through the first quarter of 1976.

Although we would much prefer to know the details of the administration's proposal before having to make our decision, we are cancelling the implementation of the management's program on the strength of your assurances. Our concern is that the administration's program be not only adequate, but also capable of winning prompt approval both by the Congress and the Reorganization Court.

It must be understood by everyone concerned however that our decision to cancel the reductions in employment and purchasing means that we are foregoing the only measures of self-help available to Penn Central to meet next month's cash shortage. Having deferred management's program since the first of December, we cannot now meet our cash needs by later instituting a similar program. The magnitude of any later self-help program to solve the cash shortage would be so extensive that continued rail operations could not be assured consistent with the requirements of safety. Thus if the aid contemplated by the program of the administration does not promptly make cash available to Penn Central it will be necessary to begin to embargo traffic mid-February, in contemplation of a complete cessation of rail operations for lack of cash in early March, as projected in the management forecasts which you have received.

Very truly yours,

ROBERT W. BLANCHETTE, *Trustee.*
RICHARD C. BOND, *Trustee.*
JOHN H. MCARTHUR, *Trustee.*

OBLIGATIONS AND OUTLAYS UNDER SEC. 213, REGIONAL RAIL REORGANIZATION ACT OF 1973

Status as of January 31, 1975:	
Total funds authorized	$85,000,000.00
Total funds appropriated	85,000,000.00
Total funds obligated/committed	81,104,003.42
Balance of appropriated funds available for obligation	3,895,996.58
Total outlays against obligations	78,071,272.42

	Obligations	Outlays	Drawdowns available under existing obligations
PC	$62,518,003.42	$62,518,003.42	0
CNJ	12,245,000.00	9,352,000.00	[1] $2,892,000.00
LV	5,000,000.00	5,000,000.00	0
AA	1,000,000.00	1,000,000.00	0
L & HR	341,000.00	200,269.00	140,731.00
Totals	81,104,003.42	78,071,272.42	3,032,731.00

[1] Includes $75,000 in trust account for rehabilitation of terminal area.

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PENN CENTRAL TRANSPORTATION CO.
Philadelphia, Pa., January 13, 1975.

Hon. JOHN W. BARNUM,
Deputy Secretary of Transportation,
Department of Transportation,
Washington, D.C.

DEAR MR. BARNUM: The Trustees have received your letter of January 10, 1975 expressing the Department's deep concern that we not implement management's program of extensive employee furloughs and severe reductions in purchases and materials and supplies required to permit continuance of Penn Central rail operations beyond late February of this year. You indicate that the administration has developed a legislative proposal which will provide the resources necessary to sustain Penn Central through the first quarter of 1976.

Although we would much prefer to know the details of the administration's proposal before having to make our decision, we are cancelling the implementation of the management's program on the strength of your assurances. Our concern is that the administration's program be not only adequate, but also capable of winning prompt approval both by the Congress and the Reorganization Court.

It must be understood by everyone concerned however that our decision to cancel the reductions in employment and purchasing means that we are foregoing the only measures of self-help available to Penn Central to meet next month's cash shortage. Having deferred management's program since the first of December, we cannot now meet our cash needs by later instituting a similar program. The magnitude of any later self-help program to solve the cash shortage would be so extensive that continued rail operations could not be assured consistent with the requirements of safety. Thus if the aid contemplated by the program of the administration does not promptly make cash available to Penn Central it will be necessary to begin to embargo traffic mid-February, in contemplation of a complete cessation of rail operations for lack of cash in early March, as projected in the management forecasts which you have received.

Very truly yours,

ROBERT W. BLANCHETTE, *Trustee.*
RICHARD C. BOND, *Trustee.*
JOHN H. MCARTHUR, *Trustee.*

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Balance of appropriated funds available for obligation	3,895,996.58
Total outlays against obligations	78,071,272.42

	Obligations	Outlays	Drawdowns available under existing obligations
PC	$62,518,003.42	$62,518,003.42	0
NJ	12,245,000.00	9,352,000.00	[1] $2,892,000.00
V	5,000,000.00	5,000,000.00	0
LA	1,000,000.00	1,000,000.00	0
& HR	341,000.00	200,269.00	140,731.00
Totals	81,104,003.42	78,071,272.42	3,032,731.00

[1] Includes $75,000 in trust account for rehabilitation of terminal area.

215 PROGRAM SUMMARY

Category	Original $150 program	Additional $150 program	Cash savings
Right-of-way programs	70.0	65.0	77.0
Capital programs and yard rehabilitation	51.6	23.0	21.0
Maintenance of way equipment	25.0	0	6.0
Lehigh Valley engines	3.4	0	0
Equipment obligations	0	62.0	62.0
	150.0	150.0	166.0
Cash requirements			300.5
Cash sources:			
Sec. 213 grant funds			134.5
Sec. 215 programs			166.0
Total (above)			300.5

AMENDMENTS TO H.R. 2051

1. Section 3 of H.R. 2051 is amended to read as follows:

Sec. 3. Section 213 of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 723) is amended:

(1) by striking out "Emergency Assistance.—" and by inserting in lieu thereof "Railroads in Reorganization.—";

(2) by adding the following at the end of subsection (a): "Where the Secretary and the trustees agree that funds provided pursuant to this section are to be used (together with funds provided pursuant to section 215 of this Act, if any) to perform program maintenance on designated rail properties until the date rail properties are conveyed under this Act or to improve such designated properties, such agreement shall contain the conditions set forth in section 215(b) of this Act. There are authorized to be appropriated to the Secretary for carrying out this subsection such sums as are necessary, not to exceed $215,000,000, to remain available until expended."; and

(3) by amending subsection (b) to read as follows:

"(b) OTHER RAILROADS.—The Secretary is authorized, pending implementation of the final system plan, to pay to a railroad operating in the region, a substantial portion of whose rail properties is likely to be transferred to the Corporation or other railroads pursuant to the final system plan, such sums as are necessary for the continued provision of essential services by such railroad. Payments made under this subsection shall be subject to terms and conditions required with respect to payments made under subsection (a) of this section and such other terms and conditions as the Secretary establishes. There are authorized to be appropriated to the Secretary for carrying out this subsection such sums as are necessary, not to exceed $25,000,000, to remain available until expended."

2. Insert the following after section 5 of H.R. 2051:

"Sec. 6. Section 206(d) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 716(d)) is amended by redesignating paragraph (5) as paragraph (6), by designating the second sentence of paragraph (4) as paragraph (5), and by adding the following at the end of the redesignated paragraph (5): 'If the profitable railroad is in reorganization under section 77 of the Bankruptcy Act, its reorganization court must decide whether to authorize its trustees to make the offers authorized in the final system plan within 30 days after the effective date of the final system plan. Any appeal from that decision must be taken to the court of appeals within five days following entry of the reorganization court's order and must be decided by the court of appeals within 30 days after the entry of the reorganization court's order. There shall be no review in the Supreme Court of the decision of the court of appeals.'."

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SEC. 7. Section 501(3) of the Regional Rail Reorganization Act of 1973 (45 U.S.C. 771(3)) is amended to read as follows:

"(3) 'protected employee' means any employee of (A) an acquiring railroad adversely affected by a transaction, (b) a profitable railroad operating in the region which transfers a substantial portion of its rail properties to the Corporation or to other railroads pursuant to the final system plan, or (C) a railroad in reorganization, who on the effective date of this Act has not reached age 65."

The CHAIRMAN. Thank you, Mr. Barnum.

I might say that we appreciate your getting through in the time that you did, because we are going to try to move as fast as we can on the bill.

I would like to ask you one question. You have proposed your own bill and then the Senate bill. Which one would you prefer in the present situation?

Mr. BARNUM. We would much prefer our own bill, Mr. Chairman. I think it avoids a number of the problems which the Senate bill creates.

The CHAIRMAN. Under section 213 of the act the trustees of the railroads in reorganization are obligated to maintain and provide service at a level no less than at the time of the enactment of the 1973 act as a condition for any 213 grant. Have the Penn Central trustees complied with that statutory condition in regard to the sum of $80 million they have received to date?

Mr. BARNUM. To the best of my knowledge they have. That specific condition has been made a part of the grant agreement to the Penn Central. It is true there have been instances where the Penn Central has not been able to maintain a section of track in the same condition it was in at the time of enactment. We have been looking at the properties and are requiring that slow orders be imposed at certain locations, and when that has occurred the Penn Central has moved to bring the track back up to condition. If you would like a better status report as to the condition of the Penn Central, we will attempt to provide that to the committee.

The CHAIRMAN. I wish you would.

[The following information was received for the record:]

EXCERPT FROM THE FINAL REPORT, "ROADWAY MAINTENANCE AND REHABILITATION PLAN PENN CENTRAL TRANSPORTATION CO."

An excerpt from the *Final Report, Roadway Maintenance and Rehabilitation Plan Penn Central Transportation Company*, submitted to the Secretary of Transportation on December 11, 1974, at his request by a team of Chief Engineers from six railroads operating principally outside of the Midwest and Northeast region, follows:

III. CURRENT PHYSICAL CONDITION

Several observations regarding the general condition of Penn Central Transportation Company fixed properties were made in the Preliminary Report dated November 20, 1974. Since an understanding of the current condition should be a prerequisite to acceptance of the Rehabilitation Plan, the most important of the comments made in the Preliminary Report need to be re-emphasized here.

Deterioration Is Accelerating

The level of maintenance of main and branch lines varies from good to very poor. Most yards are in poor condition, and some are in a deplorable state. Some of the plant is beyond repair in that it must be completely rebuilt if its use is to continue. The plant which merely requires repairs is generally deteriorating at an increasing rate. As a result, the cost of rehabilitation is growing. This is particularly true on lines and yard tracks carrying heavy traffic volumes where cross

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tie, ballast, and drainage condition is so poor that rail is being lost from premature damage.

Rail Condition Is Unsatisfactory

Rail replacement on Penn Central during the last seventeen years has been at a rate which implies an average age of 257 years. This is at least five times the expected average life of rail, without considering requirements for growth in traffic, increased wear from heavier wheel loading and the desire for faster operating speeds. As a result, the need for rail on Penn Central is very high.

Rail end condition throughout the railroad is deteriorating. This is because of poor tie and ballast maintenance, loose and missing bolts and the lack of cross and surface grinding programs, among other factors. Poor drainage is a primary reason why tie and ballast conditions have deteriorated and led to bent and joint-battered rail. Much rail in the past was cropped without being properly end-hardened, and this has led to excessive joint batter.

The cutback in surfacing work in recent years, particularly the lack of spot surfacing, has also played a major role in accelerating rail wear.

On the heavy traffic lines, rail and other steel in turnouts, particularly at crossovers, has worn badly. The wear is particularly severe where fittings and fastenings are loose and missing, resulting in the overstressing of remaining fastenings and parts.

The Chief Engineers' Team observed numerous instances of rail worn beyond safe limits, especially on yard leads, curve tracks, and branches. Broken rails were common, as were broken angle bars, dangerously-worn and broken frogs and broken switch points. These conditions were observed in varying degrees throughout the property, including the heaviest-traffic lines as well as yard and industry leads.

Insulated joints, trackage in interlockings, and road crossing trackage as a general rule are poorly maintained, the result of skipping this work during the most recent pass-through with rail or tie and surfacing programs. Consequently, these areas have become the controlling factor governing whether the plant is safe and operational at desired speeds.

Cross tie condition is poor

During the last seventeen years, cross ties have been installed at a rate which implies a tie life of 87 years. This is probably close to three times the expected average life if all lines were to remain in service.

Tie condition on most lines is generally poor. This combined with bad drainage or extended surfacing cycles generates a track with poor riding quality.

Tie condition in nearly all yard and siding trackage is deplorable. There are many broken ties. Swinging joints, broken frogs, bent and broken rail—all are witness to the fact that ties have worn out or rotted away.

Ballast condition is good to poor

The worst ballast problem areas are in the interlocking plants, at other turnouts, and in yards; where drainage is poor or nonexistent; and at grade crossings. Improvement of the drainage is a must, followed by ballast cleaning. At many locations under welded rail, the ballast problem is not continuous but isolated, so that out-of-face ballast cleaning is not necessary.

On lines in the Northern, Western and Southern Regions, the ballast material generally is crushed limestone of very poor quality. After a time it pulverizes and becomes impervious to the passage of water. Ties lay in mudholes in the consolidated limestone ballast and constantly absorb the water during rainy times of the year. As a result, tie life is greatly reduced, so is rail life, and the cost to maintain track is higher than it needs to be.

By contrast, ballast on the Eastern, Central and Northeastern Regions normally is a type of trap rock containing mostly basalt or granite material, which is probably among the best ballast obtainable for railroad use. Ballast condition on this part of the railroad is generally good to fair.

Structures are deteriorating

The extent of deferred maintenance of structures on Penn Central is so serious that current budgets do not even allow for correction of known critical deficiencies. There are sizable needs in the immediate future for painting of steel structures, including catenary poles and signal bridges; application of bridge ties; repair of shop and way station buildings; repairs and replacements of water lines and fixtures; and repairs to masonry piers and expansion bearings.

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Signal systems require rehabilitation

Position light signals are in poor condition and maintenance costs are high. Control cables for signals are in need of replacement throughout the system. When cable becomes defective due to splice failures or mechanical damage, it is usually replaced on top of or slightly below ground, making the cable subject to vandalism and further damage.

Many interlocking plants have air compressors for operation of electro-pneumatic switches with feeder lines to each switch. Extensive repairs would be needed; however, CTC proposals on many lines should be implemented instead of repair of existing systems. Much of the present interlocking and signal equipment is no longer available from manufacturers.

Communications are unreliable and costly

Penn Central supplements owned facilities with WATS lines and leased lines for data transmission. Quality for data transmission is a problem and the cost is high. Owned communication lines are subject to repeated failure and equipment is obsolete.

Electric traction systems require extensive repairs

The last time the catenary system was given extensive repairs was eight years ago. An estimated sixty percent of the clips holding the trolley wire presently need tightening. Much of the hardware is corroded and needs replacing, especially on the New Jersey Division.

Substation failures, such as power transformers and circuit breakers, have resulted in equipment being left out of service due to cost of parts or lack of force to repair, where the failure was not critical to operations.

Basic maintenance is inadequate

Because of the force reductions during the last several years, track forces engaged in basic maintenance work as opposed to rail, tie, surfacing, and other programs have dropped below the minimum effective level. For this reason, there is a pressing need for increased manpower in basic, non-program maintenance, while keeping program maintenance at a maximum level dictated by rail, ties, and other materials available. Only if it is possible to increase the amount of basic maintenance substantially will Penn Central arrest the decline of its plant.

One of the consequences of inadequate basic maintenance is that vandalism of fixed property and pilferage of materials, including rail and ties, are on an unprecedented increase. In numerous instances, we found ties, spikes, or tieplates on the rail, creating hazardous operating conditions. In some measure, the excess material on the ground has been due to poor housekeeping on the part of Penn Central, again, because of lack of funds. Increased surveillance is a must during this period of high prices to protect the railroad's property from loss or serious damage.

First priority is to arrest decline

From observations of the physical condition of the plant and projections of its continuing deterioration, it appears that it is beyond the capability of Penn Central to arrest the decline using funds available internally. By not arresting the decline, the eventual cost of rehabilitation will be much higher. This is because total disintegration of the track structure, bridges, and other plant will require complete rebuilding rather than mere repairs of components. Also, the longer the time required to rehabilitate the property, the greater the cost from transportation inefficiency, reduced equipment utilization, and shipper inconvenience.

Organization Needs Strengthening

Of great concern is whether the Penn Central maintenance organization will be able to manage effectively a rehabilitation program of the size described in the next section.

With few exceptions, there is a remarkable enthusiasm and spirit of dedication among the maintenance officers on Penn Central, at all levels. System and regional officers are well qualified as well and entirely capable of directing the rehabilitation programs.

However, a number of division officers down to supervisors of track are in need of varying amounts of training if the rehabilitation effort moves ahead. Even the most junior officer with little experience will, in most cases observed, make an outstanding maintenance officer. But while enthusiasm is abundant, knowledge

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and experience is sometimes lacking. In particular, the Chief Engineers' Team was concerned with the need to improve the level of technical knowledge and to sharpen the judgment of supervisors about what is safe vs. unsafe.

While it may be difficult to think very far ahead in the crisis atmosphere many officers must operate, there also is a need to improve the planning and scheduling of forces and material. This seems to have been a problem the past year when opportunities arose to employ production gangs in basic maintenance because materials were delayed.

On Penn Central just as on any railroad, there is a continuing need to promote good maintenance practices and adherence to standards. In Penn Central production gangs there needs to be more attention paid to the quality of the work. This partly depends on the indoctrination of employees and supervisors in the proper work habits. While training is important, a proper attitude by the supervisor toward production vs. quality is also essential.

In basic maintenance with the maintenance standards which the level of current budgets would imply. Consequently, some of the plant tends to be over maintained while at other locations extremely dangerous conditions have developed that require immediate attention. Although it was not the intent of the Chief Engineers' Team to conduct a detailed safety inspection of the property, dangerous conditions were observed repeatedly. Training is needed now to deal with the problem of ignorance of what is required, after defining more precisely what functions are expected to be performed.

The CHAIRMAN. I must say I am concerned that the trustees come hat in hand to Congress for $250 million and yet object to the conditions being placed on how they use the funds. I want your help, counsel, to address the issue the trustees raised in the Senate, namely, would the court likely refuse to let the trustees use those funds if we impose your proposed conditions in section 215(b)(1)?

Mr. EYSTER. At the time of the Senate hearing there was some misunderstanding about the intent and effect of the language in our proposed bill. The concept we were trying to establish in our proposed language is one which I think the trustees are in agreement with. We have discussed the language a number of times, and I have shown them some new language as recently as 5 or 10 minutes before this hearing began.

Essentially our proposed attempts to lay down a ground rule for carrying out the principle which is presently in section 215. That principle is that taxpayer money goes into a track improvement or program maintenance project under 215, our concept is that ConRail, Consolidated Rail Corp. should not be required to compensate the estate of the railroad for the value of the improved property, but rather, would look to the condition the property was in before the taxpayer money was provided under section 215.

I think the trustees are in agreement with that and if we have language we can agree on as achieving that purpose, it is my understanding the trustees would recommend to Judge Fullam that the court approve an agreement under the 215 language.

The CHAIRMAN. Thank you.

Mr. Macdonald, any questions?

Mr. MACDONALD. Yes, I have just a couple, Mr. Chairman.

Mainly I don't quite understand where you say on the last page of your statement, "In this regard it should be noted that costs are defined in the statute to include a reasonable profit."

To whom?

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Mr. BARNUM. To the railroad directed to perform the service. In this case, if the ICC were to direct the Norfolk & Western to operate the Penn Central, Norfolk & Western would be entitled to receive a reasonable profit for performing that service.

Mr. MACDONALD. What is your idea of a "reasonable profit"?

Mr. BARNUM. I would leave that decision to the ICC, which I think is the appropriate body for that purpose. I would suggest it should be in excess of the average profit being earned by railroads today. It would be a very difficult problem and it would be a very substantial sum in the case of anyone required to operate 20,000 miles of railroad, such as the Penn Central now has.

Mr. MACDONALD. I don't doubt that, being from an area that is very vitally affected by this matter, but we hate to see money follow money, which has been happening with no results. We have just been pouring money into the Penn Central and gotten very little back in return.

Mr. BARNUM. I share your concern, and that is indeed one of the reasons we recommend that the Congress act promptly to provide the kind of assistance that, first, can keep Penn Central operations going without having to provide another railroad a reasonable profit in doing so, and secondly, can, in effect, result in a downpayment for ConRail, rather than simply a payment in the form of a grant never to be seen again.

The CHAIRMAN. Mr. Devine.

Mr. DEVINE. As you know, my name is on this bill along with the chairman's, although there are a number of reservations we have. I would like to invite your attention specifically to that portion you address on page 12, having to do with the Erie Lackawanna. First of all, you are suggesting an amendment be offered which would provide, I think, $25 million in order to resolve some of their problems. My recollection, if it is correct, Erie said their immediate need for February was something like $15 million rather than $25 million. Why is there any divergence in that particular figure?

Mr. BARNUM. This statement was made prior to the Commission's action with respect to the 7-percent rate increase. The estimates that we now have for the Erie Lackawanna are $20 million in calendar year 1975, and an additional $5 million in the first quarter of 1976, or a total of $25 million.

Mr. DEVINE. Erie Lackawanna would prefer to be included under the same umbrella the Penn Central is. According to your statement on page 12, you object to including them under the act and on page 13 state the final plan can provide for the conveyance of properties on the volunteer basis. To whom would such conveyance take place?

Mr. BARNUM. Either to ConRail or to a solvent railroad in the area. Mr. Devine, I would urge you not to confuse two issues. We definitely would like to have sufficient funds available to keep the Erie Lackawanna operating throughout the planning period, through the first quarter of 1976. We are also prepared to have the act amended so that in the event of such a conveyance, the title V labor protective provisions would be available to the employees of the Erie. The only thing we resist is the idea of going back to the early days of the reorganization process under the 1973 act and constituting them as a "railroad in reorganization." The only benefit you obtain by virtue of

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doing that is that USRA, by designating certain properties of the Erie, would be able to require their transfer to ConRail in exchange for ConRail stock or be able to offer them to some other railroad.

Under the procedures we would recommend USRA is equally well-positioned to show which Erie Lackawanna properties should be included in the final system plan, either for inclusion in ConRail or for acquisition by another solvent railroad. And in our judgment, and in our view of the work proceeding at USRA to date, we believe that the slight benefit that could be obtained by virtue of being able to control the transfer of the Erie Lackawanna properties is far outweighed by the very substantial risk that amending the act in the respects sought by the Erie Lackawanna trustees would reopen all of the constitutional litigation and put a cloud over the whole planning process.

It took 11 months to get to the Supreme Court the first time to find that the act is constitutional. We are running out of time. I don't think we should spend the next 6 months under a cloud waiting to find out whether the parts of the act the Erie Lackawanna trustees would add are constitutional, whether the planning process should require the transfer of that property, or whether the transfer is something Erie should negotiate with the Chessie System, ConRail or any other system.

Mr. DEVINE. Don't you think the proposed amendment to provide $25 million would be a one-shot deal, and when this money ran out would put them on the auction block? Do you know of any market for Erie Lackawanna?

Mr. BARNUM. I am not suggesting that ConRail has no interest in the Erie Lackawanna properties. If the Erie Lackawanna does not continue to use them, some of its properties would be useful in the ConRail system.

Mr. DEVINE. I take it it is your position you don't want them included under the same umbrella as Penn Central because of the possible litigation that would challenge the constitutionality of the whole act?

Mr. BARNUM. That is one reason. And the other reason is that if they are made a railroad in reorganization under the terms of the act, as both the special court and the Supreme Court have found, there would be an opportunity farther down the road for the creditors of the Erie Lackawanna to sue in the Court of Claims under the Tucker Act to recover both the erosion costs and the conveyance costs not met by compensation under the act.

Mr. DEVINE. Thank you. My time has expired.

The CHAIRMAN. The committee had some new rules that the gentlemen who come in last get to speak last, but we have not adopted our rules as of yet, so we will not put them in effect today. We have been experimenting as to how we do it. We will take the gentlemen as they are here now.

Mr. Rogers.

Mr. ROGERS. Just one question.

The total amount that you are recommending would last for all of 1975?

Mr. BARNUM. Calendar year 1975, and the first quarter of 1976. We selected that period of time because under the present schedule of the

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Regional Rail Reorganization Act the transfer of the properties selected by USRA for ConRail takes place in the first quarter of 1976.

Mr. ADAMS. Would the gentleman from Florida yield?

Mr. ROGERS. Yes.

Mr. ADAMS. Isn't there a substantial risk, following up Mr. Devine's question, that if we tamper with the Northeast Rail Reorganization Act at all, as suggested by your amendment and as in the Senate amendment, that we risk litigation again from the creditors who have just lost in the Supreme Court? And why not amend the Emergency Rail Services Act of 1970, which is separate, to skid Erie Lackawanna through until we get the plan from ConRail and then deal with them?

I have little sympathy for Erie Lackawanna, because we told it to come in. They stayed out. It is their decision and, therefore, the bailing out process to me is only for the people in that area and not for Erie Lackawanna.

Mr. BARNUM. I agree with you, Mr. Adams, that the amendments in the Senate bill do create a substantial risk. I do not believe the amendments we proposed in our original bill or are proposing today, to provide financing for the Erie Lackawanna, would create that risk of litigation.

Mr. ADAMS. Why not go to the other act?

Mr. BARNUM. The Emergency Rail Services Act of 1970 originally authorized $125 million in loan guarantees and $100 million was allocated to Penn Central. I believe there is $19 million of loan guarantee authority available to us at this time. Any loan made pursuant to that act must be given priority under the Bankruptcy Act.

Mr. ADAMS. We could change that.

Mr. BARNUM. You could. You could change it along the lines of the Agnes Act, which authorized the Secretary of Transportation to enter into a loan agreement accepting for the Government, as I recall, the position of an unsecured prebankruptcy creditor. That loan could be made to Erie——

Mr. ADAMS. It would get it through until ConRail and USRA's plan was in effect and we could deal with them?

Mr. BARNUM. That is correct.

Mr. ADAMS. Thank you, Mr. Rogers.

The CHAIRMAN. The gentleman from North Carolina, Mr. Broyhill.

Mr. BROYHILL. These other members of the committee are asking legal questions. I would like to be clear as to exactly where this $250 million is going. In other words, how will that be allocated? Primarily for maintenance of ways, operating costs? Do you have a breakdown on that in the record, Mr. Secretary?

Mr. BARNUM. In the table attached to my statement, Mr. Broyhill, captioned "215 Program Summary," you will see how we would allocate, we and the United States Railway Association, the $150 million under the existing section 215. That appears in the first column.

The second column describes how we would allocate the $150 million that we urge the Congress now to add to section 215. As I said in my prepared statement, if the Congress does not adopt the amendment to section 215 to add the second $150 million, we and the United States Railway Association would go back and reconsider how to spend the first $150 million. In other words, if we had only $150 million to spend, we might not spend it the way set forth in the first column. That allocation anticipates having $300 million to spend.

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With respect to the balance in section 213, a substantial part of that would have to be spent on maintenance and operating expenses.

Mr. BROYHILL. Thank you very much.

The CHAIRMAN. The gentleman from California, Mr. Van Deerlin.

Mr. VAN DEERLIN. Thank you, Mr. Chairman.

My question doesn't address itself, Mr. Barnum, to the central subject matter before us, but to an auxiliary matter. In response to a Department request, the Senate lifted the ceiling on the salary that can be paid to the principal officer in Amtrak. On the Senate floor, apparently, an $80,000 maximum imposed.

Mr. BARNUM. $90,000.

Mr. VAN DEERLIN. $90,000. Thank you. It was in this committee 3 or 4 years ago that the question of limitations first came up, after it was disclosed that the president of Amtrak had been retained at a Government salary second only to the President of the United States. Inasmuch as that recent vacancy has been filled subsequent to the start of action on the Senate side, I wonder if you would address yourself to the urgency of our accepting an amendment like this.

Mr. BARNUM. Mr. Van Deerlin, I think it is very important that the Amtrak Act be amended to permit not only the chief executive officer, but also the other senior executive officers of Amtrak, to be paid on a level that would be commensurate with salaries at other railroads. Our original proposal to the Congress in the last session was that the act be amended so as not to place a dollar limit on the salaries that could be paid to Amtrak executives, but rather to require the board of directors of Amtrak to set the amount with due regard to the amounts paid to the chief executive officers of the other railroads of the Nation.

We submitted to the Congress and this committee at that time a schedule showing what the chief executive and other senior officers of the other railroads of the Nation were being paid, so there would be a framework within which to consider the amounts that the board of directors might select. We think it is still desirable that the Amtrak Act be amended in that respect, with respect to all senior officials I would prefer there not be a dollar limitation. I do not think the fact that Mr. Paul Reistrup, of the Illinois Central Gulf, has accepted the position should change the underlying reason for amending the act. Whether or not it is necessary to embroil this committee or the House of Representatives in this issue at this critical time, I would urge you and the committee if, in fact, it is to be an issue, to put it aside and take it up at the time you consider whatever other amendments are necessary with respect to Amtrak.

I do not want to suggest by concurring in your delay of addressing this issue that we are not wholeheartedly in support of permitting Amtrak to compensate its executives on a basis that would make their salaries comparable to those of other railroad executives of the Nation. It is from those executives we must select the management of Amtrak. It is important we not be inhibited by what, in my judgment, is an unjust limitation that prevents us from having the pick of the crop.

Mr. VAN DEERLIN. The question that also suggests itself to whether we would not have similar difficulty filling the office of Secretary of Defense or even Secretary of Transportation if we considered that Government or Government-related employment had no inducements other than material.

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Mr. BARNUM. That is a fair comment, but I would remind you, Mr. Van Deerlin, when this committee and the Congress addressed the question of what we should do with respect to the executives of the United States Railway Association, on the one hand, and ConRail, a private sector railroad, on the other hand, the judgment of the Congress was that it would be appropriate to limit the salaries payable to the officials of USRA, but it would not be appropriate to place any limitations on the salaries of the officials that were to run ConRail.

I would submit to you, Mr. Van Deerlin, Amtrak is more analogous to ConRail than to either the Secretary of Transportation or the Chairman of the United States Railway Association.

Mr. VAN DEERLIN. In the negotiations with Mr. Reistrup was there any assurance given him that the full force of the Department would be placed behind an effort to get this limitation raised?

Mr. BARNUM. Yes, sir. I gave him that assurance personally.

Mr. VAN DEERLIN. I see. I will admit, in a society that pays a 20-game winner in the American League more than the President or a Supreme Court Justice, that these are questions which don't lend themselves to hard and fast answers.

Thank you.

The CHAIRMAN. The gentleman from Kentucky, Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

I would like to ask you if you are familiar with the condition of rails and the ties on the Pennsylvania Railroad.

Mr. BARNUM. Only second-hand, Dr. Carter.

Mr. CARTER. What about the usage time of the rails? Is it true that they have been used five times as long as is usual for rails on other modern railroads?

Mr. BARNUM. That is a fair summary, yes.

Mr. CARTER. Is it true also that the ties on the railbeds are used three times as long as those on other comparable railroads?

Mr. BARNUM. I think that is also a fair summary. Of course, we are concerned with the rate at which the Penn Central has been replacing ties and rails. And they have been replacing them much more slowly than the railroads of the South and West.

Mr. CARTER. How many derailments did you have last year on Penn Central?

Mr. BARNUM. I can't give you the gross figure. I know when the Federal Railroad Administration shut down certain lines of the Penn Central, there were something like 487 derailments over a relatively short period of time, caused among other things by some 62 places where the FRA said they could not operate trains at any speed.

Mr. CARTER. Do you recommend the U.S. Government take over the railbed of this area?

Mr. BARNUM. I do not.

Mr. CARTER. All right, sir. I have a letter here from Erie Lackawanna, a copy of it, from the chairman, in which instead of asking for $25 million, they are asking for $15 million. You have increased that amount. For what reason?

Mr. BARNUM. That is correct. I believe that that letter may have been written prior to the action of the ICC last Thursday rejecting the 7-percent rate increase.

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Mr. BARNUM. That is correct. I believe that that letter may have been written prior to the action of the ICC last Thursday rejecting the 6-percent rate increase.

Mr. CARTER. This was on the 22d of January. That is possibly true. I notice you advise also the purchase of rolling stock, but you would retain title to that stock. That is, for the U.S. Government, is that correct? Or for ConRail?

Mr. BARNUM. That is correct.

Mr. CARTER. You would separate that from the ownership of stockholders, is that correct?

Mr. BARNUM. That is correct. That could come to pass in either of two ways. Let's take the situation where the railroad is currently making installment payments under an equipment-purchase agreement, and they have made five installments to date of $1 million each. There are five more installments of $1 million each to be paid.

We would make those payments and thereby acquire a one-half interest in the rolling stock.

Mr. CARTER. How long do you think it will take to get Penn Central on a paying basis, if ever?

Mr. BARNUM. Well, we don't envision trying to put the Penn Central per se on a paying basis. The USRA is wrestling with the question of what properties of the Penn Central and other railroads should be included in a system called ConRail, and the answer to the projections of profitability must be provided by the preliminary plan due February 26.

Mr. CARTER. You think it will be profitable by what time?

Mr. BARNUM. I spent this morning and will go back this afternoon to the United States Railway Association board meeting, where we are wrestling with those questions.

Mr. CARTER. Is this true? Is Erie Lackawanna in some areas parallel to Penn Central?

Mr. BARNUM. Yes; it is.

Mr. CARTER. Are you going to have them in competition?

Mr. BARNUM. Well, if the Erie Lackawanna is not able to reorganize on its own, and its properties become available either to ConRail or the Norfolk & Western or the Chessie, which also operate throughout the same region, whether or not the Erie Lackawanna line would continue in competition would depend upon the interest one railroad or another would have in providing that service.

In some parts of the region the Erie provides the fourth service. The Norfolk & Western, the Penn Central and Chessie are also there. The Erie is the only service available in other parts of the region.

Mr. CARTER. I didn't get your final answer, if you recommended——

Mr. BARNUM. As we look at it today, there are parts of the Erie Lackawanna that should be preserved in some rail system in order to provide competition.

Mr. CARTER. Thank you, Mr. Chairman.

The CHAIRMAN. The gentleman from Pennsylvania, Mr. Rooney.

Mr. ROONEY. In your testimony you talked about a 100-percent increase for fuel. Does your $250 million include increased costs for fuel which would result if we adopted the administration's energy proposal?

Mr. BARNUM. No; it does not.

Mr. ROONEY. What would you estimate that would cost?

Mr. BARNUM. Additional? I would give you an off-the-cuff estimate

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that for the period of time we are talking about, that could cost the Penn Central about another $100 million.

Mr. ROONEY. You will be coming back in August for another $100 million?

Mr. BARNUM. Not unless the ICC disregards the very evidence of increased operating costs resulting from fuel costs and does not give the railroads rate relief.

Mr. ROONEY. I have seen an engineer's report on the condition of the Penn Central track and understand it would cost between $4 and $5 billion to rehabilitate their track over the next 10 to 15 years. Do you agree with that?

Mr. BARNUM. Yes. It was done by the chief engineers of six of the prosperous railroads of the Nation, and we in the department are grateful to them for doing it. Their figure was $4.6 billion, uninflated, and the analysis we have done substantially corroborates that need.

Mr. ROONEY. Where will this money come from if we are going to rehabilitate that track?

Mr. BARNUM. Either from the loan guarantee provisions of the Regional Rail Reorganization Act or from operating income.

Mr. ROONEY. Under section 212 your Department must keep exact records of the railroads involved that receive loans and grants. Have you done a very thorough study on this subject?

Mr. BARNUM. We have done a number of audits. The Department of Transportation has on several occasions sent its auditors to Philadelphia to audit the ways in which the Penn Central has applied the funds we have made available under those grants.

Mr. ROONEY. I have no further questions.

The CHAIRMAN. The gentleman from Kansas, Mr. Skubitz.

Mr. SKUBITZ. Mr. Barnum, on page 3 of your testimony you refer to a three-point program submitted by the trustees to save money. But your organization, in turn, found this unacceptable because it would result in unsafe conditions on the railroads. That isn't anything new. On these railroads, and I am thinking now in terms of some of the questions that Dr. Carter raised, because of unsafe conditions we have had any number of rail accidents, have we not, including several serious accidents on the Amtrack line? Is that not correct?

Mr. BARNUM. That is correct.

Mr. SKUBITZ. Now, under section 213, the act will allow $85 million for operating expenses. If I understood you correctly, all but $4 million of that has been used. Is this correct?

Mr. BARNUM. That is correct. I would not limit the applicability of section 213 to operating expenses, Mr. Skubitz.

Mr. SKUBITZ. I understand. You are asking for an additional $100 million, not only for operating, but maintenance; is that correct?

Mr. BARNUM. I think the original section 213 authorized us to use those funds for operating and maintenance. I would point out to you the first application of section 213 funds was used to make installment payments for equipment purchases.

Mr. SKUBITZ. What sort of equipment?

Mr. BARNUM. Boxcars, as I recall.

Mr. SKUBITZ. Big boxcars. I believe in some instances locomotives also, is that correct?

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Mr. BARNUM. Those were acquired with a loan made under section 215, $3.4 million to Lehigh Valley.

Mr. SKUBITZ. You are asking for $100 million more for operating and maintenance; is that correct?

Mr. BARNUM. The proposal we sent to the Congress on January 17 asked for that amount. We are now asking that the $100 million be augmented in two respects: $25 million for the Erie Lackawanna and $30 million to make up for the funds that the railroads will not receive from what they had anticipated would be a rate increase.

Mr. SKUBITZ. Now, under section 215 this committee allowed $150 million, and that $150 million was to be used for maintenance, roadbeds, and things of that nature; isn't that correct?

Mr. BARNUM. It was for acquisition, maintenance, or improvement of rail facilities that would be included in the final system plan.

Mr. SKUBITZ. How much of that $150 million have you now used in roadbed improvements alone?

Mr. BARNUM. None has been spent to date for that purpose, but the chart attached to my statement outlines how we would expect to spend about $300 million, much of it on roadbed maintenance.

Mr. SKUBITZ. You expect to use it, but you have not used any of the $150 million we allocated for that purpose. And how much of that is left?

Mr. BARNUM. Well, we did use $3.4 million for locomotives for the Lehigh Valley.

Mr. SKUBITZ. About $147 million is still left; isn't that correct?

Mr. BARNUM. That is correct. The way in which that would be applied is set forth in the schedule attached to my statement.

Mr. SKUBITZ. You are now asking for an additional $150 million; is that correct?

Mr. BARNUM. That is correct.

Mr. SKUBITZ. So while the trains were being wrecked because of poor roadbeds, passenger trains being wrecked, and lawsuits are now pending, I presume either against the bankrupt railroads—which I don't think is correct—or against Amtrak, which may be covered by insurance, you did nothing? You did nothing about roadbed maintenance?

Mr. BARNUM. Well, it is not our responsibility to perform the maintenance.

Mr. SKUBITZ. I understand. You did not allocate any money for it. The bankrupt railroads could do nothing without money.

Mr. BARNUM. During this period the Penn Central was budgeting approximately $300 million a year for roadbed maintenance. I will be the first to admit that that was not enough. It was the prospect that that amount would be cut substantially and employees who could perform the maintenance would be laid off that led us to urge the Congress to supplement the amounts available.

Mr. SKUBITZ. I believe you just agreed with the chairman of our subcommittee that there was a study that would call for $5 billion to improve Penn Central alone.

Mr. BARNUM. Over 8 years.

Mr. SKUBITZ. So when we talk of $300 million that Penn Central allocated for 1 year, we are talking about peanuts?

Mr. BARNUM. It is a substantial investment in maintenance.

Mr. SKUBITZ. When compared to $5 billion it is peanuts.

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Mr. BARNUM. In our opinion the amount should be and could be doubled.

Mr. SKUBITZ. Do you think you folks should have done something about Penn Central when you saw these wrecks on the lines, when there were Amtrak trains being wrecked. Is it your position that you were not responsible because, after all, Amtrak is not your responsibility and hauling freight is? And if roadbeds are to be fixed in order to carry Amtrak trains, then it is our responsibility to help maintain those roadbeds?

Am I wrong or not?

Mr. BARNUM. Well, I believe, Mr. Skubitz, it is the Government's responsibility initially to inspect the properties of the railroads and, where appropriate, to require that service not be continued until the properties have been repaired or at least slow orders imposed.

The Federal Railroad Administration did do both of those things with respect to substantial segments of the property.

Mr. SKUBITZ. But it isn't enough, Mr. Barnum, just to inspect. It is necessary to repair and if you don't have the money, and we have allocated money for that primary purpose, it seems to me you have been negligent in not doing something about it.

The CHAIRMAN. Your time has expired.

Mr. SKUBITZ. Will I be able to ask questions at the end?

The CHAIRMAN. The second time around.

Mr. Adams, the gentleman from Washington.

Mr. ADAMS. Thank you, Mr. Chairman.

Mr. Barnum, I want to ask you, first, if, under the Supreme Court decision, is it not correct that the Court has said that a reorganization plan can be forced on the Northeast railroads? They can be required to take stock and the plan will go into effect with the caveat that if the reorganization plan is not fair and equitable, the creditors can sue under the Tucker Act?

Mr. BARNUM. Yes.

Mr. ADAMS. So that we are in a position now to go forward with this act and, in effect, reorganize the existing Northeast railroads?

Mr. BARNUM. Yes.

Mr. ADAMS. Now, if the Erie Lackawanna is placed in that act, do you not agree that since there is a split between the creditors of that estate and the trustees and the original owners of the estate, there is a very good possibility that the creditors will litigate that act again, saying that the terms of reorganization have been changed?

Mr. BARNUM. I agree with you 100 percent, and I would suggest that not only the creditors of the Erie Lackawanna, but the creditors of the Penn Central.

Mr. ADAMS. The creditors of all of the estates would at least use this as a lever for going back to court?

Mr. BARNUM. They would.

Mr. ADAMS. Now, I want to avoid that. And I want to know whether or not you believe we could not amend another act which would be the Emergency Rail Services Act, and grant in effect nonrecourse trustee certificates to the extent—I believe there is some money left in that act, we might have to increase it—to give the Erie Lackawanna enough funds to at least get through until ConRail is in a position to make an offer to them?

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Mr. BARNUM. Under the Emergency Rail Services Act of 1970 there are about $19 million that have not been committed; $100 million went to the Penn Central, $6 million has been committed, and $2 million actually given to the Central of New Jersey. I do not believe a separate appropriation act would be required to permit the Secretary of Transportation to make available the remaining amount.

Mr. ADAMS. Are you talking about the original act under which we gave money to the Penn Central?

Mr. BARNUM. The Agnes Act authority has expired, in that railroads had had to apply for funds within a certain time period.

Mr. ADAMS. All right——

Mr. BARNUM. May I apologize for taking more of your time, but the problem that might arise in the use of the Emergency Rail Services Act is it would only be a loan to the Erie Lackawanna. And the Erie Lackawanna court may not want to have——

Mr. ADAMS. I understand that. But if we dropped that down to the unsecured creditor level——

Mr. BARNUM. Or to the level of a prebankruptcy unsecured creditor. I might prefer to amend that authority so we could make a bridge loan of that nature, and at the same time amend section 213 so when the Appropriations Committee is able to appropriate additional funds under section 213, the Erie Lackawanna could be given a grant, albeit on the conditions set forth in 213, and repay the bridge loan.

Mr. ADAMS. Now I want to shift to your proposal for section 213 of the Regional Rail Reorganization Act, I have difficulty in opposing your request because you remember when we were doing that act, I recommended $285 million for interim operating money because $85 million would never work.

Mr. BARNUM. I am sure you are right.

Mr. DINGELL. Will you yield?

Mr. ADAMS. Yes.

Mr. DINGELL. Will you see to it we have drafting service from your agency on the point just previously discussed with Mr. Adams in his previous colloquy from you?

Mr. BARNUM. You are talking about the Emergency Rail Services Act?

Mr. DINGELL. Yes.

Mr. ADAMS. What I am concerned about is this: That you have asked for money to go through the first calendar quarter 1976. I am concerned about the fact that we seem to be faced with continuing litigation from creditors of these bankrupt railroads, and when we are considering the plan that comes up to the Hill at the end of July this year, that if we have just simply given away money all the year, and are continually giving away money, we are going to be faced for suits for interim erosion and additional collection.

Why should we give the total amount at this point rather than taking that into account since we are going to, obviously from your testimony just previously, have to go with another billion later on anyway?

Mr. BARNUM. Well, I am not as convinced as perhaps you are that we will have to go with another billion. I would——

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Mr. ADAMS. In other words, if the energy bill goes through in some fashion, you indicated there would be another billion. I am concerned about how we deal with these people when ConRail is about to make its offers and we have, in effect, given away an additional number of billions of dollars before we even get to the wrestling stage?

Mr. BARNUM. I don't think of it as giving it away. Under section 215 we would, in fact, be making a prepayment for ConRail.

Mr. ADAMS. I am talking about the 213 section; 215 I understand.

Mr. BARNUM. Under section 213 we intend to impose the same conditions we did with the first $10.8 million we authorized under that section.

Mr. ADAMS. The creditors will litigate with you again?

Mr. BARNUM. They did before and lost before.

The CHAIRMAN. All right.

Mr. BARNUM. May I add one thing, because I think it is important to Mr. Adams' consideration as to whether or not you should take it in bites. I would remind him of the very fair comments made by Mr. Skubitz with respect to the opportunity to improve the properties of the Penn Central. One of the reasons we would like to see the committee approve the amendment increasing 213 at this time is to allow us to begin placing orders for ties and rails and rolling stock which are very much an important part of the rehabilitation of the property.

Not to do it at this time is going to delay the day when the Government is going to be able to start doing the kinds of things Mr. Skubitz would have us do.

Mr. ADAMS. You can't do that until you see the plans.

Mr. BARNUM. We can tell you right now that by getting in line for track and rail and waiting a year and a half for its delivery, when we have the plan we will know where to put it.

Mr. ADAMS. And spend your $150 million.

The CHAIRMAN. The gentleman from Texas, Mr. Collins.

Mr. COLLINS. Mr. Barnum, you are part of the administration and I am sure you have been reading this book we have all been reading called the Budget of the United States. It looks to me like we might run $100 billion in deficit up here. So what we are talking about before this committee is borrowed money. We are going to call on the taxpayers to borrow money to provide for this railroad.

I have sat in with this committee for several years and we have had one emergency after the other. And if this happened in the hospital, I think the doctor would recommend there be some kind of an operation or surgery. In this particular report, when the trustees recommend taking positive action, you all came out against it. They said they thought we should not pay wage increases due in 1975.

To me that seems pretty reasonable. This railroad is losing money. Why pay a wage increase?

Mr. BARNUM. Because, Mr. Collins, if they do not pay the wage increase other railroads of the Nation have negotiated with the unions, effective the first of this year, in my judgment there is a very substantial likelihood the railroad would stop operating.

You talk about a substantial deficit in the total Federal budget. That is true, $52 billion. It is that size because it projects a certain level of revenues and they are a reflection of the level of taxes, which reflect income. If the Penn Central stops operating, the national income

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level will drop, the taxes will drop, and your budget deficit will increase. By making these modest investments to continue rail operations in these 17 States, you will do more to keep the deficit down than anything else.

Mr. COLLINS. You say the workers of these railroads are not willing to help or cooperate by holding the line on expenses, is that your statment?

Mr. BARNUM. I have not personally talked to the Penn Central or their unions. However, I have beeen advised by the Penn Central management that in the event they do not make the 1975 payments, increase the wages, there is a likelihood they will be struck. The management is here and could give you a first hand report on that question.

Mr. COLLINS. They made a statement here that they thought the labor force should be reduced by 4,500 people. Usually the first thing to do is try to eliminate any jobs that can be cut out. Why are you opposed to cutting these 4,500 jobs?

Mr. BARNUM. The 4,500 jobs listed there include 3,500 people that should be doing maintenance on this property. If the maintenance of way is not kept up, the whole operation will stop. Shippers will divert their traffic to other properties. Penn Central has already laid off a number of people on the operating side because the 7-percent decrease in its traffic has reduced the need for operating personnel. We would not like to see them decrease their work force on maintenance of way. There the demand is increased, not decreased.

Mr. COLLINS. As I recall, when this case first came up, the judge said he thought that about 5,000 miles of track should be discontinued. What was it the judge said? How many miles of dead track should be discontinued?

Mr. BARNUM. In a report submitted several years ago, the Penn Central trustees estimated a reduction of more than 5,000 miles.

Mr. COLLINS. Now, the Transportation Department came out against that. It seems to me if we would have discontinued that track and concentrated on the live active track, we would have active maintenance. Why were you against that?

Mr. BARNUM. That is not accurate. We were not opposed to their abandoning properties. We have supported the Penn Central in a number of its applications. The February 1, 1974, report submitted by the Department of Transportation pursuant to the Regional Rail Reorganization Act, recommended that over 5,000 miles be considered for abandonment. We did not at any time oppose the abandonment.

Mr. COLLINS. You just quoted the 1974 act, and I thought that was recommended by the Transportation Department, that service be continued as it was?

Mr. BARNUM. The Congress determined that during the planning process certain procedures should be followed before properties are abandoned. There is right in the act a separate provision that says how a railroad in reorganization may abandon its properties. Some abandonments have been performed.

Mr. COLLINS. Would you recommend in this act that we specify that 6.000 or 7,000 or however many miles it is—that they should be abandoned now? Should we put that in this bill now?

Mr. BARNUM. No, sir; I believe that is something the Congress should leave to the U.S. Railway Association.

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Mr. COLLINS. Of course, it seems if we are putting the money up, we ought to put it up on a sound basis. Why shouldn't we act on abandonments now?

Mr. BARNUM. You have in the sense you have given to the U.S. Railway Association a mandate to extract from the 25,000-plus miles of the several bankrupt railroads a viable system. That will necessarily contemplate some abandonment.

Mr. COLLINS. Have any tracks been abandoned? And if not, why not?

Mr. BARNUM. Some have been.

Mr. COLLINS. All right. Thank you, Mr. Chairman.

The CHAIRMAN. The gentleman from Missouri, Mr. Symington.

Mr. SYMINGTON. Thank you, Mr. Chairman.

I simply want to commend the witness for his succinct and informed answers, and for being with us today. I have no questions at this time.

Mr. BARNUM. Thank you, Mr. Symington.

The CHAIRMAN. The gentleman from Nebraska.

Mr. MCCOLLISTER. These proposals that DOT makes are interim until ConRail takes over?

Mr. BARNUM. That is correct.

Mr. MCCOLLISTER. What is your estimate when the final system plan will be submitted to the Congress for approval?

Mr. BARNUM. The present schedule is July 26, 1975.

Mr. MCCOLLISTER. Do you believe that date will be kept?

Mr. BARNUM. Yes, sir.

Mr. MCCOLLISTER. Then as I recall the act, we have 60 days in which to approve it in the Congress?

Mr. BARNUM. That is correct; 60 legislative days.

Mr. MCCOLLISTER. So that perhaps by early December, surely by January, ConRail will be ready to go in some form or other?

Mr. BARNUM. That is our expectation.

Mr. MCCOLLISTER. All of this we are considering today and this week. Then based on the interim situation, does it not seem likely that these same conditions which have worsened the Penn Central and other Northeast rails are likely to continue, sir, when ConRail takes over, even though ConRail may be operating on less track and be able to concentrate their maintenance effort a little better? But don't these same economic conditions that have made the Penn Central situation so urgent carry over to ConRail?

Mr. BARNUM. Many of them do; that is correct. The increased cost of fuel and the downturn in the economy do. Certainly the downturn in the automobile business will greatly affect the properties remaining for ConRail.

Mr. MCCOLLISTER. How does it affect the Department of Transportation's estimate of ConRail being a viable profitable private entity?

Mr. BARNUM. USRA is taking these matters into account in estimating the operating revenue of ConRail.

Mr. MCCOLLISTER. Have you seen anything from the USRA? Any estimates?

Mr. BARNUM. I sit on the board of directors of USRA. We met all day yesterday and will meet today and next week in preparation of the preliminary system plan which is due to be published on the 26th of

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February. The answers to the questions of what will be the viability of ConRail, what will be the cost of rehabilitation—at an estimated level, for this is a preliminary plan—will be made available on the 26th of February. It would be premature to make any guesses about it at this time.

Mr. McCollister. Mr. Chairman, I yield to the gentleman from Kansas.

Mr. Skubitz. Mr. Barnum, Mr. Adams raised the question of the Erie Lackawanna creditors proceeding under the Tucker Act if they were included under this bill. In response to that question, if I understood correctly, your answer was yes, that they could. Am I right?

Mr. Barnum. It depends on how you include them, Mr. Skubitz. If you permit the reorganization court that is presiding over the Erie Lackawanna——

Mr. Skubitz. If we were to——

Mr. Barnum [continuing]. To go back and make the determinations it might have made 120 and 180 days after the date of enactment of the Act, they would be in the same posture as the Penn Central, and the creditors would be in a position to make Tucker Act claims based on erosion and the conveyance of their properties.

Mr. Skubitz. I am no authority on the Tucker Act, but if we proceed to permit the Erie Lackawanna to come in as they want to now, the creditors could proceed under the Tucker Act.

Mr. Barnum. That is correct.

Mr. Skubitz. I think you added the phrase, "Yes, and the Penn Central people could, too"?

Mr. Barnum. That is correct.

Mr. Skubitz. That is nearly the statement I made on the floor when this bill was before us. The initial bill was on the floor, when I said "Don't be kidded, this thing is going to cost this country $10 billion to $12 billion before we get it into operation."

Now I would like to turn to the Penn Central just 1 second. Am I correct, or do you disagree, that if we had not acted, the Penn Central would have gone on the rocks?

Mr. Barnum. No question about it.

Mr. Skubitz. All right. And if I understand what you are suggesting now, you are stating that we don't want to take Erie Lackawanna in tight until the final systems plan is worked out, and that we will subsidize or provide additional funds to Erie Lackawanna in the interim. And then—is that correct?

Mr. Barnum. That is correct.

Mr. Skubitz. And then when we get the final systems plan worked out, you are not stating it this way, but we will pull the rock out from under Erie Lackawanna, force it into bankruptcy, and then be able to deal with them as we want to deal with them. Is that correct?

Mr. Barnum. No, it is not correct. They are already in bankruptcy.

Mr. Skubitz. Mr. Chairman, some way or other, I am going to get my questions in.

The Chairman. The time has expired.

The gentleman from Ohio, Mr. Carney.

Mr. Carney. I have been impressed by Mr. Barnum, Mr. Chairman. Do you think this bill itself is, is this another patch-plaster thing,

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or a band-aid? Will we be back here next year? You are the successor to this group. Is Government going to be expected from now on out to keep adding every year money to these railroads and doing an inadequate job, in my opinion? Is this going to continue?

Mr. BARNUM. I certainly hope not, sir. I think the Congress, in passing the Regional Rail Reorganization Act, took the first necessary step to a long-term remedy for the railroads of this region. I think if the Congress would take the next step and enact something along the lines of the Surface Transportation Act which this committee and the House of Representatives passed in the last session, they would take the second very meaningful and necessary step without which reorganized railroads in the Northeast will not be able to survive. They need long-term loan guarantees available to them, and certain regulatory reform, without which railroads will not be able to survive.

Mr. CARNEY. You say unless what?

Mr. SKUBITZ. In addition to the act and the amendments we have suggested today, the Congress should also enact the Surface Transportation Act, which the House of Representatives did pass last session.

Mr. CARNEY. Thank you.

The CHAIRMAN. Mr. Lent, of New York.

Mr. LENT. Thank you.

I would like to yield my time to the gentleman from Kansas, Mr. Skubitz.

Mr. SKUBITZ. Getting back to my question again, Mr. Barnum. I stated that once we subsidized them until ConRail was established, and then I said we would pull the rug out from under them. What I meant was we would cease giving them any funds to carry on. And the net result would be then Erie Lackawanna would be out of the business or be forced to take bankruptcy.

Now, you said this is not correct. I ask why.

Mr. BARNUM. The Erie Lackawanna is already in bankruptcy. Technically, it is said to be in reorganization under section 77 of the stated that we would subsidize them until ConRail was established, Bankruptcy Act. It is in reorganization. What the Erie Lackawanna will have to do in any event is either to reorganize on its own, or dispose of its property to other railroads. The trustees have determined it cannot reorganize on its own.

But, Mr. Skubitz, excuse me. The properties of the Erie Lackawanna that do or could contribute to a viable rail system will be acquired, either by ConRail or by one of the other solvent railroads in the region. The only difference between what the Erie Lackawanna trustees urge and what we urge you to do is the Erie Lackawanna trustees would have the Congress require that the properties of the Erie Lackawanna be transferred to ConRail or to a solvent railroad as determined by the USRA, assuming the court first reaches the determination that the railroad cannot be reorganized within a reasonable period of time. We urge that you put the trustees in a position where they can continue to operate for a year and a half and at that time they can negotiate either with ConRail or the other railroads in the region that could very profitably pick up parts of the Erie Lackawanna system——

Mr. SKUBITZ. Which railroads? What railroads are you talking about?

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Mr. BARNUM. The Chessie system or Norfolk & Western could use to great advantage parts of the Erie system in New York and New Jersey.

Mr. SKUBITZ. Very little.

Mr. BARNUM. I don't think that is quite accurate, Mr. Skubitz.

Mr. SKUBITZ. You say they are in bankruptcy today. They were forced there really. One of the big factors is the fact that one of their major contributors or users of the line was the automobile industry, isn't that correct? And they have lost that business.

Now, eventually they are going to go. Would it not make a lot more sense, at this moment, to consider this railroad, along with the others, in defining and establishing a final system, rather than going along later and picking up a part here and a part there? What you are saying, or I think you are going to say—is well, they will be able to come in under the Tucker Act and claim more money.

Mr. BARNUM. That is correct.

Mr. SKUBITZ. Now, if that is correct, let me ask my next question: How many miles of traffic has Penn Central got and how many miles has Erie Lackawanna got?

Mr. BARNUM. Penn Central has about 20,000 miles.

Mr. SKUBITZ. Now——

Mr. BARNUM. Erie Lackawanna has 2,800 miles in the State of New York, Pennsylvania, New Jersey, Ohio, Indiana, and Illinois.

Mr. SKUBITZ. We are talking about 20,000 against 2,000. What is the total number of cars Penn Central has as against Erie Lackawanna?

Mr. BARNUM. I would assume it is roughly in the order of 10 to 1.

Mr. SKUBITZ. And the number of employees?

Mr. BARNUM. It is about 10 to 1 also. The Erie Lackawanna employs 11,000 people. The Penn Central at last count, has around 95,000.

Mr. SKUBITZ. Under those circumstances, 10 to 1. As fas as the creditors are concerned, since Penn Central could go in and so could Erie Lackawanna, and we would have an opportunity to get this settled once and for all, aren't we talking about peanuts when we are talking about Erie?

Mr. BARNUM. You are. That is a critical point.

Mr. SKUBITZ. Let's get the job done right.

Mr. BARNUM. Let me tell you why. You are risking reorganizing the Penn Central, Lehigh Valley, CNJ, Ann Arbor and Reading under the Regional Rail Reorganization Act, all for the sake of meeting the trustees' desire that they be treated the same way. You are risking it because you are going to throw back into the courts the whole question of the constitutionality of the action. For the "peanuts" Mr. Skubitz, I suggest it is not worth the risk.

The CHAIRMAN. Time is up.

Mr. SKUBITZ. I will be back, Mr. Chairman.

The CHAIRMAN. The time has expired.

Mr. Metcalfe.

Mr. METCALFE. Thank you, Mr. Chairman.

I recall the importance of the railroads being essential to the economy of the United States, but I would like to associate myself with the questions and the remarks made by my distinguished colleagues, Mr. Collins, from Texas, and Mr. McCollister, from Nebraska, and Mr.

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Carney, from Ohio. I have the same concern as to where are we going.

Now, if my memory serves me correctly, in the 91st Congress the Penn Central came to the Congress and asked for relief and received it. I was not a Member of Congress then. I do believe that it was the feeling in the 91st Congress that we had solved the problem.

Obviously we did not, because in the 93d Congress we had to pass the ConRail bill, or the Railroad Reorganization Act. And I am directing my remarks to this—do you come back all of the time? I have the feeling that as long as you can come to Congress and then make an intelligent presentation, as you have today, Mr. Secretary, that we are just in a perpetual motion, and we are not really resolving the need of the railroads to exist.

I am concerned that it rests not with the economy, in and of itself, but more with the management at the top level. I would like to have some assurance that there has been some drastic change, recollecting that ConRail is presently in court today, that next year, if we should grant the relief, that you won't be back. I know that you have said that on two previous occasions, but you are back. Could you address yourself to that?

Mr. BARNUM. Mr. Metcalfe, I am as reluctant to come back to the Congress and ask for more money as you are to have me come back. But I am bound, obviously, to apprise you of a very serious situation with respect to this railroad. It is our judgment that it is appropriate to apply taxpayer money to keep this property operating for a year and a half. In the last Congress you made a major step in adopting the Regional Rail bill, and your subcommittee and this committee, and the House of Representatives took a second step with the Surface Transportation Act. And we are going to be coming back again and again, unless the Congress enacts this session something along the lines of the Surface Transportation Act.

Mr. METCALFE. My concern is, and then I will be through, Mr. Chairman, my concern is the lack of proper leadership in all of these instances, and it seems to me that is where we ought to focus our attention. The Southern railroads can be successful, and then the Penn Central cannot be, and now the Erie Lackawanna cannot be, why is it? I submit to you, in my limited judgment, it is because of the top management. I am concerned with that.

Mr. BARNUM. Of course, one of the effects of reorganizing these several railroads will be to create the new corporation, ConRail, which technically is already in existence. USRA and the incorporators of ConRail, which consist of the Executive Committee of USRA, will be working on the selection of the management for ConRail.

A majority of the members of ConRail's Board of Directors will be Presidential appointees so long as more than 50 percent of the outstanding indebtedness of ConRail consists of debts owing to or guaranteed by the Government. We are as aware as you of the desirability of having topflight management. I was pleased in talking to the top engineers who went to the Penn Central property to learn of their enthusiasm for the middle management officials of the Penn Central they had met. So I do not think it is as pervasive a problem as perhaps your question suggests.

Mr. METCALFE. I yield to the gentleman from Florida.

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Mr. ROGERS. I thank you for yielding.

Mr. Secretary, have you had any study done to see how these funds previously given to Penn Central and some of the others have been used? Have they been used in line with the assurances given to this committee and the Congress as to how they would be spent?

As I recall, they said they were going to fix up the lines before, and here you are coming back and saying you need this money to fix the lines again. It seems to me we are getting this repetition and nothing is being done. Nothing seems to have any impact. Have you done a study to see if the funds have been spent?

Mr. BARNUM. Several times we have ordered a review of Penn Central's application.

Mr. ROGERS. What are your findings?

Mr. BARNUM. They have been properly applied.

Mr. ROGERS. Could you furnish this committee with those findings?

Mr. BARNUM. Yes, sir.

[Testimony resumes on p. 93.]

[The following information was received for the record:]

REPORT ON AUDIT OF DEPARTMENT OF TRANSPORTATION EMERGENCY FINANCIAL ASSISTANCE TO THE PENN CENTRAL TRANSPORTATION COMPANY DATED NOVEMBER 6, 1974

The following report covers activities under the Emergency Rail Services Act of 1970 and the Emergency Rail Facilities Restoration Act.

The Report states that procedures used in affording financial aid under those Acts did not permit the auditors to determine whether funds provided to Penn Central were used in accordance with the provisions of the two statutes. For example, the Penn Central was not required to maintain separate accounting for the disposition of loan funds guaranteed under the Emergency Rail Services Act of 1970. However, on the basis of cash flow statements supplied to the Department periodically by Penn Central, funds provided the Penn Central were used only for expenses necessary to continuing rail operations.

With respect to the use of funds provided by the Department under section 213 of the Regional Rail Reorganization Act of 1973, we have no audit report comparable to the one on the two Acts cited above. However, a report is being prepared by Department auditors on Penn Central's cash management processes and subsequently, reports will follow on the use of section 213 funds.

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REPORT ON AUDIT OF DEPARTMENT OF TRANSPORTATION EMERGENCY FINANCIAL ASSISTANCE TO THE PENN CENTRAL TRANSPORTATION COMPANY

Audit Report No. HO-FR-75-3.15
November 6, 1974

By: Department of Transportation
Office of Audits
Washington, D. C.

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REPORT ON AUDIT OF DEPARTMENT OF TRANSPORTATION EMERGENCY FINANCIAL ASSISTANCE TO THE PENN CENTRAL TRANSPORTATION COMPANY

EXECUTIVE SUMMARY

The Office of Audits, OST, performed an audit of the emergency financial assistance provided to the Penn Central Transportation Company (Penn Central) under the Emergency Rail Services Act of 1970, and the Emergency Rail Facilities Restoration Act of 1972. The purpose of the audit was to determine: (a) whether the proceeds from the guaranteed loans and the direct loans provided to Penn Central were used in accordance with provisions of the laws, and the terms and conditions established by the Department of Transportation (DOT); and (b) the effectiveness of the Federal Railroad Administration's (FRA) activities in monitoring and reporting on Penn Central's use of the emergency financial assistance.

A. Emergency Rail Services Act of 1970

An adequate determination could not be made as to whether funds provided to Penn Central under the Emergency Rail Services Act were expended in accordance with the Act and the Guaranty Agreement and were used solely for expenses necessary for continuing essential transportation services, or that other revenues of the railroad were used to the fullest extent for such expenses as required by the Act.

This determination could not be made because FRA did not require Penn Central to identify those expenses necessary for essential transportation services or maintain separate accounting for the disposition of loan funds. In addition, FRA neither required nor received any data which could be used for monitoring loan fund expenditures.

Penn Central co-mingled the proceeds of the sale of the guaranteed loan certificates with other railroad revenues, and consequently, the loan monies could not be identified to any specific railroad expenditures.

For future financial assistance programs, Penn Central should be required to submit information on the specific uses of funds and maintain records identifying the receipt and specific expenditures of funds.

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B. Emergency Rail Facilities Restoration Act

A determination could not be made as to whether funds provided to Penn Central under Emergency Rail Facilities Restoration Act had been used in accordance with the provisions of the laws and terms and conditions established by FRA since there were no records to indicate the condition of Penn Central tracks, equipment or facilities prior to Hurricane Agnes or immediately thereafter. Also, no work has begun for the restoration of the Penn Yan line even though FRA directed the Trustees to proceed with the restoration, and failure to act could be considered a default under the loan agreement.

FRA's monitoring efforts did not provide a technical evaluation of the storm damages, nor were progress reports of repair and restoration of the damaged facilities prepared. For future financial assistance programs, FRA should issue monitoring procedures and assign responsibility for on-site technical surveillance of the work to be done.

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REPORT ON
AUDIT OF DEPARTMENT OF TRANSPORTATION
EMERGENCY FINANCIAL ASSISTANCE
TO THE PENN CENTRAL TRANSPORTATION COMPANY

I. INTRODUCTION

We have completed an audit of the emergency financial assistance provided to the Penn Central Transportation Company (Penn Central) under the Emergency Rail Services Act of 1970, and the Emergency Rail Facilities Restoration Act of 1972. The purpose of the audit was to determine: (a) whether the proceeds from the guaranteed loans and the direct loans provided to Penn Central were used in accordance with provisions of the laws, and the terms and conditions established by the Department of Transportation (DOT); and (b) the effectiveness of the Federal Railroad Administration's (FRA) activities in monitoring and reporting on Penn Central's use of the emergency financial assistance.

The audit included a review of the work performed by the Interstate Commerce Commission (ICC) auditors, the CPA firm of Haskins and Sells, and Penn Central's internal auditors. The ICC alone, from 1970 thru 1973, expended approximately 4500 mandays involving as high as 22 individual auditors, while Haskins and Sells' Calendar Year 1973 financial audit took 2365 mandays with a peak force of 131 auditors.

II. SUMMARY OF RESULTS OF AUDIT

A. Emergency Rail Services Act of 1970

We were unable to adequately determine whether funds provided to Penn Central under the Emergency Rail Services Act were expended in accordance with the Act and the Guaranty Agreement. We could not determine whether the proceeds from the sale of certificates were used solely for expenses necessary for continuing essential transportation services, or that other revenues of the railroad were used to the fullest extent for such expenses as required by the Act.

This determination could not be made because FRA did not require Penn Central to identify those expenses necessary for essential transportation services or maintain separate accounting for the disposition of loan funds. In addition, FRA neither required nor received any data which could be used for monitoring loan fund expenditures.

Penn Central co-mingled the proceeds of the sale of the guaranteed loan certificates with other railroad revenues, and consequently, the loan monies could not be identified to any specific railroad expenditures. As an alternative, we audited payrolls and all other operating expenditures incurred by the Railroad during the periods in which the sale proceeds

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from the loan certificates were drawn down. The total operating expenditures during the drawdown periods were accounted for. Although the payroll expenses related to this period could not be entirely verified due to incomplete personnel records, we found no evidence to indicate that expenditures during this period were applicable to other than railroad operations.

We recommend that for future financial assistance programs, Penn Central be required to submit information on the specific uses of funds and maintain records identifying the receipt and specific expenditures of funds.

B. Emergency Rail Facilities Restoration Act

We were not able to determine that funds provided to Penn Central under Emergency Rail Facilities Restoration Act had been used in accordance with the provisions of the laws and terms and conditions established by FRA since there were no records to indicate the condition of Penn Central tracks, equipment or facilities prior to Hurricane Agnes or immediately thereafter. We were able to verify expenditures for repairs and restoration of railroad property identified by Penn Central as damaged by storm Agnes, except for certain labor, materials, and overhead amounting to $355,264 which were not adequately supported by cost information. Also, no work has begun for the restoration of the Penn Yan line even though FRA directed the Trustees to proceed with the restoration, and failure to act could be considered a default under the loan agreement.

FRA's monitoring efforts did not provide a technical evaluation of the storm damages, nor were progress reports prepared on the repair and restoration of the damaged facilities. We recommend that for future financial assistance programs, FRA issue monitoring procedures and assign responsibility for on-site technical surveillance of the work to be done.

I. DISCUSSION OF RESULTS OF AUDIT

A. Emergency Services Guaranteed Loans

1. Accounting for Loan Expenditures

Our audit of the expenditures of the proceeds from the sale of trustee certificates disclosed that:

a. There was no requirement by FRA for Penn Central to keep a separate accounting of the loan expenditures, thereby ensuring better control of the funds, and allowing for a monitoring system that would ensure that the funds were used in accordance with the intent of the Act;

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b. payroll expenses relating to the periods of loan expenditures could not be entirely verified due to incomplete personnel records; and

c. the total operating expenditures during the draw-down periods of the loan funds, except for payroll, were accounted for, but we were unable to adequately determine whether the funds were used solely for expenses necessary for continuing essential transportation services, or that other revenues of Penn Central were used to the fullest extent for such expenses as required by the Act.

The proceeds from the sale of the trustee certificates guaranteed by DOT under the Emergency Rail Services Act of 1970 (Act) were placed in escrow accounts in the following banks pending release by the United States District Court:

Bank	Amount
Philadelphia National Bank	$ 33,500,000
First Pennsylvania Banking & Trust Company	33,500,000
Industrial Valley Bank & Trust Company	33,000,000
Total	$100,000,000

Penn Central withdrew the proceeds, upon approval of the court, during the periods January through April 1971, and July and August 1972, and they were co-mingled with other railroad revenues through deposits in regular bank accounts. As a result, the proceeds could not be identified to any specific railroad expenditures but could only be related to certain expenditures such as payroll, railroad retirement taxes and Federal withholding taxes:

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Date	Type of Expenditures	Withdrawals	Related Expenditures
1/28/71	Payroll	$ 15,000,000	$ 3,507,658
1/29/71	Railroad Retirement Taxes		12,816,229
2/16/71	Retroactive Payroll	20,000,000	19,540,485
2/16/71	Payroll		8,606,569
2/25/71	Federal Withholding Taxes		9,572,696
2/25/71	Payroll		4,145,502
2/26/71	Payroll	15,000,000	1,282,489
3/2/71	Payroll	10,000,000	9,824,539
3/3/71	Federal Withholding Taxes		1,549,930
3/30/71	Payroll	5,000,000	8,431,836
4/1/71	Payroll	10,000,000	3,666,095
4/2/71	Payroll		8,553,960
7/31/72	Railroad Retirement Taxes		12,578,735
7/31/72	Federal Withhold Taxes		1,385,455
8/1/72	Payroll	10,000,000	8,856,306
8/3/72	Payroll	15,000,000	3,318,849
TOTALS		$100,000,000	$117,637,333

Since the proceeds could not be identified to specific expenditures, we could only determine their use by reviewing all expenditures made during the period in which the proceeds were withdrawn. The review included: (1) the payrolls, as shown above, and (2) all other operating expenditures made in the period involved (Exhibit A).

a. Monitoring the Program

The Guaranty Agreement and the Agreement on Terms and Conditions, did not require Penn Central to maintain records specifically identifying expenditures of proceeds from the sale of the trustee certificates. For monitoring purposes, the FRA received from Penn Central financial data such as monthly cash flow statements and quarterly balance sheets. The FRA reviewed these statements to evaluate Penn Central's financial condition, but had no data specifically identifying Penn Central's expenditures of the proceeds from the sale of the trustee certificates. Consequently, FRA could not determine whether the proceeds were used for continuing essential transportation services as required by the Act.

b. Review of Payroll

While the computation of payroll expenses were found to be accurate, verification of employees' pay rates, occupations, and employment status could not be ascertained, in all cases, because of incomplete personnel records.

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The review covered ten payrolls paid by Penn Central during the period it withdrew the proceeds from the sale of the trustee certificates. The payrolls totaled $59.8 million and included 262,000 paychecks to both Train and Engine (T&E) employees and Other than Train and Engine (OTE) employees.

The review of time documents, computer runs, and net payroll indicated that: (1) no overlapping or duplicate effort was reported or paid, (2) entries on payroll records were correct, (3) gross pay amounts were correctly calculated, and (4) paychecks issued agreed with net payrolls. The review of employee time records showed certain discrepancies resulting from procedural weaknesses such as inaccurate reporting of off-duty time and lunch breaks, but were isolated incidences and not significant.

We examined available personnel records applicable to the payrolls to determine the accuracy of the employees' pay rates, occupations, and employment status. For the employees included in the payroll review, we examined the Service Record Cards which are major control documents and used to record changes in employment status such as occupation, location, pay rate, dates off duty or terminated, and pertinent remarks. The Service Record Cards were incomplete in numerous instances and did not include the necessary data to verify that: (1) all employees had been in an active employment status during the period of our audit, or (2) the pay rates or occupations on the time cards were accurate. No other personnel documents were available to provide the missing information.

Penn Central's Director of Personnel acknowledged that the personnel records were incomplete and indicated that this situation resulted from the merger of the New York Central, New Haven, and Pennsylvania Railroads into the Penn Central in 1968. Each railroad had different personnel organizations and practices. At the time of the merger, a plan to centralize the personnel function was considered, but did not materialize. He also indicated that a continuous reduction in personnel department staffing was a contributing factor.

c. Review of Expenditures Other than Payroll

Penn Central expended $227.9 million in operating expenditures, excluding payroll, during the period the proceeds from the sale of the trustee certificates were withdrawn and co-mingled with other railroad revenues.

The expenditures were reviewed to determine whether the proceeds were used for the purpose of continuing essential railroad operations in accordance with provisions of the Act. Transactions covering accounts payable, direct material and contingent payments

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(travel) were selected for review and detailed supporting documents for each transaction were examined. We found no unusual transactions or evidence that the expenditures were not applicable to railroad operations.

2. Recommendations

We recommend that future financial assistance agreements between FRA and Penn Central include provisions requiring:

a. maintainence of detailed records identifying the receipt and specific expenditures of the funds, and

b. submission of information on the specific uses of the funds in such detail and at such intervals as is necessary to facilitate continuous monitoring of the assistance programs.

B. Emergency Rail Facilities Restoration Loan

We were not able to determine that funds provided to Penn Central under the Emergency Rail Facilities Restoration Act had been used in accordance with the provisions of the laws and terms and conditions established by FRA since there were no records to indicate the condition of Penn Central tracks or equipment prior to Hurricane Agnes or immediately thereafter. We were able to verify the expenditures for repairs and restoration of railroad property except for certain shop labor, materials, and overhead as set forth below. During our physical inspection of damaged areas, we found that Penn Central's maintenance and inspection records with respect to the storm damage were unreliable in assessing the extent of damages and the repairs and restoration work performed.

1. Accounting for Restoration Costs

Penn Central established a system of work order accounts to identify storm damage expenditures as summarized in Exhibit B. Our accounting review disclosed that:

a. Maintenance of Way expenditures for facilities' repairs were adequately documented and substantiated.

b. Expenditures incurred for capital improvements relating to the restoration of destroyed bridges were also recorded properly.

c. Maintenance of Equipment costs for repairs of locomotives, cabooses, freight cars, and other equipment were identified through work orders; however, the railroad accounting system did not provide adequate cost information. Certain expenditures amounting to $355,264 could not be substantiated because:

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(1) labor and material costs were not always identified to specific locomotives and cabooses repaired,

(2) rates for the computation of costs for rehabilitated or used material as well as material overhead charged to repair work were not adequately supported,

(3) cost additives for fringe benefits and shop expense charged to repair work were not adjusted to reflect differences between actual rates and applied rates, and

(4) payments to foreign railroads for repairs of storm damaged cars were not offset by receipts by Penn Central for repairs of freight cars damaged on foreign tracks, resulting in an overstatement of A.A.R. Billings.

d. No costs have been incurred for the restoration of the Penn Yan Industrial line. Failure to restore this line to service is a violation of the loan agreement.

Maintenance of Way-Repairs

Maintenance of Way (M of W) costs accumulated by Penn Central pertain to all repair work on track, communication and signalling, electric traction equipment, buildings and bridges, and other roadway repairs on more than 90 lines which were damaged as a result of the flooding. M of W repair costs included in the loan application and audited through April 30, 1974, consisted of expenses charged to emergency work orders established for Hurricane Agnes for the following repairs:

Repairs	As of Loan Application	As of 4/30/74
Track	$2,966,058	$3,229,130
Communication & Signals	1,005,260	1,097,140
Buildings and Bridges	567,639	651,886
TOTALS	$4,538,957	$4,978,156

Audit emphasis was on costs incurred in the Harrisburg Division in the Eastern Region and the Allegheny Division in the Central Region, since the major portion of restoration repairs was done in these two areas. We also used the two divisions as a basis for selecting seven specific lines which were coordinated with the physical inspection of facilities.

An analysis of specific transactions related to expenditures for repairs disclosed no adverse findings. Each transaction was adequately

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substantiated by supporting documentation, charges were properly computed, and expenditures were identified and related to flood damage repairs.

Capital Improvements

Capital expenditures for seven projects for the rebuilding of destroyed bridges were included in the original loan application. Altogether there were ten capital projects charged for storm damage expenditures as shown in Exhibit B.

Total capital expenditures and incidental expenses audited through March 31, 1974 were $8,325,790 of which $7,014,100 (84%) was charged to the restoration of the Shocks Mills bridge. A breakdown of these costs for the seven capital projects is:

Project No.	Location	Construction Costs	Incident Expenses	Total Costs
BH 55	Mountville, Pa.	$ 62,785	$ 144	$ 62,929
BH 56	Millersburg, Pa.	40,018	7,587	47,605
BH 57	Shocks Mills, Pa	6,761,217	252,883	7,014,100
BH 61	Corning, N.Y.	1,092,261	1,023	1,093,284
BH 62	Lawrenceville, Pa.	35,350	2,200	37,550
BH 63	Tioga, Pa.	2,751	45	2,796
BH 92	Selinsgrove, Pa.	65,952	1,574	67,526
TOTALS		$8,060,334	$265,456	$8,325,790

Our review of detail cost data in the Authorization for Expenditures (AFE) files for the seven capital projects disclosed that the monthly cost summary sheets used in the preparation of the loan application were adequately supported.

Penn Central's internal audit procedures were considered adequate for the review of labor, material, and equipment rental costs based on our evaluation of nine internal audit reports of major repair contracts for damaged bridges. No exceptions were noted in six of the reports, while three disclosed audit exceptions of $32,587 due to Penn Central and $1,363 due to contractors. However, proper adjustments were made in subsequent payments to contractors.

Our review also included an evaluation of the basis for cost increases in the restoration of the Shocks Mills bridge over the Susquehanna River (Project No. BH 57) located on the A&S Branch of the Harrisburg-West Division. The original AFE dated July 13, 1972, estimated the cost of restoration to be $4.5 million, while a revised AFE submitted April 11, 1973, increased the estimated cost by $2.6 million to $7.1 million.

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The increase in costs was attributable to two major factors. First, additional core borings which could not be made until the existing structure was demolished, showed the need for deeper and more costly pier footers than orignally anticipated. This increase in scope of construction accounted for an additional $1.7 million. Secondly, the remaining cost increase was attributable to damage and delays caused by floods during reconstruction, subsequent to Hurricane Agnes. From November 8 through December 14, 1972, record rains resulted in high water which washed out the construction causeway on different occasions causing loss of material and equipment, and an extensive amount of downtime for labor and equipment.

Penn Central's normal contracting procedures provide for competition in awarding contracts, however, due to the emergency situation created by Hurricane Agnes the normal bid procedures were foregone. Penn Central awarded and negotiated contracts for the restoration of the Shocks Mills bridge and Corning bridge without formal advertising to expedite the restoration of service on these primary freight carrying lines.

Penn Central selected Spearin, Preston, and Burrows, Inc. for the restoration of the Shocks Mills bridge because this contractor had extensive experience in water works, performed work in the past, and had access to manpower and equipment to begin work immediately. Winkelman Co. was selected as contractor for the Corning bridge also because of its reputation and immediate availability to begin construction.

While the contracts were awarded without competitive bidding, we feel that in the circumstances, proper procedures were used in the way of preliminary engineering studies and price negotiation.

In our opinion, all expenditures incurred for capital improvements were recorded properly.

Maintenance of Equipment

Maintenance of Equipment (M of E) costs covered extensive repairs of 20 diesel electric locomotives at the Altoona and other shops, minor repairs of 285 diesel electric locomotives at various terminals, extensive and minor repairs and inspections of 31 electric locomotives, inspection and repairs of 14 cabooses, and various repairs to machinery and other equipment.

Total M of E costs expended through April 30, 1974 were $3,126,237 which consisted of:

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1. Heavy duty repairs of locomotives, cabooses, and freight cars at the Altoona Heavy Repair Shops and costing $794,458.

2. Bills received by the A.A.R. Billing Bureau for repairs of storm damaged cars by foreign railroads and settlements for destroyed cars totaling $163,846.

3. Various repairs of railroad equipment performed at terminals and yards throughout the regions costing $2,167,933.

a. Altoona Charges

Total M of E costs incurred in the Altoona Heavy Repair Shops were $794,458 as of July 1973, with no subsequent additional costs. Our review was concerned primarily with repair costs recorded under two major shop orders as follows:

#55100 - repair of 14 diesel electric locomotives	$724,800
#33003 - repair of 14 cabooses	40,648
TOTAL	$765,484

We examined accounting documents and procedures for costs of repairing the locomotives and cabooses, and analyzed charges for labor, material, fringe benefits, shop expenses, and material overhead. The review disclosed:

(1) Labor and Material

Penn Central's details of expenses incurred for repairing flood water and wreck damage to locomotives and cabooses, included in Attachments 1 and 8 to the loan application, identified labor and material costs to specific units. However, labor and material charges to shop orders #55100 and #33003 were not always identified with specific locomotives and cabooses repaired. Unidentified costs were allocated among the other units in the same ratio as identifiable costs. While only 1% of the labor and material charges for locomotives repairs were not identified to specific units, 54% of the caboose labor charges and 65% of the caboose material charges were not identified to individual units and were allocated among the 14 cabooses.

Also, $222,204 of the $323,934 material charges for repairs of the locomotives and cabooses was rehabilitated material used during the period September 1, 1972 through July 31, 1973.

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The rehabilitated or used material charged to the storm damage shop orders was computed at 57% of the cost of new material which represents the weighted average cost of rehabilitating used material. However, we could not determine the reasonableness of the 57% rate nor had Penn Central evaluated the adequacy or accuracy of this rate which has been applied consistently since 1971.

(2) Fringe Benefits

Fringe benefits of $43,271 for the repair of locomotives and cabooses were computed at a rate of 30.06% of direct labor costs and were adequately supported by Penn Central.

While the 30.06% rate was applied to the storm damage shop orders, there was no adjustment to reflect the actual fringe benefit rate of 29.38% in 1972 and 33.05% in 1973. However, the difference between the applied rate and actual rates for the period audited was considered relatively insignificant.

(3) Shop Expense

Shop expense, representing indirect labor, material, and miscellaneous costs associated with the operation of the repair shop, totaled $68,630 for the repair of the locomotives and cabooses. This expense, computed as a percentage of direct labor, was charged at a 48.9% rate during 1972 and a 45.0% rate during 1973 based upon the prior year actual rate. These rates were adequately supported by Penn Central. Although the actual shop expense rate was 45.0% for 1972 and 1973, there was no adjustment to reflect the 3.9% difference between the shop overhead (48.9%) applied during 1972 and the actual shop overhead (45.0%) computed for 1972.

(4) Material Overhead

Material overhead for the repair of locomotives and cabooses was $18,681, and represented costs related to the purchasing, handling, and storage of material. This overhead was computed at 4.5% of the cost of new and rehabilitated or used material through August 31, 1972, and at 11% of the cost of only new material since September 1, 1972.

The 4.5% rate was determined in January 1967 but could not be adequately supported by Penn Central. The 11% rate was based on limited cost data adjusted for estimates and assumptions. Therefore, the 4.5% and 11% material overhead rates are questionable since Penn Central's accounting system does not provide adequate cost data for determining the actual material overhead rates incurred.

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b. Association of American Railroads Billings

The Association of American Railroads (A.A.R.) adopted a manual formulating interchange rules among member railroads. The manual specifies the responsibilities for the repairs and settlement of damaged cars between the car owner and the handling line. Participating companies bill each other through the exchange of A.A.R. Billing Repair Cards. Penn Central processes all billings from other railroads (payables) and all billings to other railroads (receivables) at the A.A.R. Billing Bureau in Altoona, Pennsylvania.

Total M of E payments by the A.A.R. Billing Bureau through April 30, 1974, were $163,846. This represented Penn Central's payments to foreign railroads for repairs of storm damaged cars and settlements for destroyed cars which were on Penn Central lines at the time of Hurricane Agnes.

	Type	Cars	Amount
(i)	Cars Repaired by Foreign Roads	161	$153,772
(ii)	Settlement of Destroyed Cars	2	10,074
	TOTALS	163	$163,846

We reviewed special computer runs of all flood damage cars payable and identified total expenditures accounted for by Penn Central. We verified repair costs to A.A.R. Billing Bureau Cards and authorizations for foreign roads to make repairs. With one minor exception, all repair billings were in accordance with A.A.R. rules. Also, payments to the Erie Lackawanna and Western Maryland Railroads for settlement of the destroyed cars were proper and in accordance with A.A.R. rules.

While the payments to foreign roads and repairs for storm damaged cars were verified, the extent of receipts by Penn Central for repairs of cars damaged on foreign tracks and billed to the handling lines could not be determined. Penn Central did not maintain similar computer runs of receivables for repairs of storm damaged cars billed to other railroads, nor could they readily identify the detail billing records since documents were co-mingled with all other billings. As a result, payments to foreign lines were not offset by receipts from foreign roads to reflect net payments through A.A.R. billings.

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c. Regional Costs

The majority of M of E costs were incurred by the various regional repair shops and yards for the flood damage repairs of locomotives, freight cars, machinery and other equipment and charged to specific work orders. Total expenditures incurred by the regional repair shops through April 30, 1974, were $2,167,933. The various elements of costs were properly accounted for by Penn Central.

We also evaluated an adjustment of $987,772 made in May and June 1973 to reflect charges for rehabilitated material consumed in the field for repairs to equipment. This material was originally charged to ordinary expense rather than extra-ordinary expense identified for storm damage. The supporting documentation for the journal entry adjustments indicated that Penn Central's accounting procedures were adequate to reflect the proper amount of material charges.

Normally, costs for rehabilitated material are recorded by the Altoona Heavy Repair Shops through work orders, while the regional shops do not consider costs for rehabilitated material used in repairs. However, Penn Central dispensed the normal procedures and requested the regions to charge out rehabilitated material to account for all storm damage costs. Therefore, we investigated the possibility of duplicating storm damage costs for rehabilitated material consumed in the regions and charges by the Altoona Heavy Repair Shops for rehabilitated work performed on used parts.

An adjustment of $81,282 was made in July 1973, to correct duplicate charges for rehabilitated material initially captured under Altoona shop work orders and again when the material was consumed by the regions. Accordingly, all Altoona shop orders totaling $78,459 for rehabilitation of freight car wheels, air brakes and bodies, and locomotive tractor motors, generators, and components were eliminated from the M of E costs. The remaining $2,822 eliminated represented the rehabilitation of used material performed in shops other than Altoona. Penn Central had recognized the duplicate charges for rehabilitated material and had taken satisfactory corrective action.

In general, the accounting treatment of regional charges for equipment repairs was considered satisfactory.

d. Penn Yan Industrial Line

The terms and conditions of the loan agreement dated August 13, 1973, provided for the prompt restoration of all essential damaged facilities. Included was a provision which required the Trustees of Penn Central to restore service over 1.3 miles of their Penn Yan Industrial Line.

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The estimated cost of restoring service over the track was $150,000. This amount was included in the $1,199,289 balance available from the total approved FRA loan of $17,645,542.

The Trustees had applied to the Interstate Commerce Commission (ICC) to abandon the Penn Yan line. On November 16, 1973, the Trustees requested FRA to approve its proposal to defer construction to restore service until weather conditions permitted in the following spring, hoping that the ICC would act upon the abandonment application. FRA denied the request on January 14, 1974, and required the Trustees to proceed with the necessary restoration since the ability to abandon the line was uncertain with the enactment of the Regional Rail Reorganization Act of 1973 and the fact that ICC could no longer entertain the abandonment application.

On February 5, 1974, the Trustees advised FRA that construction of a connection between the Sodus Bay secondary track and the essential portion of the Penn Yan track was expected to begin around April 1, 1974, prcviding that weather conditions permitted and that material could be acquired and assembled at Penn Yan. However, construction did not begin as scheduled, and FRA directed the Trustees on April 18, 1974, to proceed with the restoration immediately, and reminded them that failure to promptly restore this track may be considered a default under the loan agreement and may jeopardize their eligibility for further financial assistance under programs administered by DOT.

Work Order #60257 was established on August 15, 1973, to accumulate costs for the restoration of the Penn Yan track from mile post 5.2 to 6.5. We reviewed the Work Order Detail Lists through May 31, 1974, and found that there have been no charges to the work order.

Since there has been no indication that work has begun or when the track will be restored, we believe that FRA should continue to monitor Penn Central's progress on restoration and decline to provide any further financial assistance until this condition has been met.

2. Inspection of Facilities

Our physical verification of repair and restoration included an on-site inspection of railroad facilities in selected areas along seven main lines and branches in the Harrisburg and Allegheny Divisions, a review of Penn Central's divisional maintenance records, and an evaluation of FRA's monitoring activities over the repair and restoration program. We concluded that:

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a. Penn Central has substantially completed the repair and restoration work at the selected sites, and the lines and facilities are in operation,

b. Penn Central's maintenance records for the period during the storm recovery were generally inadequate to substantiate the extent of the damage and the quality of repairs and maintenance,

c. FRA's monitoring efforts did not provide a technical evaluation of the storm damages, and

d. FRA did not prepare progress reports on the repair and restoration of the damaged facilities.

We were unable to technically determine or evaluate (1) the condition of the selected track and factilities prior to Hurricane Agnes, (2) the extent of damages to the selected points inspected, or (3) the quality of subsequent repairs and restorations. We relied on divisional documents, photographs, and the knowledge of Penn Central representatives as to the extent of damages at the selected sites and the corrective repair and restoration work. As a result, we were able to determine only that the areas identified by Penn Central as damaged by Hurricane Agnes were subsequently repaired or restored and are in operating condition.

We did not physically inspect locomotives and freight cars for practical reasons, but reviewed the related documentation and reports available at the Altoona and Enola repair shops. We determined through Penn Central's Instant Car Locator (ICL) system that a representative number of repaired locomotives and freight cars were in current use. Through these procedures, we determined that repairs and restoration of rolling stock had been completed. However, we were unable to technically determine (1) the condition of the locomotives and cars prior to Agnes, (2) the extent of damages, and (3) the adequacy of subsequent repairs and restorations.

a. Physical Inspection of Facilities

(1) Philadelphia to Harrisburg Main Line

Damage to this 104-mile line was primarily in the Harrisburg station and yard where most of the facilities and equipment were under about four to five feet of water. In addition, Penn Central performed extensive alterations and renovations to facilities and equipment in this area to accommodate freight traffic rerouted through Harrisburg because of the collapse of Shocks Bridge on the A&S Branch.

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Our verification included (a) an inspection of various track, communication and signal devices in the Harrisburg station identified as damaged by flood water; (b) an inspection at Rockville, Pennsylvania, of the crossover tracks, including applicable switches, communication and signal devices which were installed for trains rerouted through Harrisburg to by-pass the Enola classification yard; and (c) an inspection of the electric diesel sandpit in the Harrisburg yard renovated to replace the regular facility in Enola which was damaged by flood water.

(2) Atglen and Susquehanna (A&S) Branch Including Shocks Bridge

Damages to this 50-mile line were concentrated within a 20-mile area and consisted primarily of about 15 washouts or slides and the collapse of Shocks Bridge. Penn Central representatives indicated that four of these slides, including one 30 feet deep and 200 feet long, were located within the two miles between Shocks Bridge and Shocks Interlocking.

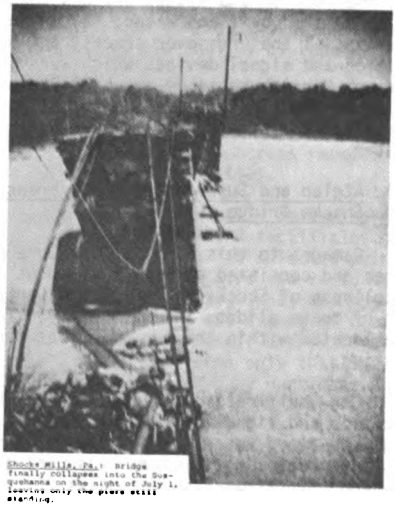
Our verification included (a) an inspection of the track, communication and signal devices at the Interlocking identified as damaged by flood water, and (b) an inspection of the track at the four slide areas identified by Penn Central. In addition, our inspection included the restoration to Shocks Bridge. Penn Central's representatives indicated that on July 1, 1972, the center sections of this bridge collapsed due to damage caused by flood waters. This severed the main freight link from all eastern and southern points to the Enola classification yard. As a result, Penn Central was required to reroute the traffic along the Columbia Branch through Harrisburg. This damage identified by Penn Central is pictured below:



Shocks Mills, Pa.: Bridge (right) began to sag. This bridge over the Susquehanna is the main freight link from all Eastern and Southern points to Enola Yard.

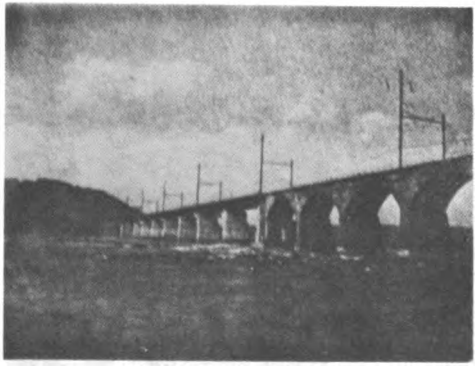
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Chiche Mills, Pa.: Bridge finally collapses into the Susquehanna on the night of July 1, leaving only the piers still standing.

Our inspection of the bridge (pictured below) on June 3, 1974, disclosed that it has been restored and is currently in operation as the main freight link through Enola Yard.



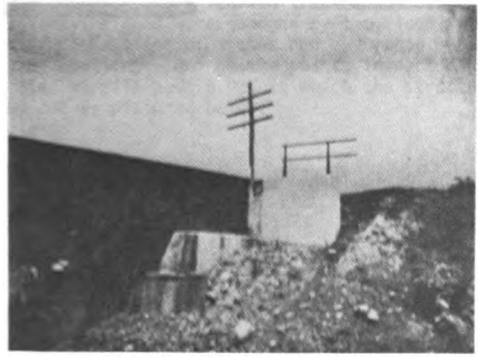
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(3) Harrisburg to Buffalo Main Line

This 308-mile line consisted primarily of approximately 12 track washouts or slides and the washout of the north span of the bridge (pictured below) at mile post 112.03.



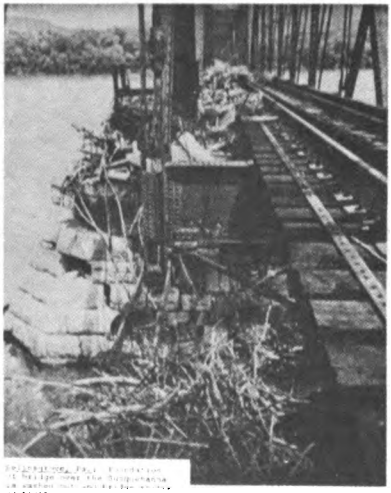
Our verification of the repairs and restorations of this line was limited to the bridge at mile post 112.03. As shown below, this bridge has been restored.



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(4) Selinsgrove Secondary Branch

The damages to this 14-mile branch line consisted of four washouts, one slide, and damage to one bridge. Our inspection covered the 14 miles of track and included an inspection of the washout and slide areas and the bridge at mile post 44.04 (pictured below).



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As shown in the picture below, this bridge has been repaired and restored to service.

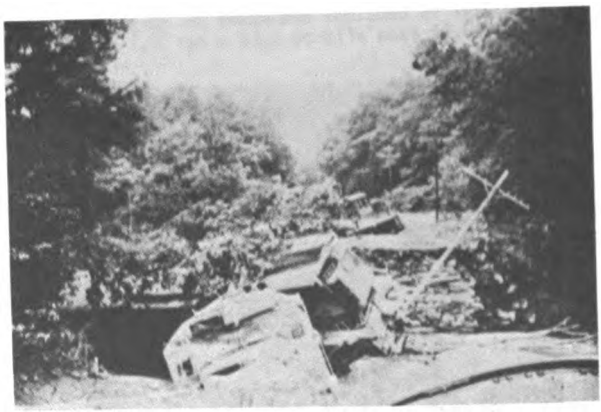


(5) Wilkes-Barre Branch

Damage was heavy along this 60-mile branch line. The washouts and slides were numerous leaving track suspended or covered with debris. Also, several bridges were damaged by the flood waters, resulting in the weakening or dismantling of arches and abutments. Our inspection covered 50 miles of the line. One of the points inspected was the under-grade bridge located at mile post 5.02, in which the structure was completely washed out as pictured below.

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This area (pictured below) was repaired and in operating condition.

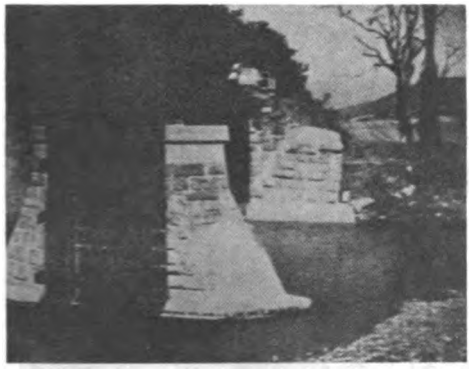


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We also inspected the bridge at mile post 16.49 on this line (pictured below). The flood waters separated the abutment at the east end of the bridge and caused the foundation to be partially washed away. In addition, the pier and west abutment were damaged.



The east end abutment and foundation (pictured below) were repaired. Also, pressure grouting and pointing was performed on the pier and the west end abutment and the bridge is currently in operation.



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The inspection also included the flood water damage to the stone arch bridge at mile post 29.67 as pictured below. The Penn Central representative indicated that the washed out west end abutment weakened the entire arch. The track and roadbed for several hundred feet approaching the structure were also damaged.



Penn Central removed the remains of the stone arches and replaced them with a steel span structure (pictured below). The bridge is currently in operation.



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(6) Harrisburg to Altoona Main Line

There were approximately 19 washouts, three slides and one bridge damaged by Hurricane Agnes on this 127-mile main line. Our verification was primarily directed toward selected repairs and restorations made at (a) mile post 119.16 where Penn Central representatives described the washout to the number 3 track as approximately 15 feet in length and 5 feet deep leaving the track suspended without any support, (b) mile post 118.86 where it was reported that the number 4 track was washed out for 1000 feet in length to a depth of 5 feet, and signal devices were damaged, (c) mile post 147.5 to the number 3 track where we were informed that the washout was approximately 50 feet long and 20 feet deep, (d) mile post 165.0 where track number 3 was again washed out, and (e) mile post 210.0 where track was washed out 1,000 feet long and up to 10 feet deep.

(7) Corning Branch

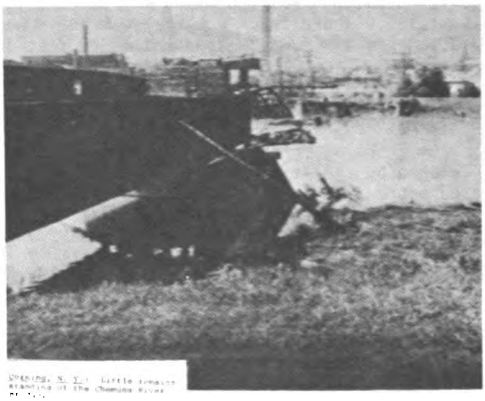
There were approximately 62 washouts, 30 slides, and 13 bridges damaged by the storm on this 180-mile branch line. Our inspection covered approximately 80 miles of the line and the Corning Bridge. This included (a) six washout and slide areas along the 80 miles traveled, and (b) track installed at mile post 92.97 which prior to Hurricane Agnes was an undergrade bridge over a city road. The Penn Central representatives indicated that since the portions of the road which passed under the tracks as well as the railroad bridge were washed out, the Public Utilities Commission and the city agreed to have the road closed. This enabled Penn Central to rebuild the track as a normal roadbed instead of rebuilding the bridge.

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In addition we inspected the Corning Bridge at mile post 71.4 which was a stone arch structure prior to the flood. Penn Central restored it by incasing the piers with steel and widening the piers approximately two feet around to reinforce the remains of the piers. Like the Shocks bridge, the main portion of the bridge was built using steel spans and steel girders over the reinforced piers and is currently in operation.

The damage to the Corning bridge and the completed repair and restoration are shown below.





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The damage to the Corning bridge and the completed repair and restoration are shown below.





While we could verify the cost of repairs and restoration of storm damage, and confirm that the lines and equipment had been restored for traffic, we could not assess the quality of the restoration and repairs.

The present condition of the track follows a pattern. Higher revenue main lines were in stable condition sustaining speeds up to 45 miles per hour. Branch lines were good to poor depending on the amount of revenue producing freight traffic. Corning Branch, for instance, a busy branch, is kept in repair to maintain trains at 30 miles per hour or more. Wilkes-Barre Branch, used primarily to service the Delaware and Hudson Railroad, is poor, with areas of unstable track just passable for trains at 5 to 10 miles per hour. There are still areas on this branch where the storm damage has not been repaired. There are still some sliding and soft spots on the Selinsgrove Secondary Branch. Even the Atglen and Susquehanna Branch, a heavy industrial branch, while purported to be in stable condition, has weak areas and some not yet repaired from the storm. We witnessed, on this line, a near derailment when a compromise joint and rail cracked on both sides under a moving freight train near Shock's Bridge. The track was immediately put out of service. The Montandon Industrial Line, a one customer line, is in poor condition and has been maintained only to take trains up to 10 miles per hour.

Preventive maintenance by Penn Central has been deferred since before the merger. Track maintenance at the present time consists of whatever efforts are required to keep the lines open with priority given to high density routes. By Penn Central statistics, the number of slow orders issued has risen from 558 in the beginning of 1971 to 2,084 as of June 1, 1974, affecting 8,151 miles of raod (Exhibit C). Derailments caused by track, equipment, and other causes number 2,538 for the first five months of 1974 (Exhibit D).

b. Railroad Maintenance Records

Repairs and restoration work in the wake of the storm was done under emergency conditions. There were no cost estimates made of the damaged areas nor engineering studies for restoring facilities except capital improvements. Damage was assessed by teams of inspectors traveling throughout the Divisions. Reports were made to Division offices by telephone, with requests for work crews, material, wrecking equipment and whatever was needed. Headquarters was kept informed by the Division offices in the same manner, i.e., verbally.

Three basic sources document the extent and location of damage caused by the storm: (1) photographs, (2) flood damage reports, and (3) work order documents. Photographs taken of the flood damaged areas provide the best description of the extent of damage. Photographs, however, were not taken of all the flooded sites.

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Flood damage reports provide a written description of the extent and location of storm damage. These reports were instituted immediately after the hurricane, and were updated every twelve hours for the first few days. The reports identify the rail line, the mile posts, and the type of damage. However, the reports, which were prepared hurriedly from information passed along verbally through the divisions, are inaccurate in many instances, and contain poor estimates of the extent of damages. The third source of documentation relates to the actual repair work. These documents include material invoices, time cards for manpower use, etc., and are associated with the various work orders that accumulate the cost of repairs and restoration. These are the source documents for the accounting records. Our comments on the accounting for storm damages are set out in paragraph III. B.1. of this report.

In attempting to evaluate track conditions prior to the storm damage, we found that track inspection records for that period were not available. We were informed that it was Penn Central's policy to keep track inspection records only one year. The only documentation relating to track conditions was the Track Maintenance Charts. These charts, by track sections, show the last time maintenance was performed in the categories of: (1) grinding, (2) welding, (3) surfacing, (4) ties, (5) bars, (6) rail, (7) ballast cleaned, and (8) joints straightened. The charts are a history of maintenance but do not give track conditions at any given time.

c. FRA Monitoring Activities

The FRA has no history of the condition of Penn Central's tracks, equipment, or facilities prior to Hurricane Agnes, nor technical evaluations of the repairs and restoration work done since the storm. The FRA Philadelphia Regional Office had not been assigned responsibility for monitoring the loan program, and as such did not have technical records of the storm damage nor inspection reports of the progress of restoration and replacement of damaged facilities. Some surveillance had been performed prior to the loan by the FRA Office of Safety Track Inspection Force; namely, an aerial survey of the flood damaged areas on July 3, 1972, and a ground inspection of the areas a year later. The inspection force reported that the existing on-ground conditions were as represented by Penn Central. No documentation was made available to support this conclusion.

3. Recommendation

We recommend that:

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a. For future programs involving financial assistance affecting railroad maintenance or capital improvements, FRA clearly assign responsibility for on-site technical surveillance of the work to be done under the program.

b. FRA issue procedures for monitoring future loan programs to assure that the funds provided will be used to accomplish the intended purpose.

IV. MANAGEMENT REACTION TO RESULTS OF AUDIT

A. FRA Official Comments

The FRA indicated that generally the audit observations and recommendations were well taken and consideration will be given to recommendations in the development of guidelines for administering future Federal assistance programs. However, FRA disagreed with the observations and recommendations on FRA's administration of the Emergency Rail Services Act of 1970, and the Emergency Rail Facilities Restoration Act of 1972, maintaining that the audit comments reflect an unfamiliarity with the applicable laws, and a lack of understanding of the responsibilities of various FRA offices.

The FRA contends that the audit conclusions are unsound and maintains that the proceeds of the guaranteed trustee certificates were spent in accordance with the Act and the terms and conditions of the guarantee, were fully documented through cash flow information submitted by Penn Central, and there was no reason for requiring the trustees to deposit the proceeds from the certificates in a segregated account.

The FRA further maintained that the condition of Penn Central's track and equipment prior to the Agnes storm had no relevance to the administration of the loan program, and the only concern of the "Agnes" Act was to provide the financial assistance necessary to restore essential railroad operations. For the same reasons, FRA contends that there was no need for technical evaluations of the storm damages nor were progress reports necessary for the restoration work. FRA also contends that the quality of the restoration work was beyond the scope of the auditors' responsibilities and an audit determination in this area was not necessary since the Act does not

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establish a quality level of restoration. (The full text of the FRA response is contained in EXHIBIT F as an attachment to this report.)

B. Auditor Comments

The auditors were well aware of the applicable laws pertaining to the Penn Central Federal assistance programs, the terms and conditions of the agreements, and the background actions leading to the programs. These particular areas were thoroughly researched by the auditors. The data obtained is summarized in Section V of the audit report and was used as the guidelines for performing the audit.

In addition to ensuring compliance with the applicable laws, agreements, etc., the auditors have the responsibility of determining the degree of reliance that can be placed on the controls established, in this case by Penn Central, over the expenditures of emergency funds earmarked for specific purposes. An auditor must deal with the facts, and while at times may give an opinion based on reasoning, there must be sufficient and relevant evidence obtainable to provide a factual basis for an audit determination. It follows that, because the trustee certificate proceeds were not identified to specific expenditures by Penn Central, the auditors could not render an unqualified audit opinion as to their ultimate use. It also follows that, while the auditors were able to review the accounting for the expenditure of funds under the direct loan program, they were unable to make an audit determination as to whether the funds were used for program objectives since no means were available to measure the extent of damages that Penn Central claimed was caused by the storm.

The FRA indicated there was no need to have the trustees deposit the proceeds from the certificates in a segregated account and maintain separate accounting for the disposition of the funds. Such an accounting procedure provides for effective internal control of such funds and has been used to good advantage in both industry and Government. As a matter of fact, the Interstate Commerce Commission (ICC) has followed this practice in guaranteeing loans to railroads. In a bankrupt situation, where there are terms and conditions attached to a loan action requiring specific use of loan funds, sound business practices are necessary to provide practical program administration.

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For FRA to rely wholly on reviews of corporate financial statements and cash flow data prepared by Penn Central is not considered sufficient to monitor the Federal assistance program. If Penn Central had been required to maintain separate accounting, FRA would have been in a position of not only assessing Penn Central's overall cash position, as was the case, but to monitor the loan funds as they were being expended and to ensure that the funds were used solely for expenses necessary for continuing essential transportation.

The FRA disagreed with the audit conclusion on the disposition of the direct loans furnished under the "Agnes" Act and indicated there was no requirement under the Act for technical input into the Federal assistance program.

The auditors recognize that the Act does not specifically provide for such input, but good management practices should provide for an independent assessment of the extent of storm damages to railroad track and equipment and an evaluation of the resources necessary to restore the facilities to working order.

During a physical inspection of railroad facilities, even though accompanied by FRA and Penn Central personnel, the auditors were unable to verify what specific work (other than capital improvements, i.e., bridges) had been done under the Federal assistance program. The majority of information as to storm damage and the extent of restoration work was gained verbally from Penn Central representatives. The FRA representative was not familiar with either the storm damage or the restoration work. Under such conditions as well as the unavailability or unreliability of field maintenance and inspection records the auditors were unable to determine if Penn Central used the loan funds solely for storm damage and not for normal maintenance and repairs as well. This situation was corroborated with Penn Central officials after the inspection trip.

The primary issue raised by the auditors involves the extent to which the Penn Central Federal assistance programs were administered by the FRA. An integral part of effective program administration consists of technical evaluations of the work to be done. This is an accepted practice in Government where programs entail a measurable end product.

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There was no evidence that the FRA Office of Safety, which has technical expertise, provided in-depth input into the program either from Headquarters or from the Philadelphia Region which has inspection cognizance of the territory where the majority of the storm damage occurred. As cited in the audit report, only an aerial survey of the flood damaged areas was made right after the storm and a ground inspection a year later. These reports only evidenced general observations of the situation and not technical evaluations of the damages. Without such evaluations of the damages and on-going site inspections with periodic reporting by FRA Office of Safety of the progress and type of work being done by the railroad, FRA had to rely only on information prepared and submitted by Penn Central officials.

In the absence of reliable technical data, the auditors attempted to determine the pre-storm condition of railroad property as a basis for comparing the extent of restoration of certain track locations where the damage and the extent of repairs were verbally identified by Penn Central divisional representatives. This technique was used not for qualitative analysis but an attempt to verify that stretches of track verbally identified as damaged were in fact damaged and repaired under the loan program. The auditors were unable to do this for the reasons cited in the audit report.

V. BACKGROUND

The Department of Transportation has provided emergency financial assistance to Penn Central pursuant to provisions of the Emergency Rail Services Act of 1970 (guaranteed certificates) and the Emergency Rail Facilities Restoration Act (direct loans) approved October 27, 1972.

Financial assistance under these Acts was made available to railroads undergoing reorganization under Section 77 of the Bankruptcy Act. The Penn Central filed a petition for reorganization June 21, 1970, in U. S. District Court for Eastern Pennsylvania. The petition was approved by the Court and Trustees were appointed on July 22, 1970, to manage the property of Penn Central. By March 1974, assistance provided to Penn Central was:

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LEGISLATION	TYPE OF ASSISTANCE	AMOUNT (MILLIONS)
Emergency Rail Services Act of 1970	Guaranteed Certificates	$100.0
Emergency Rail Facilities Restoration Act	Direct Loans	17.6
	Total Assistance	$117.6

The Emergency Rail Services Act of 1970 authorized the Secretary of Transportation to guarantee payment of principal and interest on certificates issued by the Trustees of the Penn Central under the following conditions:

A. The proceeds from the sale of certificates would be used solely for meeting payroll and other expenses which, if not met, would preclude continued provision of essential transportation services by the railroad.

B Other revenues of the railroad, including proceeds from the sale of assets, would be used to the fullest extent possible for such expenses.

C. The guaranteed certificates would be treated as an expense of administration and receive the highest lien on the railroad's property and priority in payment under the Bankruptcy Act.

On January 26, 1971, a guarantee agreement was signed by the Secretary of Transportation, as Guarantor, and the Trustees of Penn Central for the creation and issuance of:

A. $50,000,000 certificates due January 15, 1976, at 6.5 percent interest, known as the 1976 Certificates.

B. $50,000,000 certificates due January 15, 1986, at 7.05 percent interest, known as the 1986 Certificates.

The Federal Reserve Bank of New York was appointed fiscal agent for the authentication, registration, transfer, exchange and other services connected with the certificates. Authority to monitor the program was delegated to the Federal Railroad Administrator by the Secretary of Transportation.

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The Emergency Rail Facilities Restoration Act authorized the Secretary of Transportation to make direct loans to Penn Central for damages to facilities and equipment as a result of the natural disaster, more specifically known as Hurricane Agnes, which occured during the month of June 1972. The storm struck at points along more than 4,000 miles of railroad right-of-way. Floods cut the main lines in eastern and central Pennsylvania and portions of Maryland and southern New York State. About 80 Penn Central branch lines, secondary and industrial tracks were damaged by slides and washouts, while 25 railroad bridges were demolished and 23 others damaged.

The principal condition imposed on Penn Central under the Act was that the funds would be used solely for restoring and replacing railroad facilities, equipment, or services which were determined to be essential to public service including, without limitation, bridges, track, track structures, signal and communication systems, and rolling stock, or for the reimbursement of expenditures for such restoration or repairs.

On August 13, 1973, the Trustees entered into a loan agreement with the Federal Railroad Administrator, acting on behalf of the Secretary of Transportation, for an approved amount of $17,645,542 in direct loans payable over a twenty-year amortization period at 5.5 percent interest.

VI. SCOPE

We reviewed the legislation, policies, and procedures pertaining to the Federal Railroad Administration and as applicable to the railroad emergency loan programs, and the controls instituted by FRA and Penn Central over the use of the emergency loan funds.

Our audit included (a) a review of the Penn Central accounting records and supporting documentation to determine the propriety of transactions involving funds provided by DOT pursuant to the legislation, (b) a physical verification of additions, restorations, and improvements made to Penn Central facilities and equipment in storm damaged areas, and (c) a review of FRA operations to determine whether the results of the programs have been achieved.

Our procedures included selective testing techniques of Penn Central's transactions, and the use of DCAA's time-share computer to obtain random samples for statistical testing of Penn Central's payrolls. We coordinated our work program with the Philadelphia Audit Region of the Interstate Commerce Commission, and with Haskins and Sells, Penn Central's CPA firm.

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Our procedures included selective testing techniques of Penn Central's transactions, and the use of DCAA's time-share computer to obtain random samples for statistical testing of Penn Central's payrolls. We coordinated our work program with the Philadelphia Audit Region of the Interstate Commerce Commission, and with Haskins and Sells, Penn Central's CPA firm.

The audit was performed at Penn Central Headquarters, Philadelphia, the Alleghany and Harrisburg Divisions, and the Altoona Heavy Repair Shops in Pennsylvania. We reviewed activities during calendar years 1971, 1972, and 1973, the periods of financial assistance.

VII. PERSONNEL CONTACTED

A listing of key FRA and Penn Central Railroad personnel contacted during our audit is attached as Exhibit E.

VIII. AUDIT COUNSEL

We will be pleased to provide audit counsel on any matter discussed in this report.

Albert S. Mayolo
Manager, Headquarters Audit Operations

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EXHIBIT A

PENN CENTRAL TRANSPORTATION COMPANY
TOTAL OPERATING EXPENSES - JANUARY THROUGH APRIL 1971
AND JULY AND AUGUST 1972

Account	Amount
Labor	$557,876,514
Office Supplies and Equipment	6,411,324
Locomotive and Train Supplies	1,651,105
Contractual Services - Maintenance of Way	5,468,902
Miscellaneous Employee Expense	13,963,102
Fuel	21,358,332
Utilities	22,433,203
General Supplies	9,762,672
Miscellaneous Operating Expenses	1,053,515
Expenses Relating to Capital Program Activity	184,635
Fees and Professional Services	3,200,050
Rents Paid	46,097,909
Contractual Services - Maintenance of Equipment	31,877,244
Depreciation	45,920,646
General Expenses	30,425,523
Casualty Expenses	23,251,969
Joint Facility Expenses	21,577,108
Transportation Services	5,522,193
Credits	(62,283,050)
TOTAL	$785,752,896

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PENN CENTRAL TRANSPORTATION COMPANY
SCHEDULE OF REPAIRS AND RESTORATION COSTS
INCURRED AS RESULT OF HURRICANE AGNES

EXHIBIT B

	COSTS INCURRED AS OF LOAN APPLICATION (AS OF 4/30/73)		COSTS INCURRED TO DATE (AS OF 4/30/74)		
I. Maintence Of Way & Structures					
A. Repairs					
Track	2,966,058		3,229,130		
Communications & Signals	1,005,260		1,097,140		
Buildings & Bridges	567,639		651,886		
		4,538,957		4,978,156	
B. Capital Improvements					
Construction	6,416,899		8,741,390		(2)
Expenses Incident to Const.	293,338		307,165		(2)
Preliminary Engineering	290,200		801,024		(2)
		7,000,437		9,849,579	
C. Abandonments					(1)
Demolition Costs		1,023		-0-	
Total Facilities Repairs		11,540,417		14,827,735	
II. Maintenance of Equipment					
A. Altoona Heavy Duty Repairs					
Freight Cars	88,381		46,340		(3)
Locomotives	769,673		744,008		(3)
Miscellaneous	3,731		4,110		(3)
		861,785		794,458	
B. A. A. Billing Bureau					
Cars Repaired by Foreign Roads	39,537		153,772		
Settlements For Destroyed Cars	10,074		10,074		
		49,611		163,846	
C. Regional Costs					
Repairs of Equipment		1,047,253		2,167,933	
Total Equipment Repairs		1,958,649		3,126,237	
III. Other Expenditures					
A. Transportation & Other Depts.	977,275		987,612		(4)
B. Excess Per Diem	4,192,877		5,161,187		(4)
Total Other Expenditures		5,170,152		6,148,799	
Total Storm Damage Expenditures		18,669,218		24,102,771	

(1) Item not considered eligible for purpose of loan.

(2) Represents costs for 10 capital projects of which 7 were included in loan.

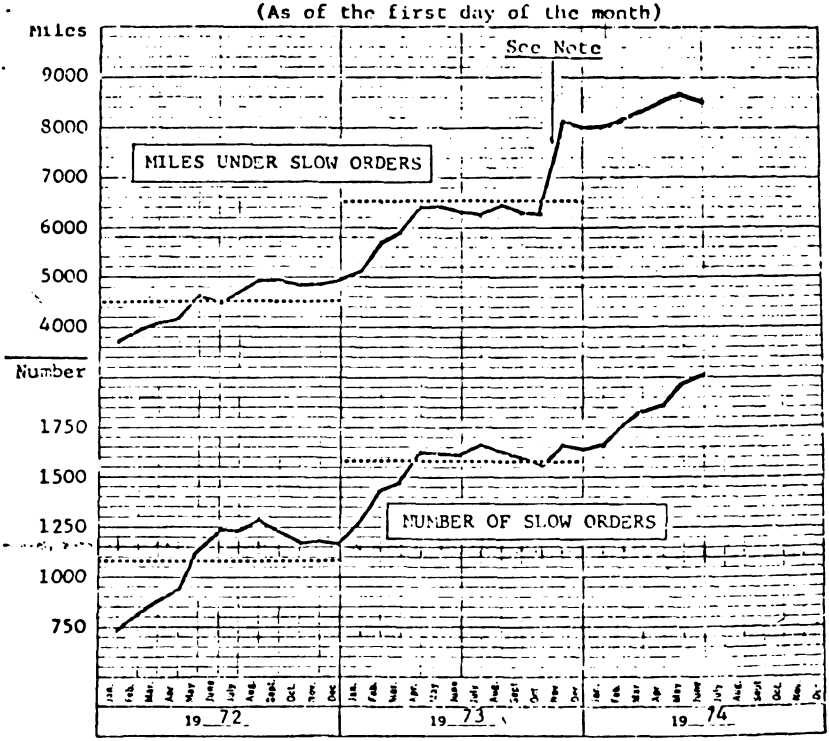
(3) Costs adjusted in July 1973 to reflect duplication of charges for rehabilitated material.

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EXHIBIT C

SLOW ORDER STATUS

(As of the first day of the month)



---------- 12 Month Average For Year

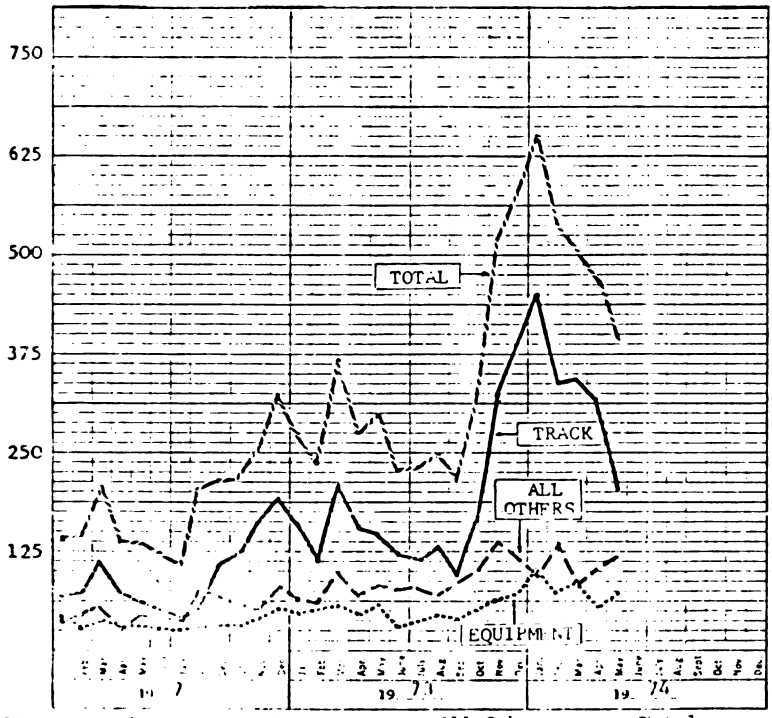
	Slow Orders				
	Miles			Number	
		Vs. Same Date Previous Year			Vs. Same Date Previous Year
June 1 '72	5376			568	
Jan. 1 '73	3738	+ 862	+30.0%	745	+ 187 +33.5%
Jan. 1 '73	5143	+1405	+37.6%	1262	+ 517 +69.4%
Jan. 1 '74	8020	+2877	+55.9%	1666	+ 404 +32.0%
Feb. 1 '74	8180	+2430	+42.3%	1760	+ 337 +23.7%
Mar. 1 '74	8346	+2406	+40.5%	1792	+ 331 +22.7%
Apr. 1 '74	8540	+2065	+32.0%	1852	+ 232 +14.3%
May 1 '74	8606	+2172	+33.8%	1968	+ 335 +20.5%
June 1 '74	8515	+2171	+34.2%	2084	+ 465 +28.7%

Note: FRA Track Standards Became Effective.

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EXHIBIT D

Derailments



CAUSES: Track —— Equipment ..... All Other — — — Total —·—·—

	Reported Causes							
	Track		Equipment		All Others		Total	
Year	No.	Vs. Same Period Prev.Yr.	No.	Vs. Same Period Prev.Yr.	No.	Vs. Same Period Prev.Yr.	No.	Vs. Same Period Prev.Yr.
1972	1167		424		627		2208	
1973	2130	+ 83%	617	+ 46%	1032	+ 65%	3779	+ 71%
Cumulative								
Jan.'74	450	+185%	101	+115%	98	+ 42%	649	+137%
2 Mos.'74	785	+191%	166	+ 66%	228	+ 78%	1179	+137%
3 Mos.'74	1129	+135%	245	+ 55%	307	+ 35%	1681	+ 94%
4 Mos.'74	1442	+126%	304	+ 48%	403	+ 36%	2149	+ 88%
5 Mos.'74	1645	+109%	373	+ 41%	520	+ 37%	2538	+ 77%

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LISTING OF PERSONNEL CONTACTED

FEDERAL RAILROAD ADMINISTRATION

Frederick G. Bremer	- Associate Administrator, Office of Administration
Patrick O'Driscoll	- Office of the Chief Counsel, Commercial Division
Stanley J. Prymas	- Office of Policy and Plans
Rudolph H. Williams	- Office of Policy and Plans
Mac E. Rogers	- Associate Administrator, Office of Safety
Robert A. Johnson	- Director, Region 2, Philadelphia

PENN CENTRAL TRANSPORTATION COMPANY
HEADQUARTERS OPERATION

Norman J. Hull, Jr.	- Vice President, Controller
Raymond C. Lepley	- Treasurer
Philip Nowlan	- Assistant Treasurer
Robert W. Thomas	- Assistant Controller
Jack Dawson	- Assistant Controller, General Accounting
Ronald Dalessio	- Accounting Project Analyst
Charles Reese	- Director, Equipment, Planning & Control
William Diamond	- Supervisor, Central Expenditures
Robert Davis	- Supervisor, Property Accounting
Thomas Wright	- Supervisor, Taxes and Post Payroll
N.J. Algeo	- Director, Operating Management Controls
E.R. Varalli	- Assistant Vice President- Budget Planning
Melvin H. Miller	- Senior Operations Analyst
N.J. Nawn	- Manager, Personnel Accounting

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Jack Groves	- Assistant Supervisor, Material Accounts
James Stuart	- General Mechanical Superintendent - Freight Cars
William Mull	- Manager, Material Accounting
S.W. Seeman	- Director, Personnel Administration
Vernon Gross, Jr.	- Special Assistant to Trustees
James Howard	- Legal Counsel to Trustees
Robert Smith	- Chief of Engineering
William Pope	- Chief of Track Engineering
William Sponseller	- Chief Engineer, Construction
Jack Cunningham	- Chief Engineer, Communications and Signals
Robert M. Woods	- Supervisor - Contract Audits
James Herska	- Revenue and Billing Audits

HARRISBURG DIVISION

H.J. Deeds	- Divisional Engineer
Michael Dunn	- Assistant Divisional Engineer

ALLEGHENY "A" DIVISION - Altoona

Harold E. Richards	- Divisional Engineer
Jerry Rudy	- Assistant Divisional Engineer

ALLEGHENY "B" DIVISION - Williamsport

L.P. Bonfardin	- Divisional Engineer
J. Arduini	- Assistant Divisional Engineer

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ALTOONA HEAVY REPAIR SHOP

Joseph S. Fadale	- General Manager
Robert Schaffer	- Administrator Assistant

ENOLA LOCOMOTIVE SHOP

J. McKeone	- Shop Supervisor
J.C. McConnell	- Acting Terminal Foreman

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Mr. ROGERS. Have all of the moneys been spent appropriately?

Mr. BARNUM. Yes, sir.

Mr. ROGERS. Have they fixed the rails as they should have?

Mr. BARNUM. They have been applied as required under the grant agreements entered into with the Penn Central, to continue rail operations. I cannot tell you they were able to fix all the rails. The agreements that we have made with the Penn Central trustees did not contemplate they would fix all the rails.

Mr. HEINZ. I would like to talk particularly about the question of the Erie Lackawanna Railway and its potential for inclusion under the Rail Reorganization Act. One of the possible concerns that strikes me that we might have is that if we accept the proposition that we should wait to include the Erie Lackawanna, it is possible that a further determination of their assets, liquid as well as fixed, if you will, might take place, and that the resulting shell would be an even more difficult organization to include within a regional rail reorganization plan.

Can you tell us whether there has been any serious diminution of the basic resources of the Erie Lackawanna during the last year, during which period they elected to go under chapter 77 rather than come in under the act, as they had an opportunity a year or so ago?

Mr. BARNUM. In response to your question, there has been, in fact, a deterioration in their situation. That is why they have concluded they cannot reorganize under section 77 of the Bankruptcy Act. In our judgment they could not have reorganized successfully under section 77 even when the court concluded that they could. And we submitted to that court the data available to use that suggested that they could not reorganize under the act.

With respect to your first comment, I do not agree. Your statement was that if you proceed as we would urge you to proceed, there is a danger that the Erie Lackawanna will deteriorate more during the next year than it would if you proceeded as the trustees urge you to.

I submit there is not any difference with respect to maintenance—the physical condition of the Erie Lackawanna—whether you proceed their way or our way. The only difference between the two is that under the procedure urged by the trustees, USRA could require transfer of Erie Lackawanna properties to ConRail. Under the procedure we urge they could not require a transfer. But they can and, indeed, are being included in the preliminary system plan, and I assume the final system plan will designate properties of the Erie Lackawanna that should be included in the rail system in the Northeast.

The only difference between the two approaches are the points I made in my prepared statement. First, by proceeding in the manner preferred by the Erie Lackawanna, the Government will be subjected to claims under the Tucker Act and, secondly, the whole planning process may be thrown into a state of confusion.

Mr. HEINZ. One pertinent question, it seems to me, is it possible for the trustees under chapter 77 to, let's say, go out and decide to pay off as many creditors of the Erie Lackawanna as they possibly could, thereby giving as much of the Erie Lackawanna back to those creditors prior to a time when they might come in under the act? Is that possible for them to do that without going to jail?

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Mr. BARNUM. It would only be possible if they were able to submit to the reorganization court a plan of reorganization which contemplated continued operation as a railroad. They have concluded they cannot submit such a plan. Their alternatives are two: They could either terminate the reorganization and go into liquidation, or they could dispose of certain parts of the property under section 77(o) of the Bankruptcy Act and use the proceeds from those sales to pay down on some of their debt.

Mr. HEINZ. I don't wish to put words in your mouth, but it sounds as if it might be possible for the trustees to embark on a course where there would be a lot less left. I also understand you don't think that a terribly likely possibility, it would always be up to the court to approve such a plan. In the limited available time, let me ask one last question.

The CHAIRMAN. One last one.

Mr. HEINZ. That is this: Would the Department of Transportation have any objection to the Congress making available to the Erie Lackawanna the following kind of proposition, namely, an election that they could come in under the Rail Reorganization Act, but as part and parcel of that election they would waive whatever right they had under the Tucker Act?

Mr. BARNUM. That would have to be an election made not only by the Erie Lackawanna trustees, but by all of the creditors of the Erie Lackawanna. I suggest that is a rather desperate hope.

The CHAIRMAN. The time of the gentleman has expired. The gentleman from Maryland, Mr. Byron.

Mr. BYRON. I have one question, Mr. Secretary. Do you see any delay in some of the local transactions that are going on now? I have reference to one. I think under discussions over on the Eastern Shore of Maryland where Southern Railway may acquire part of the Penn Central line, is that going ahead?

Mr. BARNUM. The acquisition is not going ahead. Its under consideration.

Mr. BYRON. Will anything occur in this legislation delay which will significantly retard the progress of that?

Mr. BARNUM. The only thing in the legislation before you that would have an effect on that particular question, I suppose, are the following: First, some of the rehabilitation that might be accomplished or some of the equipment that might be improved under our proposal might impact that region. I don't know specifically whether that properly would be rebuilt, but that is a possibility.

What could impact that region would be a delay in the implementation of the final system plan under the Regional Rail Reorganization Act, the starting up of ConRail in January, and the transfer of properties of the bankrupts to other railroads, such as the Southern, by further constitutional litigation, such as undoubtedly would arise in the event the act were tampered with in a way that it reopened the whole question as to whether it was a uniform act under the bankruptcy clause of the Constitution. That would delay indefinitely the transfer of the properties to the Southern or any of the other railroads that have expressed an interest in acquiring such properties.

The CHAIRMAN. I am going to divert for one question from the gentleman from New York, Mr. Hastings.

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Mr. HASTINGS. I have one question I will ask. The time schedule concerns me. Penn Central announced its letters of embargo are scheduled to go out on the 14th of February if they do not receive assistance from the Federal Government. It becomes apparent the House of Representatives will probably not complete action prior to the legislative recess scheduled to start this coming Friday. Do you agree with the Penn Central position unless they have this legislative assurance and a guarantee of the money, that service will be curtailed by the 14th or after the 14th of February?

Mr. BARNUM. Well, I can't assure you that that dire prediction is absolutely true.

Mr. HASTINGS. What is your feeling? Do you support generally their position?

Mr. BARNUM. We are proceeding on the assumption that it has a significantly high degree of likelihood that it would be foolhardy to disregard it. We think there is a very high likelihood that that is exactly what will happen. We do not think, with all due deference, that it is too late for the Congress to adopt the amendments prior to the recess. There is a separate problem as to whether the Appropriations Committees could meet in time to approve the additional funds that would be necessary under section 213.

Mr. HASTINGS. You will agree then it is a dangerous gamble for the Congress to take a recess without completing action on this as it relates to the continuation of service by Penn Central?

Mr. BARNUM. Yes, sir.

Mr. HASTINGS. Thank you.

The CHAIRMAN. Mr. Moorhead.

Mr. MOORHEAD. Mr. Secretary, one of the things that concerns me is there are so many miles of this railroad that are considered nonprofitable and still the railroad is being compelled to operate it. From the testimony you gave earlier, I believe it is about a third of all the traffic that Penn Central has is really in the nonprofitable area.

Would it be possible if they were allowed to abandon this track, that they could operate profitably as a railroad? They could operate in the black?

Mr. BARNUM. It is possible, but not within the time frame we are talking about. In other words, even if you were to authorize the abandonment overnight of one-third of the lines, and we are not talking about that much, that would not return sufficient cash to Penn Central to permit it to continue to operate during the year and a half we are talking about.

Mr. MOORHEAD. When ConRail takes over, are they going to be compelled to operate all of this trackage, or can they cut down to the point where they have a profitable railroad to operate?

Mr. BARNUM. The act specifically directs USRA to design a profitable rail system out of the properties of the bankrupts.

Mr. MOORHEAD. They are ordered to design it. That doesn't mean that design necessarily has been adopted?

Mr. BARNUM. That is going to be up to the Congress, when the final system plan is submitted. That is entirely correct.

Mr. MOORHEAD. No one wants any traffic abandoned in their area.

Mr. BARNUM. That is equally correct. But the Congress did provide in title IV of the Regional Rail Reorganization Act both a procedure

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and funding authorization for subsidies to help State and local governments continue the operation of properties that USRA does not designate for continued rail service

Mr. MOORHEAD. In this ConRail, as you have it proposed, going to be a Government-subsidized railroad, or is it one that will be able to take care of its own financial needs?

Mr. BARNUM. Initially it is going to rely very heavily upon loans guaranteed by the Government. USRA will make those funds available to ConRail, and that will be the vast bulk of ConRail's initial debt.

Mr. MOORHEAD. I understand there are certain portions of the track that Penn Central has that other railroads would perhaps like to have taken over and believe they can operate on a financially successful basis. In the long run will it be better for this country if that track remained in private service under railroads that could operate efficiently, and at a profit, or is it better to let the whole thing go into a Government-subsidized organization that really isn't within private enterprise?

Mr. BARNUM. Well, I do not equate with nationalization an entity that is able to use Government-guaranteed loans, for example. What the Regional Rail Act contemplates is creation of a privately owned operating entity, ConRail, the stock of which will be owned by the estates of the bankrupt railroads that contribute properly to ConRail. The only respect in which ConRail will differ from any of the other privately owned railroads is that under the Regional Rail Reorganizational Act ConRail has access to $1 billion of federally guaranteed loans, but it is debt that will have to be paid off in the normal course and is not in essence any different from what the other railways of the Nation would be able to incur under the Surface Transportation Act, to wit, by borrowing money guaranteed by the Federal Government. I do not think of that as a subsidy in the way of grants being made to Railroads.

It is to contribute to the subsidized operation. It is not at all the same kind.

Mr. MOORHEAD. How long would you expect it to be before ConRail would be able to operate totally free of the need of Government help of any kind?

Mr. BARNUM. This is the very question which the USRA is addressing now in the preparation of the preliminary system plan to be published on the 26th of February.

The CHAIRMAN. The time of the gentleman has expired. The Chair would like to make a request now that we continue on for a short time, but that we come back at two o'clock for consideration of this bill instead of the consideration of our rules. We will put that off to a later date.

I think this is an emergency and I think we need to get it done. Is there any objection to that?

Mr. HEINZ. Before we will be able to take any legislative action, would it not be the case that we must complete our organizational meeting and adopt at least some rules of procedure to operate under? Otherwise it will be impossible for this committee, without being subject to a point of order on the floor, to present any legislation.

The CHAIRMAN. I believe we can proceed under the rules of the House when we do not have the regular rules, and they are always in order, and I think we can do as we said.

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Without objection we will come back at two o'clock, but we will continue for a few short minutes. I am turning the Chair over to the gentleman from Massachusetts. Our next questioner is Mr. Ottinger from New York.

Mr. OTTINGER. Thank you, Mr. Chairman.

I want to congratulate you for your really brilliant and very knowledgeable testimony here this morning and for the fine job you are doing in a most difficult situation. There are a couple of things I think there are some misconceptions on and I would like to clarify on a kind of broad scale.

First of all, I understand the moneys we are being asked to provide or authorize here are solely for operating expenses and for maintenance of way of the railroads and are not in any way reachable by creditors of the railroads; is that correct?

Mr. BARNUM. The funds that we are recommending be made available would be available for operating, maintenance and for acquisition of property that would ultimately go into the ConRail system, such as rails, ties, equipment to install rails and ties, and rolling stock. The property that would be purchased clearly could not be reached by the creditors. The right of way, however, is subject to a lien by the creditors. Unless we protest the enhancement in value by the conditions we have suggested in our amendments to sections 213 and 215, so that ConRail would not have to pay for it a second time in acquiring the property, the enhancement would go to the creditors. And that is precisely why we have urged that when we are authorized to enter into an agreement to upgrade property, the increase in the value of the property not be made available to the creditors, but rather to the benefit of ConRail.

Mr. OTTINGER. Ordinarily when a corporation goes through a bankruptcy proceeding, it is discharged of all of its debts. I take it that the problem we confront here is that we can't complete that process without running the risk of having the property of the railroads sold off and no longer available for rail purposes; is that correct? That is why we have to step in here at this juncture.

Mr. BARNUM. Well, your question really goes more to the situation we had when the Regional Rail Reorganization Act was passed. It was true at that time that if the Congress had not stepped in and permitted a multibank railroad reorganization in a single court, the likelihood was that each of the railroads would have had to liquidate perhaps all of its property because it could not reorganize independently. That is precisely why the Congress collected the reorganizations into a single proceeding and authorized the funding for the rehabilitation of the properties so that what came out could be reorganized as a railroad.

Mr. OTTINGER. Do you have any estimate of the exposure because of the Supreme Court decision in the transfer of these properties to ConRail? I take it there is a swap or property for stock. And the Court said we would, to the extent that that arrangement might operate unfairly with respect to the creditors, that we would assume those liabilities. Do you have any estimate of what the plant is on there and what the degree of exposure is? I have heard everything from $13 to $130 billion.

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What is the realistic liability to which we are exposing the Government?

Mr. BARNUM. The court described two possible liabilities. One is liability for what is called erosion—liability for the effect of continuing the operation of the railroads as railroads during the redesign process. In my judgment the reorganization courts would have, indeed each of them has, required continued operation of the railroads, and, in fact, what we have been doing under section 213, and propose under 215, has made those railroads lose less money during the planning periods than they would have otherwise. If anything, the creditors owe us.

With respect to the conveyance liability, it was our judgment when the act was enacted initially, that the going concern value of the viable parts of the bankrupt properties was the highest and best use of those properties, and their being collected in a single viable corporation, the stock of which would be returned to the estates of the bankrupts, would adequately compensate the estates of the bankrupts. That is still our judgment.

Mr. MACDONALD [presiding]. I hope I don't sound like a broken record, but we have been burned twice now, and I was wanting your assurance, Mr. Secretary, that if the people of New England rebuild once again the roadbeds that have been the cause of much of the delay and many of the problems that we have, that we won't have to go through it another time with nothing to show for it.

Mr. BARNUM. Well, I will give you what assurance I can, Mr. Chairman. Of course, some of the rail properties in New England are not bankrupt. The Maine Central and the Delaware & Hudson are not bankrupt, and the State of Vermont is operating a railroad in that part of the region. The Boston and Maine is in reorganization, but has elected not to reorganize under the Regional Rail Act.

None of these will benefit directly from what we are recommending to you at this time. There are substantial properties of the Penn Central, the old New Haven in the New England region, that will be upgraded. Indeed, one of the projects we propose to fund under our proposal is the upgrading of the line between New York and Boston.

Mr. MACDONALD. My last question: Even though you say that the benefits will flow, does that also mean there will be no New England money spent on roadbeds up there?

Mr. BARNUM. No. I think some of the funds we are making available to the Penn Central, or would want to be able to make available to them, would be spent in the New England region. I know categorically that some of the properties on the main line from New York to Boston, for example, will be ungraded as a result of the program we have recommended to you.

Mr. MACDONALD. And that is no matter how local people decide to vote? If that is left to local decision, it will not matter how they vote? They are going to get the money in any event?

Mr. BARNUM. What we are urging the Congress to do now will not trigger any local decisions as to where the money will be spent. What the Congress did in the Regional Rail Reorganization Act was to authorize $90 million a year for 2 successive years which the States in the region could use along with matching funds to continue operations or to acquire properties of railroads that would otherwise be abandoned.

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The provision we are recommending the Congress to adopt that is intended initially to apply to the Erie Lackawanna would be available to the Boston Maine if that railroad determined it needed financial assistance during this period.

Mr. MACDONALD. It is not forced on them if they do not want it?

Mr. BARNUM. Absolutely not.

Mr. MACDONALD. Thank you.

Mr. Rinaldo, I apologize for interrupting your time.

Mr. RINALDO. Thank you very much.

I want to commend the Secretary for his excellent testimony. I feel that from the district I represent this legislation is certainly worthwhile, necessary, and most desirable. But I have some questions, very basic questions.

I think we should look beyond the legislation in question and get to the heart of this type of subsidization. What we are doing time and time again is asking the taxpayer to foot the bill. I want to give an example of one city in my district where, in effect, the constituents get hit not only with higher Federal taxes, but get hit again on their local property taxes.

The Central Jersey Railroad's tax delinquency to the city of Elizabeth, N.J., dates back to 1967. They now owe the city $1.5 million in back taxes. In addition there also is a $75,000 assessment for paving and sewer work.

Penn Central has been delinquent since 1970. They owe more than $200,000 in back taxes. The interest owed by these two railroads alone to the city of Elizabeth exceeds $445,000.

The city of Elizabeth has been fighting this matter and has been unsuccessful in collecting any of the back taxes because the railroads have been protected from foreclosure of their property assets. State law in New Jersey requires taxes from railroad property to be carried as anticipated revenue. As a result of this fact, the city is faced to make up for the unpaid taxes by increasing the local property tax rate for all property owners.

Before we vote on this matter, where more money is going to be poured into the railroads, and where they are going to take it for purportedly good uses, I would like to know whether or not any provisions are being made for the payment of back taxes.

Mr. BARNUM. There are.

Mr. RINALDO. Could you please explain?

Mr. BARNUM. I understand that the Penn Central and some of the other railroads have negotiated settlements of some of their tax delinquencies. In our consideration of the cash flow of those railroads and the needs for additional funding under section 213, we have taken into account those obligations that the trustees had incurred.

We have recognized them as legitimate claims on the estates, just as we have recognized claims for back wages. And the funding we are making available to the Central of New Jersey and Penn Central, which we would now urge Congress to increase, in fact permits those railroads to make those settlement payments to your constituents and the other towns.

Mr. RINALDO. I assume you mean they are negotiating with the Court?

Mr. BARNUM. With the approval of the Court.

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Mr. RINALDO. All right. One other point: While I can say that I agree with most of your testimony, to be perfectly honest about it, I disagree completely when you say there should be no dollar limitation on salaries of officials in Government supported entities. I think this is completely wrong. I very strongly feel that there should be salary ceilings on those officials.

With this type of certainly needed and desirable legislation, we should not be bothered with a contentious, as you put it, and controversial issue unrelated to the crises of the Northeast railroads. I raise this point because of the Senate amendment which increases the salary of the Amtrak president from the current level of $60,000 to what I feel is a staggering $90,000.

When you consider the economic state of the Nation, and the problems we are having with the economy in our fight against inflation, I think it would be a grave mistake to increase any Government official's salary by 50 percent. For those reasons I would hope that not only this committee, but you would also agree that this type of encumbrance should not be included in this legislation.

If it comes up as a separate matter, that would be fine, because I would be perfectly willing to vote against it at that time.

Mr. MACDONALD. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Secretary, I am sorry I was not here when the session started, but we were in the process of organizing the Government Operations Committee.

What consideration is to be given to a railroad which was eligible, but did not choose in the statutory time limit to be brought into Con-Rail under this plan?

Mr. BARNUM. Considerable consideration must be given to both of those questions. There is a specific direction in the statute that in designing the preliminary and final system plans USRA shall look at the impact on rail competition. And USRA is specifically required to consult with the Attorney General and the Federal Trade Commission concerning the specific consequences of the plan.

Also, under section 206(d)(3) of the act, at any time USRA would authorize the transfer of property of a railroad in reorganization to a railroad not reorganizing under the Act, ICC review of that transfer is required under section 5 of the Interstate Commerce Act and USRA must specifically consider whether the transfer would have a substantial adverse effect upon ConRail or on any carrier in the region which is not reorganizing under the Act.

Mr. BROWN. Now, if Erie is not embraced in the ConRail plan, am I correct in understanding they will be eligible for loans for operating purposes?

Mr. BARNUM. Under the proposal we have made, they would be. But I would like to clarify the statement "not embraced in the Con-Rail plan." Under out proposal, the Erie Lackawanna properties would appear in the ConRail plan. The only difference between what we urge you to do and what the Erie Lackawanna trustees urge you to do is that under our proposal, the fact they are included in the USRA design for the region does not require the trustees to hand over the property. The trustees on the other hand, want to be told they must hand over the property without any choice.

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But the Erie Lackawanna will be in the preliminary system plan, and the lines appropriate for continuation by ConRail will be designated in the final plan.

Mr. MACDONALD. The House is in session, but I think we probably can go another 4 minutes or so.

Mr. BROWN. Thank you. I will complete my questions by that time.

Mr. MACDONALD. If I am in the chair, the gentleman will be the first recognized when we come back.

Mr. BROWN. Are you suggesting terminating now or continuing for a couple of minutes?

Mr. MACDONALD. It depends on the length of the question.

Mr. BROWN. If I may be the first to question at 2 o'clock, I would be delighted to stand at this moment.

Mr. MACDONALD. If I am in the chair, I will be the first to recognize you, with pleasure, the gentleman from Ohio.

Mr. BROWN. Let me ask two more questions now, and then I will hope to resume at 2 o'clock.

What happens to the Erie after the ConRail plan goes into effect? I gather you are not eligible under the law to continue to loan the money to operate competitively, if they are not in the plan?

Mr. BARNUM. Again I have to come back to that term "in the plan." The real distinction is whether their transfer is mandated by virtue of the plan. In any event, our proposal would permit the Erie Lackawanna to continue operating between now and the time of conveyances under the final system plan.

Mr. BROWN. But you could not loan the money after that point?

Mr. BARNUM. Not under this act, nor could we loan money to any other railroad. We could do it only to ConRail itself. But the Surface Transportation Act would provide substantially the same kind of authority to make federally guaranteed funds available to Erie Lackawanna or whatever railroad were to acquire Erie. But the trustees have told us the Erie Lackawanna cannot reorganize on its own, so its properties would have to be acquired by some railroad.

Mr. BROWN. You will eventually have to bring them into the plan and embrace their properties in some way or another in the ConRail plan, isn't that fair?

Mr. BARNUM. There are two aspects to the ConRail plan. One is the design of ConRail. Let's assume for present purposes that USRA concludes that ConRail should be a single railroad embracing those properties of the bankrupts that can be combined into a viable rail system. In addition to the ConRail design, the preliminary and final system plans will also show where properties of bankrupt railroads could better be combined with solvent railroads to provide competition.

Those would be in the plan just as much as the designated properties that are part of ConRail, Inc., if you will.

Mr. MACDONALD. I would think this is an appropriate place to discontinue. We will continue at 2 o'clock.

[Whereupon, at 12:25 p.m., the committee recessed, to reconvene at 2 p.m. of the same day.]

AFTER RECESS

[The committee reconvened at 2 p.m., Hon. Harley O. Staggers, chairman, presiding.]

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The CHAIRMAN. The committee will come to order and it is my understanding when the committee stopped, we were in the midst of a question by Mr. Brown. I will recognize Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. Secretary, as we were discussing the future of the Erie Lackawanna and the circumstance which exists wherein it is not part of the ConRail system now, but is in a bankrupt status. You indicated, I think, that the Erie Lackawanna would be planned into the ConRail plan, but it would not be taken into the ConRail plan at this point or you did not favor that.

Now my question is, really, if eventually, why not now?

Mr. BARNUM. Well, we certainly contemplate that USRA would, in the submission of the preliminary system plan, indicate those parts of the Erie Lackawanna which should be continued in service, either as a part of ConRail or as a part of another competitive service. In the latter instance they might be acquired either by the Norfolk & Western or Chessie System or consolidated with the Delaware & Hudson, which is in the same region.

Mr. BROWN. At any rate the area would have to be dissolved and you can't dissolve it after ConRail started?

Mr. BARNUM. That is the same as is true of all other railroads in the organization. It wouldn't be any different. The only difference between the treatment suggested to you whereby you make the Erie Lackawanna a railroad in reorganization, is that it would lie within the power of USRA to take or to dictate which parts of the Erie Lackawanna would be included in the ConRail system.

USRA would not have any greater right to dictate acquisition of other parts of the Erie Lackawanna by any other railroad such as Norfolk & Western and the Chessie System, whereas if you do not amend the act to allow the Erie Lackawanna to become a railroad in reorganization, it would be the Erie Lackawanna trustees who would have to negotiate sale of those parts of its system that were sought either by ConRail or by ConRail's competitors, the Chessie and Norfolk & Western.

In the latter instance, the Court would have to pass upon the compensation that was proffered to the Erie Lackawanna trustees whether by ConRail or by one of those profitable railroads and the Court would determine the appropriate value; that would be that. If you allow the Erie Lackawanna to be a "railroad in reorganization," once USRA determines that certain parts of the property shall be taken for the system, whether to be included in ConRail or acquired by other solvent railroads, if and to the extent that the compensation tendered to the Erie Lackawanna trustees in the form of common stock of ConRail is not adequate to compensate the creditors of Erie Lackawanna, then under the Supreme Court's decision they would have a claim in the Court of Claims for the shortfall.

What I am suggesting that you do is put the Erie Lackawanna trustees in a position where they can negotiate a sale for the same value of their property as the creditors ultimately would get if the property were taken. The difference is that when the corporate entity acquires the property, it would pay full value, whereas if the Erie is a railroad in reorganization, the taxpayer would pay the difference, and that is what we recommend against.

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Mr. BROWN. One final question, if I may.

I understand you. In the 1974 report of USRA it was suggested as an alternative the creation, an alternative to ConRail, the creation of a separate fixed plant entity to acquire and rehabilitate with Government funds the rights-of-way of railroads in the Northeast. What is your opinion of that suggestion which would appear to rationalize the Federal Government's relationship with the rights-of-way of the various modes of transportation, because we maintain the highways, the barge lines, airways, and so forth?

Mr. BARNUM. From the outset the USRA has considered as an alternative way of restructuring the railroads in the Northeast and Midwest the formation of a separate corporation to own the facilities over which the railroads might operate. They are still considering it and I imagine the preliminary system plan will include an analysis of that possibility. But the idea of separating the two entities does not necessarily entail ownership by the Federal Government of the entity that owns the right-of-way.

I think there is a very major difference, in fact in my judgment a controlling difference, between having the Federal Government finance State-owned highways over which anybody may operate—all of the trucks and buses and you and I in private cars—on the one hand, and what I think you suggest, that is, that the Federal Government own the right-of-way over which one railroad might operate.

Mr. BROWN. Over which any airline might fly?

Mr. BARNUM. Yes.

The CHAIRMAN. Now, we have a time conflict here and I am trying to accommodate some witnesses, if I can, and I might ask you, Mr. Secretary, to step aside, if I can, because we want to get the evidence of Mr. Stafford in here and his plane is leaving.

Mr. BARNUM. I will be pleased to accommodate him any way you like, Mr. Chairman.

The CHAIRMAN. Yes, because the Commissioner needs to give us some answers. We will come back to you.

Mr. Stafford, take the chair, please. Would you insert your statement in the record and try to summarize it, if you would, please.

STATEMENT OF HON. GEORGE M. STAFFORD, CHAIRMAN, INTERSTATE COMMERCE COMMISSION, ACCOMPANIED BY FRITZ KAHN, CHIEF COUNSEL, AND JOHN A. GRADY, DIRECTOR, BUREAU OF ACCOUNTS

Mr. STAFFORD. Yes, if I may. May I introduce our General Counsel, Mr. Fritz Kahn; and John A. Grady, Director of Bureau of Accounts. If I may place our statement in the record for your consideration, fine [see p. 104].

I would like to make two or three comments that seem to have been pretty much discussed at a number of occasions this morning. There is no practical way under the act that we can take over and force another railroad to operate all of the Penn Central or any other major railroad under this act. We found this out by trial and error. We thought perhaps, when we asked for the authority originally, we could.

We appear only able to make it work on small railroads because the

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directed roads invariably have all kinds of problems and most of them are already in bankruptcy themselves and those not in bankruptcy want to be absolutely assured that their income is to be guaranteed, and I have been even told by one of the major railroads that "I will take you through the courts if this is what you tell me I have to do."

So I would not want this committee to be under the impression that that act have given us authority, that it would suffice in a real crunch. It just will not. We were able to take care of the one very small road very recently with the help of DOT's money that it had available for front-end expenditures.

There has been some question about our views on the Erie Lackawanna being included. We feel that it should be. While we recognize the inherent dangers of perhaps having the entire case reopened, the litigation of the act reopened, we feel that there are some advantages to doing this, and we have to take that chance.

Now, the reason for the Commission's being in favor of EL's being included in the Northeast railroad rather than being kept out is that we feel that it has to be part of planning in the Northeast-Midwest rail system to insure that the Boston Maine and other New England roads have an outlet, a friendly connection into the Midwest and/or New York areas for not only competitive reasons, but for their own lifeblood.

We talked about "Let's just keep them alive and then later we can buy in if we want to." But it was my judgment when I voted this way in the USRA meeting that the best way was to include EL from the start to be sure there was a system, competitive system, worked into the Northeast-Midwest with a proper competitive outlet with a friendly carrier from the Northeast.

There were a number of statements made from the desk here this morning about the catastrophe that the ICC brought on by our turning down that 7-percent rate increase the other day. There were a number of reasons why the ICC turned down that rate increase, but whether we had turned it down or not made absolutely no difference to the Penn Central or any of the other Northeast railroads in bankruptcy. By their own admission in a petition filed before the Commission, they would have had little if any chance for gaining any income because the Chessie System refused to take the rate increase, thereby creating a competitive situation in which those roads that needed the revenue badly could not take the increase and still get traffic.

So whether we gave them a rate increase or not, after the Chessie decided it did not want that rate increase or would not take it, this, for all practical purposes, closed the door on any rate increase, any income or a rate increase for those roads that need it so badly in the Northeast.

I have spoken on the section 1(16)(b) problem, the 7-percent increase, so if you have questions, I will be glad to answer them.

[Testimony resumes on p. 117.]

[Chairman Stafford's prepared statement and attachments follow:]

STATEMENT OF GEORGE M. STAFFORD, CHAIRMAN, INTERSTATE COMMERCE COMMISSION

Mr. Chairman, members of the committee, the committee has requested our appearance here today in connection with its consideration of a bill, H.R. 2051, designed to make more government funds available to ease the economic stress

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of the Penn Central and other rail carriers being reorganized pursuant to the system plan for the purposes of carrying out the goals of the Act.

In short, the bill is designed to enable all railroads involved in that reorganization to continue to provide essential transportation services during the planning process and to perform maintenance and improvements that are necessary for safe and efficient operations.

Specifically, the bill amends sections 211, 213, 215, and 303 of the Rail Act. The amendment to section 211 is to clarify the U.S. Railway Association's (Association) authority to make loans prior to the effective date of the final system plan for the purpose of carrying out the goals of the Act.

The amendment to section 213 would increase the amount of money authorized for interim relief by $100 million. It would authorize the imposition of the conditions set forth in new section 215(b) where the funds are to be used for maintenance or improvement of the designated rail properties.

The bill would revise the obligational authority under section 215 of the Rail Act by increasing the limit on the authorization for the Association to issue obligations from $150 million to $300 million. Moreover, it would permit the Secretary, with the approval of the Association, to enter into agreements with the trustees of railroads in reorganization in order to (1) perform program maintenance, (2) improve railroad facilities or equipment, and (3) acquire railroad facilities or equipment for lease or loan to railroads in reorganization until the date rail properties are conveyed under the Rail Act.

Unlike section 215 of the Rail Act, H.R. 2051 would amend that section so as not to require the Secretary to issue "regulations setting forth procedures and guidelines for the administration of this section" *prior* to entering into these agreements, nor would it require, as does the existing statute, that the agreements be for the acquisition of facilities which are "necessary to improve property that will be in the final system plan" and that the Secretary "specifically identify" the improvements to be made under the agreements. Rather, the Secretary is given the apparent necessary flexibility to impose reasonable terms and conditions in the agreements; however, where the agreements or advance of emergency funds are for either program maintenance or for improving facilities or equipment, the agreements must contain the conditions set forth in section 215(b) of the bill. Generally, those conditions are styled to conserve for ConRail or the government the increased value of the properties resulting from the agreements under section 215 or from the advance of emergency funds under section 213.

Other amendments would permit the Association, with the approval of the Secretary, to designate in the final system plan the obligations incurred pursuant to section 215 which will be refinanced by Conrail and those obligations from which Conrail will be released. Additionally, the Secretary can convey to Conrail, with or without consideration, any property or interest acquired under sections 213 and 215.

Finally, section 303 of the Rail Act would be amended so as to empower the Special Court to decide, in situations where property maintained or improved with section 213 or section 215 funds is sold, leased or transferred pursuant to the final system plan to an entity other than Conrail, what portion of the proceeds is value attributable to such maintenance or improvement.

As you are aware, the Penn Central presently faces financial problems so severe that it has announced its intention to issue an embargo for inbound traffic effective on February 14. This imminent shutdown of operations would have immediate, disastrous consequences for the Northeast. Thus, we fully support H.R. 2051, which would provide the necessary emergency funding to keep the Penn Central operation.

There are no viable alternatives to a shutdown of Penn Central operations except Congressional authorization of emergency financial aid. It has been suggested that another alternative is for the Commission to utilize its emergency authority under section 1(16)(b) of the Interstate Commerce Act to direct another railroad to take over the defunct operations of the Penn Central. We think it important to emphasize that section 1(16)(b) simply could not be successfully utilized for this purpose. There are several reasons why this is the case.

First is the matter of cost. Under H.R. 2051, the Penn Central is simply being provided with sufficient financial aid to continue its operations, but the cost under section 1(16)(b) would be substantially greater. These costs are com-

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prised of three basic elements—(1) the payment to the directed carrier of a reasonable profit for its performance of directed service; (2) the reimbursement of those costs which are not met by revenues under directed service; and (3) the payment of rents to the Penn Central for the use of its equipment and facilities.

To illustrate the cost of directed service, we have computed several of the expenses attendant to the operation of the Penn Central. Foremost is the reimburement of those losses incurred by the directed carrier in the performance of the directed service. At present, Penn Central has informed us that it anticipates losses for 1975 of $340 million. Of course, this cost would be met whether Penn Central's operations are continued by virtue of a grant under section 213 of the Rail Act or a section 1(16)(b) service order. However, there are several additional expenses which would be incurred if Penn Central's operations are maintained pursuant to the Commission's authority. A substantial additional expense includes a reasonable profit to be accorded the directed carrier which, based upon a reasonable return on historical revenues, could amount to as much as $64 million for the maximum 240-day period of directed operations. Another cost peculiar to directed service is the payment to the defunct carrier of sums for the use of its properties. This sum does not lend itself to ready computation due to such variables as the portion of the system to be operated and the constitutional minimum that the government may be required to accord the Penn Central estate for its use of these properties.

These two costs are the most salient; however, there are other additional expenses peculiar to directed service which will also be incurred, such as administrative costs incident to the directed carrier's assumption of Penn Central's operations.

In sum, section 1(16)(b) will prove to be the more costly of the two alternatives for purposes of maintaining Penn Central's operations.

Another very serious problem in ordering directed service of the Penn Central is the availability to a directed carrier of the necessary funds to commence the operations and continue them until payment by the government. Presently, the provisions of section 1(16)(b) provide not startup funds whatsoever. Instead they establish a procedure whereby the directed roads can be compensated for the directed service only after the termination of the effectiveness of the service order.

The massiveness of the losses of the Penn Central over the last several years demonstrate the great financial burden that would be placed on any railroad that was directed to take over these operations. In this regard, it should be noted that section 1(16)(b) precludes the Commission from issuing any emergency order directing such takeover service if such an order "would substantially impair the ability of the carriers so directed to serve adequately its own patrons or to meet its outstanding common carrier obligations." Given the very large amounts of money that a directed railroad would have to expend to take over the Penn Central, it appears that such an action would "substantially impair" that carrier's ability to carry on its own service in an adequate manner.

From an operational standpoint it may be possible to continue the Penn Central's system in its entirety if a carrier could be found which could incur the substantial losses discussed above. However, no such carrier exists. Consequently, from a financial standpoint it would be necessary to divide the system among several carriers. This, in turn, presents extensive operational problems which would quite simply destroy the level of efficiency which presently exists on the Penn Central. Several of the operational difficulties are the division of revenues among more than one directed carrier; the rerouting of traffic among the directed carriers; the division of work forces among the directed carriers; and lastly, the allocation of equipment and expenses among the directed carriers.

The Commission stands ready to utilize its directed service authority and in fact recently has done so with respect to the defunct Lehigh-New England Railway Company, a small carrier in Northeastern Pennsylvania.

But as the short discussion above indicates, the problem and costs attendant to a directed service operation of the magnitude contemplated in the instant case make its use in this situation impractical. Thus, as I stated at the outset, the emergency funds made available by H.R. 2051 are essential to the continuation of Penn Central's operation.

Concerning funds presently available, the latest information we have with respect to the disposition of the funds available under section 213 of the Rail Act shows that there is less than $4 million remaining which is uncommitted.

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I am submitting a copy of the status of the section 213 fund for the record (Exhibit A).

Pursuant to the authority conferred in section 215 of the Rail Act, the Department of Transportation and the Association have jointly developed a program for disbursement of the $150 million provided for in that section. I am submitting for the record a list of the carriers participating in the section 215 agreements and the respective amounts of money involved (Exhibit B).

The need for additional funds can be gleaned from examining the cash position of some the carriers involved in the reorganization under the Rail Act.

We receive cash reports on a daily basis from the Penn Central and the Central of New Jersey. Weekly cash reports are received from the Lehigh Valley and monthly reports are received from the Erie Lackawanna and the Boston and Maine. The latter two railroads are now not included in the Rail Act; however, the trustees of the Erie Lackawanna are seeking to be reorganized under the Rail Act, and the Senate has passed an amendment that would permit the trustees of Erie Lackawanna to petition the Reorganization Court to issue an order allowing the Erie Lackawanna to be reorganized under the Rail Act.

The cash reports received by us show that these railroads are generally unable to maintain a consistent, positive cash flow despite their ability as railroads in reorganization to defer payments on certain prebankruptcy debt and interest (excluding equipment obligations) and property taxes. In order to maintain operations, some of these railroads, particularly the Penn Central, Central of New Jersey and the Lehigh Valley have needed substantial funds from outside sources in the nature of government grants and sales of Trustees Certificates.

We believe the ability of the bankrupt railroads to maintain an adequate cash position from operations will be severely strained in 1975 as a result of the following: (1) the present continual steep decline in traffic volume; (2) the increase in costs from the continuing inflation, particularly higher railway labor costs, resulting from the recently announced settlement with four unions, which may set the pattern for the remaining unions; and (3) the need to correct the ever-increasing maintenance deficiencies.

I am submitting cash flow summaries for those bankrupt railroads for which we receive cash reports and which will become part of the new Conrail and for the Erie Lackawanna (Exhibit C). A cash forecast for the Penn Central for 1975 and the first quarter of 1976 is also submitted (Exhibit D). The projected cash deficit for the Penn Central for 1975 is $209 million and for the first quarter of 1976, the projected deficit is $42 million, not including a $50 million payment on a maturing Government Guaranteed Trustee's Certificate due January 15, 1976. A certain deficit for 1975 of $6.1 million is forecast by the Lehigh Valley Railroad. By the end of this month the Erie Lackawanna predicts an $8 million cash deficit, and the Central Railroad of New Jersey forecasts a $7.2 million deficit by the end of the first quarter in 1976 (Exhibit E).

As a result of our decision in Ex Parte No. 305, *Nationwide Increase of Ten Percent in Freight Rates and Charges, 1974*, the Commission has been able to compile data from the railroads that summarizes deferred maintenance and delayed capital improvements. The data shows that as of June 30, 1974, the reporting railroads claimed total deferred maintenance of $2.9 billion, of which about $2.6 billion represents deferred maintenance on roadway and $0.3 billion in equipment. Delayed capital improvements totaled about $4.3 billion and was almost evenly divided between roadway and equipment. A substantial portion of these figures is attributable to the railroads in reorganization. I am submitting for the record a resume of the deferred maintenance and delayed capital improvements of the railroads in reorganization as of September 30, 1974 (Exhibit F). It is estimated that the rate increase of 10 percent authorized in Ex Parte No. 305 will generate revenues of $1.2 billion during the new year, most of which must be utilized for deferred maintenance and delayed capital improvements as stipulated in the order in that proceeding. The Ex Parte No. 305 figures illustrate the substantial nationwide problem that exists with regard to deferred maintenance and capital improvements.

Because of the serious need of the railroads in reorganization to use the revenues derived from this increase for operating expenses, the Commission has relieved these carriers from the requirement that they utilize these revenues for deferred maintenance and capital improvements. However, we believe that Ex Parte No. 305 and H.R. 2051 are consistent in that they both recognize and address the need for improvement in rail facilities. Moreover, the fact that the railroads in reorganization have been relieved of the requirement that they use their increased

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revenues for deferred maintenance and capital improvements perhaps increases the logic of making the additional section 213 funds available for program maintenance and facility improvements.

I would like to take a moment to comment on the amendment to section 205 (d) (2) of the Rail Act was passed by the Senate.[1] This amendment could be construed to mean that the function of the Public Counsel's Office will be expanded to include not only the statutory functions of the Rail Services Planning Office, but also all other aspects of the reorganization process provided by the Act, including, presumably, proceedings before the Association and all of the courts involved in the reorganization process.

While it is true that the Commission's Rail Services Planning Office (RSPO) and the Public Counsel staff that has been employed by that Office, have made a valuable contribution to the planning process under the Rail Act, we believe, for several reasons, that the broad Senate amendment of section 205(d) (2) is inappropriate. By broadening RSPO's authority to employ attorneys to work on all aspects of the reorganization process, the amendment would create serious confusion as to RSPO's role under the Rail Act. RSPO is assigned certain specific functions under the Rail Act in order to ensure that the views of the users of rail service receive adequate consideration in the planning process.

Under the Rail Act, as presently structured, the positions of rail users are already effectively represented by RSPO and its Office of Public Counsel through the established statutory channels. In light of this effective representation, we seriously question whether the broad language of the Senate amendment is necessary and whether it would not provide authorization for repetitious and needlessly expensive activities.

This is not to say that if a specific need for additional public representation existed that the Commission would oppose curative legislation. On the contrary, the Commission undoubtedly would support legislation specifically designed to meet that need. For example, it has been suggested that there is a need for public representation by RSPO in state rail plan proceedings. Apparently a need does in fact exist, and we would support a statutory amendment, which specifically provided for such representation. However, we see no need for the sweeping language of the Senate amendment.

In conclusion, based upon the financial data that we now possess, it is clear that additional financial assistance will have to be made available in order to avoid a shutdown of essential rail service and to maintain and improve the plant and facilities of properties which may eventually be taken over by ConRail.

Thank you for this opportunity to present the views of the Commission on this legislation. That concludes the presentation of my formal statement. I and those members of the Commission's staff who are with me will attempt to answer any question you may have.

Exhibit A

STATUS OF GRANT FUNDS AUTHORIZED BY DOT[1] AS OF JANUARY 24, 1975

	Funds committed by DOT	Total funds drawdown	Balance available for drawdown
Penn Central Transportation Co	$62,500,000	$45,500,000	$17,000,000
Central Railroad Co. of New Jersey	12,245,000	9,353,000	2,892,000
Lehigh Valley Railroad Co	5,000,000	5,000,000	
Lehigh & Hudson River Railway Co	341,000	200,269	140,731
Ann Arbor Railroad Co	1,000,000	800,000	200,000
Total	81,086,000	60,853,269	20,232,731
Less authorized	85,000,000		
Less committed	81,086,000		
Balance available	3,914,000		

[1] Section 213 of the Regional Rail Reorganization Act of 1973 authorized the Secretary of Transportation to provide up to $85 million in emergency assistance to railroads in reorganization pending implementation of the final system plan.

[1] The amendment deleted the language in section 205(d)(2) of the Rail Act which reads ". . . in the course of hearings and evaluation which the Office is required to conduct and perform under other provisions of this Act." and inserted therefor ". . . in the course of the reorganization process as provided by this Act."

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EXHIBIT B

SECTION 215 LOANS

Under the Regional Rail Reorganization Act of 1973, Congress authorized interim assistance of up to $150 million for rehabilitation before the Consolidated Rail Corporation starts operations. The Secretary of Transportation is authorized, with the approval of the United States Railway Association (USRA), to enter into agreements with railroads in reorganization for this purpose.

The amounts authorized by USRA are as follows:

Penn Central Transportation Co	$144,100,000
Lehigh Valley Transportation Co	3,400,000
Central Railroad of New Jersey	2,500,000
Total	150,000,000

The government has guaranteed $3.4 million of obligations issued for the acquisition of 12 locomotives which have been leased to the Lehigh Valley Railroad. The Department of Transportation is presently in the process of negotiating agreements with the Penn Central Transportation Company and the Central Railroad of New Jersey.

EXHIBIT C

PENN CENTRAL TRANSPORTATION COMPANY

CASH FLOW SINCE REORGANIZATION

Since reorganization, Penn Central has been unable to generate a positive cash flow despite Court ordered deferment of payments on (1) pre-bankruptcy debt principal and interest (excluding equipment obligations); (2) leased line rentals; and (3) property taxes, and despite a continuous and substantial deferment of maintenance and capital expenditures.

The railroad, in fact, would have had to cease or curtail operations during the past four years, if not for the receipt of substantial amounts of cash from non operating sources, such as 1) $100 million from the sale of Government guaranteed Trustee's Certificates in 1971 and 1972; 2) $17.5 million received from non recurring sources in 1972; and 3) $50.5 million of grant funds from DOT received between January 1, 1974 and January 23, 1975.

In addition to the above described funds the railroad has consistently resorted to various cash management measures in order to avert a cash shortage. These measures include the following: (1) deferral of payments on accounts payable; (2) deferral of payments on equipment obligations by taking advantage of applicable grace periods and (3) advance receipt of funds from Amtrak for passenger service operations. See page 2.

A summary of cash flow from 1971 to January 23, 1975 follows:

CASH FLOW SUMMARY

[In millions]

	Year 1971	Year 1972	Year 1973	Year 1974	Jan. 1, 1975 to Jan. 23, 1975
Total cash receipts	[1] $2,542.8	[2] $2,572.6	[3] $2,766.2	[4] $3,051.1	[5] $190.8
Total cash disbursements	2,521.4	2,588.8	2,750.1	3,074.0	194.0
Cash excess or (decrease)	21.4	(16.2)	16.1	(22.9)	(3.2)
Cash balance—Beginning of period	18.9	40.3	24.1	40.2	17.3
Cash balance—End of period	40.3	24.1	40.2	17.3	14.1

[1] Includes $75 million received from issuance of Government guaranteed trustee's certificates.
[2] Includes remaining $25 million attributable to issuance of trustee's certificates.
[3] Includes $17.5 million from nonrecurring sources, i.e., property sales and withdrawal of funds from a contingen compensation reserve fund.
[4] Includes $30.5 million of grant funds from DOT pursuant to Railroad Reorganization Act of 1973.
[5] Includes $15.0 million of grant funds ffom DOT pursuant to Railroad Reorganization Act of 1973

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CASH FORECAST—JANUARY 1, 1975 THROUGH THE FIRST QUARTER 1976

The most recent long-range cash forecast released by Penn Central dated December 3, 1974, shows that the railroad projects a cash deficit of almost $157 million for the year 1975. See Attached schedule PC–2.

However, this forecast has been revised significantly although a schedule similar to Exhibit PC–2 has not been prepared. Penn Central's financial officer recently informed us that the projected cash deficit for 1975 has been increased to $209 million, as a result of a further large drop in automobile traffic and the revenue losses attributable to the coal strike. In order to cover the projected $209 million 1975 cash Penn Central contends that it needs an additional $167 million of grant funds in excess of the $42 million already committed by DOT for 1975.

Another $42 million is projected to be needed in the first quarter of 1976. This does not include cash needed for a $50 million payment on a maturing Government guaranteed Trustee's Certificate due January 15, 1976. The second $50 million installment is due January 15, 1986.

The forecast shown in Exhibit PC–2 which has been revised as described above is based upon the following assumptions:

(1) Traffic volume will decline 7% from 1974 levels. The above described revised forecast took into account further traffic decline in automobiles and coal.

(2) Rate increases of 7% and 5% will take effect on April 1 and September 1, 1975.

(3) A new labor contract will be settled by and paid beginning January 1, 1975. The terms of the recently announced tentative labor agreement would raise the original forecasted increase by only $700,000 for the year 1975.

(4) Maintenance expense will be at 1974 levels.

(5) An ordinary loss of $341.2 million is projected for 1975, which would be the largest ordinary loss in the carrier's history and substantially larger than the operating deficits reported for 1972, $197.9 million, 1973, $189.0 million, and the first ten months of 1974, $130.1 million.

(6) Although a $15.7 million negative cash balance is forecasted for the end of December 1974, the 1975 forecast is predicated upon a zero cash balance at January 1, 1975. The railroad averted a 1974 year end deficit by cash management.

(7) The forecast also assumes that no funds will be derived from nonoperating sources, such as Government grants. However, as indicated previously, $42 million of grant funds were committed by DOT for 1975.

Penn Central's cash forecast for 1975 is predicated upon a sharp decline in the nation's economy. Although the magnitude of the cash deficits may be overly pessimistic, the railroad, even when the economy has been strong, has not been able to operate without the receipt of substantial sums from nonoperating sources.

PENN CENTRAL TRANSPORTATION CASH POSITION, YEAR 1974

1974	End of month cash balance: Actual	Previously forecasted (in millions)	Grant funds received during month	How cash crisis at end of month was averted
January	$30.6	$27.5		
February	32.5	(3.0)		Deferral of payments attributable to the following: (1) accounts payable $12.0; (2) interline freight balance due other railroads, $8.0; (3) retroactive incentive per diem $4.4; (4) equipment obligations and by taking advantage of applicable grace periods $7.8.
March	15.1	1.1	$10.7	Deferral of payments on accounts payable $13.0 and grant funds received during month, $10.7.
April	14.4	(6.2)		Deferral of payments on accounts payable $14.0.
May	17.5	11.8	9.8	Deferral of payments on accounts payable $10.0 and grant funds received from DOT $9.8.
June	16.7	1.5		Deferral of payments on accounts payable $7.0.
July	17.9	6.8		Deferral of payments on accounts payable $14.0.
August	17.6	(15.3)		Advance receipt of funds from Amtrak $10.4 and Metropolitan and Connecticut Transit Authority $10.9, and deferral of payments on accounts payable $6.0.
September	24.2	(3.1)		Advance receipt of funds from Amtrak, $11.2 and deferral of payments on accounts payable.

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PENN CENTRAL TRANSPORTATION CASH POSITION, YEAR 1974—Continued

1974	End of month cash balance: Actual	Previously forecasted (in millions)	Grant funds received during month	How cash crisis at end of month was averted
October	$11.8	$6.3	----------	Deferral of payments on accounts payable $5.3.
November	19.6	(2.4)	----------	Advance receipt of funds from Amtrak $10.7 and deferral of payments on accounts payable $8.0.
December	17.3	(15.7)	$10.0	Advance receipt of funds from Amtrak $10.5, deferral of payments on accounts payable $11.0 and grant funds received from DOT.
Total			[1] 30.5	

[1] Grant funds were received from DOT, pursuant to section 213 of the Regional Rail Reorganization Act of 1973. The railroad received $15.0 million of grant funds between Jan. 1 and Jan. 23 1975; an additional $17.0 million of grant funds was available for drawdown as of Jan. 23, 1975.

Source: Weekly reports of Penn Central's cash position prepared by Bureau of Accounts.

( ) Represents deficit.

LEHIGH VALLEY RAILROAD CO. CASH FLOW SUMMARY

[In millions]

	Year 1973	Year 1974
Total cash receipts	$99,428	[1] $116,131
Total cash disbursements	97,417	119,166
Cash excess or (decrease)	[1] 2,011	(3,035)
Cash balance—Beginning of period	2,678	4,692
Cash balance—End of period	4,692	[2] 1,657

[1] Includes $3 million of grant funds from DOT pursuant to Regional Rail Reorganization Act of 1973, which was received in September 1974 and utilized to fully pay deferred wage increases to union employees.
[2] Represents balance at Dec. 27, 1974.

ERIE LACKAWANNA RAILWAY CO. CASH FLOW SUMMARY

[In millions]

	Year 1972	Year 1973	Year 1974
Total cash receipts	$278,727	$307,832	$343,544
Total cash disbursements	278,943	307,625	344,420
Cash excess or (decrease)	(216)	207	(876)
Cash balance—beginning of period	3,530	3,314	3,521
Cash balance—End of period	3,314	3,521	2,645

CENTRAL RAILROAD CO. OF NEW JERSEY CASH FLOW SUMMARY

[In millions]

	Year 1973	Year 1974
Total cash receipts	$89,765	[1] $109,554
Total cash disbursements	89,123	111,199
Cash excess or (decrease)	642	(1,645)
Cash balance—Beginning of period	1,827	2,469
Cash balance—End of period	2,469	824

[1] Includes $7,970,000 of grant funds from DOT pursuant to Regional Rail Reorganization Act of 1973. Between Jan. 1 and Jan. 24, 1975, the railroad received $13,383,000 of grant funds.

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EXHIBIT D

INTERSTATE-COMMERCE COMMISSION, BUREAU OF ACCOUNTS, SECTION OF FINANCIAL ANALYSIS

PENN CENTRAL TRANSPORTATION CO., CASH REPORT—WEEK ENDED JANUARY 24, 1975

I. COMPARISON OF ACTUAL AND FORECASTED CASH BALANCES

The daily cash balances, from Monday, January 20, 1975 to Friday, January 24, 1975 were as follows:

[In millions]

	End of day cash balance		Actual versus estimated excess or (deficiency)
	Actual	Estimate	
January 20	$26.0	$21.1	$4.9
21	21.3	19.3	2.0
22	17.8	15.4	2.4
23	14.1	11.4	2.7
24	19.2	14.7	4.5

The actual cash balance at January 24, 1975, was $4.5 million in excess of forecasted, primarily because $3.7 million of cash received from affiliated companies in connection with tax allocation agreements was not previously forecasted by the railroad.

A breakdown of cash receipts and cash disbursements for the week ended January 24, 1975 appears on page 5.

II. FORECASTED CASH POSITION—JANUARY 1975 AND FIRST QUARTER 1975

Penn Central's cash forecast for the month of January 1975 shows that a positive cash balance is expected for each day of the month, except for January 31, 1975, when a $3.8 million cash deficit is projected. However, this forecast is already predicated upon the following assumptions:

(1) Draw down of $20 million of grant funds from DOT, as follows: $5 million on January 3, $10 million on January 14 and $5 million on January 28. The railroad received $15.0 million of such funds between January 1, 1975 and January 24, 1975.

(2) Advance receipt of funds from Amtrak, $12.0 million on January 24, for February 1975 passenger service. The railroad received $11.7 million on January 24.

(3) Deferral of payments on accounts payable throughout the month, ranging from a minimum of $7 million to a high of $11 million.

(4) Deferral of payments on equipment obligations, in order to take advantage of applicable grace periods.

On the basis of these assumptions, the railroad expects to have sufficient cash to perform normal operations in January. Further cash management will avert the projected small $3.8 million end of month cash deficit.

DOT has agreed to provide Penn Central with an additional $12 million of grant funds, which the railroad plans to draw down on an "as needed" basis, in either late January or early February. Only $3.9 million of the $85 million of grant funds authorized by the Regional Rail Reorganization Act of 1973, was remaining and uncommitted as of January 24, 1975 (See Exhibit A).

Penn Central anticipates a critical cash position in February. A financial officer of the railroad indicated that at least $50 million of additional funds from outside sources will be needed in February and March in order to provide sufficient cash for operations during the remainder of the first quarter of 1975.

III. CASH FORECAST—JANUARY 3, 1975, THROUGH THE FIRST QUARTER 1976

The most recent long-range forecast released by Penn Central, dated December 3, 1974, shows that the railroad projects a cash deficit of almost $157 million for the year 1975, see page 6.

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However, a Penn Central financial officer has just informed us that the projected cash deficit for 1975 has been increased to $209 million, as a result of a further large drop in automobile traffic and the revenue losses attributable to the coal strike. In order to cover the projected $209 million cash deficit, the railroad estimates that it needs an additional $177 million of grant funds in excess of the $32 million already committed by DOT for 1975.

About $42 million is projected to be needed in the first quarter of 1976. This does not include cash needed for a $50 million payment on a maturing Government Guaranteed Trustee's Certificate due January 15, 1976. The sceond $50 million installment is due January 15, 1986.

The railroad's forecast is based upon the following assumptions:

(1) Traffic volume, which was originally projected to decline 7% from 1974 levels, is now expected to decline even further, due to further large drops in automobiles and coal. Heavy stockpiling of coal by shippers, in anticipation of a strike in November 1974 has resulted in lesser than anticipated coal traffic in early 1975.

(2) Rate increases of 7% and 5% will take effect on April 1 and September 1, 1975.

(3) A new labor contract will be in effect in 1975, similar to the recently announced tentative labor agrement with four unions. See Part IV for a description of this agreement.

(4) Maintenance expense will be at 1974 levels.

(5) The railroad originally projected an ordinary loss of $341.2 million for the year 1975, which is now higher as a result of the anticipated larger decline in automobile revenues. This would be the largest ordinary loss in the carrier's history and substantially larger than the operating deficits reported for 1972, $197.9 million, 1973, $189.0 million, and the first eleven months of 1974, $156.9 million.

(6) The forecast also assumes that no funds will be derived from non-operating sources, such as Government grants. However, as indicated previously, $32 million of grant funds were committed by the Department of Transportation for 1975.

Penn Central's cash forecast is predicated upon a sharp decline in the nation's economy. Although the magnitude of the cash deficit may be overly pessimistic, the railroad, even when the economy, has been strong, has been unable to operate without the receipt of substantial sums from non-operating sources.

IV. TENTATIVE WAGE AGREEMENT

Four railway labor unions tentatively agreed to a new contract with the railroad industry, covering the three years beginning January 1, 1975. The agreement calls for wage increases of 10% effective January 1, 1975, 5% on October 1, 1975, 3% on April 1, 1976 and 4% on July 1, 1977. In addition cost of living adjustments would be paid on January 1 and July 1 of 1976 and 1977. Fringe benefits are also included in the settlement.

If this agreement sets the pattern for the other rail labor unions, Penn Central estimates that its labor costs in 1975 will increase $130 million and at least $180 million for 1976. Retroactive back pay due for the month of January 1975 will require a $9 million lump sum payment.

V. TRAFFIC VOLUME

Total carloadings for the first three weeks of 1975 were 14.5% lesser than for the same period of 1974. Subtsantial declines were reported for the railroad's major commodities, coal down 18.1%, food and kindred products down 20.4%, transportation equipment down 40.9% and pulp, paper and allied products down 35.6%.

VI. DAILY CASH BALANCES—JANUARY 1975 AND PRIOR THREE MONTHS

See attached Exhibit B.

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VIII. SUMMARY OF RECEIPTS AND DISBURSEMENTS

[In millions]

	Last week actual—Monday, Jan. 20 to Friday, Jan. 24	Forecasted—Monday, Jan. 27 to Friday, Jan. 31
A. Cash balances:		
Beginning of period	$14.8	$14.7
End of period—Actual	19.2	
End of period—Forecasted	14.7	(3.8)
Actual over forecasted—Excess (deficiency)	4.5	
B. Cash flow:		
Receipts:		
Revenues collected	57.1	47.7
Amtrak	11.7	
Grant funds from DOT		5.0
Other	6.7	5.3
Total receipts	75.5	58.0
Disbursements:		
Other railroads—Interline	23.9	13.1
Per diem	3.4	1.9
Accounts payable—Utilities Service, etc	8.9	9.3
Materials and supplies, fuel oil	9.3	9.1
Paychecks	15.1	13.9
Federal withholding tax	4.0	3.3
Railroad retirement tax	1.3	19.6
Equipment lease rentals	1.5	2.0
Equipment debt service—Principal and interest	.8	
Other	2.9	4.3
Total disbursements	71.1	76.5
Excess (decrease)—Receipts over disbursements	4.4	(18.5)

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1975 BUDGET PLANNING DOCUMENT—SOURCE AND APPLICATION OF FUNDS MAINTENANCE AT 1974 LEVELS

[Dollars in millions]

	January	February	March	April	May	June	July	August	September	October	November	December	Year
Source: Ordinary income (loss)	$(49.2)	$(44.0)	$(28.2)	$(29.5)	$(26.7)	$(22.4)	$(35.8)	$(29.6)	$(20.2)	$(16.8)	$(18.9)	$(19.9)	$(341.2)
Adjustments to earnings:													
Taxes accrued	5.0	5.1	5.0	5.1	5.0	5.1	5.0	5.1	5.0	5.1	5.0	5.1	60.6
Taxes paid			(.1)			(.1)			(.1)			(.1)	(.4)
Interest accrued	9.9	9.4	9.9	9.7	9.8	9.7	9.8	9.8	9.6	9.8	9.5	9.7	116.6
Interest paid	(4.2)	(4.4)	(.9)	(1.5)	(.2)	(1.2)	(4.0)	(4.1)	(.8)	(1.4)	(.2)	(1.0)	(23.9)
L.L. rents accrued	2.5	2.5	2.6	2.5	2.6	2.6	2.5	2.6	2.6	2.6	2.5	2.5	30.6
L.L. rents paid	(.2)			(.2)			(.2)			(.2)			(.8)
Depreciation	7.2	7.2	7.2	7.1	7.2	7.1	7.1	7.1	7.1	7.1	7.1	7.0	85.5
Other	(3.4)	(13.6)	6.5	(15.6)	(4.0)	21.8	(6.1)	(18.1)	2.5	(4.4)	(20.3)	16.5	(38.2)
Total adjustments	16.8	6.2	30.2	7.1	20.4	45.0	14.1	2.4	25.9	18.6	3.6	39.7	230.0
Cash from operations	(32.4)	(37.8)	2.0	(22.4)	(6.3)	22.6	(21.7)	(27.2)	5.7	1.8	(15.3)	19.8	(111.2)
Proceeds from sale of salvage	1.5	1.3	1.5	1.7	2.0	2.0	2.0	2.0	1.7	2.0	2.0	2.0	21.7
Total sources	(30.9)	(36.5)	3.5	(20.7)	(4.3)	24.6	(19.7)	(25.2)	7.4	3.8	(13.3)	21.8	(89.5)
Applications:													
Capital program-equipment	.7	.5	.5	.5	.5	.5	.5	.5	.5	.5	.5	.5	6.2
Capital program-road	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	18.0
Debt retirement	1.9	9.6	4.9	3.8	1.2	5.5	2.4	4.0	3.0	2.8	1.9	2.2	43.2
Total application	4.1	11.6	6.9	5.8	3.2	7.5	4.4	6.0	5.0	4.8	3.9	4.2	67.4
Net increase (decrease) in cash	(35.0)	(48.1)	(3.4)	(26.5)	(7.5)	17.1	(24.1)	(31.2)	2.4	(1.0)	(17.2)	17.6	(156.9)
Beginning cash	.0	(35.0)	(83.1)	(86.5)	(113.0)	(120.5)	(103.4)	(127.5)	(158.7)	(156.3)	(157.3)	(174.5)	.0
Ending cash	(35.0)	(83.1)	(86.5)	(113.0)	(120.5)	(103.4)	(127.5)	(158.7)	(156.3)	(157.3)	(174.5)	(156.9)	(156.9)

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EXHIBIT E

CASH NEEDS

LEHIGH VALLEY RAILROAD CO.

As of January 28, 1975, the Lehigh Valley has drawn down all of the $5 million of grant funds committed by the Department of Transportation, as follows:

Date and purpose:	*Amount*
September 1974: To fully pay deferred wage increases	$3,000,000
Dec. 28, 1974: General operations	700,000
Jan. 24, 1975: General operations	1,300,000
Total	5,000,000

Lehigh Valley estimates that it will need additional grant funds of $6,078,000 for the remainder of 1975 in order to maintain operations.

ERIE LACKAWANNA RAILWAY CO.

Erie Lackawanna Railway Company projects an $8.3 million negative cash flow during the month of February, thereby causing the estimated $280,000 positive cash balance at February 1, 1975 to decline to a $8.0 million deficit at the end of the month. The railroad estimates that it will need about $10 million of grant funds by the end of February 1975 in order to avert a cash shortage at that time and enable normal operations to continue during the first six months of 1975.

CENTRAL RAILROAD CO. OF NEW JERSEY (CNJ)

Through January 28, 1975, CNJ received grant funds totalling $9,353,000, of which $7,970,000 was drawn down during 1974 and $1,383,000 in January 1975. Available to CNJ, as of January 29, 1975, were $2,892,000 of grant funds, already committed by the Department of Transportation.

In order to avert a cash shortage, CNJ estimates that it will need about $3.6 million of additional grant funds for the year 1975, plus an additional $3.6 million for the first quarter of 1976, as indicated by the following:

[In millions of dollars]

	Year 1975	1st quarter 1976
Estimated negative cash flow	[1] 7.9	3.6
Less: grant funds received and to be received, as of Jan. 29, 1975	[2] 4.3	
Cash needed to avert a deficit	3.6	3.6

[1] Estimated cash deficit at Dec. 31, 1975, $8,700,000 less actual positive cash balance at Jan. 1, 1975, $824,000.
[2] Total of (1) $1,400,000, actually received between Jan. 1, 1975, and Jan. 24, 1975, and (2) remaining grant funds available for drawdown $2,900,000.

EXHIBIT F

CLASS I RAILROADS IN REORGANIZATION [1]—DEFERRED MAINTENANCE AND DELAYED CAPITAL EXPENDITURES AS OF SEPT. 30, 1974

[In millions]

	Total deferred maintenance	Roadway	Equipment	Total delayed capital expenditures	Roadway	Equipment
Penn Central Transportation Co.	$901.0	$786.0	$115.0	$1,105.8	$683.0	$422.8
Central Railroad Co. of New Jersey [2]	22.5	13.6	8.9	15.8	1.5	14.3
Lehigh Valley Railroad Co.	31.6	27.9	3.7	211.2	4.6	206.6
Ann Arbor Railroad Co.	7.8	6.1	1.7	2.8		2.8
Reading Co.	68.6	68.6		76.9	21.4	55.5
Erie Lackawanna Railway Co.	23.8	18.1	5.7	125.0	28.5	96.5
Total	1,055.3	920.3	135.0	1,537.5	739.0	798.5

See footnotes on p. 117.

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The CHAIRMAN. You answered one of them of mine, in fact, that of the ICC not approving the rate increase. Is there any regulation change you think you need from the Congress to help you to help the railroads?

Mr. STAFFORD. Help us to help these railroads?

The CHAIRMAN. Yes, sir.

Mr. STAFFORD. I think the restructuring program you have, with the additional money that is being asked for today, is a proper approach. We cannot enrich the other railroads in this country because of the shortage of funds of the Northeast railroads, and the rate increases come to us on the basis of their being interrelated among all of the railroads.

The CHAIRMAN. Would you let me interrupt right there because I am trying to find out, if there is something you need that we can make this coordinate in a legislative way.

Mr. STAFFORD. Mr. Kahn, would you want to speak on that?

Mr. KAHN. I just want to note for the record, Mr. Chairman, that the Interstate Commerce Commission supported much of the Surface Transportation Act, particularly the funding provisions, title I, I believe.

The CHAIRMAN. You think that would help you if this had passed the Congress?

Mr. KAHN. We think it would have helped the railroads materially, yes.

The CHAIRMAN. Mr. Dingell.

Mr. DINGELL. Thank you, Mr. Chairman.

The CHAIRMAN. I might say I hope we can get through with this gentleman because this gentelman has to catch a plane.

Mr. DINGELL. I will try to stay within my 5 minutes, Mr. Chairman.

The CHAIRMAN. Fine.

Mr. DINGELL. Mr. Chairman, your comments that you could not direct another railroad to take over the function of the entire Penn Central is eminently correct, however, you do have powers under the Rail Reorganization Act to direct utilization of Penn Central track, equipment, and so forth, by operation of another railroad to provide emergency and critical service; is that a fact?

Mr. STAFFORD. We have that authority.

Mr. DINGELL. Have you made any studies or prepared for utilization of that power?

Mr. STAFFORD. We have had meetings and tried several times to make this work. Would Mr. Brooks like to speak on this? He is our expert.

---

[1] Excluding the Boston and Maine corporation, a railroad in reorganization, which has elected not to be subject to the Rail Reorganization Act of 1973.

[2] Data shown represents deferred maintenance and delayed capital expenditures as of June 30, 1974. This railroad has not yet filed its report for Sept. 30, 1974.

Source of data: Reports filed by the respective railroads as required by the Interstate Commerce Commission in connection with Ex Parte 305, Nationwide Increase of 10 Percent in Freight Rates and Charges, 1974. For reporting purposes, deferred maintenance is defined by the Commission to be the accrued deterioration or deficiency in the physical operating condition of railroad track structures, cars and locomotives, and other property used in the provision of transportation service resulting from the failure and/or inability to properly maintain plant and equipment, which produces an adverse effect on railroad operations to an extent that services to shippers have been rendered partially or wholly inadequate and/or has resulted in diminishing the railroads' competitive ability.

Delayed capital expenditures represent actually planned, specifically identified capital improvements necessary for the provision of adequate or improved transportation service to shippers and which had not been undertaken, scheduled, or otherwise committed because funding or financing was not, or projected to be, available through June 30, 1975. They exclude improvements in progress and those scheduled or otherwise committed and recognized in capital budgets in effect or applicable on June 1, 1974. These capital improvements are further identified as delayed expenditures which would (1) add to or improve the carriers' plant and/or equipment so as to increase its usefullness, capacity, durability and efficiency, and (2) which are capitalizable in the property accounts in accordance with the Commission's accounting regulations.

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Mr. DINGELL. I think it would be much more helpful if you submit to us a monograph on this point. I get the distinct impression you already foreclosed in your own mind the utilization of this power. That I think would be most critical.

Mr. STAFFORD. For major efforts. We will supply the requested information.

[See letter dated February 6, 1975, with attachments, from Kenneth H. Tuggle, Acting Chairman, ICC, p. 119, this hearing.]

Mr. DINGELL. You have the problem in the Northeast that has to be met. I think you can arrange to alleviate that problem.

Mr. STAFFORD. We have arranged for the Lehigh and New England in that we were able to set that up under that program so that it would continue to operate.

Mr. DINGELL. Well, you have, for example, coal and fuel supplies in certain heavy industries—steel and that sort of thing—and have you made plans to meet these needs under that section if need be?

Mr. STAFFORD. This has been all part of the conversation about "how could we do this" with another railroad who may be bankrupt.

Mr. DINGELL. I would feel more confident if you had conversations that went to greater depth in how to do this. I would think you could make a specific statement today you have performed a particular planning function directed at accomplishing this particular preparatory action.

Mr. STAFFORD. I mentioned one healthy railroad among a number of others I had, along with one gentleman in the room today, that meeting where we were suggesting that one of them was going to have to take over a segment of another bankrupt line. The one representing the very healthy road was the one who assured me that I would have to take him through the courts of the land to get him to move on that.

Mr. DINGELL. Well, that may very well be. However, the power essentially is there and if you need some embellishment, we would comply.

Mr. STAFFORD. On a short-term action, major action, there needs to be a guarantee of front-end pay instead of after-the-fact—and with a profit, I might add.

Mr. OTTINGER. Will you yield?

Mr. DINGELL. Yes.

Mr. OTTINGER. I would like to see, in writing to this committee, the plans which you are making.

Mr. STAFFORD. All right.

[See letter dated February 6, 1975, with attachments, from Kenneth H. Tuggle, Acting Chairman, ICC, p. 119, this hearing.]

Mr. DINGELL. I must confess I am not of the view you have done planning at all for utilization of this power, either to ascertain what is economically feasible, or proper or what is legally in your capacity to do. What about your scrutiny of the costs, and so forth? It seems that this committee is continually deluged with demands for money from Penn Central on an emergency basis.

Every time I hear the words "Penn Central" I think of a figure of $250 million, which is usually the amount they want. Can you tell us what you have reported in disclosure provisions in ICC to watch these people, to see they don't go bankrupt some night when you go to bed?

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Mr. STAFFORD. We have regular reports, some on a daily and weekly and monthly basis, and I would like Mr. Grady, Director of the Bureau of Accounts, to speak to it.

Mr. DINGELL. Yes.

Mr. GRADY. I might say that each week we send up to the House Commerce Committee the report of the Penn Central and have done it for about the last 9 months. It is a quick look at the cash projection. I believe the last one that was sent up was for the week ending January 24 and that memorandum pointed out the problem of embargo by February 18.

Mr. DINGELL. You say that on January 24 you sent us word, "We are going to have an embargo on the week of the 14th." That was readable in the newspaper the same day or the same week. I think your obligation is—well, haven't you folks—or what were you doing in December?

Mr. GRADY. I think we were sending up reports at that time starting the problem, the cash needs of Penn Central. I think a review of those reports would indicate actually the Penn Central was, in fact, going to have a cash problem and had a cash problem.

Mr. STAFFORD. I believe the railroad itself was reporting direct to Congress. It was reporting direct to the Department of Transportation, direct to USRA, about their growing problems, too.

Mr. DINGELL. How much money does the railroad need to get them through July 1 of this year? How many millions?

Mr. GRADY. I don't have July 1. I actually have for the year 1975 and that has been revised to $209 million.

Mr. DINGELL. $209 million would get them through July 1?

Mr. GRADY. No, through December 31.

Mr. DINGELL. Of this year?

Mr. GRADY. Yes, sir. I might add to that, that in thinking about the cash needs of the Penn Central, I think it is important to actually consider that in forecasts of the $209 million it is predicated upon an increase in rates of 7 percent effective April 1, 1975, which actually translates into $85 million—that is, of revenues—and also a further increase effective September 1, 1975, of 5 percent, which translates into revenue of $34 million.

So, in total I am saying to you, sir, the $209 million, absent any increase in rates, is then actually translated to $328 million.

Mr. DINGELL. Well, just for the record, if you please, how much will it take to get through July 1? I think we are in a problem of sending out piles of money to Penn Central.

[Testimony resumes on p. 127.]

[The following letter and attachments were received for the record:]

INTERSTATE COMMERCE COMMISSION,
OFFICE OF THE CHAIRMAN,
Washington, D.C., February 6, 1975.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR CHAIRMAN STAGGERS: At the Committee hearing on H.R. 2051 held on February 4, 1975, the Commission was asked by several Members of the Committee to provide certain information. The enclosed material is intended to be responsive to those requests.

The material is divided into three subject areas—the Commission's assessment of the Penn Central's likely cash deficits for various time periods from now

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through the first quarter of 1976 and the procedures used by the Commission to make its assessment; the Commission's view of the likely economic effect of a Penn Central shutdown on the Northeast region and the country in general; and a description of what the Commission has done to implement its section 1(16)(b) emergency authority and the problems that it has encountered in the actions that it has taken to date.

I believe that this material is fully responsive to the requests made by the Members at the February 4 hearing, and I hope it is helpful to the Committee. Please let me know if the Commission can be of any further assistance in this matter.

Sincerely yours,

KENNETH H. TUGGLE, *Acting Chairman.*

FORECASTS OF PENN CENTRAL'S FUTURE CASH DEFICITS

At the hearings on H.R. 2051, questions were raised concerning the Commission's evaluation of financial data prepared by railroads, particularly those of forecasts of the Penn Central.

As a result of the court decision in *Burlington Northern v. I.C.C.*, 323 F. Supp. 273, affd. 462 F.2d 280, cert. den. 409 U.S. 891, the Commission is usually denied access to financial forecasts. However, Penn Central does furnish earnings and cash flow forecasts although at times not on a current basis. It is often necessary, therefore, that we prepare forecasts of our own. However, the carriers' forecasts are a useful tool and the court's decision could be overcome in part by a condition in Government loans or grants requiring the railroads to make available to the Commission all of its forecasts including all documents supporting those forecasts.

The forecasts of Penn Central submitted with Chairman Stafford's prepared statement compared favorably with those the Commission had prepared and evaluated. Penn Central's forecast shows large cash deficits for the year 1975 and the first quarter 1976. We believe it to be reasonable and based upon valid assumptions except for the inclusion of the 7% rate increase effective April 1, 1975 and a 5 percent increase on September 1, 1975. The forecast shows:

> Substantial cash deficits as follows: $100 million at June 30, 1975; $160 million at September 30, 1975; and $220 million at March 31, 1976.
>
> The projected cash deficits would be even greater if rate increases assumed by the railroad for 1975 were not realized. Absent these rate increases, the cash deficits would be $127 million at June 30, 1975; $230 million at September 30, 1975; $300 million at the end of 1975; and $400 million at the end of the first quarter of 1976.

To assure the accuracy of the Penn Central financial data our auditors maintain a continuing surveillance of the railroad's records and the basis for these forecasts. In addition the cash balances are monitored daily. The following is a description of the monitoring activities conducted by the Commission in order to evaluate the financial position of the Penn Central.

In our evaluation of the financial position of a carrier there are three main areas of study; economic factors, the physical condition of plant and equipment and financial factors. These three areas are interdependent on each other and are not studied in a vacuum or in a separate and distinct manner. The information that is obtained from our review of these areas is coordinated and utilized in our evaluations.

An economic study or review of territories served by the individual railroads is made. These reviews include the trends in population, industrialization, agriculture, and income. Forecasts on the above items are then made which evaluate the estimates of the traffic that can be expected to be generated from the region. Both short (2 to 3 years) and long term forecasts are then prepared.

A study of the territory served establishes the base in which the railroad must operate. Part of Penn Central's problem is the loss of industry in the Northeast to other sections of the country. On the other hand, Southern Railway has benefited from the industrialization of the South. In our review we also consider information from statistics released by the Department of Labor and Commerce.

Although the railroads carry hundreds of different commodities, many railroads are dependent on a relatively few in order to survive. For example, the Monongahela Railway Company derives over 90% of its revenues from coal alone. If the mines served by the Monongahela were closed for any reason, permanently or temporarily for a protracted period, bankruptcy of the railroad could easily

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result, causing economic hardship to communities served by this railroad. Therefore, commodity statistics are studied for each railroad with great care paid to any changes in trends. The economic studies attributable to regions and trade association economic studies are used in making forecasts. While trade associations are generally overly optimistic, they are particularly good in assessing trends by geographic regions.

In addition, the rate structures of important commodities are analyzed in order to determine profitability and competitiveness. The profit generated per carload of autos is considerably higher than that for coal so it is extremely important to know on a commodity by commodity basis where a railroad is gaining or losing traffic in order to make projections about future profitability.

Also reviewed are traffic volume data, by commodity, in regard to the percentage originated, terminated and received from connections. Changes in these percentages can be a clue in determining a railroad's competitiveness and changing economic conditions in its territory.

In order to assess a railroad's competitive standing, we utilize the information derived from the previously discussed regional and commodity studies and we attempt to answer the following questions:

Is the railroad maintaining its overall share of the traffic generated in its territory?

Is the railroad maintaining its share of traffic by commodity generated in its territory?

How does the railroad's market share compare with its competitors? What are the trends?

How does the service offered by the railroad compare with its competitors?

How do the rates charged by the railroad compare with its competitors?

What steps are being taken by management to meet or beat competition and increase its market share?

Since the product that the railroads sell is "ton miles", for which they are paid on the basis of moving a commodity a certain distance, the condition of the physical plant largely determines a railroad's capacity, the quality of its service and its overall competitive position. Because of the overall efficiency of a car on rail, it can take a long time for deferred maintenance of a railroad to become evident.

Eventually it will, but during the years maintenance is deferred earnings are overstated. This practice results in borrowing cash from the future. Thereafter, future earnings may not be sufficient to provide the cash needed to correct maintenance deficiencies, and inadequate and inefficient service continues.

By means of engineering studies, historical studies and data provided by the railroads, the life span of much of the material used on a railroad's right of way has been established within a fairly narrow range. The railroads, in their annual reports to the Commission, show the actual units replaced for the year of several of the following main items needed for a proper track structure.

The number of cross ties a railroad has in place together with the number replaced are reported each year. The average life of a cross tie is about 37 years, thus a replacement rate of 2½% of total ties is considered adequate. By analyzing tie replacements for the past 20 years, we can evaluate whether the historical replacement rate is adequate. By comparing actual replacement rate with our assumed adequate rate of 2½%, we can estimate the amount of deferred maintenance since we know how much it costs to put a cross tie in place, currently about $20 per tie.

The same procedures discussed above are used to evaluate rail replacement. Rail has a useful life of about 55 years and it costs about $70,000 a mile to install. In order to get a fair picture and not overstate deferred maintenance, our evaluation of rail replacement is based upon equated track miles, which is a smaller number than the total track mileage operated and is derived by weighting mileage attributable to main line, secondary track, branch, yard and siding track.

Ballast replacement in terms of physical units are not reported to the Commission, although the annual cost (dollarwise) of replacing ballast is furnished. However, if a railroad is deferring ties and rail renewals, ballast replacement is also deferred. By estimating an average deficiency in the replacement rate for rail and cross ties over a period of 20 years, a reasonable estimate can also be made for the total dollar amount of ballast deferrals.

When railroads defer maintenance to any great extent, they usually have to reduce the speed of trains operation until the deficiency is overcome. These

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slow orders are currently being reported to the Commission in connection with reports required by Ex Parte 305. The percentage of mileage under slow orders and the tend are closely monitored. Slow orders are not as reliable an indicator of deferred maintenance as an evaluation of cross tie and rail replacement levels because a railroad can eliminate a slow order by changing the posted speed.

Accidents and derailments are a good indicator of deferred maintenance. A certain number can always be expected but a sharp rise is an indication of trouble. Trends in costs attributable to accidents and derailments are also monitored.

The amount and condition of a railroad's freight cars and locomotives are a vital measurement of a railroad's capacity and ability to offer service. The following information is used to evaluate the physical quality of a carrier's equipment:

(1) The total number of equipment operated;
(2) The average age of equipment;
(3) The average capacity of each car and total capacity of the fleet;
(4) The percentage of rolling stock owned to leased;
(5) The bad order ratio (the percentage of cars needing repairs to the amount owned and leased); and
(6) Equipment rental charges.

All of the above is done not only in the aggregate but by type of car. Trends are carefully monitored and are related to the regional and commodity studies to ascertain whether the railroads have sufficient ejuipment to meet the needs of shippers along their line. This is also an indicator of competitive position.

An evaluation of each Class I railroad's financial condition is made quarterly, based upon quarterly income statements and balance sheets filed by the carriers. By means of certain financial indicators, each Class I railroad is categorized as being in satisfactory, marginal or poor financial condition. The classification is then compared with that of previous quarters to determine the extent changes have taken place. Particular attention and concern is given to those railroads showing a decline in financial rating.

These quarterly financial statements are also reviewed and analyzed to show cumulative figures for the year to date. These figures are analyzed to evaluate the quality of earnings and the basis for preparing or evaluating projections of future earnings.

Revenue figures are checked against the carloading figures for each railroad to determine whether revenues are in line with traffic levels. Revenues per carload are calculated in order to determine trends and the effects of any rate increases. Continual declines in revenues per carload could indicate a deterioration in traffic mix, fierce competition, or both. Comparisons are made with preceding quarters and the same year earlier periods.

Maintenance of roadway figures are reviewed as to adequacy and comparability with earlier periods. A yearly rate figure (adjusted for quarterly differences) is calculated to provide comparison with prior year figures where the adequacy of maintenance levels is more or less known as a result of the procedures previously discussed in the section on the physical condition of roadway. Adjustments are also made to correct for inflation.

Maintenance of equipment expenditures are analyzed in much the same way as for roadway outlined above.

Transportation expenses are compared to traffic levels and are computed on a per carload basis. This is then compared with prior periods to determine if any trends are developing. Wage increases are factored in. Deteriorating trends (increase in expense per carload) could be a sign of declining efficiency, change in traffic mix, deferred maintenance or even poor management. Trends in transportation costs per carload are very useful in making forecasts.

Taxes, while compared quarterly for forecasting purposes, are more thoroughly analyzed at the end of the year. Property taxes are closely reviewed.

Equipment rents are compared to traffic levels to determine if a railroad is depending too heavily on the use of other railroads' cars. This can and has resulted in car shortages, causing losses in traffic and competitive position.

Also, heavy dependence on long term leases results in an understatement of fixed charges, or an overstatement of coverage. It also distorts the balance sheet which is discussed below.

The ration of fixed charges to the balance available for fixed charges is computed. Trends are determined to see if default of interest payments are likely which could result in bankruptcy.

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Non-operating income is also reviewed and compared with prior periods because a substantial increase in non-operating income could be wholly responsible for a rise in net income, thereby masking an actual decline in income from carrier operations.

In reviewing the balance sheet we review items such as:

The ration of current assets to liabilities.

Cash and equivalents measured in the number of days as it relates to expenditures.

The relationship of long term debt to equity.

The capitalization in relation to the property account.

Leases, which are fixed liabilities of the company, are capitalized, where possible, to give an adjusted picture of total long term debt.

The quality of receivables and delay in collection are evaluated.

Economic Impact of Penn Central Shutdown

A complete and abrupt shutdown of the Penn Central would have a disastrous economic effect on the population and economy of both the Northeast region and the country as a whole, especially in view of the current economic recession with no improvement in sight.

As the Nation's second largest rail carrier with its more than 17,000 miles of track carrying freight through 17 states of the Northeastern United States, the Penn Central loss of freight traffic would severely affect the auto, food, and other manufacturing industries, since it serves more than 50 percent of the Nation's manufacturing plants and moves more than a million tons of freight every 24 hours.

Commuter passenger service in Boston, Philadelphia and New York are operated by this carrier for a total of close to a quarter of a million passengers daily.

It is estimated that a complete and abrupt shutdown of that railroad would have its impact primarily in the Northeast. The best estimate is that the result of a shutdown would be a 5.2 percent decrease in the rate of economic activity in the Northeast and a 4 percent decrease for the rest of the Nation. An eight-week shutdown would cause the real GNP, in view of the current recession, to fall at a rate of between —9.3 and —9.6 percent (annualized rate) as compared to the —9.1 percent decline (annualized rate) recorded in the 4th quarter of 1974. The GNP growth rate would therefore be expected to fall by an additional 3–5 percent, due to an 8-week shutdown.

Viewing the effects of a shutdown from an industrial sector standpoint, the following chart demonstrates the impact of an 8-week shutdown on industries in the Northeast:

EFFECTS OF PENN CENTRAL SHUTDOWN

Industrial sector	Percent reduction within sector	Reduction in value added factor (in millions of deflated (1958) dollars)[1]
Wholesale and retail trade	13	142
Chemicals and products	31	24
Prim. nonferrous metals	38	23
Prim. iron and steel	10	20
Electric energy	13	17
Motor vehicles	7	15
New construction	6	14
Printing and publishing	9	12
Food products	5	9
Rubber and plastics	8	7

[1] Value added is a generally used indicator of economic activity. It is comprised of wages and salaries, interest, and rental payments originating in that industry.

In calculating these figures, the following factors were taken into account. It is difficult to completely substitute other modes for some heavy bulk commodities, mainly coal, iron ore, non-metallic minerals (sand and gravel), chlorine, lumber and grain, by non-rail modes; however, these commodities do not move at present both by truck and by barge in varying quantities. It is, for example, technically

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feasible and quite common to move both lumber and grain by truck although such moves are increasingly uneconomical compared to rail as size of shipment and length of haul increases. With the water mode, the limiting factor is accessibility to the waterways. Special analyses were made of mode substitution for coal and iron ore in the Northeast. There was found to be relatively limited substitution of water for rail on coal movements. In the North Central States where coal is used most extensively, there are few waterways adjacent to generating plants. In New England where many power plants are on the water, they now use oil (or receive coal by water already); there remain only four plants in New England which use coal as the principal fuel. There would appear to be some possibility for barge substitution on iron ore although at the expense of increased circuity. It should be mentioned that most lines carrying these heavy bulk commodities over long distances are densely patronized lines which would continue to operate. In the analysis, it was not assumed that any of these commodities would be impossible to carry by non-rail modes but rather that a significant proportion could not be carried in the short run because of a lack of suitable equipment.

Technically, substitution of *intermodal* moves for current all rail moves in low volume lots, i.e., two or three cars per day per shipper, is practical today for both merchandise and bulk materials. This would substitute largely motor carrier moves for that portion of the all rail currently occurring on light density lines. Merchandise traffic is currently moved in piggyback service by utilizing efficient mainline haul service with truck pickup and delivery into light density areas. Intermodal service for bulk commodities, while not as well developed commercially as merchandise traffic, is currently being provided and expanded. The major constraint to short term implementation of greater increased use of either merchandise or bulk intermodal service exists in the need to expand both terminal and equipment capacity.

Commission Implementation of Section 1(16)(b) Emergency Authority

The Regional Rail Reorganization Act established a comprehensive planning process for reorganization of financially troubled railroads in the northeast and mid-west region. That Act created the U.S. Railway Association and within the ICC the Rail Services Planning Office to conduct this planning process and provided those organizations with funds totaling approximately $50 million to carry out their planning.

Section 601(e) of that Act, which added section 1(16)(b) to the Interstate Commerce Act giving the Commission certain emergency powers to direct rail service, was not intended to provide a solution to the northeast problem in the event of the failure of the general process. In keeping with that intent, section 601(e) speaks in terms of a temporary and very costly method of continuing limited, essential rail services.

Section 601(e) provides the means whereby service might be continued for a brief period, for instance, should Penn Central, for whatever the reason, be obliged to discontinue service on certain lines. If Penn Central were forced to do so, the Commission would consider the individual lines in terms of the essential character of their transportation service and could order another carrier to operate the service found to be essential.

Should Penn Central go forward with its present proposal to discontinue all service over its system before the end of February, we do not believe section 601(e) provides a feasible or adequate alternative to the legislation proposed by the Administration.

The Commission is fully cognizant of the potential devastating effect of a cessation of all service by the Penn Central. The Commission further intends to continue its cooperation with the other parties involved in the planning process and also to move forward with its own internal planning under section 601(e).

Soon after the enactment of the Regional Rail Reorganization Act of 1973, the Commission established a Northeast Rail Task Force which was directed to consider and plan for emergency situations that might require the Commission to take action under the powers newly given it in section 601(e) of the Regional Rail Reorganization Act. That provision amends section 1(16) of the Interstate Commerce Act by adding a new subparagraph (b) and will be referred to throughout this memoranda as section 1(16)(b).

One of the initial undertakings of this Task Force regarding section 1(16)(b) was the institution of a pilot project in cooperation with a major rail shipper

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with numerous facilities located on the lines of Penn Central, many of which are heavily dependent on rail service. This pilot project was begun with the expectation that, in order to reduce expenses, the Penn Central might decide to cease providing service on certain of its unprofitable branch lines and that service on some or all of such branches might be so essential as to require a directive under section 1(16)(b). It was antipicated by the cooperating shipper that such a situation was likely to arise.

As a first step in this pilot project, direct contacts were made with high officials of Penn Central, and cooperation and advance information with regard to cessations of service were sought. The Task Force was given assurances that the Commission would be given full and early warning when such a cessation was contemplated; no such cooperation has been forthcoming with regard to the present situation.

Armed with pledges of assistance from the Penn Central, the Task Force scheduled two field trips to examine first-hand the operating situation on branches of the Penn Central which serve facilities of the pilot project shipper. The first field trip, in July 1974, covered the area of the Bonhampton Branch off the Penn Central New York Philadelphia mainline near Edison and Metuchen, New Jersey. The Bonhampton Branch not only provides switching service for adjacent industries but also contains the Ford classification yard where cars are switched for several industrial parks along the PC mainline.

In addition to demonstrating the poor condition of the track and facilities of even those Penn Central lines which carry considerable traffic, the observations of the Task Force on the Bonhampton Branch reemphasized the almost total interdependence of branch and mainline operations. Obviously, a cessation of service on a particular branch requires revisions in operations on contiguous mainlines and in more distant yards. To direct another carrier to perform the transportation service on a particular branch necessitates even greater operational dislocations. Assuming that operations on the mainline were to be continued by the original carrier, that carrier would either have to agree to continue to drop or pick up cars for the branch from its through trains at the proper siding or receiving yard, or an arrangement would have to be developed whereby the traffic originating or terminating on the branch would be marshalled at the connection between the original and directed carriers. The former arrangement would undoubtedly be more efficient but would probably require some compensation to the original (mainline) carrier, while the latter would clearly involve a great increase in switching time and cost. Consideration must also be given to the equipment to be used in conducting the branch operation. If an agreement between the carriers could be reached, rental of all equipment previously used in the branch operation would be advisable, with such rental expenses as a reimbursable cost, but in lieu of such a rental agreement, a directed carrier would have to have excess equipment of its own to be used in operation of the branch and possibly in movements between the branch and the actual connection of the lines of the directed and original railroad. All such operational adjustments would, of course, add to the overall cost of conducting an already unprofitable operation by a carrier unfamiliar with the situation. Though these observations were made solely with respect to a single branch, their ramifications for system operations are apparent.

The second field examination of the Task Force covered PC facilities serving two plants of the pilot project shipper in Ohio, near Columbus and near Mansfield. As both of these facilities are served almost directly off Penn Central mainlines, they represent a somewhat different set of operational problems. Cars for both facilities are switched from nearby classification yards along the main line by switching crews from those yards which move the cars from the yard to the plant along the main line tracks. Thus, directed service to either of these plants would require the hiring by the directed carrier of both main line and yard crews, which would add directly to the cost of that service. Consideration of the rail service to these facilities reemphasized the interdependence of main line and local service seen in New Jersey. To continue only main line service without distribution of cars to and from classification or switch yards, which are often no more than additional tracks directly off the main line, would create impossible congestion, and the movement of cars to and from such yards requires detailed coordination with mainline movements.

While the Task Force has not encountered an actual cessation of service by Penn Central on a branch line or to a particular facility which required action

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under section 1(16)(b), in September and October 1974, the Task Force was engaged in emergency planning for a threatened cessation of service on the entire Central of New Jersey system. The CNJ situation makes it apparent that problems of directed service on branch lines are many times magnified for an entire rail system and that planning for directed service over an entire system involves many additional considerations.

In applying its experience derived from the CNJ process and the PC branch line pilot project, the Task Force has approached its efforts with regard to directed service over the entire Penn Central system from several directions. Initially, consideration was given to the feasibility of directing that operations be conducted under section 1(16)(b) in essentially the same manner and to essentially the same extent as presently performed under Penn Central management. Under this option, the question immediately arises as to what other railroad, in a service area in which connecting railroads are almost all in reorganization themselves, could or would undertake such directed operations, especially in light of the specific statutory requirement that performance of a directed service shall not "substantially impair the ability of the carrier so directed to serve adequately its own patrons or to meet its outstanding common carrier obligations" (Section 1(16)(b)(B)). As discussed in greater detail below, the relative enormity of the Penn Central system, its increasing daily operating losses, and the weak condition of many of its connecting railroads, in conjunction with the lack of provision in section 1(16)(b) for an initial influx of Federal start-up funds, indicates that performance of directed service over the entire Penn Central system by a single directed carrier would be virtually impossible.

However, one common carrier by railroad which would not be restricted in its service of its own patrons by imposition of a directed service order would be the newly-incorporated Consolidated Rail Corporation. This carrier is not yet an operating entity and is, in reality, little more than a board of directors. To direct the Consolidated Rail Corporation to operate over the Penn Central system would and could do little more than impose that carrier, in name only, over a continued PC operation. At the moment, the Consilidated Rail Corporation has no readily available source of funds with which it could meet start-up costs or daily operating deficits, though potentially a loan from the United States Railway Association under section 211 of the RRRA could be forthcoming. A direction to the Consolidated Rail Corporation would certainly provide that entity with valuable operating experience and would preserve all properties which would eventually be acquired by it, but as noted below, the add-on costs in addition to mere operating deficits might be considered prohibitive.

The Task Force has given more intensive consideration to having two or more carriers perform directed operations over separate portions of the Penn Central. The Penn Central system could be divided on the basis of different criteria, such as major traffic flows or Penn Central internal divisions. From traffic density and directional data available to the Task Force, it is apparent that, in very general terms, Penn Central is primarily an east-west carrier, with most traffic moving toward the northeastern consumer areas. Most of this traffic flow is concentrated on several major main lines, namely Chicago-Cleveland-Buffalo-Boston, Chicago-Fort Wayne-Pittsburgh-Philadelphia, St. Louis-Indianapolis-Columbus-Pittsburgh, St. Louis-Indianapolis-Columbus-Cleveland and Washington-New York-Boston along the Northeast Corridor. While these flows emphasize Penn Central's general east-west orientation, there is obviously a large amount of crossing of major flows and multi-directional feeder traffic and a limited number of origin-destination points at which most movements over Penn Central converge. Any division of the Penn Central on this east-west traffic flow basis (with, hypothetically, one directed carrier operating a north portion and another the south) would be complicated by these factors which would lead, as noted below, to excessive duplications and employment and increased costs.

Penn Central's existing internal operating divisions often bear little resemblance to current operating realities and have been given only minimal consideration as a viable basis for division of Penn Central among directed carriers. Later discussion herein indicates that the problems of and constraints imposed by utilization of such divisions would unduly complicate directed service without providing concurrent operating benefits.

While demonstrating the predominance of east-west movements on the Penn Central, the traffic flow data analyzed by the Task Force shows certain key points through which such flows pass. Consideration is being given to artifically

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dividing the Penn Central along generally north-south lines through such points. These divisions could offer greater potential for directing carriers operating primarily outside the region to perform the PC operations, could limit somewhat the points at which interchanges would have to occur, and could thus avoid some costly delays, but, as enlarged upon at a later point, actual interchanges would be greatly increased, the number of employees and amount of equipment utilized would rise, and shipment delays would occur.

Section 1(16)(b), when read in conjunction with the pertinent legislative history, emphasizes the continuation under its auspices of only essential services and at the lowest possible cost to the Federal government. In recognition of this intent, the Task Force has also examined the possibility of directing service over limited portions of the Penn Central system. An immediate problem arises in determining what is essential enough to warrant directed service: what is essential or critical to a single patron using Penn Central service on a branch line may not appear in the same light to a more detached analyst, and what may today appear to the Interstate Commerce Commission to be nonessential in terms of temporary directed service may, under the criteria to be applied by the United States Railway Association to which we are not yet privy, be included in the rail properties to be acquired by, and which should thus be preserved for, the Consolidated Rail Corporation.

Several reduced forms of the Penn Central which could be operated under a section 1(16)(b) directive are, however, under active consideration. Penn Central itself has, on prior occasions, recommended that its system be reduced to either a 15,000 or 11,000 mile core of essential lines. Either core system would maintain service to much of the traffic currently moved by Penn Central. Yet, it is questionable whether either of these reductions in actual mileage would make the Penn Central that much more manageable under directed service by a single carrier.

In light of the many serious problems which would arise from the issuance of a directive for a single railroad or even several railroads to operate the present Penn Central, the option of operating only major main lines and terminal areas is under intensive analysis. Such a directed operation would, of course, be intended merely to maintain traffic flows into and, to a more limited extent, out of the area served by the Penn Central and thus reduce the ripple effect of a cessation of service on railroads which connect with Penn Central. However, operation of only main lines and terminals could prove to be of very temporary benefit without further operations of switching and industrial facilities. Terminal to terminal operations along main lines only could result almost immediately in impossible congestion, with traffic inbound to the Penn Central moving in but not being distributed and only a limited amount of outbound traffic which originates immediately contiguous to a terminal point moving out.

A perhaps more popular variation of the main line only approach is also being considered whereby certain branches, industries, or stations of particular importance could be served on a greatly reduced basis. Attention is currently directed toward coal mines and their dependent industries, facilities which rely heavily on bulk movements by rail, and movements of rail-bound commodities.

The Task Force has long been aware of the overwhelming economic and social ramifications of a cessation of rail service by the Penn Central, which, despite its continuing economic woes and deteriorating service, remains the second largest rail carrier in the Nation. While the effect of such a shutdown upon industries and shippers relying upon its freight service would be devastating, both intercity and commuter rail passengers are also heavily dependent upon continued operation of the Penn Central system.

Should the Penn Central management make a determination that certain of its services should be curtailed, section 1(16)(b) could provide a method by which a portion of those services would be maintained, upon a finding that such services are essential. However, because of the character and enormity of the Penn Central itself, because of the findings required by and specific funding provisions of section 1(16)(b), and because of the specific financial and operational difficulties described herein, a directed operation does not appear, at the present time, to be a feasible alternative to the increased funding of the overall planning process envisioned by the Regional Rail Reorganization Act.

The CHAIRMAN. The gentleman from Ohio.

Mr. DEVINE. Mr. Chairman, I want to ask you a general question

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because of the fact you have been on the Interstate Commerce Commission for in excess of 5 years. Most of us that are called upon to cast a vote on this matter, and other related matters as far as Penn Central, are always confronted with the question: "Why in the world are there very healthy railroads in this country such as Southern and Union Pacific and some others, yet Penn Central and the crowd in the Northeast are always coming here hat in hand, crying for more and more?"

It must be poor management or something and can you give us an opinion from ICC based on your 5 years in living with this matter?

Mr. STAFFORD. Yes, sir. In fact, I have a feeling it has gone back further than 5 years, because it was just as I became Chairman that they went under.

But, in the first place, you are right, they had some rather questionable management, as we understand it, but more than that it is the nature of the beast, so to speak. In the days when coal was king and the railroads could handle their usual basic commodity of coal, they had an ongoing income, a base income that rode them through most of the crises.

But once the environmental problems hit, then much of the coal that was being carried here in the East was no longer considered to be what it was. This cut the basic income for the railroad.

Second, a great deal of the heavy manufacturing that in years past was in this area has moved out of the Northeast into other areas of the country, and there has been a changeover into manufacturing of the type that was more susceptible to truck movement and/or other competing forms.

Then, the Northeast railroads just do not have any long-haul operations. They have so many high-priced terminal areas to serve.

Mr. DEVINE. What you are saying is environmental factors plus competition from the trucking industry would not apply to the healthy railroads as well?

Mr. STAFFORD. It does apply to the healthier railroads, and some are healthy. Union Pacific's latest report shows a 12-percent rate of return.

Mr. DEVINE. I am trying to get this for the record, Mr. Chairman, and you would add to that, of course, the fact you said they had some real serious management difficulties?

Mr. STAFFORD. They did have.

Mr. DEVINE. Do you think they have been resolved in any sense?

Mr. STAFFORD. I think they have been resolved to a great extent, but it is very difficult to run a railroad when you cannot spend any money. You can't deplete the creditors' interest, and you must be sure that all of the actions you take as a manager of a railroad are actions that are supposed to take care of the money, and you forget some of the service problems that go with this.

Mr. DEVINE. Thank you, Mr. Chairman.

The CHAIRMAN. The gentleman from New York, Mr. Murphy.

Mr. MURPHY. Mr. Stafford, briefly describe what is involved in a closed-end procedure.

Mr. STAFFORD. Closed-down procedure?

Mr. MURPHY. About the tariff regulation.

Mr. STAFFORD. When you embargo, which is what they say they will

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have to start doing, when you embargo the traffic, that means there will be no more of the Penn Central moving freight into Philadelphia or New York or any of these places. They are going to have to depend on alternate forms of transportation, the trucking, water carriers where possible, any form, but they cannot—again by Court order—deplete the creditors' money that is in that railroad.

Mr. MURPHY. But must they apply to ICC for 30 days' notice and certain other statutory regulation requirements?

Mr. KAHN. The regulations of the Interstate Commerce Commission which are found, Mr. Congressman, at 49 CFR 1006 simply require that notice be given to the shipping public, and no length of time is specified in the regulation.

Mr. MURPHY. There is no 10-day or 30-day requirement?

Mr. KAHN. No, because the embargo provisions actually were designed to deal with emergency situations. If there is a derailment on a line, or a line has been disrupted, and the railroad very rapidly must issue an embargo to preclude additional shipments coming along.

Mr. MURPHY. The ICC or court or any other body has nothing to say about it?

Mr. KAHN. The Commission does have the opportunity to determine whether the embargo notice is reasonable, but beyond that, I think, it has very little or no jurisdiction, Mr. Congressman.

Mr. MURPHY. What are our plans for sustaining critical operations of the railroad, not the whole operation, but just critical operations?

Mr. STAFFORD. That pretty much speaks to Congressman's Dingell's comment a few moments ago, that perhaps we should be able to meet some critical situation in a special line into perhaps Philadelphia or a special line into some particular coal mine, something of this kind. These matters have already been under consideration by our Bureau of Operations. But we keep running into the financial problem in that those lines that could handle it and are connected are generally some other bankrupt line in many of the cases, and unless they have a front-end payment, instead of a grant of 90 days after they have started, then they may put in a bill.

They cannot afford to move in and start operating because they are already strapped trying to keep grinding their railroad with the limited income they have in bankruptcy.

Mr. MURPHY. But you will have a plan for operation in those critical situations?

Mr. STAFFORD. We won't have a successful plan for completely taking over the operation of Penn Central if it shuts down.

Mr. MURPHY. The Justice Department has communicated with the committee in support of the ICC's position not to expand the role of the Office of Public Counsel within the Rail Service Planning Office. As the Chairman of the ICC, do you have any control of the action of Public Counsel of the Rail Service Planning Office or over the director of that office?

Mr. STAFFORD. There is George Chandler sitting back there, who used to be on my staff, and that counsel works for him now. But, yes, I suppose I do, through the fact that it is, because it is funded through our funding process. So, yes, I guess I could say something of some concern, except I recognize that Congress was insisting as nearly as possible that this be an autonomous office.

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Mr. MURPHY. But their funding is rather narrow and wanted to be sure that that funding was not diverted to the purposes other than that intended?

Mr. STAFFORD. That is right. The confusion that may result is why we suggest that you not go along with the Senate amendment on that.

The CHAIRMAN. The time of the gentleman has expired. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. Chairman, I believe in your statement you state that Penn Central this year will lose $340 million; is that correct?

Mr. GRADY. Since the forecast we had originally made, actual forecast, was $340 million, and it is not $280 million, normal operating loss.

Mr. CARTER. Of course, I believe coal production in our country is at an alltime high.

Mr. STAFFORD. Can I make a comment?

Penn Central obviously has a problem with equipment. They have been able to get outside help to rebuild some 70-ton coal cars, but they have another 1,500 they were hopeful that we would help with the funding of, but USRA has made a determination that that would be counterproductive and is proposing to go for 100-ton cars, to build new 100-ton cars, so they are limited to some extent by not having all of the cars they need.

Mr. CARTER. In other words, coal is being mined at an alltime record rate, it seems to me that Penn Central certainly should not be losing that much money with Pennsylvania being one of the largest coal-producing States.

Mr. STAFFORD. I know, but the automobile is really a very high income product for railroads and that is down considerably.

Mr. CARTER. But if affects Southern, too, and Southern still makes money.

Mr. STAFFORD. No, not as much.

Mr. CARTER. As a matter of fact, what about Union Pacific?

Mr. STAFFORD. Yes, I just said Union Pacific had, I believe, 12 percent.

Mr. CARTER. What about Erie Lackawanna? Why are they going bankrupt? Could you explain that? Was it the same type of management that we had at Penn Central?

Mr. STAFFORD. Well, they have had the same problems, to some extent, coal, and automobiles to a great extent, and all of these things have created difficulties, plus that which I was saying about the East as a whole. They have had good management.

Mr. CARTER. They had good management?

Mr. STAFFORD. Yes.

Mr. CARTER. I rather doubt that. I think if it had good management, certainly they should show a little profit when Southern. Union Pacific, and these other companies make such profits as they do.

Mr. STAFFORD. Well, keep in mind, and I am from the West myself, but you have long hauls out there.

Mr. CARTER. Long hauls in the South, too.

Mr. STAFFORD. And considerable long hauls in the South, but here in the East it is a different story.

Mr. CARTER. Yes, sir. It is a sad story.

Mr. STAFFORD. Yes; it is.

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Mr. CARTER. It is a sad story in the history of our country. We hear a lot about productivity and also referring to the workingman not producing as much as other people, but doesn't that lack of productivity begin at the head, at the top of the companies as well? Don't we have some dead timber, deadwood there?

Mr. STAFFORD. I don't know.

Mr. CARTER. Thank you, Mr. Chairman.

The CHAIRMAN. The gentleman from Washington State, Mr. Adams.

Mr. ADAMS. Mr. Stafford, I gathered you support the proposition that we should grant the additional amount of money to the Penn Central?

Mr. STAFFORD. Yes, sir.

Mr. ADAMS. I understand also that you believe that the Erie Lackawanna should be included in the Northeast reorganization plan?

Mr. STAFFORD. Yes.

Mr. ADAMS. Did you hear the colloquy this morning I had with Mr. Barnum to the effect this may cause that entire plan to then be put under an injunction?

Mr. STAFFORD. Yes. This was discussed in the board meeting.

Mr. ADAMS. What conclusion did you arrive at?

Mr. STAFFORD. The conclusion—well, I would rather leave it to the president of the board to speak on that when he follows me here at the table, because I am sure they kept a specific record on what was said.

Mr. ADAMS. Is that the conclusion of the ICC?

Mr. STAFFORD. The Chairman of the ICC, as a member of the board, supported the majority side, which was the view of the president of the USRA.

Mr. ADAMS. Don't you believe that we should wait before giving the total amount of money to the Penn Central until the USRA plan is presented to Congress so we will have, in effect, a bargaining position with the creditors of these various bankrupt lines at that point?

Mr. STAFFORD. That is no problem, real problem. There is no real problem with that so long as we have the money to keep operating.

Mr. ADAMS. Can one of your staff tell me what your payroll projections are, not what the losses are, but what is necessary in order that that they make their necessary payroll payments of money to maintain their equipment to continue through October of this year?

Mr. STAFFORD. May we supply that for you? Do you have that?

Mr. GRADY. The forecast here, it actually forecasted this.

Mr. ADAMS. Let's put it this way. I know what their forecast is. Do you have an independent one as the regulatory agency in charge of the operations?

Mr. STAFFORD. I guess the answer to that would be "No."

Mr. ADAMS. Have you made an independent investigation of the present status of the Penn Central as far as its cash flow is concerned and the basic operating needs between now and the end of the year?

Mr. STAFFORD. We make a continuing review; I actually wouldn't characterize it as a complete investigation, but it is a kind of financial oversight and it is done more or less on a short-range basis and not a real evaluation of the exactness of the long-term forecasts.

Mr. DINGELL. Will you yield?

Are you aware that the Northeast rail legislation specifically mandates you folks down at ICC to watch that? Why aren't you doing it then?

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Mr. STAFFORD. We are up to that point.

Mr. DINGELL. Well, you are apparently not, because you can't answer the question of the gentleman from Washington.

Mr. GRADY. The question was a special investigation?

Mr. ADAMS. No; I want to know if you have an independent set of figures that come from the regulatory agency, as opposed to a submission from the interested parties, as to the amounts necessary to meet payroll and other expenses through October of this year? I use October because the USRA plan is supposed to be up here by August, and we are supposed to consider it in September. What I am leading up to is, we are going to take a big bath with this bill on the House floor and we are going to take a big bath with the public when it comes up and I want to be very certain the members of this committee and other Members of Congress have some factual background that comes from a number of sources as to what the need is so that we are in a position to defend ourselves.

Mr. GRADY. I can respond to that, Congressman. I can say that the thing we do is a financial oversight, the evaluation of the assumptions used in projections, and if we find the projections are unreasonable, then we take exception to that projection.

Now we have evaluated the assumptions used in the forecast. As I previously actually pointed out, a problem that in my judgment is a problem of the magnitude in the projections, well, that is a rate increase matter. We can inquire of some of the dollars and operating expenses, but I think the big dollars are in the evaluation of the rate increases. We will supply further information for the record.

[See letter date February 6, 1975, with attachments, from Kenneth H. Tuggle, Acting Chairman, ICC, p. 119, this hearing.]

Mr. ADAMS. Now you have turned down the rate increase; isn't that correct?

Mr. GRADY. Pardon?

Mr. ADAMS. The rate increase has been turned down; has it not?

Mr. STAFFORD. Yes. But, as I said before, the Penn Central and most of the other Northeast railroads could not have realized a cent from a rate increase as long as the Chessie continues to say "We are not going to take a rate increase." It is a competitive situation and the railroads themselves all filed petitions with us indicating—and that was on December 20, I believe—that a rate increase would in no way be helpful.

Mr. ADAMS. All right, the Norfolk & Western—did that railroad also decline it?

Mr. STAFFORD. No.

Mr. ADAMS. They did not?

Mr. STAFFORD. No.

Mr. ADAMS. Answer this and then I will stop, Mr. Chairman.

Mr. STUCKEY. Could I yield the balance of my time to the gentleman?

The CHAIRMAN. I will come back to him in a minute, but go ahead and ask your question.

Mr. ADAMS. Is the Erie Lackawanna in its original status a subsidiary owned by a subsidiary of the Norfolk & Western?

Mr. GRADY. That is right. It is owned by the Dereco Co., which is owned by N. & W.

Mr. ADAMS. Then we have a situation where one of the major outside profitable lines in this area is requesting that we take over a subsidiary which has gone down, is that right?

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Mr. GRADY. Yes.

Mr. ADAMS. Or that we supply money to it?

Mr. GRADY. Yes.

The CHAIRMAN. The gentleman from Kansas, Mr. Skubitz.

Mr. SKUBITZ. Thank you, Mr. Chairman.

I have one or two questions. What you are really telling us today is that the Penn Central is in a spot today regardless of how it got there; that unless this committee acts, the Penn Central is going to close down?

Mr. STAFFORD. That or the Government is going to have to take us, and they are practically doing that.

Mr. SKUBITZ. If it does close down, insofar as the Midwest is concerned, it will be disastrous because we won't be able to move our things to the East, and the Easterners will not be able to move it to the West. That is the problem before this committee.

My next question is, you do favor inclusion of—I am not so sure I do or don't at this moment—but I am asking questions and I am trying to get answers.

Mr. STAFFORD. The answer is, "Yes; we favor it."

The CHAIRMAN. Mr. Stuckey.

Mr. STUCKEY. Mr. Chairman, I yield my time to the gentleman from Washington.

Mr. ADAMS. Mr. Stafford, it has been proposed by trustees of the Penn Central that they will embargo certain freight and that they would have to start shutting down operations. From your independent regulatory position and from your check on the cash flow, to follow up on my prior question, on what dates will this occur?

Mr. STAFFORD. The 14th, I believe.

Mr. GRADY. That should be February 25.

Mr. ADAMS. In other words, you are stating to us they cannot meet their February 25 payroll, is that correct?

Mr. GRADY. Yes, sir.

Mr. ADAMS. Is it possible for, in your opinion, one of the agencies of the Government, either Department of Transportation or either under the Emergency Rail Services Act, to grant them any funds out of the $19 million left in that fund in order to continue in operation through that payroll?

Mr. Kahn, if you want to reply.

Mr. KAHN. The money under the Emergency Rail Services Act of 1970 would not appear to be available because of the requirement that the Government as a guarantor of the trustees' certificate would become a preferred creditor.

Mr. ADAMS. Let me have that again, why, because they become a preferred creditor? Wouldn't that be possible in order to meet that payroll?

Mr. KAHN. Because it is very likely that the sale of the trustees' estate certificates would be opposed by the creditors of Penn Central, on the theory that it would further dilute their interests.

Mr. ADAMS. Well, if it were opposed by them, could the trustees still do it?

Mr. KAHN. If able to persuade the judge to authorize the sale, I would think so; yes, sir.

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Mr. ADAMS. We are dealing with a very severe time problem here, and I want to know if there is any other alternative that you know which will give us the opportunity to pass such legislation as necessary to keep them operating?

Mr. KAHN. As I am sure you know, Congressman Adams, that same legislation, the Emergency Rail Services Act of 1970, did include a provision enabling the Secretary of Transportation to lease properties of the Penn Central in the event of actual or threatened cessation of essential services, so I believe that perhaps that remains a possibil of essential services, so I believe that perhaps that remains a possibility.

Mr. ADAMS. Now, I have a question that follows up on my original one of the ownership of the Erie Lackawanna. If it were to come into this act, it could then be operated over by profitable railroads who were ordered to do so by the ICC. You have indicated before that you didn't think this was a very good solution and that it would not work out for the general Northeast system. Do we not have a problem that since the Erie Lackawanna, originally a subsidiary of the Norfolk & Western, then the only three profitable connecting systems that go into that area are the Norfolk & Western, the Chessie, and the Southern, that you would be faced with a potential conflict of the Government placing Erie Lackawanna into this system and then allowing the one that originally operated it to operate over the tracks at a profit when they have not been able to operate their subsidiary at a profit?

Mr. KAHN. That is an inherent problem, of course. But I believe it is the thinking of the majority of the USRA Board that the problem of the Erie Lackawanna can be dealt with better, more effectively, if it could be forced into one or more of the structures. I believe a majority of the Board of USRA does not believe the possibility that pieces of Erie Lackawanna might be purchased either by ConRail or by profitable lines in the area offers a realistic alternative.

Mr. ADAMS. You do not think the exchange provisions or the other provisions would be ample to deal with the problem of the Erie Lackawanna then?

Mr. KAHN. That is correct.

Mr. ADAMS. Now, taking your regulatory hat as opposed to your USRA hat, I want to know if you think the same way.

Mr. KAHN. The Commission briefly considered the matter in preparation for today's appearance and decided in support of the position of the USRA.

Mr. ADAMS. In other words, the regulatory commission has no position to take with us other than that we should go along and place Erie Lackawanna into this system and then put a total amount of money into the system so the whole thing will turn over?

Mr. KAHN. We perhaps would not phrase it that way, but the answer would have to be "Yes."

Mr. ADAMS. I phrased it that way deliberately. Thank you. Mr. Chairman.

The CHAIRMAN. The gentleman from New York, Mr. Hastings.

Mr. HASTINGS. I thank you, Mr. Chairman.

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Let me see if I can get your statement into perspective here. On the final page, page 13, you say:

> It is clear that additional financial assistance will have to be made available in order to avoid a shutdown of essential rail service and to maintain and improve the plant and facilities of properties which may eventually be taken over by ConRail.

So you are stating that the consequences of the failure of this Congress to produce this legislation could very well result in the shutdown of the Penn Central?

Mr. STAFFORD. Right.

Mr. HASTINGS. Now as relates to the question of time and I asked the question this morning of Mr. Barnum, the scheduled date is February 14, if by the end of the week this Congress does not pass the legislation and goes away, what do you expect to have happened by the 14th and the following week?

Mr. STAFFORD. I would expect just what they say, they will start embargoing.

Mr. HASTINGS. There is no provision, as I understand from Mr. Murphy's question, for you to establish a 10-day or 30-day waiting period, is that correct?

Mr. STAFFORD. That is correct.

Mr. HASTINGS. Then the financial impact, and let me ask you to comment, what would be the impact on industries throughout the Northeast and unemployment and economy in this country, what in your judgment would be the impact?

Mr. STAFFORD. Just like any major closedown that you have, the unemployment rolls will grow and the Nation's business—even more than just a business closing down, the Nation's business comes to a halt.

Mr. HASTINGS. Then is it fair to say we are facing a critical problem?

Mr. STAFFORD. Yes.

Mr. HASTINGS. There is no question about using that terminology, a critical problem in this country, unless the Congress acts?

Mr. STAFFORD. I consider it a critical problem.

Mr. SKUBITZ. May I ask if that is not quite correct, Mr. Chairman. If they close down, you have the authority to send the trains over that line to pick up the trade?

Mr. STAFFORD. Congressman, our problem is, and we advised a few moments ago about it, we have found, through our efforts, that it just does not work in any major sense. We were able to do it in a very small sense on the Northeast road just the other day, but that was a very small situation where the Department of Transportation was able to find the funds to front end the operations; in other words, to give the other railroad the money to keep them operating over the line.

Mr. SKUBITZ. I got news for you. If you operate the way we are now, you operate under big disadvantages.

Mr. HASTINGS. I appreciate your yielding back. Does the judge have anything to say about shutdown of Penn Central?

Mr. KAHN. I am unaware the trustees have brought the matter before Judge Fullam.

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Mr. HASTINGS. Would he have jurisdiction on the question, however?

Mr. KAHN. I would assume so. I would assume before the railroad would actually be able to issue the embargo notice, it would have to present the matter to Judge Fullam.

Mr. HASTINGS. That will remain as a question mark as to what he might do?

Mr. KAHN. Yes.

Mr. HASTINGS. In relation to Erie Lackawanna, if I understand, you say you favor inclusion of Erie Lackawanna in the ConRail system?

Mr. STAFFORD. Yes, and the majority of the Board and the Commission supported my statement.

Mr. HASTINGS. Now USRA, in a letter recently to the chairman, Mr. Staggers, said they felt the litigation would only refer to the amendments provided by this legislation relating to Erie Lackawanna and not to the entire act itself, as concern has been expressed, rightfully so by Mr. Barnum, and do you share that feeling that the litigation would probably only relate to the amendments rather than to the whole constitutional question again?

Mr. KAHN. Yes. The principal issue, as I am sure you know, the principal issue that we litigated before the Special Court and Constitutional Court was the question of the availability of the Tucker Act remedy.

That matter now appears to be settled. We do not perceive that the amendment which we endorse will reopen that question.

Mr. HASTINGS. The only legitimate concern.

Well, thank you, Mr. Chairman.

The CHAIRMAN. The gentleman from North Carolina, Mr. Preyer.

Mr. PREYER. I have no questions at this time, Mr. Chairman.

The CHAIRMAN. The gentleman from Texas, Mr. Collins.

Mr. COLLINS. Mr. Chairman, I appreciate having you here with us today. I was interested in one or two points and am disturbed about the fact this railroad continues to be a bankrupt operation. One thing that I do not understand is giving them a blanket salary increase instead of relating it to a merit basis of achievement or productivity. Is there any basis you know of where this salary increase is on merit or more productivity?

Mr. STAFFORD. Are you talking about Amtrak?

Mr. COLLINS. I am talking about 1975, Penn Central.

Mr. STAFFORD. You are talking about the general pay increase?

Mr. COLLINS. That is right, if they are going to give this bankrupt railroad a 1975 pay raise identical to efficient, profitable railroads, I ask are they giving them one just because everybody is getting one.

Mr. STAFFORD. Yes, sir, it is an industrywide negotiation.

Mr. COLLINS. Who did that negotiation? Did you have anything to do with that?

Mr. STAFFORD. We have absolutely nothing to do with labor.

Mr. COLLINS. Are you familiar with the total trackage? If the Penn Central didn't have to operate dead tracks, it would make it easier for them to hit the black in this operation. How many tracks or miles of tracks did Judge Fullam suggest they consider?

Mr. KAHN. The trustees proposed the abandonment of approximately 5,000 or 6,000 miles of their 20,000-mile system, but at that time

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Penn Central estimated that out-of-pocket savings would come to only about $20 million a year, so the out-of-pocket savings of curtailing the operations over these lines would not be significant.

Where the money begins to build up, however, is in the cost of rehabilitating those lines to acceptable levels.

I think that is the heart of the Penn Central problem, a broken down railroad system sadly in need of rehabilitation.

Mr. COLLINS. You agree that Penn Central was considered a model as far as maintaining its tracks?

Mr. KAHN. No, sir.

Mr. STAFFORD. It may have been many years ago.

Mr. COLLINS. Yes, many, many years ago, but today all we talked about is the fact that the tracks are in very, very sorry condition.

Mr. STAFFORD. They are.

Mr. COLLINS. Now it would seem to me to be better to concentrate on the tracks where you have mileage that is making money which are active tracks, and get all of this dead trackage closed up and out of business. How many miles of track did they actually close?

Mr. STAFFORD. The USRA Board has been meeting on it and they will have their initial report before the Congress late this month.

Mr. COLLINS. Yes.

Mr. STAFFORD. And that will be in the report when it comes up.

Mr. COLLINS. Every time it comes up every Congressman with 10 miles of track in his district runs down to introduce a bill to delay it. We ought to tie it in once and for all and eliminate the dead trackage. How much actually has been eliminated? Has any?

Mr. STAFFORD. Since when?

Mr. COLLINS. Since we have discussed this bankruptcy situation.

Mr. STAFFORD. In the last 5 years, it is my recollection that it has been close to 1,900 miles.

Mr. COLLINS. Of the 8,000 miles?

Mr. STAFFORD. Total all over the country.

Mr. COLLINS. Well, the rest are not sick like Penn Central. How much with them?

Mr. STAFFORD. We have been held up through another action. The environmentalists took us to court in New York.

Mr. COLLINS. What do environmentalists have to do with whether a railroad track ought to be operated or not?

Mr. STAFFORD. Well, it has been used for many reasons. I don't say it is all bad, but it has thrown a monkey wrench into our operations, keeping us from our work.

Mr. COLLINS. You don't see any action the way the thing stands now unless the Congress requires action? When are these tracks going to be closed, the 6,000 miles of Penn Central?

Mr. STAFFORD. I don't know that 6,000 miles are going to be closed or what that amount will be, but you will have the initial report from USRA later this month.

Mr. COLLINS. Thank you very much, Mr. Chairman.

The CHAIRMAN. The gentleman from New York, Mr. Ottinger.

Mr. OTTINGER. Mr. Chairman, I was not at all satisfied with your answers to the questions from my colleague from New York, Mr. Murphy, with respect to your ability to hold up any discontinuance of

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service on the Penn Central. Why on earth do you treat this as an emergency provision under the same provision which would apply if a train had broken down on the tracks and you have to ask without notice, rather than as an ordinary discontinuance of service in which there is a delay?

Do I perceive you provided it in the law and regulations?

Mr. KAHN. The normal abandonment provisions affecting the railroads were superseded by provisions of the Regional Rail Reorganization Act. The ICC presently has no jurisdiction to pass on the abandonments in the Northeast area.

Mr. OTTINGER. There is no provision in law under which you can hold up a railroad's proposed discontinuance of service for any situation, emergency or otherwise?

Mr. KAHN. The jurisdiction was conveyed to the United States Railway Association, or USRA, so that while we don't have that power, the USRA does have that power.

Mr. OTTINGER. Yes, sir. Do you know what those provisions are?

Mr. KAHN. The provisions are in section 304(f) of the Regional Rail Reorganization Act.

Mr. OTTINGER. I will be glad to yield to my colleague.

Mr. FLORIO. Has there been a request by ICC for such statutory authority to give you safeguard protection or safeguard authority to stop some of this?

I am negatively impressed with the agency's inability to deal with what is a unilateral decision by a railroad to stop and you apparently have nothing to say about it. Have you tried to do anything further about your statutory authority?

Mr. KAHN. I think the fact remains, Mr. Congressman, the railroad will stop running because of lack of money.

Mr. FLORIO. That is a position put forth, but my point is, don't you feel that there should be some mechanism available to you to examine this matter?

Mr. KAHN. The Congress sought to deal with the problem of the railroads in the Northeast comprehensively in the Regional Rail Reorganization Act and discontinuance of operation pending the promulgation of the final system plan was a matter entrusted to USRA.

Mr. FLORIO. And the answer is you have no such authority?

Mr. KAHN. No, sir.

Mr. OTTINGER. You said you make regular audits, pass them up here.

You have power to criticize or comment on those and have you ever, in fact, made a statement to us that the representations of railroads are inaccurate?

Mr. GRADY. Within the last couple of years?

Mr. OTTINGER. You may answer.

Mr. GRADY. I should like to clarify the question, that is in the last couple of years or prior to the bankruptcy?

Mr. OTTINGER. I will say at any time, but of course the last couple of years are the most critical.

Mr. GRADY. Well, I think the bankruptcy, the clash with the staff was extremely critical. The involvement in Penn Central had some diversified activities and felt these activities contributed toward their problem and I think we spoke out on them.

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Actually, subsequently, under the stewardship of the trustees we have been kind of critical of some of the forecasting techniques or earlier forecasting techniques, but I think they have sharpened their skills and their forecasting and so, well, I guess the answer is in the last couple of years the answer would be "no, we have not."

The CHAIRMAN. The gentleman from California, Mr. Moorhead.

Mr. MOORHEAD. Mr. Chairman, in answer to some earlier questions you stated that if the railroad was able to cut back the 6,000 miles of nonprofitable lines, they would only save about $20 million a year. We are told we need $245 million at least for them to operate through the first quarter of 1976.

Why is this railroad so terribly unprofitable? Why is it costing so much more money than other railroads to operate in the country if they can't even operate at a profit after they lose all of their nonprofitable trackage?

Mr. STAFFORD. Well, first those other railroads that you speak of have been extremely well-managed, most of them, and they have very long hauls, most of them, and the long haul, without a great number of terminals to be served at such close distances, makes a great deal of difference.

So the long haul railroads, with few terminals, have a much better go at making money.

Mr. MOORHEAD. How is this new railroad system you are planning going to be able to operate this thing at a profit ever?

Mr. STAFFORD. Perhaps it is a little difficult to speak when we have not come out with the report. You may want to speak more to the point with the president of USRA, who will follow me.

That will hopefully be guided more to a profit.

Mr. MOORHEAD. Wouldn't it be a little better system to turn portions of this Penn Central Railroad over to other railroads that can operate at a profit where there is a management that can take it over and wants to take it over?

Mr. STAFFORD. If this does not work, that will probably be what will happen, or the Government will take it over.

Mr. MOORHEAD. How many billions of dollars down the line, though?

Well, I have no further questions.

Mr. KAHN. Mr. Moorhead, I think you will learn from the trustees of the Penn Central this afternoon that they probably would not be here, but for the combination of the crippling coal strike and the reductions in the automotive industry. Both coal and the automotive industries are important sources of traffic for Penn Central, and Penn Central, while cutting back its operations, was not able to reduce its costs commensurate with its reductions in income.

Mr. MOORHEAD. Well, have they been compelled to do things by your Commission that they should not have been compelled to do so, they couldn't do and still operate as a regular business?

Mr. KAHN. I know of nothing.

Mr. MOORHEAD. No further questions.

Mr. GRADY. I have something to add to your comments about the Penn Central.

The CHAIRMAN. You may finish that answer.

Mr. GRADY. I think it is interesting to note we have problems and the problems seem to focus around the Northeast or the East and we have

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major motor carriers in that area that are also in financial difficulty and it might be indicative of the problem.

The CHAIRMAN. The gentleman from Colorado, Mr. Wirth.

Mr. WIRTH. Mr. Stafford, I know you have to leave, and can you tell us where you are going to go?

Mr. STAFFORD. Well, to Florida. I have a speech.

Mr. WIRTH. Who are you speaking to?

Mr. STAFFORD. To the Board of Governors of the American Trucking Association.

Mr. WIRTH. Might I just register for the record at this point that it seems to me that we in the Congress and this committee are being backed into a very severe corner in terms of providing $250 million to a railroad.

Mr. STAFFORD. Yes.

Mr. WIRTH. And you are Chairman of the Interstate Commerce Commission and heading off to Florida to speak to the Truckers Association.

Mr. STAFFORD. Well, it is a long-time commitment which I had and it is not something recent. I will send you a copy of the speech, sir, if you would like that.

Mr. WIRTH. I much would rather have you here for these proceedings, which is much more important to the economy of this country.

Mr. STAFFORD. I am at the call of the committee and if the committee desires me to stay, I will certainly do so.

Mr. WIRTH. Fine. Can you tell me if the Penn Central Railroad that we are in the process of subsidizing to the point of $250 million, is that a subsidiary of a larger corporation?

Mr. STAFFORD. Yes, the Penn Central is a subsidiary of the Penn Central Holding Co.

Mr. WIRTH. Does the Penn Central Co. have other subsidiaries?

Mr. STAFFORD. Yes. Do you recall what they are?

Mr. KAHN. Well, there are two other subsidiaries, the Great Southwest.

Mr. GRADY. That is not right.

The Penn Central Co. subsidiary, is that the question?

The Penn Central Transportation Co. has subs under it, but actually the Penn Central Holding Co. has one minor sub and its major sub, of course, is the Transportation Co. The balance of the subs fall under the Transportation Co., as with Great Southwest, which is a Pennsylvania Co., which is a solvent holding company below the Transportation Co.

Mr. WIRTH. I am confused.

Mr. GRADY. Well, you have the Penn Central Co., a holding company, which is essentially a shelf organization and the stock in the hands of the public is held in the company and that company owns the Transportation Co., and then the Transportation Co.—well, the Transportation Co. owns the Pennsylvania Co. and actually the Great Southwest.

Mr. WIRTH. Do you know about the Pennsylvania Co. and other companies?

Mr. GRADY. Yes.

Mr. WIRTH. And you know about their profit structure?

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Mr. GRADY. Yes.

Mr. WIRTH. Are there other profitable subsidiaries as opposed to the railroad or parent or holding company?

Mr. GRADY. Yes.

Mr. WIRTH. And is there any way in which a taxpayer in this country might assume it would have been possible for the holding company to spinoff their profitable operations into one company and let the taxpayers of the country take a bath in relation to railroad operations?

Mr. GRADY. I don't think the holding company can actually do it, but I believe there is some court decision that prohibits the Pennsylvania Co. from passing any of its assets up to the Transportation Co.

Mr. WIRTH. Is there anything that this committee can do about that to make sure that the more profitable assets can, in fact, be moved to the railroad in such a way that this $250 million could be picked up in some other fashion?

Mr. GRADY. I think the problem is that the stock of the Pennsylvania Co. is pledged to the bank and there are some legal aspects of this that actually prevent that from happening until its legal obligation has been met and I believe there is something like a $300 million loan where the stock of the Pennsylvania Co. has been pledged to the banks and most of these assets that you would be speaking about would actually come below that tier.

Mr. WIRTH. Thank you.

The CHAIRMAN. The gentleman from Indiana, Mr. Sharp.

Mr. SHARP. No questions.

The CHAIRMAN. The gentleman from Michigan, Mr. Brodhead.

Mr. BRODHEAD. No questions.

The CHAIRMAN. The gentleman from North Carolina, Mr. Hefner.

Mr. HEFNER. One question and I know you want to go to Florida and I would like to go with you, if I may. One question for my own information and I yield the remainder of my time to Mr. Moffett.

Mr. Hastings asked the question if we don't vote one penny to Penn Central, in essence they will cease operations. Have you done any surveys or can you give me some idea of what impact this could have on the economy on unemployment, and on the gross national product of this country? Do you have any figures, sir, for the impact if we don't vote one penny to Penn Central?

Mr. STAFFORD. I do not have figures before me at this time although I can supply some.

[See letter dated February 6, 1975, with attachments, from Kenneth H. Tuggle, Acting Chairman, ICC, p. 119, this hearing.]

Mr. HEFNER. We have heard in Senate testimony that it could raise unemployment to 12 percent. We heard this and we heard it could cost a number of dollars to the economy and how it would affect it this way and that way. In essence we have been told that if we do not act within the next week or 2 weeks, Penn Central will close down and Congress will be taken to task for adding another 5 percent unemployment to the country. I don't think this is exactly a fair situation to be placed in.

Mr. STAFFORD. No, it is not. That is right.

Mr. HEFNER. But you do not have figures?

Mr. STAFFORD. Not at this time.

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Mr. HEFNER. I yield the remainder of my time to Mr. Moffett.

The CHAIRMAN. Mr. Moffett.

Mr. MOFFETT. Mr. Stafford, I have just a couple of loose ends that I would like to pick up on.

First of all, the relationship between the rejected rate request and this proceeding has been brought up previously. Where would a citizen find the information on that rate request and the Commission's decision?

Mr. STAFFORD. We will be happy to supply you with all of the information about it.

Mr. MOFFETT. Is that true for a citizen, an average citizen?

Mr. STAFFORD. Yes, an average citizen can walk in and get the information.

Mr. MOFFETT. Maybe you are not aware of it, but during the luncheon hour my office attempted to get that information and we were told one had to go to the Commission and copy it down. I would suggest that we make the information more readily available.

Mr. STAFFORD. We will have one in your office this afternoon, whatever it is, and is there something specific?

Mr. MOFFETT. I simply wanted to study it during the noon hour, since this issue has been raised. I want to examine the Commission's reasons for turning down the request. That is all.

Mr. STAFFORD. All right, I will see it is sent up to you.

Mr. MOFFETT. Not only for a Member, but I think it should be made available for citizens also.

The second question, Mr. Stafford. Again, this relates to the business of hearings on shutdowns.

Mr. STAFFORD. I have a copy of the order here, if you would like that. That is what we put out, or that is the information that is available.

Mr. MOFFETT. But the order does not really give you reasons.

Mr. STAFFORD. I have forgotten what it says right now.

Mr. MOFFETT. The order does not give your reasons, but isn't there a decision rendered by the Commission?

Mr. KAHN. I didn't hear the question.

Mr. MOFFETT. Is a decision rendered by the Commission when you turn down a rate request, or when you approve one? The decision is printed, is it not?

Mr. KAHN. In mimeograph, you have it published. With respect to ex parte 310, general rate increase, I should note as the railroads of the country came in and sought special permission from the Commission to publish their tariff in this particular format, and all we did was find they had not made a case for our granting special permission for the procedure they proposed, and it was not justified under the circumstances. This is without prejudice to them.

Mr. MOFFETT. I understand that. The second question relates to your involvement in terms of a discontinuance of service. Can you or can you not hold a hearing on the embargo? If the Penn Central says on February 14 it wants to shut down, and I think there is still confusion on that, might you hold a hearing?

Mr. KAHN. The Commission can always hold a hearing, but it has no effective remedy in the circumstances where Penn Central is faced with inability to meet the payroll on February 25 and the Commission can enter all of the orders it chooses and cannot do anything to enforce such an order.

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Mr. MOFFETT. Do you plan on holding a hearing?

Mr. STAFFORD. I had not planned on holding a hearing. This is a rather useless thing, useless item when it is money that will determine their actions. I am hopeful that some way may be found of funding this, but I don't know what it would be.

Mr. MOFFETT. Let me speak to that then and ask you some questions on it quickly. The RSPO, which falls within your Commission, issued a report on January 10, I believe, commenting on the USRA's report of October, I believe it was, and in that report they indicated they felt both DOT and USRA had construed too narrowly the notion of profitability, if you will, and had construed too narrowly, or ignored, in fact, the goals of the act, section 206.

Now, do you share the view that perhaps they have not paid enough attention in their preliminary plan—and I understand the preliminary system plan comes out on February 26—but to date do you share the view that USRA and also DOT, have too narrowly construed the legislation and, in fact, in seeking to abandon lines in the Northeast, for example, have perhaps not taken social profitability into consideration; in other words, the firms are left without rail service and so forth.

I am speaking to the Rail Reorganization Act, I think you understood that, but do you share the view that RSPO appears to have adopted?

Mr. KAHN. I think the judgment of the Rail Services Planning Office was somewhat premature. They were basing that simply on the analysis or the methodology devised by the USRA in dealing with the light density line problems. The Board of Directors of USRA, on which Chairman Stafford sits, has been very mindful of taking into account the additional factors, disruption to the local community, environmental considerations, and the like.

Mr. MOFFETT. Well, they were also reflecting comments of the citizenry, weren't they?

Mr. KAHN. Again, based upon methodology of the light density line analysis.

Mr. MOFFETT. I have one more question. Do you favor the separate fixed plan entity proposal that the Government take over eventually the railbeds?

Mr. STAFFORD. I would rather not set up that kind of corporation for the Government to take over.

Mr. MOFFETT. It sounds like an inevitability and I get that impression.

Mr. STAFFORD. It may be, but it is the next step then to nationalization.

The CHAIRMAN. Mr. Florio.

Mr. FLORIO. In deference to your schedule I will ask one question.

Mr. STAFFORD. I already missed it.

Mr. FLORIO. Following up on the previous question, you gave what I thought was a good argument as to why this program will inevitably fail. You talked about environmental considerations which in some way would stop coal and shorthaul operations in the Northeast. I was wondering, in reference this morning to the National Mass Transportation Act, if the rationale for that is not the same as we we have in the Northeast, that is, it is naive to expect an operation such as this to ever operate in the black and that maybe we are going to have to face the

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fact we are talking about continuing programs of governmental operating and capital subsidies. Are we being naive in expecting it to work or perhaps we should face the fact it will not work and address ourselves directly to the issue of Government operating or capital subsidies on a continuing basis.

Mr. STAFFORD. I think there is a basis for what you are saying, but I hope we are not working with that in mind.

Mr. FLORIO. Do we have Plan No. 2 ready?

Mr. STAFFORD. Oh, we have a plan. USRA has a plan in mind and we hope, all of us hope it is going to be a profitable program but, as the Acting Secretary of Transportation said this morning, that it would be a program that would require continued Federal funding for some period of time.

Mr. FLORIO. My question is, do we have Plan 2, ready, if in fact Plan 1 does not work out? Is there someone at ICC who is working on what the next step is?

Mr. KAHN. The USRA preliminary plan will be out February 26 and will discuss the matter comprehensively.

Mr. FLORIO. Which matter?

Mr. KAHN. The ability to fashion a rail system in the East that will be viable and, if not, why not. In turn, the Rail Services Planning Office of the Interstate Commerce Commission will be conducting hearings throughout the area on the preliminary system plan and itself will offer comments on that. So there will be a second opportunity to have public input on these very important issues.

The USRA will prepare the final system plan and the Interstate Commerce Commission will comment on it, and then it will come to Congress. By that time I think there will be a thorough dialogue on these issues.

Mr. FLORIO. I am not sure that really is the point. What I want to know is whether anyone is working on a plan in lieu of the situation you just described. That is to say, we are putting all of our eggs in one basket and hope we can have a profitable rail system. If it is not probable, then we will work it out later. Is that essentially what you are saying?

Mr. STAFFORD. I think enough information is being gathered in USRA, that if that eventuality came about, it would be possible.

The CHAIRMAN. The gentleman from Pennsylvania, Mr. Heinz.

Mr. HEINZ. Mr. Chairman, I have no questions at this time.

The CHAIRMAN. The gentleman from California, Mr. Moss.

Mr. MOSS. Mr. Chairman, what is the nature of the authority you have in auditing railroads, this one, or any other? Is it very broad?

Mr. STAFFORD. Yes.

Mr. GRADY. Yes, I think it is broad, except for one aspect.

Mr. MOSS. Would you tell me that aspect?

Mr. STAFFORD. That aspect is that the auditors are precluded from obtaining financial forecasts.

Mr. MOSS. All right. Then have you, on this particular railroad, undertaken any special surveillance under your auditing authority?

Mr. STAFFORD. Yes, we have, sir, but we have not been denied the financial forecast of the Penn Central.

Mr. MOSS. You have not been denied it?

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Mr. STAFFORD. Yes, sir, we have not been denied that.

Mr. Moss. So you have had available all data you feel that are necessary to make an evaluation of the true condition of this railroad and of the competence of the management of this railroad; is that correct?

Mr. STAFFORD. Yes.

Mr. Moss. Have you concluded then that the trustees, who operate as officers of the court and also as representatives of the creditors, are giving this railroad at this time the best possible management obtainable?

Mr. STAFFORD. It is an extremely difficult question to answer.

Mr. Moss. I realize that and that is why I asked it.

Mr. STAFFORD. If you wanted my judgment?

Mr. Moss. That is what I want and that is all I expect you to give me.

Mr. STAFFORD. I would say in my judgment that the answer would be "yes," I think they are doing all that they can do under the trying times and circumstances.

Mr. Moss. Do you feel you are fully conversant with the reasons for the crisis in the cash flow, that it is all attributable to declining traffic, or that any portion of the problem relates to management judgment itself?

Mr. STAFFORD. Yes, I think so, sir. I think we have evaluated the Penn Central by a month-to-month, week-to-week basis, and of course as you got into financial matters, you can evaluate management.

Mr. Moss. That is precisely the point. Have you evaluated on a month-to-month, week-to-week basis using their figures or yours?

Mr. STAFFORD. It is on their figures, evaluating the assumptions and accepting their figures.

Mr. Moss. Were these assumptions prepared by auditors different than those previously preparing assumptions for Penn Central under its prior management?

Mr. STAFFORD. The auditors that they now have are actually a different set of auditors than they had actually prior to the bankruptcy.

Mr. Moss. Are the auditing principles under which they operate today different than those under which they operated prior to the change in management?

Mr. STAFFORD. Well, again in my judgment, yes.

Mr. Moss. Could you tell us the nature of the difference in the principles which underlie the auditing now going on than those which were followed under the previous management?

Mr. STAFFORD. If I had to characterize it, I would say that the prior management maximized income and there was no cash there in the till. They used every accounting device to have the financial statements appear to be better than the results of that, again in my judgment.

Mr. Moss. Maximizing?

Mr. STAFFORD. Yes, maximizing.

Mr. Moss. Is there a possibility of their minimizing here?

Mr. STAFFORD. Again, in my judgment, I don't think so.

Mr. Moss. Thank you.

The CHAIRMAN. I want to thank you gentlemen for coming and giving us the benefit of your views. I would like to ask this question before you go.

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In regard to the discontinuance now of a service, under section 304 (f) of the Northeast Railroad Reorganization Plan it expressly provides the USRA must approve of abandonment or discontinuance. I cannot see how Penn Central can embargo without Government permission.

Do you have any response to that?

Mr. KAHN. That would be my reading of 304(f).

The CHAIRMAN. Thank you kindly for coming and giving us your views.

Now, Mr. Barnum, you may come back.

STATEMENT OF HON. JOHN W. BARNUM ET AL.—Resumed

Mr. BARNUM. Yes, sir.

The CHAIRMAN. The gentleman from Colorado will continue his questioning of Mr. Barnum.

Mr. WIRTH. Mr. Barnum, thank you very much for your patience and I must say I personally am very encouraged to hear someone in front of us as well prepared as you are.

Mr. BARNUM. Thank you.

Mr. WIRTH. As I understand, we are talking about a request for $250 million, is that correct?

Mr. BARNUM. More than that in light of the suggestion that $25 million be added for Erie Lackawanna and an additional $30 million for section 213 to take into account the fact the rate increase was not put into effect in February.

Mr. WIRTH. We are talking about $305 million. Who arrived at the figure?

Mr. BARNUM. That was arrived at by the Department of Transportation on the basis of data supplied to us by the various railroads in reorganization.

Mr. WIRTH. Was the ICC involved in helping to develop those figures?

Mr. BARNUM. No; they were not.

Mr. WIRTH. If you were an independent management consultant and came in and looked at these data, do you think it is reasonable to assume you might arrive at a different figure than $250 or $305 million?

Mr. BARNUM. Well, I could have easily arrived at the conclusion that more money should be authorized under section 215 so that the Penn Central and other railroads in reorganization could go ahead with the rehabilitation and maintenance that those railroads clearly need. The judgment that went into the decision on this particular figure is what is the amount we should ask of Congress at this time before the new system is in place?

Mr. WIRTH. Are you assured in your mind this $250 million figure or the $305 million figure is the correct figure and that you will not be coming back to the Congress in the next year for more funds?

Mr. BARNUM. All I can do is give you my best judgment as of this time, Mr. Wirth. The figure is predicated in part on a prediction by Penn Central their revenues will decrease in the coming year by about 7 percent. In our judgment that is a minimum decrease in revenues.

To the extent their revenues decrease by more than 7 percent, we may very well need to find other ways in which either to cut costs or to meet the requirements for additional funds.

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Mr. WIRTH. We also have the factor of the $100 million increase that we talked about this morning in terms of the energy proposals of the President.

Mr. BARNUM. I was going to ask permission of the Chair to correct the record in that respect. During the recess I inquired of Penn Central just what the impact of the likely increase in cost of fuel would be on the Penn Central. I was advised by the Penn Central officials here that for their system a 1-cent increase is equal to $5 million a year. Now, a $50 million cost would go to the bottom line, of course, if there were an average fuel cost increase, let's say, of 10 cents per gallon.

I am further advised they have already taken into account about $30 million of that $50 million, so that instead of the $100 million figure I gave you this morning, it would be $50 million total cost to the Penn Central, $30 million of which has already been taken into account in their estimate of their needs. In addition, however, there would be the increased needs of the other railroads.

Mr. WIRTH. We could be talking about $325 million, $20 million on top of the $305 we just arrived at?

Mr. BARNUM. If you assume that none of the new cost increases in fuel were to be passed on to tariff increases, that is correct.

Mr. WIRTH. We heard from ICC about two rate increases coming up, one worth approximately $80 million and the second worth about $35 million.

Mr. BARNUM. I think that is approximately correct.

Mr. WIRTH. OK, they were assuming those rate increases in their figures?

Mr. BARNUM. The Penn Central was assuming the rate increases. The absence of the 7-percent rate increase cost the Penn Central at a rate of about $10 million a month.

Mr. WIRTH. We are really talking about what could be a very flexible figure, running from a minimum of $250 million, adding the 55 and 20 for fuel and rate increase assumptions, I mean it could be as much as $150 million more than the $250 million we originally talked about?

Mr. BARNUM. That is very fair. I must say I am quite mindful of your concern and that of other members of the committee about repeated requests for additional funds for Penn Central, and it would be easy for me on each occasion to come in with a big balloon figure and safely say I would never come back again. And it would be a big balloon. But I think it is better from your viewpoint and ours that we make as tough an analysis on each occasion as we can. Of course we have to recognize that circumstances might change.

Mr. WIRTH. One final point. I notice in Mr. Stafford's testimony he was talking about a loss to Penn Central of $340 million this year and it was corrected at the time of his testimony to $380 million, and there is a $40 million slip on the figure there. You know the skepticism on the figure and I don't know what we can do to pin it down on this hearing.

Mr. BARNUM. It is pretty tough. For example, it is snowing outside now and if it snows 4 feet, I am pretty sure the estimates we have of Penn Central's loss will be understated.

Mr. WIRTH. It seems to me there is something about the salary of the individual running this railroad, some controversy about his salary. Could you explain that?

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Mr. BARNUM. The only thing before the committee at the present time is the amendment in the Senate bill authorizing Amtrak to compensate its chief executive officer up to $90,000 a year instead of at the present ceiling of $60,000. That does not have anything to do with the Regional Rail Reorganization Act as such.

Mr. WIRTH. Do you think there is merit in the idea of awarding the man or woman running a system such as this on some kind of performance contract, if they meet certain deadlines or meet certain expectations they would be rewarded appropriately rather than setting a ceiling on their salary?

Mr. BARNUM. Indeed that is the way in which the board of directors of a corporation ideally should treat its senior executive. I think it would be very difficult for the Congress to set out a specific formula whereby the board of directors would be able to determine how much to award the president of Amtrak or the chief executive of Amtrak.

Don't forget, unfortunately we are not talking about a profit-making organization. The question with Amtrak is not how much of a profit they make, but how much support do they need from the Federal taxpayers?

Next year it will probably be in excess of $350 million. That is just in operating losses. In our judgment it is highly desirable to put Amtrak in a position to compensate its executives so as to be able to get the best executives in the railroad community to run Amtrak.

The question has been raised, "Why should he be compensated any more than the Secretary of Transportation?" I suggest that the position of the president or chief executive officer of Amtrak is a very different position than the position of Secretary of Transportation or other official of the Government. He is meant to be running a for-profit corporation although, in fact, it is not operating at a profit. ConRail will be a for-profit corporation and. consequently, there is no ceiling on the salary of its chief executive. But you can contemplate what we are talking about when you compare next year's predicted $350 million deficit at Amtrak and the proposed $30,000 increase in salary for the chief executive officer. Another difference is that it is desirable to retain Amtrak executives for a longer period than the average political appointee, which is around 2 years.

Mr. WIRTH. I agree there is a lot of symbolic value in it and I suggest if we put that kind of loan on an individual salary and it does seem to cause a lot of attention and interest, we might be able to say to an individual, say reward him inversely, not a profit sort of thing, but reward him if his company loses less money than we expect.

Mr. BARNUM. It ought to be run from the executive officer through the board on down, the way a for-profit corporation is run, with due consideration given to cost efficiency and profit levels, in my judgment.

Mr. WIRTH. Thank you, Mr. Barnum.

The CHAIRMAN. The gentleman from Indiana.

Mr. SHARP. Mr. Secretary, I wondered about the protection of the interests of the public on this subsidy. As I understand it, the subsidy we are asked to vote on now will be protected in the sense it automatically returns to ConRail; in other words, it becomes an asset of theirs?

Mr. BARNUM. That is corect. All of the funding that will be provided under section 215 will, in effect, be down payments for assets that will be acquired by ConRail, whether they are ties or rails or equipment

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to install ties or rail or rolling stock. To the extent section 215 money is used to improve the value of a strip of track, for example, the increase in value will inure to the benefit of ConRail and not to the benefit of the estate.

We would like to do the same thing to the extent possible with the funding provided under section 213. All of the funds spent under 213 are not susceptible to that recovery and it will be necessary that some be outright grants.

Mr. SHARP. I assume the previous subsidies from the Government are not the type for which recovery is made?

Mr. BARNUM. Under section 213, the first payment we made was $10.8 million to the Penn Central in respect of installments falling due in February last year for some rolling stock. That represents an equity interest that the Secretary of Transportation will transfer to ConRail when it starts up. The balance of the funds expended under section 213 were made available in the form of grants. Much of it was made available to perform specific tasks which, in turn, have improved the operating efficiency of the railroad. One such project I have in mind involved the Central of New Jersey and to the extent that the operating efficiency of the Central of New Jersey was improved by virtue of that grant, the Central of New Jersey now needs less funds to continue to operate.

Mr. SHARP. As I understand the answer you gave to one of the gentlemen earlier, it is envisioned that ConRail or it is hoped that it will operate without continuing subsidy from the Government, but will have loans to get it in a position of being profitable, and this, I assume, we can interpret as initially being a subsidy to ConRail?

Mr. BARNUM. It is in the sense it is a federally guaranteed loan, but it is precisely the same thing that the Surface Transportation Act contemplates for railroads throughout the Nation.

Mr. SHARP. Thank you very much.

Mr. Chairman, I would like to yield the balance of my time to Mr. Moffett.

Mr. MOFFETT. Mr. Barnum, you are a member of the USRA board?

Mr. BARNUM. The Secretary of Transportation is a statutory member.

Mr. MOFFETT. That board will be involved, I assume, in formulating the preliminary system plan that will be issued on February 26?

Mr. BARNUM. That is correct.

Mr. MOFFETT. There are various provisions in Public Law 93-236 for public participation all along the way and following the issuance of the preliminary system plan it is my understanding there is a 60-day period for public comment; is that true?

Mr. BARNUM. That is correct.

Mr. MOFFETT. And following the issuance of the final system plan later on in the year, there will be public hearings; is that correct?

Mr. BARNUM. The final system plan will be considered by Congress and the ICC will submit to the Congress a report on the final system plan.

Mr. MOFFETT. But there is no direction in the legislation for public hearings on the plan?

Mr. BARNUM. Not on the final system plan, sir.

Mr. MOFFETT. I see.

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Mr. BARNUM. Those hearings are on the preliminary system plan in anticipation of preparing the final system plan.

Mr. MOFFETT. I think it is safe to assume you favor public participation in this project all the way?

Mr. BARNUM. Very definitely and by individuals and States and by local organizations. This has been very helpful in the USRA planning process.

Mr. MOFFETT. I, like many other Members of Congress, am urging my constituents to take part in this and yet I wonder, if, in a sense, they are not facing a stone wall on some of the concepts and options that USRA supposedly is considering. I refer specifically to the idea of the Government taking over the roadbeds, and your statement this morning and Mr. Stafford's statement that you already are opposed to that option, the separate fixed plan entity option. You seemed to indicate earlier, if it were a separate corporation, it might be different, but I am talking about the Government taking over the roadbed. But in a sense then you are not going to be influenced, you say, by public comments.

Let's suppose there were a torrent of comment saying, "We want the Government to take over the roadbeds." You wouldn't be swayed by that?

Mr. BARNUM. There is a difference between listening and being persuaded, sir.

Mr. MOFFETT. What is your position? Is it firm on that?

Mr. BARNUM. The Regional Rail Reorganization Act mandated that USRA consider the formation of a for-profit corporation by exchanging all equity in the for-profit corporation for properties of the bankrupt railroads, specifically contemplating that one or more Con-Rails would be established to run a rail system.

Congress, in adopting that act, did not make any reference to the railroads. So construed narrowly, the mission of USRA is to carry out the responsibilities set forth for it in the Regional Rail Reorganization Act.

I agreed with the other members of the USRA Board that in addition to the strict mandate, USRA should indeed consider other solutions that may be available to present railway problems.

Mr. MOFFETT. It is true one of the options considered is a separate fixed plan entity?

Mr. BARNUM. That is true, but that can, of course, be a privately owned corporation just like the operating company can be.

The CHAIRMAN. The gentleman from North Carolina, Mr. Hefner, or, well, Mr. Brodhead.

Mr. BRODHEAD. Thank you, Mr. Chairman. I yield to Mr. Moffett.

Mr. MOFFETT. Thank you, Mr. Brodhead.

I would like to continue with this line of questioning a moment and I would like to pin down what is being considered in terms of the separate fixed plan entity. I have a feeling it is important in order to determine exactly what we are doing today and what we are considering to be consistent with that public law. Is there some consideration being given, not to a separate corporation, but to the Government taking over the roadbeds?

Mr. BARNUM. The question has been raised, but I do not think it is the appropriate way to solve the problem in the Northeast and I will oppose it.

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Mr. MOFFETT. But there is some consideration being given it?

Mr. BARNUM. The matter is being discussed.

Mr. MOFFETT. That is good. Now, as far as the RSPO is concerned. they have criticized, as I read the January 10 report, the preliminary views; they have criticized both the DOT, as I mentioned to Mr. Stafford, and you may have heard. Both DOT and USRA were taking too narrow a view of the goals of the act, not giving enough attention, for example, to environmental considerations, and by that I mean what the environmental alternatives to rail are—and there are environmental implications and—perhaps not giving a wide enough definition to profitability.

Would you like to comment?

Mr. BARNUM. That is their judgment. It is not mine.

Mr. MOFFETT. You disagree with it?

Mr. BARNUM. I do.

Mr. MOFFETT. Now, as far as the role of the ICC is concerned, this was raised again by Mr. Stafford. There seems to be some contradiction between what you said this morning and what he said this afternoon as far as the relationship between the rate requests being turned down and your contention that $30 million extra was needed because the rate increase was turned down. Do you care to make further comment on that?

Mr. BARNUM. I don't think Mr. Stafford disagreed with my conclusion that an additional $30 million should be included in the act to make up for the rate increase not being approved. I did not, in my testimony this morning, suggest that the ICC's refusal to approve the 7-percent rate increase is the reason we are here.

All I said this morning was that it increased the amount of funds that would be necessary for the bankrupt railroads to continue operating until such time as a rate increase is granted, if indeed it is granted at all.

Mr. MOFFETT. You don't feel there is contradiction between your testimony and his on that point?

Mr. BARNUM. No; I think we are entirely consistent in this respect.

Mr. MOFFETT. One final point, Mr. Barnum. Again I realize we are not considering this now, but it is being considered in the Senate and Mr. Wirth raised it and it deserves to be raised again, I think. Mr. Brinegar in a letter to Senator Magnuson indicated that that amendment relating to the Amtrak salary ceiling was justified and in his words the administration requested this measure for one good reason—that it will save money.

He also refers to it as an "anti-inflationary measure." Now, would you consider rail service to be an essential service, an essential public service?

Mr. BARNUM. Certainly some of it is.

Mr. MOFFETT. Would you say that one who is engaged in a management position in rail service could be construed to be engaged in public service even though it may not be paid for entirely by the Government?

Mr. BARNUM. I am sure you could. I am sure that many of the railroad officials of the Nation feel that their job day-in and day-out is a public service, and I agree with them.

Mr. MOFFETT. Well, it certainly happens, I would think, that people

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leave jobs in corporations, say to become schoolteachers and take pay cuts or leave jobs in corporations to go into local government and take pay cuts. Is this too much to expect from the new head of Amtrak or other Amtrak officials engaged in public service, that it is a buyer's market and there is a lot of talent in this country? Why do we have to have an unlimited ceiling and pay people $90,000 a year?

Mr. BARNUM. Because I don't think, in selecting the chief executive of a corporation that is currently losing $350 million of the taxpayers' money, we should limit the number of people who are available for selection as the chief executive officers to those that are so dedicated to public service they are willing to take a salary cut of 50 percent.

There is a management dictum you should pay an executive in accordance with how much a mistake he might make will cost and I suggest that if you followed that dictum in the case of Amtrak, $90,000 is a very modest sum.

Mr. MOFFETT. Thank you.

The CHAIRMAN. The gentleman from North Carolina.

Mr. HEFNER. I realize, Mr. Secretary, the importance of our railroads and how the collapse of Penn Central will affect my State. There are only a couple of questions I would like to ask.

Let me refer back to Mr. Wirth's question. You alluded to it, and you said that you had made a phone call on this during the luncheon hour. There is $20 million that this 1-cent tariff could effect; that is, 1 cent could effect a $20 million increase to Penn Central?

Mr. BARNUM. $20 million over and above the Penn Central estimate that was provided to us and which had been provided to the committee. Penn Central already had taken into account in its estimate the other $30 million which, in the course of a year, a 10-cent increase in the cost of fuel would cost the Penn Central.

Mr. HEFNER. You are taking this into consideration based on the fact that should the President's energy proposal go through Congress there could be 10 cents added onto fuel prices? Have you taken that into account in your proposal?

Mr. BARNUM. No; we have not included that $20 million in our proposal because it is our expectation the ICC would approve a rate increase sufficient to cover the increased cost of fuel as it did on the occasion of the oil embargo when fuel costs doubled overnight.

Mr. HEFNER. Have you taken into consideration also any inflation we may have for the remainder of 1975? If we have inflation that exceeds what you anticipate, will you be back sometime, say, in July or October, asking for more money for Penn Central?

Mr. BARNUM. We have attempted to take that into account and have, of course, taken into account the cost of wage increases. We have tried to fix costs as precisely as we can, that is, the cost of the ties and rails we would be buying, since we would contemplate placing those orders in the very near future. And to the extent that the cost of rails, for example, is tied to some wage increase increase in the steel industry or to some other cost increase, perhaps we would end up with fewer rails for the same number of dollars, but the program as such would still be a valid program.

Mr. HEFNER. That is my interest. I would like to know if what we are talking about here is hundreds of millions of dollars and if in 6

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months we will be talking about an additional $100 million. This is my first visit here to the annual Penn Central "pilgrimage," so to speak, and I would like some assurance that if we vote on this proposal, we will be through with it until at least next year.

Mr. BARNUM. I would like to be able to give you an ironclad guarantee in that respect, but I mentioned on earlier occasions we are proceeding on certain assumptions, such as a 7-percent downturn in traffic, and if the downturn exceeds that, our revenue assumptions will be too low.

There are other things that can affect the operation of the Penn Central, and I didn't mean to be frivalous when I talked about a snowstorm. A big storm could have a serious impact on Penn Central, just as the Agnes flood did. There are many ways in which the Penn Central economics could be affected. The automobile industry is a major contributor to the traffic of Penn Central, and if the automobile industry is turned around by virtue of automobile bonuses and that traffic downturn is turned back up, we will have a different situation.

These things are not within our control. All we can do is give you our best estimates today.

The CHAIRMAN. Thank you. I think everybody has had an option to ask questions of the Secretary. Is there anyone else with further questions?

The gentleman from Kansas has a question.

Mr. SKUBITZ. I have one question. Mr. Barnum, this morning during our discussion before we were rudely treated by my colleague who wanted to interrupt to ask questions, you had agreed that the claims of the creditors of the Erie Lackawanna were peanuts compared with the claims of Penn Central. Then you raised our interest on the question of the constitutionality of this question.

Now, I would like to explore that just a minute with you. I want to get your views on it because it disturbed me. I am hoping that the fellows representing URSA are listening, because I want them to rebut what you say.

Now, if there is a constitutional question involved by the taking in of the Erie Lackawanna, who is going to bring the action? What grounds is it going to be on and if it is an injunctive action of some sort, will it be based on just the inclusion of the Erie Lackawanna or will it be on the whole act or will it be against further planning by the USRA?

Mr. BARNUM. Your reference to peanuts this morning, Mr. Skubitz, was to the relative size of the Erie, I thought.

Mr. SKUBITZ. Not the peanuts, but let's get to the constitutional question you talked about.

Mr. BARNUM. I would like to clarify that, because what I was referring to at least was the size of the Erie Lackawanna and specifically the relative contribution of the Erie Lackawanna properties to the total reorganization process. I was not speaking of the claims of the creditors of the Erie Lackawanna, and when I talked about 2,800 route-miles and 11,000 cars and so on, as being roughly 10 percent of the size of the Penn Central. The point there was that the costitutional litigation that might result from including Erie Lackawanna as a railroad in reorganizational could jeopardize the whole ball game and I didn't want to see this Congress do it for the sake of what

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in our judgment is the relatively small contribution that would be made by virtue of being able to control the property of the Erie Lackawanna, as distinguished from merely designing it into the system and negotiating for it.

If you rewrite the act so as to make the Erie Lackawanna eligible to become a railroad in reorganization and, in effect, put them in with the railroads whose bankruptcy courts determine within 120 days after the act was enacted that they could not reorganize on a profitable basis and written 180 days after enactment determined they could effectively be reorganized under the act, what you have done is to open the door to resumption of constitutional litigation by the same people who in the Penn Central and other reorganization courts contended that the Regional Rail Reorganization Act was not constitutional, that it was not a uniform bankruptcy act as contemplated by the Constitution, and that it did not provide a fair and equitable process.

Now, a question was asked by Mr. Hastings earlier, I think a question I would like to have you focus upon. He asked:

If you amend the Act now to permit Erie Lackawanna to be treated as a railroad in reorganization, is it not more likely, if that addition were determined to be improper, that merely that amendment would be struck down as unconstitutional and the balance of the Regional Rail Reorganization Act would be left intact?

Yes, I think that would be the likely ultimate outcome if a court decided that the amendment was unconstitutional. But two points: First, I don't acknowledge saying that by amending the act at this time you will make the act unconstitutional. I say that any such litigation should fail.

But, second, what I am saying is that amending the act now to make the Erie Lackawanna a railroad in reorganization will give the creditors who attacked the act in the first instance another opportunity to attack it, to reopen the litigation, not just concerning the Erie Lackawanna, but concerning the Penn Central and how these Erie Lackawanna amendments will affect Penn Central and its ability to reorganize on a fair and equitable basis. The damages that the courts in those proceedings will enter injunctions, whether temporary injunctions or otherwise between now and the time the final system plan is submitted to Congress in July is such that I think the addition of the authority to control the Erie Lackawanna is simply not worth the candle.

We should recognize that USRA once was enjoined with respect to how far it could proceed, and if the court determined it would not be fair to permit USRA to submit a final system plan to the Congress for its consideration until the court had a full opportunity to examine the question of whether the act, as amended, gave the creditors, and not just Penn Central or Erie Lackawanna creditors, but all of the creditors, an opportunity to have their claims heard, you might find that the whole procedure under the act could be enjoined for 6 months or a year.

You see, in considering whether the act was constitutional the first time, the courts examined whether the procedures under the act were likely to be fair and equitable to the creditors and the Special Court, in particular, laid emphasis on the fact that in its judgment the act was constitutional for two reasons.

They said, first, there is a Tucker Act remedy available in the event the creditors are not adequately compensated by transfer of the

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ConRail stock. But the Court also said that the existence of the Tucker Act remedy in and of itself is not enough to make the act constitutional. Therefore the Special Court, a very erudite court and one that will pass on this question again, looked to see whether the procedure under the act and what it knew then as to the viability of ConRail created a sufficient likelihood that the creditors of the bankrupt railroads would get adequate compensation the first time, not by virtue of going under the Tucker Act, but by virtue of acquiring ConRail stock.

If we have to litigate the whole question again, whether the Regional Rail Reorganization Act, as amended, is likely to have a fair and equitable result for creditors, even if the court would conclude in the end, "Yes, it would," you have had months of litigation; and even if it concludes in the end, "No, it wouldn't by virtue of the addition of Erie Lackawanna" and, therefore, strike out only the part of the act which allowed the inclusion of Erie Lackawanna, and leaves the rest of the act standing, we would be many months down the road and in our judgment the possible advantage of controlling the Erie would not be worth the risk.

Mr. SKUBITZ. You are iffing the whole thing.

Mr. BARNUM. The whole thing is iffy and I suggest to you that if you amend the act to keep the Erie Lackawanna going throughout the process without treating them exactly like other railroads in reorganization, the USRA still is going to plan inclusion of Erie Lackawanna property in the system through its transfer to ConRail or other solvent railroads, and the only difference you have is that instead of giving stock for the property, you put the Erie Lackawanna to the job of negotiating the sale of the property.

Mr. SKUBITZ. The thing that interests me just a little, and maybe I don't understand it properly, that from Chicago clear into Youngstown or that area the Eire Lackawanna might be the best line to follow, rather than either one of the Penn Central roads.

Mr. BARNUM. Well, it is clearly duplicative.

Mr. SKUBITZ. If we do what you do, we would plan the whole thing and work in reverse.

Mr. BARNUM. I don't want to prejudge what the preliminary plan will say with respect to which Erie Lackawanna properties should be included in the preliminary system, and I think you should query USRA on this point when they are here, but I think it is fair to say very little of the Erie Lackawanna's properties will be needed for inclusion in ConRail, very little, and not the properties you mention from Youngstown to Chicago which are substantially a duplicate of the Penn Central mainlines.

There are three systems for that part of the country—Penn Central, Norfolk & Western and Chessie, and the Erie Lackawanna is not a necessary ingredient to a competitive rail system in that area.

The CHAIRMAN. Thank you. If there are no further questions, that is it.

Mr. DINGELL. I would like to ask Mr. Barnum a couple of questions. I think he made a very sensible statement when he inferred that it was his personal policy that the Erie Lackawanna ought to be kept out until closure. I would assume it is also the administration's position?

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Mr. BARNUM. That is the administration's position. It was arrived at by the Department of Justice, on the basis of the danger of litigation, and by the Department of Transportation, taking into cognizance the advantages and disadvantages of includnig it in a system of reorganization.

Mr. DINGELL. I specifically request of your drafting service to see that either the House or Senate bill is appropriately amended to assure that position is implemented.

Second of all, you indicated a potential substantial liability here and I would like you to indicate to us, not what is the bounds of it, but any reasons why we ought not just simply give DOT enough money to assure that the railroad will continue running through July 1 so that we can have a fresh look at it at this time with a little bit more careful preparation than we have had, because all of a sudden we came back here and were told to send Penn Central another $250 million, and you recall we heard this once before.

What is your view on that and how much would it take?

Mr. BARNUM. Well, I think it would be desirable to enact all of the provisions we have recommended to you.

You may have heard the questioning this morning concerning section 215 funds and how they would be used. The $300 million would be used to place orders for ties and rails and equipment which, if ordered now, would be available to ConRail when it comes into being. It is not money you are giving away to creditors of the bankrupts, but a down payment for the new ConRail system.

I think it is very desirable that we get started on that process.

Mr. DINGELL. You are suggesting we commence that forthwith?

Mr. BARNUM. I do, indeed.

Mr. DINGELL. What is the total amount, however, that would be necessary to carry it through July 1 in funds? I personally propose to limit this to July 1.

Mr. BARNUM. Well, if you limited it to July 1, what you would be talking about is merely what the cash shortfall of Penn Central would be between now and that time. We estimate that would require about $100 million. You would not be achieving for yourself the flexibility to make payments to Penn Central in respect of maintenance programs or the acquisition of equipment which the Penn Central should otherwise be making, but because we would be making them would relieve the Penn Central of a cash obligation.

I think if we address the question of what is the appropriate way to keep them going, we would have to make grants, but should also make other payments that would be available ultimately to ConRail. If you merely put more money on the table in the form of grants, you will never see a dime of it again.

Mr. DINGELL. That is the point that makes me apprehensive. If you please, what safeguards are needed to assure in legislation, either the House bill or Senate bill, that there be no fattening up of the residue of the estate to the advantage of the trustees and the creditors and to the disadvantage of the United States and ConRail? How much of an amendment is needed to the bill for this point and, if so what amendment is necessary, either the Senate or House bills, if you please?

Mr. BARNUM. We believe the language we submitted in the original bill which was introduced by the chairman and Mr. Devine meets that point. We think the language adopted by the Senate on this

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point would create confusion and is not as clear as you would want to see it for the proposition you urge. Therefore, we urge that you revert to the language in the House bill.

We have been discussing with representatives of the Penn Central certain modications of the language which would in our judgment achieve the same objective and we will submit it to you for your consideration.

It is important that it be crystal clear that none of the expenditures or none of the enhancements of property that are achieved by virtue of these expenditures inure to the benefit of the creditors. That is our purpose and we will supply any language you desire to achieve that end.

Mr. DINGELL. Throughout your testimony you referred to the potential Tucker Act liabilities of the United States. You have been referring to that as a potential and not as a device toward creating any legislative history or creating vested rights in Penn Central, Penn Central's trustees or creditors.

I assume we are in agreement on this because I want the legislative history of our announcements and pronouncements today to be very clear we are not moving forward with an eye toward having further litigation which will enrich the estate, at least this particular member—I am not looking forward to having this legislation moving forward to enrich the body of the estate to such degree that it would benefit the creditors beyond that which was already in the estate at the time that the estate went bankrupt.

Mr. BARNUM. That is correct, Mr. Dingell.

One moment this morning when you were absent from the Chamber, I was aksed a question as to the parameters of the Tucker Act liability by virtue of extension of the act and the act in its present form. I gave my opinion to the effect there was not any such liability and that the erosion that might be incurred is not something that ultimately should be borne by the taxpayers and that the difference between the going concern value of the properties as we expect they will be awarded to creditors in the form of ConRail stock would adequately compensate them for those properties and, therefore, there would not be a Tucker Act judgment.

Mr. DINGELL. I asked particularly for the fact we are creating legislative history. Now, with regard to the additional grants which will be made by amendment to the statute, so it will be clearly interpreted by the court if the matter comes into the hands of the courts, as it no doubt will.

Mr. BARNUM. Of course, the Tucker Act question arises only if the committee considers it desirable to put Erie Lackawanna into the system as a railroad in reorganization.

Mr. DINGELL. I think your point on that was eminently sensible, and it is a pleasure to have you before us.

Mr. BARNUM. Thank you.

The CHAIRMAN. Any further questions? If not, I want to thank you in behalf of the committee, and I thank you. You very well explained your part in this, Mr. Barnum. I want to congratulate you.

Mr. BARNUM. Thank you, Mr. Chairman, and I would like to thank you and members of this committee, to which I welcome so many new and obviously well-informed members.

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This is going to be a very difficult piece of legislation to mark up. It is very complicated, and I commend you for addressing it so promptly and urge you to keep it moving.

The CHAIRMAN. We will try to do that and thank you very kindly.

At this time we will have Mr. Arthur D. Lewis, chairman of the board of United States Railway Association, come forward.

Mr. DINGELL [presiding]. Mr. Lewis, if you will identify yourself and your associate at the witness table, we will be most pleased to receive your statement.

I would suggest that you file your entire statement, and we will receive your additional comments, or summary, as you might wish.

STATEMENT OF ARTHUR D. LEWIS, CHAIRMAN OF THE BOARD, U.S. RAILWAY ASSOCIATION, ACCOMPANIED BY JORDAN JAY HILLMAN, GENERAL COUNSEL

Mr. LEWIS. I am Arthur Lewis, chairman of the United States Railway Association, accompanied by our general counsel, Mr. Jordan Jay Hillman.

The fundamental issue we pose is that if Congress wants a competitive system of transportation in an area bounded on the west by Buffalo, extending down through eastern Pennsylvania, upper New Jersey, the New York metropolitan area, New York State, and to provide a competitive system of transportation from New England to the West, that it should give very serious consideration to including the Erie Lackawanna Railroad as a "railroad in the reorganization" under the Regional Rail Reorganization Act.

We do not believe that you can forecast the alternatives that might exist if the properties of the Erie Lackawanna are not subject to mandatory conveyance.

The Erie Lackawanna properties east of Buffalo are critical to establishing competition in that area and we do not see a control of the situation that is involved with a resolution of the assets of the railroad in the section 77 proceedings in the reorganization court.

We think, also, that if competition is desired and if it cannot be brought into being by a utilization of the assets of the Erie Lackawanna, that the potential effect on the profitability of the ConRail system can be substantial.

We also believe that the litigation which could take place during the period of planning is of such nature that it would be concluded by the time that our planning processes would be concluded, and that the likelihood of a delay in the planning process would be minimized.

On the other hand, if we present to Congress as a final system plan a system that does not provide competition in the area that I mentioned, we don't know what the alternatives would be and the delay in the process that might exist.

I am willing to accept any cross-examination you might have.

[Mr. Lewis' prepared statement follows:]

STATEMENT OF ARTHUR D. LEWIS, CHAIRMAN OF THE BOARD, UNITED STATES RAILWAY ASSOCIATION

My name is Arthur D. Lewis. I am chairman of the board of the United States Railway Association. I appreciate this opportunity to explain to the committee why the association now believes that the effective planning of a regional rail

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system makes it desirable that there be the opportunity for a judicial reclassification of Erie Lackawanna as a "railroad in reorganization" under the Regional Rail Act.

As the committee knows, when the Regional Rail Act was enacted, there were eight major railroads in section 77 proceedings in the Northeast/Midwest region. They were the Penn Central, Lehigh Valley, Central of New Jersey, Lehigh and Hudson River, Reading, Ann Arbor, Erie Lackawanna, and Boston and Maine. The Regional Rail Act provided for a review of the prospects for each of these section 77 railroads by its reorganization court and the special court. The purpose was to identify those that were to be reorganized under the Regional Rail Act and those that were to continue under section 77.

In each case, except for the Boston and Maine and the Erie Lackawanna, it was finally determined that reorganization would proceed under the Regional Rail Act. In those two cases the reorganization courts determined that their railroads could be reorganized on an income basis under Section 77 within a reasonable time and that their reorganizations should continue outside the Act. These determinations were not appealed to the Special Court and became final.

Since that time the Association's planning has been based on the premise that an Erie Lackawanna system separate and independent of ConRail would provide a kind of competitive balance within the region which came closest to what Congress was likely to require as part of any regional plan. In particular, Erie Lackawanna provides important access to major rail markets in Eastern Pennsylvania, Northern New Jersey and Metropolitan and upstate New York and New England. It links these markets with major markets and rail connections to the West, particularly through Chicago.

Erie Lackawanna's Trustees now consider that carrier no longer capable of reorganizing on an income basis within a reasonable time. In such case, the further possibility is presented of the liquidation of its rail properties on a piecemeal basis. The Association views this possibility with concern. If an independent Erie Lackawanna cannot serve in the competitive role we have envisioned for it, the Association may find it difficult to find effective alternatives absent the availability of its rail properties under the processes of the Regional Rail Act.

If the Committee wishes that I go into further aspects of the potential use of Erie Lackawanna's rail properties at this time, I could do so. In one sense, however, I feel under some constraints since the Association's Board has had no opportunity to reach any final specific determinations under the Preliminary System Plan of the most useful transfers of Erie Lackawanna rail properties. In general, however, if Erie Lackawanna is not capable of independent existence, our aim would be to link its major eastern markets to viable major mid-western gateways.

If arrangements cannot be negotiated with other independent profitable railroads, it would also be possible to transfer essential Erie Lackawanna rail properties to ConRail. Such transfers might increase the viability of ConRail as compared to the independent operation of Erie Lackawanna rail properties—whether by Erie Lackawanna itself or other railroads. Such added financial benefits to ConRail, however, could involve the sacrifice of substantial competition.

If the sacrifice of competition is conceived by the public and Congress to be too great, certain other devices can be created by the Association to increase competition, including the development of competitive options involving the Erie Lackawanna properties—or perhaps, in the extreme, to construct a new and separate rail system to that envisioned as ConRail to provide this competition on the Erie Lackawanna routes.

We are presently of the view that in reaching a reasonable balance among the goals of the Act, Congress in this situation would opt for the direct competitive use of Erie Lackawanna's rail properties. But if in fact the will of Congress is to the contrary and it prefers to resolve the balance in favor of added ConRail viability, that alternative would still be available given Erie Lackawanna's status as a "railroad in reorganization". In either case the Association thinks it essential, if Erie Lackawanna is unable to reorganize successfully on its own, to be able to include its rail properties within the conveyancing provisions of Section 303 of the Regional Rail Act.

Our conviction is based on what we understand to be the basic alternative legal consequences resulting from Erie Lackawanna's status either as a "railroad in reorganization" or as a "profitable railroad".

With Erie Lackawanna as a "railroad in reorganization" its rail properties can be fully integrated into a Final System Plan independent of the complex Section 77 approval procedures which would otherwise come into play. Conversely, if it is left as a "profitable railroad" under the Regional Rail Act, the

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disposition of its rail properties, as we understand it, is seemingly subject to initial ICC approval as part of a plan of reorganization, and then to reorganization court affirmation of that plan. Either approval phase, if subject to conflicting views of interested parties, could delay any decision considerably beyond the statutory time table for a Final System Plan. In such case the entire regional system could be subject to the uncertainties surrounding the ultimate availability of Erie Lackawanna rail properties. Indeed if that carrier, as a so-called "profitable railroad", remained ineligible for any adequate form of federal financial assistance under the Regional Rail Act and was truly incapable of independent reorganization, we might be faced with the forced liquidation of its rail properties. That process could include whatever property dispositions which might serve to maximize values available for the estate and its creditors—without regard to public rail service needs.

The Association, in viewing Erie Lackawanna's rail properties as important to the structuring of a sound and adequate regional rail system, is fully aware of the arguments which been made regarding the possible exposure of the government to increased Tucker Act liability. Basically, we fail to see how the inclusion of Erie Lacakawanna as a "railroad in reorganization" could substantially affect the matter.

First, it should be assumed, as we certainly believe will be true, that consistent valuation principles and methods will be used throughout. In such case, initial Tucker Act exposure without Erie Lackawanna, if any, should be increased, if at all, by roughly no more than the ratio that Erie Lackawanna's rail properties transferred under Section 303 bears to the totality of properties so transferred, including those of the vastly larger Penn Central system.

Second, we realize that it has been argued that the courts have upheld the Regional Rail Act because of a combination of a Tucker Act remedy and a "sufficient possibility" of ConRail viability. The basis for such views are found principally in Judge Friendly's Special Court opinion. I note also, however, that writing in dissent from the Supreme Court's decision, Justice Douglas seemed to premise his conclusions in part on his apparent belief that "all the parties" have conceded the lack of any prospect of ConRail's profitability. I would only add that the Association is not included among any such parties. In any case no one can say that "the possibility" of ConRail viability was wholly irrelevant to the judicial proceedings. However, we do not read the opinions of the Special Court, or of Justice Douglas, as being predicated on the particular factor of Erie Lackawanna's status under the Regional Rail Act. If this matter was considered at all, Erie Lackawanna's independent competitive role as a "reorganizable" railroad could only have been viewed at the time as a negative factor in ConRail's viability.

We recognize that litigation seeking to bring into issue once more the validity of the entire reorganization process of the Regional Rail Act is a possibility that could arise from any amendment. Such litigation would be possible in connection with amendments which have at least been suggested to confer on Erie Lackawanna the financial advantages of Sections 213 and 215 and Title V without imposing the conveyancing obligations of Section 303. But as to all such litigation, we believe the courts would focus on the validity of the amendment itself and not, once more, on the entire Act. The validity of the Act's reorganization processes have been fully litigated before the Special Court and the Supreme Court. They have been found to be "fair and equitable". They have been held constitutional. Let us suppose then that some demonstrable injury to certain interests could conceivably be proved to result from the possible reclassification of Erie Lackawanna, or any other carrier similarly situated, as a "railroad in reorganization". We would assume in such case that it would be the amendment, as the source of the injury, which would be enjoined, and not the entire reorganization process of the Act, which has already been upheld.

The Association has done its best to evaluate the risks of litigation with the risks of Erie Lackawanna going under with its rail properties free from the planning controls of the Regional Rail Act. It is our view that a possible delay in ultimate Congressional approval of a Final System Plan could be greater as a result of no amendment, given Erie Lackawanna's present status as a "profitable railroad", than possible temporary delays occasioned by further litigation, if any, in the wake of an amendment.

Moreover, we think it is important to keep in mind that the proposed amendment would not establish Erie Lackawanna as a "railroad in reorganization" by

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Congressional fiat. It would instead submit the issue for judicial determination in a manner much like the procedures previously upheld by the Special Court and Supreme Court. If the courts should disagree with the views of Erie Lackawanna's Trustees as to that railroad's reorganizability, then the matter is ended. On the other hand, should they concur in the Trustees' views, then for the reasons I have stated, the United States Railway Association thinks it important for Erie Lackawanna's reorganization to proceed under the Regional Rail Act.

Mr. DINGELL. Thank you very much.

The Chair will recognize my good friend and colleague, Mr. Skubitz.

Mr. SKUBITZ. You don't agree, Mr. Lewis, with the statement made by Mr. Barnum regarding the big constitutional issues that may be involved or the litigation. Is that right?

Mr. LEWIS. Well, I think that he indicated that the constitutional issues would be resolved favorably. We agree with that. We do not agree that it would be a long and time-consuming process in the disposition of the case.

Mr. SKUBITZ. Is it your feeling that by the inclusion here you are in a much better position to draw up a final system plan than you are by simply providing the existing law and then waiting to a later date to try to fit the Erie Lackawanna into your plan?

Mr. LEWIS. We think the only way we can be assured of the utilization of the Erie Lackawanna property is to have it come in. We don't think there is any process outside of the plan that will guarantee that, or even assure it.

Mr. SKUBITZ. That is all, Mr. Chairman.

Mr. DINGELL. Mr. Wirth.

Mr. WIRTH. No.

Mr. DINGELL. Let me inquire here, have you consulted chiefly, sir, with your legal counsel with regard to the potential liability of the United States under the Tucker Act if we include the Erie Lackawanna at this time, either to the creditors of Erie Lackawanna, or creditors of Penn Central or some of the other railroads in bankruptcy that are potentially includable in the plan?

Mr. LEWIS. Yes.

Mr. DINGELL. Perhaps the Chair could request his judgment on this.

Mr. HILLMAN. Mr. Dingell, we recognize all of the theoretical points which have been made, and trying to place them in a proper context we conclude that the inclusion of the Erie Lackawanna should not in any circumstances have any substantial effect on the total amount of a possible Tucker Act judgment.

Mr. DINGELL. Go ahead, sir.

Mr. HILLMAN. I was saying, Mr. Dingell, we conclude there should not be any substantial, significant effect on any possible Tucker Act judgment.

With respect to the first part of your question dealing with the Erie Lackawanna creditors and the possible incremental effect of a Tucker Act judgment, I would note the point that was made very effectively this morning, I believe by Mr. Skubitz, that given the relationship of the size of the Erie Lackawanna, whether it be by trackage, by employees, by any measure of value of rail properties, by total assets, to the Penn Central system and the other railroads in reorganization, that relationship in itself should suggest that the Erie Lackawanna is a relatively small factor.

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I think it can be safely assumed that the U.S. Railway Association in its valuation procedures and techniques will follow a consistent pattern in dealing with rail properties of all of the railroads.

So that the incremental effect of bringing the relatively small Erie Lackawanna system and its rail properties in part into the plan should be minimal with respect to any possible total Tucker Act judgment.

Now, with regard to any additional Tucker Act liability with respect to claims of creditors of other railroads, I believe it is very difficult to foresee any possibility of increased Tucker Act exposure. When the special court in particular considered the possibilities of ConRail profitability, it did so in the context of an independent Erie Lackawanna system which would provide important competition to ConRail.

Now, there are two ways in which the Erie Lackawanna rail properties, basically, can be used if it were a railroad in reorganization.

Either it can be used to assure the continuance of a competitive system, which should not further impact the earnings of ConRail, or, if it should prove necessary in the final analysis to bring Erie Lackawanna eastern properties in particular into ConRail, because of the lack of buyer, the result one would assume would be to increase the viability of ConRail, which would have the benefit of those longer hauls on its own system.

For these reasons it is difficult for me to perceive how the exposure, or the potential exposure of a government to a Tucker Act judgment, could be significantly affected, either with respect to Erie Lackawanna creditors or the creditors of any other estate.

Mr. DINGELL. Could I ask this question? Isn't it possible to accomplish the same end without bringing them in as a railroad in reorganization, just simply buying up pieces at Erie Lackawanna?

Mr. HILLMAN. No, sir. While I believe in theory it might be possible, I believe as a practical matter it could not likely be accomplished for this reason.

The Erie Lackawanna isn't like any other so-called profitable railroad, and I use the term as applied in the statute, in that before any transfers of rail properties from Erie Lackawanna as a profitable railroad can be made, they must be approved through the entire reorganization process under section 77 to which Erie Lackawanna is subject.

As we see it, this very likely involves the approval of the transfers as part of a reorganization plan by the ICC, subject to affirmation by the reorganization court.

At this time we have no understanding or no assurance as to what divisions or conflicts there might be among the various classes of creditors or equity holders on the Erie Lackawanna. We have no conception, except from past experience, as to how long it might take to complete an ICC approval of a plan of reorganization, together with the affirmation of any such plan by courts.

Our problem boils down to this——

Mr. DINGELL. The Erie Lackawanna is a subsidiary of a profitable railroad, are they not?

Mr. HILLMAN. Its stock is held apparently by a profitable railroad. What the value of that stock may be at the present time is difficult to tell, of course. But the road is being operated by its trustees.

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The problem, if I may say, Mr. Dingell, posed by your question, is this, and this is also what Mr. Lewis has referred to: That with this kind of delay in the disposition of the Erie Lackawanna properties, you may have this situation when the final plan is put into effect: first, that there has been no decision under the Erie Lackawanna reorganizations procedures as to how those properties can be transferred; second, Congress has approved a final system plan without those properties; third, the matter has come before the special court for valuation, and that valuation will include the value of the consideration going to all of the other creditors.

If the Erie Lackawanna properties should ultimately be disposed of in one way or another, it might be in a way which provided competition to ConRail, or it might be in a way that augmented ConRail's own earnings.

That factor at that time could not be taken into account by the special court because there could not be a completed regional plan. And that is one problem with which we foresee great difficulty.

Mr. DINGELL. Thank you very much.

Mr. SKUBITZ. Sir, do you think that a Chicago-Buffalo run of the Erie Lackwanna is an important part of a viable railroad system?

Mr. LEWIS. No, sir; not the entire distance. The distance from Marion, Ohio, to Buffalo is reasonably important to ConRail, but not critical. The only thing that is critical——

Mr. SKUBITZ. From Marion to Buffalo. We are talking about a little over half of it; is that right?

Mr. LEWIS. Yes, sir. Well, not in terms of total mileage, because there is extensive mileage throughout New York State and the New Jersey-New York area that is north-south. There is extensive mileage.

Mr. SKUBITZ. I see; that is right.

Mr. LEWIS. It is the carrier that gives a competitive balance to the northeastern part of the country. Without it, we don't have that. That is the critical element.

If Congress is willing to certify a final system plan that does not have that competition assured, then it can take this course. But if it is concerned about that, then to that degree of concern it should be concerned about this problem.

Now, I would like to say one thing more. There is nothing that says the reorganization court must sell this property to ConRail or to any other railroad.

If it goes on the blocks, it goes on the blocks to anybody who can use that property at any point for whatever purposes it wants to use it.

Mr. SKUBITZ. They can sell it to anybody else they want, but they would lose the benefit.

Mr. LEWIS. If it didn't go to the profitable railroad, the possibility there would be an arm's-length relationship and negotiation between the trustees and a profitable railroad during this planning process is remote.

The CHAIRMAN. The gentleman from North Carolina.

Mr. HEFNER. Just one question.

Do you have any interest or has anyone expressed any interest in buying the bankrupt railroad, Erie Lackawanna? Is there indication that anybody is interested in buying this railroad in the foreseeable future?

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Mr. LEWIS. No, sir, there is none at all.

The CHAIRMAN. I would just like to say that during the 1973 consideration of the act, we never considered at all anything about the Erie Lakawanna. It was never brought up for inclusion in that act at all.

I would like to know, has the USRA a recommendation on how this will affect the 10,000 employees of that railroad? Will we need to raise the title V funds if we include the Erie Lackawanna in the act?

Mr. LEWIS. As I understand, Mr. Chairman, the recommendation by the Department of Transportation is to include one way or another the employees in the protection provisions of the act whether they come in as a railroad in reorganization or not.

Now, as to the amount of money required, there is no way at this point to determine whether the amount would be increased by working with the Erie Lackawanna as a railroad in reorganization or not.

I cannot tell you that. But as I understand it, the provisions here that have been requested by the U.S. Department of Transportation would amend the act to provide that kind of protection in any event.

The CHAIRMAN. I would think it would be very important that the welfare of 10,000 employees should be looked about.

Mr. LEWIS. As I understand it, whether it is brought in as a railroad reorganization or left outside, according to the proposals of the Department of Transportation, the employees would be protected.

Mr. HILLMAN. If I might comment on that, if one can talk about the possibilities of litigation, I suppose we feel that our imaginations can lead us to see just as great a chance for a possibility of litigation in connection with the DOT proposal to confer on the Erie Lackawanna benefits under the act, such as 213, 215, and title V aid for employees, without imposing the obligations that go with the mandatory conveyances. Because in one sense it could be at least argued, and I am not stating this as a final position, but at least in one sense it could be argued that this, too, is a differential treatment of a single railroad unlike the treatment given to any other railroad.

And, we feel in line with your questioning that the surest way of putting the Erie Lackawanna employees in the same class as the employees of all other railroads in reorganization, would be to have it classified as a railroad in reorganization.

The CHAIRMAN. But if it is included into this act, I am sure that we would have to put in some more funds. And I think the employment of those 10,000 members should be protected one way or another.

The gentleman from Colorado has a question.

Mr. WIRTH. If we were to include the Erie Lackawanna, what would the annual cost to the Government be of that?

Mr. LEWIS. $25 million.

Mr. WIRTH. $25 million?

Mr. LEWIS. You are speaking of the interim period between now and the end of the year?

Mr. WIRTH. Yes.

Mr. LEWIS. I believe that that probably is a reasonable guess. It is predicated upon an upward trend of traffic in the last half of this year.

Mr. WIRTH. It would be in the ball park of $25 million?

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Mr. LEWIS. Yes.

Mr. WIRTH. As I understand it, the Erie Lackawanna is a subsidiary of a parent corporation.

Mr. LEWIS. Dereco Co.

Mr. WIRTH. Do you have any idea what the annual profits of Dereco Co. is in a given year?

Mr. LEWIS. No; I have not. But I know the Norfolk & Western has written the value of the common stock of this company off the books 100 percent.

Mr. WIRTH. I come from the State of Colorado, very distant from the concerns of the Erie Lackawanna, although I am sure a number of products from Colorado run on that railroad.

A number of people in my district would be concerned about the process by which the Erie Lackawanna can be spun off and then, in turn, subsidized by the Government at a time when the parent corporation is profitable. Isn't that a reasonable layman's question to ask?

Mr. LEWIS. The ability of a corporation to fail and have limited liability of the stockholders of that corporation is a fairly standard law. My general counsel here can talk to that.

Mr. WIRTH. Assume that is so. Are you convinced as the chairman of the board of the U.S. Railway Association that the process by which the Government allows this to happen and examines what goes on in the Erie Lackawanna is an adequate process? Do you think there should be changes whereby we look at a Penn Central or Erie Lackawanna to assure that there is as clear a break for the public as possible, or that we are not in a lot of various bookkeeping devices or monitoring and losing a great deal of money?

Mr. LEWIS. Yes, sir. We have not had as much time to study the Erie Lackawanna problem as we have the Penn Central, because we have been studying it for about 8 months in great detail. But the analysis we have made of the books convinces us that they have given us a conservative figure. It is not an optimistic figure.

Mr. WIRTH. I find myself looking at the Penn Central and Erie Lackawanna, and I am sure there will be a number of others coming up at which we are looking at very, very significant deficits.

I have a haunting feeling this is an area in which we ought to change jurisdictions from the ICC to FTC, perhaps, in terms of the way the stock is controlled, or ought to conduct a full-fledged investigation as to where the money is going in the railroads.

Would that make sense to you, in terms of sound public policy?

Mr. LEWIS. I would like to suggest that such public policy considerations start with our filing of the preliminary system plan and perhaps a final plan which does address itself to a greater extent to the whole problem of the rail industry in the United States and specifically to the problem of the carriers in the Northeast.

I think it can put the matter of additional law into some better perspective. But I certainly think that it is timely in this country that we address ourselves to the very serious problems of the interrelationships between all forms of transportation and the effect of public policy so negative against the rail industry. It is a very serious problem.

Mr. WIRTH. Thank you.

The CHAIRMAN. The gentleman from Kentucky, Mr. Carter.

Mr. CARTER. I thank the distinguished chairman.

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I will only ask about one question, since it is a pretty rough one.

You think public policy has been strongly against the railroads?

Mr. LEWIS. I think public policy has caused some of the real problems of the railroad industry. The rail industry has lost its competitive position in this country in the last 50 years, and one of the reasons causing this has been the effect of public policy. It has also contributed to the problems of bankruptcy in the Northeast.

Mr. CARTER. How do you account for the good position of Southern Railroad, for instance?

Mr. LEWIS. If you have an industry that averages a given rate of return on invested capital, you are going to find some by virtue of their route structure that will do better than others. And others by their route structure and other circumstances will do worse.

Actually, the Southern happens to be simply one of the finest managed companies in the country, but also happens to be managed in one of the fastest growing regions in the country.

It is located in an area that fortunately lost the Civil War and doesn't have excess trackage that is existent in the Northeast. It is a line that inherently has certain advantages. But among other things, it has an absolutely excellent management.

In the Northeast we have had problems in addition to management, problems that affect those carriers to a greater degree than the southern carriers and western carriers.

Mr. CARTER. Then you think inherent factors influenced Penn Central's bankruptcy more than its management; is that correct?

Mr. LEWIS. I would say underlying conditions were fundamentally more important, yes, sir.

Mr. CARTER. You think that probably public policy affected Penn Central; is that correct?

Mr. LEWIS. Well, public policy in conjunction with the fact that simultaneously you had rapid technological developments in other forms of transportation which in addition to public policy caused a major deterioration in the competitive position of these carriers.

Mr. CARTER. Wouldn't you agree there was very poor management of Penn Central?

Mr. LEWIS. During the period of its—yes, I will have to agree to that.

Mr. CARTER. Do you agree further that there is a great deal of spinoff from Penn Central into other areas, and from the core of the Penn Central area into other diverse developments, some of which were quite profitable? Isn't that correct?

Mr. LEWIS. I am sorry, I didn't understand the question, sir.

Mr. CARTER. Well, Penn Central itself or the Penn Holding Co., which was established, I believe, in 1847, has many diverse holdings, if I understand correctly, I think perhaps that they lost interest in the main investment and concentrated on others to the detriment of the railroad.

Mr. LEWIS. I don't think there was any question about that.

Mr. CARTER. Personally, I must say I feel it was extremely poor management that accounted for much of the difficulty there.

Mr. LEWIS. I cannot argue with that, sir.

Mr. CARTER. I am glad we agree with that. I didn't understand your statement at first.

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The CHAIRMAN. The gentleman from Connecticut, Mr. Moffett.

Mr. MOFFETT. Mr. Lewis, just for the record, since I asked the other two questions, how do you regard the RSPO's apparent unhappiness with the way that the USRA and the DOT have construed the original as a matter of fact?

Mr. LEWIS. Well, I think our construction of it, sir, is correct.

Mr. MOFFETT. How would you define profitability under the act in terms of the unprofitable branch lines that are being suggested, or by which it is being speculated?

Mr. LEWIS. Our basic formulas are to attempt to determine which of the branch lines develop incremental cash revenue sufficient to cover the incremental cash costs, and if they don't do that, then we believe that constitutes a test of viability. And we are currently dealing with the extent to which lines are brought into this system that do not meet what we would consider that test.

Mr. MOFFETT. I understand that.

Now, you are also familiar, I am sure, with section 206 of the act.

Mr. LEWIS. Yes, sir.

Mr. MOFFETT. It regards the final system plan. Section 206A8 speaks about the minimization of job losses and associated increases in unemployment and community benefit costs in the area presently served by rail service.

Now, I think that the House is going to approve something in the way of relief, because of this particular factor. I know in my district we can't afford to take a chance on losing rail service. But we can't afford it now and we can't afford it next year, either.

So, what I am asking you is, is it not conceivable that you can have a line on which there are factories that employ people and maintain jobs, but that under your definition could be construed as unprofitable, and if so, then what?

Mr. LEWIS. There are subsidy provisions in the act.

Mr. MOFFITT. I understand that.

Mr. LEWIS. Part of the criteria for which the subsidy would be used would be to cover the losses on branch lines on which the economic impact would be serious.

Mr. MOFFETT. How does the loss cover the economic impact if a factory is closed?

Mr. LEWIS. The States would join with the Federal Government to provide subsidies to keep the line in being.

Mr. MOFFETT. Do you think that the State capability of doing that, my State or any other, is adequate?

Mr. LEWIS. I am not able to pass judgment on the ability of the States to develop this program, although I will say that in terms of the total expenditures for the support of transportation facilities throughout the region, the added support for rail branch lines is de minimis.

On the other hand, in terms of the actual net profit for a ConRail or ongoing system, it is extremely important. There is sufficient subsidy money in the act, we believe, to cover the entire amount.

Mr. MOFFETT. If it could be shown there is not sufficient money and that plants are going to close if lines are abandoned, would you support amending the legislation to insure that we broaden the definition of profitability?

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Mr. LEWIS. What we would like to do is amend the legislation to provide an increased level of subsidy.

Mr. MOFFITT. Thank you.

The CHAIRMAN. Thank you kindly, Mr. Lewis, for coming and giving us the benefit of your views.

Without objection, the Chair wishes to place in the record, as though read, statements submitted by Congressman J. Edward Roush of Indiana and Joseph P. Vigorito of Pennsylvania.

STATEMENT OF HON. J. EDWARD ROUSH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. ROUSH. Mr. Chairman, I am grateful for the opportunity to present my views before this committee on the question of whether or not the Erie Lackawanna Railway should be included under the provisions of the Rail Reorganization Act of 1973. It seems to me that there are two important aspects of the question.

(1) Is the inclusion of the Erie Lackawanna essential to the economic well-being of the considerable area served by the Erie Lackawanna?

(2) Will the continued operation of the Erie Lackawanna facilities under the terms of whatever system is finally proposed as ConRail contribute to the economic viability of the ConRail system?

The second of these questions is easiest to deal with.

Of the seven bankrupt railroads initially listed in the Rail Reorganization Act of 1973, the Erie is the second largest both in terms of miles of road operated and in terms of operating revenues. Erie trackage totals 2,979 miles and represents 5.5 percent of all rail trackage in the 17-State northeastern region and 1.4 percent of all rail trackage in the United States. Erie operating revenues represent about 2 percent of the total for the country.

In the Northeast region, when all systems are considered, Erie ranks fourth behind Penn Central, the Chessie System, and the Norfolk & Western in terms of miles of trackage operated. It is difficult to imagine a viable plan for the Northeastern rail system which does not include the Erie Lackawanna as a major part.

Congress recognized this in 1973 when the Erie Lackawanna was designated for inclusion in the basic reorganization of bankrupt railroads. It might be tempting to suggest that since the management of Erie Lackawanna were eager to prevent the Erie from being included under the act less than 1 year ago, we should not be too anxious to include the Erie Lackawanna now. Such an argument would be, essentially an argument that the Erie should be penalized for attempting to reorganize on its own. Frankly, I believe that the entire system of rail transportation in the Northeast would have been improved if the Erie Lackawanna had been successful in its attempts to reorganize under Chapter 77 of the bankruptcy regulations and had emerged as a strong private carrier capable of complementing and competing with ConRail. It now appears that this will not be the case. However, this apparent failure to successfully reorganize should not be the occasion for losing the assets of the system and the economic benefits brought to Indiana, Ohio and New York by the operation of the Erie Lackawanna facilities.

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I think it is quite probable that certain segments of the Erie system will be declared unprofitable after analysis by the United States Railway Association. It should be pointed out, however, that we will not have the benefit of this analysis until the Erie Lackawanna is included under the system.

Finally, let me turn to the economic well-being of the area served by the Erie, and in these remarks I shall concentrate on my own district, the Fourth District of Indiana; and I shall begin with comments about my own home town, Huntington.

There is located in Huntington two major industries that depend on the service provided by the Erie Lackawanna. The Majestic Co., a manufacturer of furnaces and other home heating equipment, depends on the Erie Lackawanna for shipment of products and for receiving materials used in its manufacturing operations. It is fair to say that Majestic would be damaged, perhaps critically, if the Erie was not there for shipping and receiving.

There is also a large religious publishing company. Our Sunday Visitor, which depends on the Erie for shipments of the paper used in its operations. Its costs would rise significantly if an alternate source of transportation had to be found. There are numerous smaller examples in Huntington alone.

In addition, 200 to 300 employes of the Erie Lackawanna reside in my district. In times of high unemployment, it is almost intolerable to think of adding 20 or 30 people to the jobless roles. An additional 200 or 300 is out of the question.

The Erie Lackawanna is also utilized by numerous grain elevators, in business to funnel the corn and wheat and soybeans produced in northeastern Indiana to major grain marketing centers where the products can be added to our Nation's food supply or exported to improve the Nation's trade position. While the crops would still be grown and the grain shipped without rail service, the increased cost of transportation would, in the end, result in a pressure to raise the price of food on grocery store shelves and reduce the competitive position of American grain in international markets.

In consideration of the importance of this vital transportation resource to my district, the northeastern region of the United States, and ultimately to the Nation, I urge that the inclusion of the Erie Lackawanna Railway, under the provisions of the Rail Reorganization Act of 1973, be approved.

Thank you, Mr. Chairman.

STATEMENT OF HON. JOSEPH P. VIGORITO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. VIGORITO. Mr. Chairman, I urgently request the adoption of the legislation to incorporate the Erie Lackawanna into the Regional Rail Reorganization Act.

In my testimony I intend to explore the following: the legal considerations involved in the proposed amendments to section 207(b) of the 1973 act, the urgent cash need of the Northeast railroads; the impact of recession on recovery of the Erie Lackawanna, and the possible human suffering if there is dissolution of any of the Northeast railroads.

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As you are aware, there are several legal issues which have been raised about the proposed amendments to the 1973 Rail Reorganization Act. It is my understanding that the Erie Lackawanna Railway Co. attempted to reorganize under section 77 of the Bankruptcy Act. However, because of serious cash-flow problems caused by the deepening recession, Erie Lackawanna has found it no longer possible to reorganize under section 77 of the Bankruptcy Act. Now the Erie Lackawanna has only two alternatives. One, it can go bankrupt; or two, it can be incorporated under the Rail Reorganization Act. The second alternative, which is the only acceptable one, however, requires that the Congress amend Section 207(b) of the 1973 law so that the Erie Lackawanna can be restored to the status of "railroad in reorganization," which is necessary for the continued operations of essential transportation services. It is clear that the Erie Lackawanna is no longer a profitable railroad and should not be expected to operate as one, and indeed cannot continue to long function as one.

One of the critical reasons for this legislation is to help ease the urgent need for cash to continue the minimum standards of railroad delivery systems. For example, at present the Erie Lackawanna is only making such repairs that are absolutely necessary to keep the rail cars operating. In the last year Erie Lackawanna's percentage of main line under "slow orders" has increased from 3 percent to more than 20 percent, which means that Erie Lackawanna is in imminent danger of falling into total disrepair. We in Congress must insure adequate delivery systems of our marketable goods. One way to insure this in the Northeast is by upgrading the Erie Lackawanna into a truly serviceable railroad, once again.

Finally, I believe that we in Congress must consider the human suffering that will occur if we do not take the action presently pending before this committee. The Erie Lackawanna estimates that 10,000 of its employees would be added to the unemployment rolls if it is not incorporated into the rail reorganization. It should be remembered that the maximum railroad employees receive in unemployment compensation is $63.50. Also, within a few days following dissolvement of the railroad, additional layoffs would occur affecting the employees of shippers who formerly used the Erie Lackawanna. Surely, we have a public responsibility to the people who work for and are served by the Erie Lackawanna to avert the tragic impact of the tremendous job loss which would occur if this railroad failed.

In closing I would like to relate that my District has been greatly impacted by the present curtailment of Erie Lackawanna services. Erie Lackawanna has closed its principal car repair facility at Meadville, Pa., which has created extreme economic suffering in that community. As a result, I appear here to seek your expeditious and positive consideration of the legislation presently before the committee.

The CHAIRMAN. That concludes the session for today. The committee will stand adjourned until 11 o'clock tomorrow morning.

[Whereupon, at 5 p.m., the committee adjourned to reconvene at 11 a.m., Wednesday, February 5, 1975.]

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EMERGENCY ASSISTANCE TO NORTHEAST RAILROADS

WEDNESDAY, FEBRUARY 5, 1975

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The committee met at 11:50 a.m., pursuant to notice, in room 2123, Rayburn House Office Building, Hon. Harley O. Staggers (chairman) presiding.

The CHAIRMAN. The committee will come to order.

We will start in with our witness this morning, the Honorable Robert W. Blanchette of the Penn Central Transportation Co., and Charles A. Horsky, counsel for the trustees. Is that all you have with you?

Mr. BLANCHETTE. I can introduce my entourage. Seated at my immediate right is Mr. Jervis Langdon, president of the railroad. At his right is Mr. Paul Duke, the general counsel of the railroad. At my immediate left is Mr. Ernest R. Varalli, our assistant vice president in charge of the budget and the forecast, and on his left is Mr. Charles Horsky, special counsel to the trustees.

The CHAIRMAN. All right, sir, you may proceed.

STATEMENT OF ROBERT W. BLANCHETTE, TRUSTEE, PENN CENTRAL TRANSPORTATION CO., ACCOMPANIED BY CHARLES A. HORSKY, COUNSEL FOR THE TRUSTEES; JERVIS LANGDON, PRESIDENT; PAUL DUKE, GENERAL COUNSEL; ERNEST R. VARALLI, ASSISTANT VICE PRESIDENT; BUDGET AND FORECAST

Mr. BLANCHETTE. Mr. Chairman and members of the committee, it has been suggested, sir, with your leave, that I deposit my testimony of record and that I summarize it in the interest of time.

The CHAIRMAN. If you would, that would be fine with the committee [see p. 174].

Mr. BLANCHETTE. We appreciate the opportunity to be here, sir, and our testimony deals with three points. The first point is the immediate short-range cash outlook for the Penn Central, and the necessity in the absence of any outside assistance, to begin an orderly cessation of operations in the middle of this month. The inability to meet the payroll at the end of the month is what creates this imminent cash shortfall.

We are, sir, as I am sure everybody realizes, judged on only the basis of hindsight. And if on February 25 the railroad must stop because our employees are not paid, and we have not taken precautionary measures to avoid vandalism, to avoid cars being stranded

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throughout the 20,000 miles of our system, we will then have been judged to have been reckless and irresponsible with the property of the estate.

The second point, sir, deals with the cash outlook for the railroad between now and the first quarter of 1976 when it is anticipated that ConRail, or the final system plan, will come in operation. I am going to revise my testimony slightly as a result of the figures that we received from the Department of Transportation's testimony. I am going to revise it in a way that they are compatible.

The Secretary of Transportation has projected that the railroad will suffer deficiency in cash through the first quarter of 1976 of some $252 million. When we wrote our testimony it was on the basis of the Senate testimony of the DOT, and as we read Mr. Barnum's figures yesterday, that figure of $222 million in our testimony appears to be $252 million. But there are several very important qualifications to this.

First, unlike Mr. Barnum, our figures, and they have been verified, show only maintenance and repair at the 1974 level of operations. There is no $25 million in there to improve the northeast corridor, not a penny to improve anything. It just keeps the railroad operating to meet its payroll and its fuel costs, and there is very, very minimal maintenance.

Second, the $250 million figure does not represent $50 million in Government guaranteed trustees' certificates which mature in January of 1976. We have no present ability to pay those trustees' certificates when they become due. We are not very attractive on Wall Street for refinancing. If we don't meet those payments they become a direct obligation of the United States. So, that price tag is there, whether any of us like it or not.

In addition, as this committee is aware from yesterday's testimony, the Interstate Commerce Commission suspended a proposed 7 percent rate increase which our projections had said would start being realized in April. For every month beginning in April under our figures, for every month that rate increase remains in suspense, we will have an additional cash shortfall of $9 to $10 million a month.

Adding these things together as best I could, and assuming that the suspension of the 7-percent increase lasts for 5 months, our figures, when reconciled with the Department of Transportation figures, show a shortfall over this period of time of $530 million.

The CHAIRMAN. Over what period of time now?

Mr. BLANCHETTE. Between now and the end of the first quarter of 1976. I want to emphasize one sentence in my testimony when I give that figure. All long-range cash forecasts are subject to the possibility that future events may make them unrealistic in either direction. The U.S. Railway Association, the Department of Transportation, have sent auditors to verify these figures and they have told us we are optimistic. When you are going to lose $350 million over a period of time, you can afford to be modestly optimistic. That kind of a crystal ball that far away can never be considered an ironclad guarantee.

The last point contained in our testimony deals with the terms and conditions which would be imposed under H.R. 2051. In summary, those terms and conditions which apply not only to improvement moneys under section 215, but also as well could apply to grants under section 213, result in a heads I win, tails you lose proposition.

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The conditions in H.R. 2051 boil down to this: if money is spent to do the ordinary repair and maintenance of the railroad under those conditions, the estate can never be compensated for more than the value of those properties at that time taking into account their physical condition. And any increase in value, not because of the improvement but because of inflation, because of scrap prices being higher, or for any reason completely unrelated to the investment the Government has made, can never be recouped by the estate. Conversely, any decrease in value because of a recession or a depression or a drop in scrap prices, or a drop in land values, any decrease is taken off the estate. The estate only gets valued at the time of the conveyance for any decrease in value. But it can never get anything upside, even though the upside increase in values is unrelated in any way, shape, or form to the improvement that was made by the section 213 or the 215 investment.

Now, we are not anxious or desirous or in any way suggesting that the Penn Central be paid twice or any estate be paid twice for an investment which is made by somebody else. Section 215 already purports to serve that goal with a don't pay twice provision. We have no objections to provisions which would further insure against that possibility.

There are two ways of doing it. The first way is to take subsection (B)2 of section 215 and make that the same clause as obtains in subsection (B)1. That merely says you will never be paid that portion of any sale to ConRail or to anyone else which reflects value attributable to the maintenance and improvement provided pursuant to the agreement. In other words, there is a link to the increase in value, and where the increase in value is attributable to the increase made, nobody is going to claim it.

Now, there is another way of doing it. That was done in the Senate version of this same bill. That says that the corporation will never have to pay any portion of the value which is attributable to the maintenance or improvement performed pursuant to the agreement. It then goes on to say the association, meaning the U.S. Railway Association, and the Special Court, shall in determining value pursuant to section 303 of the act, take into account the physical condition as of the effective date of the agreement to improve the properties.

Let me go on to say, sir, we don't know whether the section 215 amendments, even as modified or amended, will work. We don't know how they will be implemented. They have one basic fault: they destroy the symmetry of the original reorganization act. That symmetry contained section 213 which is what I call "keep it alive money", payroll, diesel fuel, ordinary repair and maintenance.

Aside from that was section 215 which the Congress said should be used to do things over and above the ordinary repair and maintenance of the railroad. These amendments destroy that and purport to use section 215 not to improve or rehabilitate or do things over and above the normal level of maintenance, but to do the ordinary programed maintenance of the railroad. As a result, they treat ordinary repair as a form of investment.

Whether this will work, Mr. Chairman, I cannot tell you. I can only tell you we will do the best we can to engage in responsible and sensible agreements with the Department of Transportation. We will submit

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them to the courts, and if everybody acts reasonably in the premises, this use of section 215 may work. If it does not, we are still confronting the same $350 million gap.

I think that concludes my summary, sir, thank you.

[Mr. Blanchette's prepared statement follows:]

STATEMENT ROBERT W. BLANCHETTEE, TRUSTEE, IN BEHALF OF THE TRUSTEE OF THE PROPERTY OF PENN CENTRAL TRANSPORTATION COMPANY, DEBTOR

Mr. Chairman and members of the committee, we are most grateful that the Committee has scheduled its first hearings of this Congress on this measure. The railroad's cash situation must be resolved quickly or it will be unable to continue operating.

This presentation consists of two parts. First, we shall spell out both the present and prospective cash situations of the railroad. We shall then turn to the proposed DOT Amendments to the Regional Rail Reorganization Act of 1973.

The railroad's cash position is the first point. At the time the Act was passed, there was great concern whether Section 213 would be adequate to fund the transitional period before Conrail was formed. The coal strike last fall and the continuing fall-off in the economy, particularly the slump in automobile production, made it inevitable that the railroad would be in a cash crisis beginning in December 1974. As soon as we had quantified the dimensions of the problem, we brought the facts to the attention of the Department of Transportation. On November 20, we told the Department that the only self-help measures we could institute would be an immediate large scale lay-off of employees and a drastic cut in purchases of materials. Even then, the railroad would not be able to pay any increase in wages resulting from industry-wide bargaining negotiations: when these negotiations are concluded, the wage increases will become effective as of the first of this year. Because the employee furloughs and the cut in purchases would have seriously undermined maintenance programs, the Secretary requested that we defer these programs, and we did so.

Since then a cash crisis has been postponed only through the full cooperation of the Department of Transportation in making available substantially all of the money presently authorized and appropriated under Section 213. Of course, we have taken every possible step available to us to stretch our cash resources as far as they can go—from obtaining advance payments from Amtrak to deferring the payment of current bills. In January, we suffered a cash drain of about $2 million a day. Because DOT grants were used to make up the difference, we have exhausted the funds under Section 213. And, because we agreed to defer our self-help measures, we have passed the point where they could be implemented in time to be of help. At the end of February, the railroad will face a payroll of more than $14 million. Without outside cash assistance it will be unable to make those payments. We shall not ask our employees to go on working for nothing because realistically and morally, we do not see why they should.

If no assistance is available, this is what we will have to do: in mid-February, we will anounce that on a specific date in the future, probably February 18, the railroad will begin to decline accepting shipments for future delivery. Then, on or about February 25, the railroad will cease operations altogether.

The announcement is necessary so that shippers can prepare to make other arrangements wherever possible after the cessation date and so that undelivered goods will not be stranded at various points on the railroad. An unannounced, sudden shut-down would cause even greater disruptions.

This is a very unpleasant prospect for everyone. Of course, the railroad could always lift the embargo if cash later became available. However, the cash drain will be greatly magnified as a result of diversion of traffic that will necessarily take place once the announcement is made. We believe that publication of the announcement should be avoided if Congress can make that at all possible.

We now turn to the longer term cash outlook. The Secretary of Transportation has projected that the railroad will suffer a deficiency in cash through the first quarter of 1976 of some $222 million. There are several qualifications to that figure, one very recent. First, this sum reflects a railroad operation with maintenance and repair at basically the 1974 level. It contains no improvement or

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rehabilitation programs. Secondly, it does not assume any additional cash losses as a result of embargoes or even a temporary shut-down. In addition, it excludes $50 million in Government-guaranteed Trustees' Certificates which become due and payable in January 1976. These Certificates will become obligations of the United States if they cannot be re-financed. Finally, last week, the Interstate Commerce Commission suspended a 7 per cent rate increase proposed by most of the nation's railroads. Our projections had anticipated this increase going into effect beginning in April. This means a further reduction in cash of between $8 and $10 million per month during the time that the suspension is in effect. Due to these factors, the amount specified by the Department would not appear to be sufficient—by an amount in the order of $100 million—to maintain Penn Central operations through the first quarter of 1976 when Conrail is anticipated to become operational. We must add, finally, that all long-range cash forecasts are subject to the possibility that future events may make them unrealistic in either direction.

We now turn to the proposal of the Department of Transportation. That proposal contains terms and conditions that would preclude the railroad from taking full benefit of the assistance program, and would thus simply fail to resolve the cash crisis.

The difficulty with the legislation lies in the new conditions which it imposes upon the use of money authorized under Section 215, and under certain circumstances, under Section 213 as well. As Section 215(b)(1) would be amended, any agreement to use funds—to perform program maintenance, to improve rail properties, and the like—is subject to this condition: when the property involved is transferred to Conrail, Conrail is not obliged to compensate Penn Central for any portion of the value of the properties "in excess of the value of such properties determined on the basis of their physical condition as of the effective date of the Agreement."

This would mean that any increase in the value of property which might occur, not by reason of the Section 215 expenditures, but, for example, by reason of normal appreciation in values, would be forfeited if the railroad were to agree to use Section 215 funds.

On the other hand, if the property were to decrease in value after the Section 215 expenditure was made, for reasons equally unrelated to that investment, the estate would get only the lower value.

This is a heads I win, tails you lose proposition. As Trustees we would be unable to recommend to the Reorganization Court that the estate risk such a forfeiture. Further, we believe that the Reorganization Court could not approve any such Agreement. In short, if the Department's Bill were passed as written, the funds which would seem to become available to Penn Central under Section 215 would in fact not be available.

This problem is aggravated by reason of the fact that under the proposed Amendment, the same conditions may be imposed on grant monies. It is true, of course, that in Section 213 this limitation must be agreed to by the Trustees, but we can anticipate that an effort will be made by the Department of Transportation to structure as many Section 213 grants as is possible in this way. In that event, this legislation would not help Penn Central at all and the cash crisis would persist.

We believe the Amendment has invited these difficulties by failing to recognize that there are two very separate cash problems. The first is the lack of working cash to keep the railroad in operation. The second is the lack of cash to make capital-type of improvements necessary to rehabilitate the railroad.

The present Act makes that distinction. Section 213 addresses itself to the lack of working cash through the vehicle of grants. The only condition imposed is an assurance that the level of service be maintained. Section 215, on the other hand, provides funds for what are, in essence, investments in the future of the railroad. The condition imposed there is the very legitimate one assuring that the bankrupt estate not be paid the value of an investment made by others. We believe that this separate treament of the two different problems is sound and should be preserved.

The fault of the proposed Amendment is its attempt to convert an operating subsidy into a form of capital investment. The railroad's working cash shortages stem from a variety of sources: wages, fuel costs, transportation expenses, and ordinary repair and maintenance. All are necessary to keep the railroad operational during the transition to Conrail; they benefit the public convenience and necessity, not the estate or its owners. Some of these expenses leave nothing

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behind of a tangible nature after they are made; fuel is consumed, wages are paid out. Other expenses do; a broken rail is replaced, a defective engine is repaired. But they are all ordinary operating costs, not investments. To pick and choose among them and then determine which should qualify for Government assistance is a counterproductive effort.

It is also an effort which could lead to fatal delays. The railroad's programmed maintenance is current and on-going. It would simply not be possible, as the amendments contemplate, to settle upon the value of rail properties to be maintained "on the basis of their physical condition" at the time agreements for the next few months are reached. On this score alone, there would be prolonged litigation while the job waits to be done.

We have, therefore, great difficulty with the new condition imposed in Section 215(b)(1), especially if that condition is expanded to cover operating costs. This does not mean that we oppose the legitimate claim of the Government that when it has invested in capital expenditures, it will not pay a second time. We have no objection to provisions which would insure against that possibility. Indeed, there is a very simple method by which this can be done—adopt in Subsection (b)(1) of Section 215 the language of Subsection (b)(2). In the latter Section, the bill proposes that in the event of a transfer—not to Conrail but to a profitable railroad—of property on which money has been spent under Section 215 then that portion of the proceeds of such a sale "which reflects value attributable to the maintenance and improvement provided pursuant to the Agreement" shall be returned to the Secretary.

That seems entirely appropriate. It does not suggest that the Government may take credit for any appreciation in value unrelated to its investment. It merely requires an appropriate allocation of whatever value has been added so that the Government does not in effect pay twice.

This problem was resolved in the Senate by a change in the language of Subsection (b)(1) which we believe eliminates the problem. As passed by the Senate, that Subsection reads: "(1) the Corporation shall not be required under Title III of this Act to compensate a railroad in reorganization for any portion of the value of the properties subject to the Agreement and designated under the final system plan for transfer to the Corporation which is attributable to the maintenance or improvement performed pursuant to the Agreement. The Association and the special court shall, in determining value pursuant to Section 303 of the Act, take into account the physical condition as of the effective date of the agreement . . . ."

If Section 215 retains its present objective—the funding of capital improvements—it would not alleviate the railroad's working cash problem. The $222.1 million cash deficiency to which the Secretary has referred is only the shortfall in the railroad's ability to meet operating expenses. That figure does not cover the problem of rehabilitating the railroad or performing maintenance over the levels of 1974. Again, we believe that Section 213, without new conditions, should be the vehicle for dealing with working cash problems.

The CHAIRMAN. We will have to go, and we will have to come back later after lunch for the questioning.

Mr. ROONEY. I wonder if all of the members of the committee could get a copy of this testimony prior to coming back here, so they can peruse through it?

The CHAIRMAN. I believe it could be delivered to their offices, could it not? The ones that are here, of course, have a copy.

The committee will adjourn until 1:30.

[Whereupon, at 12:05 p.m., the committee recessed, to reconvene at 1:30 p.m., the same day.]

AFTER RECESS

[The subcommittee reconvened at 1:30 p.m., Hon. Harley O. Staggers, chairman, presiding.]

The CHAIRMAN. The gentleman from Nebraska.

Mr. MCCOLLISTER. Is it the intention of the Chair we hold a markup session tomorrow?

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The CHAIRMAN. If possible.

Mr. MCCOLLISTER. Would it not be possible, since the House will have only a pro forma session, to begin this afternoon to try to establish a quorum for tomorrow?

The CHAIRMAN. If we could, yes. I think it is a good suggestion.

When we adjourned at noontime Mr. Blanchette was before the committee and had given his testimony and was open for questions. I have perhaps one or two things.

How much money would you need to go through June 30, 1975?

Mr. BLANCHETTE. Before the liability for increased wages as a result of an industrywide settlement that will become retroactive to January 1, 1975, we will need $58 million. Now, at some point there will be a wage increase for our employees. And after that agreement is entered into, then it must be processed and the timecards and payroll cards processed, so that our estimate is that at least by June 30, 1975, that wage increase will be implemented. Therefore, to cover the wage increase, the figure is $106 million.

The CHAIRMAN. $106 million.

Mr. BLANCHETTE. Will keep the railroad operational through June 30, 1975, on its 1974 level of maintenance and repair, as best we can estimate.

The CHAIRMAN. $106 million to keep it operating until July 1 of this year?

Mr. BLANCHETTE. Yes.

The CHAIRMAN. On the same level as 1974 service. All right. I read your testimony and, of course, heard you when you were here, and understand that you had induced the Senate to change some of their language on 213(b), I believe.

Mr. BLANCHETTE. Yes.

The CHAIRMAN. I don't know what this committee will do. We will take it under consideration, of course, when we get into markup. We hope to have that marked up tomorrow morning if it is possible.

Now, I have no further questions at this time because we have heard the testimony of the Department of Transportation and also the ICC. But I just wanted to know what your opinion was of how much you would have to have until July 1 of this year, which would be $106 million.

Now, until the 31st of December, what was that?

Mr. BLANCHETTE. To December 31 of this year?

The CHAIRMAN. Yes, sir, through December 31.

Mr. BLANCHETTE. As near as we can estimate, $180 million would——

The CHAIRMAN. Would take you through——

Mr. BLANCHETTE. December 31, 1975. In that we assume, sir, that the ICC will give us a 12-percent rate increase on September 1, 1975. That was part of our original forecast for the year. In other words, our forecast for the year, I realize this is painfully difficult and not very interesting, but our forecast for the year assumed a 7-percent rate increase which we would begin to benefit from in April. We then had an additional 5-percent rate increase beginning September 1, 1975.

The Interstate Commerce Commission has suspended the 7 percent, and we are assuming as a matter of just crystal balling, that at some point we will get additional rate increases. And if we do, and if they are effective September of 1975 on a basis of a 12-percent increase—

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namely the 7 that was canceled and the 5 we had originally forecast, and that we get assistance from that vehicle—then the cost of maintaining operations through 1975 is approximately $180 million.

The CHAIRMAN. You talk as if you are fairly certain you would get this in September. Is this some kind of an agreement or understanding?

Mr. BLANCHETTE. No, sir, it is not. Mr. Varalli here, our budget forecaster and resident expert on numbers, just put that into his forecast. A 1-percent increase is $19 million a year. So I cannot make that mental calculation of what happens if we don't get the 12 percent, but 1 percent is $19 million a year.

The CHAIRMAN. What if it is only 7 percent now? Do you have that calculated at 7 percent?

Mr. BLANCHETTE. We calculated a 7-percent rate increase beginning in April, and a 5-percent rate increase on top of that beginning in September. That was the basis of our original figures. We had to make some revisions, as I stated in my testimony earlier this morning, to reflect the fact that since we made our figures and forecast, the ICC suspended that increase.

The CHAIRMAN. You know, yesterday I didn't hear the ICC or anybody else mention anything about a 12 percent, only 7 percent.

Mr. BLANCHETTE. We have not applied for the 5 percent. They have no official knowledge of it. The application has not been filed. We may be optimistic. That is one of the reasons that the auditors said we were optimistic. To get a rate increase, the first thing that has to be done is that the industry must join in it. Then when the industry joins in it, the application must be made. So that if we don't get a rate increase, then the figures are off by that much.

The CHAIRMAN. May I interrupt you there and ask you, because this morning you were talking about $350 million seeing you through the first quarter of next year. Is that predicated on the assumption that you do not get an increase in rates?

Mr. BLANCHETTE. No, that assumes we get the 12 percent effective September 1, 1975.

The CHAIRMAN. That is quite a jump from $180 million to $350 million there for one quarter.

Mr. BLANCHETTE. Well, we have two factors in the first quarter of the year. First is the $50 million Government guarantee obligation to which I referred this morning. And secondly, as you know, Mr. Chairman, from history, the first quarter on the railroad, the winter months, are the most severe cash draining months. They are disproportionate to the calendar year. We have two bad seasons that we can always count on. First is the first quarter of the year, when you have adverse weather conditions and a general slackening, and secondly, in the summer when many industries have their vacation schedules and close their plants. Every year since 1971 we have had problems in those two periods.

The CHAIRMAN. All right. I just am trying to get what your prediction was here, because as I say, when we have to take into consideration what the ICC predictions were and also the DOT, it looks to me like you are asking for $120 million for one quarter of next year, the first quarter.

Mr. BLANCHETTE. The difference between $180 and $350 million.

The CHAIRMAN. And it is $106 million to run through June 30, and $180 million through December 31?

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Mr. BLANCHETTE. Yes.

The CHAIRMAN. Mr. Macdonald?

Mr. MACDONALD. No questions.

The CHAIRMAN. Mr. Devine.

Mr. DEVINE. I would like to direct a question to Mr. Langdon if he would care to respond, and would like to predicate the question on a statement. You were here yesterday when I questioned the Chairman of the Interstate Commerce Commission about the causes of some railroads being successful and others unsuccessful. Were you here at that time?

Mr. LANGDON. Yes.

Mr. DEVINE. Let me make a statement. I would like to quote from Dunn's Review a couple of months ago, where it made reference to Southern Railroad. I am not an advocate of Southern, they don't touch my district, but they are an example of a successful railroad?

"In the first 9 months of 1974 the net income was $71.8 million or $4.76 a share on operating revenues of $678 million. That profit was not only 35 percent higher than the first 9 months of 1973, it was 29 cents a share higher than all of last year. The most important element of the strength of the railroad is the satisfactory and farsighted top management."

They go on to say that the difference between Southern and the old-line companies is that the old-line companies start with operations. They have the line and let the customers come to them. But the Southern starts with marketing and it has been very clever about soliciting the best business.

It says that there are a lot of misconceptions about the railroad business and most of them grew out of the fact that the whole railroad industry is being judged by the difficulties of just one part of the country. But in fact 9 out of 10 largest U.S. railroads are making a profit.

Railroads carry more freight than all the airplanes, trucks, and barges combined, and do it with the most efficient use of fuel. A train is 4 times more efficient than a truck, and 60 times more than an airplane.

In addition, if railroads keep their present share of business, which seems more than likely, it will mean a 100-percent increase in traffic levels by 1990, hardly the stereotype image of the railroad business.

When you look at the Southern Railroad you feel you go as far away from the stereotype as you can get. This is a quote from a Dunn's Review.

My question suggested perhaps it was poor management on the part of Penn Central that gets them into these difficulties. I believe you indicated to me before the hearing you would like to be able to respond to this.

Mr. LANGDON. Let me join with the magazine in commending the management of the Southern Railway. I think it is absolutely tops. I agree with that.

Over on the Penn Central the problem though is one that goes far beyond management. In the first place, we are dealing with a plant and trying to conduct transportation on a plant which has tremendous obsolescence. It is a very old plant, particularly in the eastern part of the operation, with terminal facilities that are probably as inefficient and as difficult to operate as are found anywhere in the country.

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In addition to that, for 20 years maintenance has been deferred, to the point where today on the Penn Central in order to just make up the deferred maintenance in the roadway properties, according to the findings of these independent engineers whom Mr. Barnum referred to yesterday, over $2 billion has to be spent in order to make up deferred maintenance in the road accounts alone.

Now, in addition to that, we serve a territory, and this is where this is a very sharp difference between our operation and those in the South—we serve a territory where the economic growth has been much slower than in the Southeast. And the growth in the East has been in a direction where truck transportation has been benefited more than railroad transportation. And the South has grown, all the economic industries, by percentages of 40 and 50 and 60 percent, whereas our growth has been relatively small and modest.

As I say, the eastern growth has been concentrated in the areas of production where the truck is the more efficient method of transportation, particularly when it can operate over publicly provided highways.

Mr. DEVINE. What time frame are you putting this growth in? Twenty years, ten years, or what?

Mr. LANGDON. Since World War II. And we on the Penn Central Railroad are confronted with a competitive situation on the highways which is almost beyond belief. We have an Interstate Highway System paralleling the entire railroad. All main lines are paralleled with the Interstate Highway System, which has been built in a large part since World War II. The truck traffic over those systems has been growing at a rate of 20 and 30 percent a year. We have trucks operating on the Jersey Turnpike every 5 seconds right around the clock, 7 days a week. On Interstate 80 and other east-west highways, the truck traffic is so dense it is equivalent of 60, 70 piggyback trains every 24 hours.

The result is that the railroad is slowly and very gradually being confined to the type of traffic which is not competitive with the highway; namely bulk traffic for the most part, although there are still other types of traffic where the competitive situation allows the railroad to participate.

But the reason why in our territory, and I think this bears directly on your question of yesterday, the C. & O. and the N. & W. are able to make out better than the Penn Central, is that they have such very substantial portions, much more substantial than ours, of bituminous coal, which is not competitive with highway transportation. And 50 and 55 percent of their tonnage is coal, whereas it is only 23 and 24 percent in our case. This cannot move over the highways.

Moreover, those two carriers don't serve the territory where most of our operating problems occur, on the eastern seaboard and New England.

So that this Penn Central problem, while management had a part to play, of course, is far beyond management control. The only way that the property is ever going to be made to have earning power is to have the kind of restructuring which hopefully is in contemplation in development of the final system plan by the USRA. I think USRA may be able to come up with a system so designed and financed that there can ultimately be viability in this railroad operation. But short of that, there is really very little hope.

Mr. DEVINE. Mr. Langdon, we have used up our time, but you should be identified as formerly a trustee, and now president of——

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Mr. LANGDON. I was one of the four trustees originally in the Penn Central, and then earlier last year, in April I think it was, I was demoted to president.

Mr. DEVINE. Thank you, Mr. Chairman.

The CHAIRMAN. The gentleman from California, Mr. Moss.

Mr. Moss. At the moment, Mr. Chairman, I would like to reserve my time.

The CHAIRMAN. The gentleman from Kansas, Mr. Skubitz.

Mr. SKUBITZ. I have only a few questions. I am trying to get these figures in mind. If I understand Mr. Blanchette correctly, originally the DOT recommended $200 million?

Mr. BLANCHETTE. Yes.

Mr. SKUBITZ. This was before the rate increase was denied by the ICC?

Mr. BLANCHETTE. Yes.

Mr. SKUBITZ. Then the DOT revised its figure upward to $252 million, is that correct?

Mr. BLANCHETTE. I believe that to be the case.

Mr. SKUBITZ. What you are saying in your testimony, if I read it correctly, is that the $252 million that DOT has recommended does not include $25 million that Penn Central must shell out for Amtrak improvements, is this correct?

Mr. BLANCHETTE. That is correct.

Mr. SKUBITZ. And it doesn't include $50 million to pay off guaranteed certificates that will be due in 1976, is this correct?

Mr. BLANCHETTE. Yes.

Mr. SKUBITZ. And an additional $25 million to make up for the losses because of the failure to provide the rate increase?

Mr. BLANCHETTE. Yes; that latter amount, sir, reflects the judgment on our part that the rate suspension would last 5 months, rather than the 3 months which the Department assumed. I don't think there is any way of knowing which of those assumpions is correct.

Mr. SKUBITZ. So what you are telling this committee is that the figure submitted by DOT, $252 million, is actually $100 million short insofar as Penn Central is concerned?

Mr. BLANCHETTE. Yes, sir.

Mr. SKUBITZ. Now, did you discuss this with the DOT? Did you present your figures to them?

Mr. BLANCHETTE. We believe that——

Mr. SKUBITZ. Before you came—I am not asking what your belief is—did you do it? Did you tell them: "Now look, you are not taking into consideration the $25 million that is necessary for maintenance because of Amtrak, and you are not taking into consideration the $50 million on certificates that are going to be due in 1976"?

Mr. BLANCHETTE. We did, sir.

Mr. SKUBITZ. You did. And they said, "Phooey, nothing doing"?

Mr. BLANCHETTE. Or words to that effect.

Mr. SKUBITZ. Now then, take the $50 million in certificates that are due in 1976. Can those be refinanced?

Mr. BLANCHETTE. I don't know what the situation will be later this year. Right now we have probably as poor a credit rating as any entity in America.

Mr. SKUBITZ. Yes; but you have a Government guarantee in back of them. That is the only reason you got rid of them in the first place.

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Mr. BLANCHETTE. If you will assume that the Government will guarantee the refinancing of that $50 million, then we can go to our financial advisers with one postulate.

Mr. SKUBITZ. If we do that, it means we don't have to raise $50 million at this moment, doesn't it?

Mr. BLANCHETTE. That is correct.

Mr. SKUBITZ. Would this require legislative action?

Mr. BLANCHETTE. I believe it would, sir.

Mr. SKUBITZ. You believe it would.

Mr. BLANCHETTE. Counsel advises that it would.

Mr. SKUBITZ. That is all, Mr. Chairman.

The CHAIRMAN. The gentleman from Michigan, Mr. Dingell.

Mr. DINGELL. I would like to defer my questions briefly.

The CHAIRMAN. The gentleman from New York, Mr. Hastings.

Mr. HASTINGS. I thank you, Mr. Chairman.

Mr. Blanchette, on page 3 of your statement, you outline what will happen if you don't get the financial assistance that you are requesting here from this committee. You will announce on a specific date in the future, probably February 18—now, at one time I understood the date was going to be the 14th of February; now it is probably the 18th. Could you tell me what that means?

Mr. BLANCHETTE. It is an unfortunate part of drafting which I take responsibility for. We will announce about February 14 that on a date in the future, February 18, the railroad will not accept deliveries for future traffic. You have to make the announcement some time in advance before you can begin declining the traffic. We have to notify our shippers and the various agencies involved that beginning on February 18 we won't take any shipments. So that way, they can start from the time of the announcement, namely February 14, or whatever that date happens to be, to not start cars in our direction.

Mr. HASTINGS. All right. Now, after you make that announcement, presuming you are going to, is there any approval required from the ICC?

Mr. BLANCHETTE. No, sir.

Mr. HASTINGS. Is there approval required from the organizational court?

Mr. BLANCHETTE. No, sir.

Mr. HASTINGS. Under the Reorganization Act, there is a question, and I asked this question advisedly because it has been suggested and in fact there is a period of time available in which you must make some application for approval. As far as the ICC is concerned, and the court is concerned, the answer is negative?

Mr. BLANCHETTE. That is correct.

Mr. HASTINGS. Now, under the Reorganization Act, section 304(f), after the date of enactment of this act no railroad in service may abandon service unless authorized to do so by the association.

Now, is there any requirement you read, and your counsel read, subsequent to that——

Mr. BLANCHETTE. Section 304(f) is an amendment in essence to section 1(18) of the Interstate Commerce Act. The difference is, in the Interstate Commerce Act, the approval of the ICC was required before an abandonment or discontinuance of operations. This substitutes the USRA. It has always been the case in the event of an emergency,

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such as a flood, that embargoes issue to prevent chaos or destruction or just because there is an inability to perform the service. There has never been an interpretation that either section 1(18) of the ICC Act or any other law prevents a railroad or common carrier from taking the normal precaution that it takes once it is confronted with an emergency.

Mr. HASTINGS. Then the situation as you present it seems to be clear once you make the decision to issue the letters of embargo, there is no holding action as far as requirements of any Federal statute or Agency you are aware of?

Mr. BLANCHETTE. No, sir.

Mr. HASTINGS. If this committee and this Congress does not finalize action on some form of this legislation by the 14th, will that procedure take place?

Mr. BLANCHETTE. It will.

Mr. HASTINGS. Whether or not it is in the process of formulation, it will take place?

Mr. BLANCHETTE. It will take place.

Mr. HASTINGS. You are saying that, categorically?

Mr. BLANCHETTE. Yes, sir.

Mr. HASTINGS. I have had many people from this committee indicate otherwise and there is a wire story out now that suggests in fact this will not take place; I want some assurance. I have no reason to disbelieve you, I might say that. Your position seems to be backed up by DOT, ICC, and USRA. There are some, in fact, who feel your letters of embargo will not be sent out. I would like your assurance here on the record.

Mr. BLANCHETTE. Mr. Hastings, I can give you my assurance and the assurance of my cotrustees. As I said this morning, we learned we are judged by hindsight. And if on the 25th of February our employees do not report to work, and they ought not if we can't pay them, and we have not taken the precaution to protect the fruits and vegetables and the commodities that we carry, and we are not able to protect our property against vandalism and theft, we are guilty of an irresponsible act. And we are not going to present ourselves in that situation.

Mr. HASTINGS. I understand the date of the 25th. But I want to make clear in my mind, this Congress is scheduled to go out of business as of tonight as a matter of fact, and not come back until the 17th. There does not appear to be time for complete action on this measure. You are saying, lacking that action, that Penn Central will go through with its embargo?

Mr. BLANCHETTE. Yes, we will.

Mr. HASTINGS. Thank you, very much.

The CHAIRMAN. I would like to make one statement, Mr. Blanchette. I believe that that is a sort of irresponsible statement of yours, what you intend to do in the face of what Congress intends to do, and I think you know what we intend to do. We are trying to pursue this the best we can.

Now the fact that you are going to do certain things regardless. I thought that on the 18th was when you could do this. And we would hope that maybe we would have some action by the 18th.

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Now, to me, I just don't believe it is a responsible answer that you have given to the gentleman from New York. Because you know it is impossible under the circumstances to get this done before we leave. I have done everything in my power to hurry it up, and I think every member of the committee. We will get it done.

The gentleman from California.

Mr. Moss. Mr. Blanchette, we seem to have some very interesting escalation of figures that have been submitted to this committee, and at this moment I defy anyone to tell me what you people really want. Have you an audit that sets forth definitively the projections which you have summarized for the members of this committee here this afternoon?

Mr. BLANCHETTE. We do not audit our own forecasts, but the U.S. Railway Association has sent auditors to look at these figures, and the Department of Transportation as well.

Mr. Moss. What did you rely upon for the statements you have made here as to the needs of the trustees to continue to operate for varying periods? They were, I think, $180 million to July 1 and/or a little less, and then something under $200 million by December 31, and $350 million by the end of the first quarter of 1976, as I recall? What did you rely upon for those projections?

Mr. BLANCHETTE. The cash and revenue forecast prepared by the management.

Mr. Moss. All right. Have you those prepared forecasts available for this committee?

Mr. BLANCHETTE. Yes, sir.

Mr. Moss. Mr. Chairman, I would ask that those be received by the committee and be made a part of this record so that we may undertake an analysis of them.

[The following information was received for the record:]

CASH NEEDS

Cash numbers used at House Hearings held in Washington on February 4 and 5, 1975, were based on the Source and Application of Funds Statement that showed the end of 1975 cash as a deficit of $209.7 million and Mr. Brinegar's letter of January 17, 1975, to Mr. Albert in which it states Penn Central's cash needs through the first quarter of 1976 are $222.1 million.

1. The House committee was told we need $106 million to get through until the end of June. (May, 1975 cash was used since May's ending cash was worse than June's).

	Millions
Ending cash may	$(142.0)
Less grant money received in January	32.0
Total	(112.0)
April 1, 7% tariff canceled (cash through the end of June)	(22.5)
Total	(134.5)
Cash management (Amtrak, payables, etc.)	28.5
Total	(106.0)

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2. The House committee was told we needed $180 million to see us through the year 1975.

Ending cash December	(209.7)
Less grant received in January	32.0
Total	(177.7)
D.O.T. testified we would lose about $30.0 million because of 7% tariff canceled	30.0
Total	207.7
Cash management	27.7
Total	180.0

3. The House committee was told we needed $350 million through the first quarter of 1976.

D.O.T. letter of Jan. 17, 1975	[1] 222.1
7% tariff canceled until Sept. 1975	50.0
Extra corridor money	25.0
Trustee certificates	50.0
Total	347.1

[1] Includes cash management.

E. R. VARALLI.

Mr. DINGELL. Would the gentleman yield?

Mr. MOSS. Yes.

Mr. DINGELL. Any audits made by the trustees on which those figures are based, and any other records, books, and documents, shall be made available.

Mr. BLANCHETTE. You may have any document in our possession.

Mr. MOSS. We recognize that. We are trying to isolate those that will be most helpful to us.

You have just stated that on the 14th you are going to give a notice of an intent to embargo. Do you have to have concurrence of the Interstate Commerce Commission in that?

Mr. BLANCHETTE. No, sir.

Mr. MOSS. You do not regard that as a de facto discontinuance of service?

Mr. BLANCHETTE. No, sir.

Mr. MOSS. What do you regard it as?

Mr. BLANCHETTE. We regard it as a response to an emergency. There is a difference between a——

Mr. MOSS. You come here at a fairly late hour in this crisis that confronts you with what you, as trustees, should have certainly been intimately familiar with quite a while ago?

Mr. BLANCHETTE. We started November 20, 1974, sir.

Mr. MOSS. What?

Mr. BLANCHETTE. We started to alert the Department of Transportation and meet with Secretary Brinegar and his staff.

Mr. MOSS. When did you alert this committee?

Mr. BLANCHETTE. I believe we alerted this committee in—I don't have my book, but it was in December of 1974, and it was in early December.

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Mr. Moss. Well, this committee, of course, has not really completed its formal organization. You have come here, and you tell us that you are going to try what I would regard as almost a blackmailing of the committee with a threat of the imposing of a summarily ordered embargo. I believe it to be an unreasonably ordered embargo.

I want you to know that I for one very deeply resent this kind of highhanded dealing with the Congress of the United States. I think it is reflective of a lack of appreciation of your obligations to the Congress.

This is not an option here that is just ready for you to pick at will, but we are supposed to act responsibly after making certain determinations that you did not call to our attention until very, very recently.

I yield to the gentleman from Michigan, and then, of course, to the chairman of the committee.

Mr. DINGELL. Mr. Blanchette, your communications to this committee were to our counsel, Mr. Gamble, were they not?

Mr. BLANCHETTE. Yes, sir.

Mr. DINGELL. You went to him and told him in December that you had a cash crisis that you were working out with the Department of Transportation. That is what you told him, wasn't it?

Mr. BLANCHETTE. Not quite in those words.

Mr. DINGELL. What did you tell him, exactly?

Mr. BLANCHETTE. My recollection is that we told Mr. Gamble, and I think a telephone call was also placed to the chairman, but I don't—there was no—that conversation did not occur.

Mr. DINGELL. What did you tell him exactly, and how, and where, and when?

Mr. BLANCHETTE. We told him we foresaw a completely unmanageable situation on the railroad in the first quarter of 1975 which would continue; that all sources of assistance under the Regional Railway Act would have been exhausted prior to the expiration of the first quarter of 1975; that we had developed a means of avoiding that through a three-point program which was in our opinion the only self-help measure left to us, and that was to furlough 4,500 employees who did not enjoy labor protection as a result of the Penn Central merger; second, to immediately cut our purchases of materials and supplies by $92 million a year; and third, to announce that when the wage increase went into effect beginning January 1, 1975, that we would be unable to meet that increase.

We further advised counsel that we had apprised Secretary Brinegar of this program, and that he requested us not to put it into effect, and that he was going to make the remaining moneys available to us to abide the event. That we had told the Secretary that the remaining sums of money available under that bill would not be adequate to survive the crisis, but it would buy him 30 to 40 days' time.

We exchanged a comment about the difficulty of obtaining any kind of legislation in the last part of the previous Congress, and we made ourselves available for any further information or corroboration of that figure, and a set of facts.

Mr. Moss. I yield to the gentleman from West Virginia.

The CHAIRMAN. I would like to set this whole thing in perspective here, because as you know, this Congress didn't convene until the middle of last month. After that we received from the Secretary of Transportation a communication to the Speaker which was trans-

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mitted to me probably the next day, that they had a bill proposed entitled "The Regional Rail Reorganization Act Amendments of 1975."

After these were turned over to the counsel to go over and correct and put in the proper forms to introduce; after they were perfected, I—the counsel or I, had my staff to ask Mr. Devine to cosponsor it with me, and he agreed, and we introduced it on January 23.

I might say to the gentleman that we have been in the process of trying to organize this committee as every other committee in Congress has been. We still are not fully organized. We are proceeding under the House of Representatives rules at the present time in order to expedite this.

I don't know that Congress could have done anything more than they are doing now. I don't see how they can—I think you come late to tell us that unless we get this done by the 14th, that we are in difficulty.

The gentleman from California, I believe his time has run out.

Mr. Moss. I merely want to make this observation. It is my opinion that this action by the trustees, this statement as to their intention to proceed now with the notification of the embargo, constitutes one of the most arrogant actions that I have ever encountered during my 22 years of service in this Congress.

I think that you people are open to the widest possible public censure for your handling of this and for the manner in which you have dealt with the Congress of the United States.

I have the minimum of patience with you, and the kind of problems that you bring in always at the very last possible moment.

The CHAIRMAN. The gentleman's time has expired.

The gentleman from Texas, Mr. Collins.

Mr. COLLINS. I yield to the gentleman from Florida right now.

Mr. FREY. I would like to pursue the line of questioning opened by the gentleman from California. From looking over section 118 of the ICC followed by section 304(f) under which we are now operating regarding interim abandonment, I am trying to find where you get your authority for your action.

Section 306(f), as you know, in essence talks about no railroad discontinuing service or abandoning any line other than in accordance with the provisions of this act. I am really having difficulty in following your explanation on how the Penn Central is doing it. I wish you could explain it more.

Mr. BLANCHETTE. Let me give you an analogy, sir, that was one of our previous annual pilgrimages here. That was in response to Hurricane Agnes. Hurricane Agnes destroyed good parts of the railroad, especially in Pennsylvania. We embargoed vast segments of line because it was impossible to render service over those lines.

Mr. FREY. That was before the act under which we are now operating, right?

Mr. BLANCHETTE. No, sir. Well, I(18) of the Interstate Commerce Act was in effect. This act makes no difference except to substitute the agency which gives the approval.

Now, embargoes are intended for that kind of thing. There is no intent to discontinue service, and in fact we are not intending to abandon a line. Those lines will remain there and service will resume as soon as we are able to pay our employees.

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Mr. FREY. Now, concerning the Agnes matter, whom did you go to? Did you go to anyone?

Mr. BLANCHETTE. We sent out notices routinely, and when service was put back because of the Congress passing the Agnes Relief Act, we had the money to repair the lines. We repaired them and resumed the service.

Mr. FREY. How long was that delayed?

Mr. BLANCHETTE. In some cases it was several months. And some places are still down, I am advised by Mr. Langdon. There is one branch in particular that still is out of service.

Mr. FREY. Let me go on to another point. There seems to be some question of interpretation about section 213 as to what should be included in it. For instance, whether operating expenses or machinery are included. I get the impression that DOT seems to think section 213 is to be interpreted in the broadest sense. What is your feeling about it?

Mr. BLANCHETTE. The present 213, or 213 as it would be proposed to be amended?

Mr. FREY. The proposed.

Mr. BLANCHETTE. Well, the proposed amendment to 213 puts a potential lid on it, in that once any 213 grant is made with the terms and conditions of section 215(b)(1) then the estate cannot recover any normal appreciation in value after that improvement or infusion is made, whether that is attributable to that improvement or not.

Mr. FREY. One last thing, and I think that although directly unlike the gentleman from California, I particularly feel and I believe many of us feel we are tired of having these things come up at the last minute, facing a situation which is a tough one to face because of the obvious economic impact.

I am not sure what the answer to our dilemma is. I am not even sure, personally, if sometimes we are just pouring money down a drain. I wish the Penn Central knew what to do and which way to go. But I hope we are not going to be sitting here 6 months from now faced with the same problem.

I yield to the gentleman from New York.

Mr. HASTINGS. I can understand the concern of the gentleman from California. It is our right and responsibility to sit and try to judge with the proper amount of time as to the merit of arguments presented by the Penn Central and other railroads. But I don't think that this Congress is in fact going to respond when we have asked for a lot of information, both yourself and the gentleman from Michigan, and we are not going to have the opportunity to even take a look at that until after an 11-day recess.

Now, my part of this country is going to be very seriously impacted by any embargo that is to be put into effect by the Penn Central Railroad. Industry after industry in the northeast said they must close down their plants. My concern is not what is good for Penn Central, it is what is good for the economy for my part of the country, and the rest of the country.

Unemployment today is a critical as ever in history. Yet for us to walk away for 11 days on a recess honoring Abraham Lincoln, who took 1 day to be born, this Member fails to understand, at least the questions raised by this impending action.

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The CHAIRMAN. The time of the gentleman has expired.

The gentleman from Colorado, Mr. Wirth.

Mr. WIRTH. I yield to Mr. Moss of California.

Mr. MOSS. We tried yesterday, I understand, to get the ICC to express an opinion as to whether or not the trustees do in fact have the power that Mr. Blanchette says they have with regard to their right of suspension. I ask, therefore, that the committee direct the General Counsel for the Interstate Commerce Commission to prepare a formal opinion directly on this point and to do so with dispatch and get it to the members of this committee as quickly as it is consistent with a thorough job.

Mr. DINGELL. If the gentleman would yield——

Mr. MOSS. The gentleman from Colorado has the time.

Mr. DINGELL. Would the mandate to the ICC also require comments not only under the ICC statute but I believe also under section—well, also under 304(f)?

Mr. MOSS. We can work with Counsel for the precise outlining of the opinion we seek from the ICC. I would ask unanimous consent to hold the record at this point to receive that opinion.

I thank the gentleman from Colorado for yielding.

The CHAIRMAN. Without objection, the record will be held open for it. and it will be requested of the ICC.

[The following letter was received for the record:]

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Interstate Commerce Commission
Washington, D.C. 20423

OFFICE OF THE GENERAL COUNSEL

February 6, 1975

Honorable Harley O. Staggers
Chairman
Committee on Interstate and
Foreign Commerce
House of Representatives
Washington, D.C. 20515

Dear Chairman Staggers:

In response to the telephone call yesterday afternoon from Mr. John L. Gamble of the staff of the House Committee on Interstate and Foreign Commerce, I am pleased to submit the following brief synopsis on the law pertaining to embargoes invoked by carriers subject to the jurisdiction of the Interstate Commerce Commission.

The law imposes a duty upon a common carrier railroad to render service. Section 1(4) of the Interstate Commerce Act, 49 U.S.C. 1(4), expressly provides "it shall be the duty of every common carrier subject to this part to provide and furnish transportation upon reasonable request therefor."

As broad as that declaration appears to be, the railroads long have been recognized to have an inherent right to refuse to handle shipments in an emergency situation. As the Commission noted, in Coal from Arkansas and Other States, 49 I.C.C. 727, 731, "Where physical disabilities prevent the carriers from handling certain kinds of traffic for destinations, or where the consignees are unable promptly to accept delivery, the embargo is properly invoked."

An embargo is an emergency measure imposed normally because of a physical inability by the carrier to perform the transportation. Powell-Meyers Lumber Co. v. St. Louis, I. M. & S. Ry. Co., 45 I.C.C. 594; Murray v. Director General, 69 I.C.C. 477; Missouri & Illinois Coal Co. v. Illinois Central R. Co., 22 I.C.C. 39.

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The right of carriers to limit their duty to provide transportation by the issuance of embargoes in the time of emergency is not disputed. The question in this case is whether the fact that a railroad is losing money on the operation of a particular service justifies the issuance of an embargo suspending that service. In almost all cases in which the laying of an embargo has been approved, the embargoes were issued because whether conditions, traffic congestion or other physical or operation conditions made it impossible for the carrier to provide transportation to a particular area. Holt Motor Co. v. Nicholson Universal S. S. Co., 56 F. Supp. 585, D. Minn. 1944; Baltimore Chamber of Commerce v. Baltimore & Ohio R. R. Co., 45 I.C.C. 40 (1917); Krauss Brothers Lumber Co. v. Director General, 66 I.C.C. 637 (1922); Murray v. Director General, 69 I.C.C. 477 (1922); American Mfg. Co. v. Director General, 77 I.C.C. 52 (1922). The Railroad cites only one case in which an embargo issued because of financial conditions was upheld and in that case, Gross v. Director General, 58 I.C.C. 604 (1920), the carrier, with the approval of the Commission, was terminating its entire operation. New Orleans Traffic & Transp. Bureau v. Mississippi Valley Barge Line Co., 280 I.C.C. 105 (1951), specifically held that financial losses on a carrier's less-than-bargeload operation did not justify the imposition of an embargo on that operation. We agree with the decision in New Orleans Traffic that the unauthorized imposition of an embargo on a particular service because the continuation of that service would result in a financial loss is an unlawful practice and that the Commission can annul such an embargo. Cf. Meyers v. Jay Street Connecting Railroad, 2 Cir., 1958, 259 F. 2d 532.

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An embargo may not be employed as a device for effecting a discriminatory practice. Prudential Oil Corp. v. Merchants & Miners Transp. Co., 43 I.C.C. 696; E. L. Rogers & Co. v. Philadelphia & R. Ry. Co., 12 I.C.C. 308. Neither may an embargo be imposed to accomplish results which the law requires shall be effected only by means of published tariffs. Powell-Meyers Lumber Co., supra.

The carrier must give notice of an embargo. Eastern Ry. Co. v. Littlefield, 237 U.S. 140, 145. The law does not require that the embargo notice be published as schedules are published, American Wholesale Lumber Assn. v. Director General, 66 I.C.C. 393, although it has been the practice for such notices to be published through the Association of American Railroads as if they were tariffs.

Since 1973, the Commission has had in effect regulations governing the giving of notice of an embargo. 49 C.F.R. 1006. In essence, they require that written notification, specifying the extent of the embargo, the date on which it is to become effective and the reasons therefor, shall be posted at each of the affected offices of the carrier and served upon connecting railroads, as well as being mailed to the main and regional offices of the ICC.

The leading and most recent case is New York Central Railroad Co. v. United States, 201 F. Supp. 958 (S.D. N.Y. 1962), remanded for mootness, 301 U.S. 805 (1962). That case arose from the efforts of the New York Central Railroad to terminate less-than-carload service. Frustrated by its unsuccessful efforts to obtain Commission authorization therefor, the railroad by an embargo notice announced that it would no longer accept less-than-carload shipments. The Commission, without hearing, entered an order, Service Order No. 638, of its Safety and Service Board No. 1, setting aside the embargo for the reason that the embargo was not valid and that there was presently a need for the service. The railroad brought suit to challenge the Commission's action, alleging, among other things, that the Commission did not have the statutory authority to annul the embargo and that the Commission's order constituted unlawful interference with the carrier's managerial discretion. The court rejected these contentions, saying,

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Hon. Harley O. Staggers
February 6, 1975
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On the basis of the foregoing, I am of the opinion that a railroad may not employ an embargo to effect abandonments that would require the advance authorization of the Commission or other public body. The Commission has the power to look into the lawfulness of an embargo and, even in the absence of a hearing, to order its revocation if determined to have been improperly imposed. On the other hand, I am of the view that, if a railroad foresees an imminent inability to perform transportation for reasons beyond its control, it has not only the right, but, as I perceive it, the duty to give notice of the impending shutdown to the shippers it serves and the railroads with which it connects.

I trust the foregoing will be of some aid to you and the Committee, but please let me know if I might be of further assistance.

Respectfully yours,

Fritz R. Kahn
General Counsel

Mr. WIRTH. Mr. Blanchette, I would like to review the bidding, if we could. Before doing that I would like to say I believe it is the concern of everybody on this committee for the economy of this country and to keep the Penn Central going. We are not going to let it go down the tube.

I think, however, we have a right to know what kind of numbers we are looking at. To review very briefly, yesterday, as I remember, the bidding started at $250 million and immediately went to $285 million, after which we talked about the President's energy proposal and what a variable that might be, after which we went to the rate increase, after which we went to a discussion of the losses of the Penn Central which changed in a matter of minutes from $340 million to $350 million.

That was yesterday's confusion. Today, as I understand, we started at $275 million. Is that correct?

Mr. BLANCHETTE. No; I started at $350 million.

Mr. WIRTH. It was my understanding coming in we started at $275 million, then added $25 million for the New England Corridor, and $50 million for the trustees' certificates?

Mr. BLANCHETTE. Yes.

Mr. WIRTH. Which were new variables as far as the testimony to this committee is concerned.

Mr. BLANCHETTE. Yes.

Mr. WIRTH. We are up to $350 million, adding today $75 million to yesterday's request.

Further, today we have discussed $23 million for the rest of the Northeast Corridor, coming in from the Department of Transportation estimate, is that correct?

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Mr. BLANCHETTE. Well, the $25 million for the Northeast Corridor is part of the $350 million figure. I don't recall a $23 million figure.

Mr. WIRTH. The other railroads then. Adding a further $23 million. And $25 million further for the Erie Lackawanna, if that were to be included in the package, bring us up to $398 million.

Anyway, the purpose of this is to ask you if it would be possible for you to get to the committee tomorrow morning a simple outline of the basic amount of your request? If we start at, say, $275 million. What is included in that $275 million? You know, nothing that has to be many, many pages. A summary statement that can be simply understood.

Then if you could add to that the other variables we have talked about, the Northeast Corridor, the trustees' certificates, the other DOT requirements, then what other variables you may be thinking about in terms of what would happen if the President's energy proposals went through, what would that add to the cost? What are the variables related to the rate increases? Maybe there are one, or two, or three variables.

Could you get that to us as to what you think a firm low number is, and what a potential high number might be, explained in a form that could be seen in ledger form? It seems to me that is a reasonable request, and I have not seen anything like that.

Mr. BLANCHETTE. You will have that tomorrow morning, sir.

Mr. WIRTH. Could we have with that some kind of assurance that also conforms with the numbers presented to us by the DOT yesterday?

Mr. BLANCHETTE. I cannot do that. We disagree. The Department and the trustees disagree as to some of the variables. I cannot make the DOT agree with me, or Mr. Varalli here who prepares these figures, that the rate increase will begin in September. They may have a different figure. We can reconcile.

Mr. WIRTH. Can you let us know where the areas of disagreement may be?

Mr. BLANCHETTE. Yes, sir.

[The following information was received for the record:]

PENN CENTRAL TRANSPORTATION CO.,
Philadelphia, Pa., February 5, 1975.

JOHN GAMBLE, Esq.,
Committee on Commerce, House of Representatives, Rayburn House Office Building, Washington, D.C.

DEAR MR. GAMBLE: As requested by Congressman Wirth at the conclusion of the hearings this afternoon by the Penn Central trustees, I am enclosing the estimate of financial requirements discussed there, with appropriate explanatory notes detailing the reasons for the difference between the figures used at the hearing and those in the Department's original estimate transmitted with the proposed bill on January 17. I am also sending a copy directly to Congressman Wirth.

Since there may be further questions concerning Penn Central's requirements and the basis for the estimates, Mr. Varalli, who was present at the hearings today, will return to Washington tomorrow and be available to the committee at 10 o'clock in the morning for any questions you may wish to have him answer.

Sincerely,

CHARLES A. HORSKY.

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Estimate of potential requirement for financial assistance—Penn Central

	Millions
1. Estimate by DOT of Jan. 17, 1975	$222.1
2. Suspension of the tariff increase	[1] 50.
3. Trustees' certificates due Jan. 15, 1976	[2] 50.
4. Expenditure on Northeast corridor	[3] 25.
Total	347.1

[1] DOT's original projection assumed a 7-percent rate increase effective in February and a 5-percent rate increase in September. Penn Central's cash forecast assumed that the 7-percent increase would not become effective until April 1975. At the hearing before the committee, Mr. Barnum adjusted his figure of needs by adding $30,000,000 to the requirements, apparently on the assumption that the 7-percent increase would be deferred for only 3 months. However, if the full suspension period is permitted to run until September, Penn Central will not receive the revenues for the 5 months April through August. Seven percent is estimated to produce approximately $9,000,000 to $10,000,000 a month, and hence the $50,000,000. The 12 percent referred to at the hearings is the total of 7 percent and 5 percent.

[2] Neither the original DOT projection of Penn Central's cash needs nor its testimony before this committee has ever included any allowance for the repayment of the $50,000,000 of Trustees' Certificates, presently due Jan. 15, 1976.

[3] In DOT's letter to Speaker Albert dated Jan. 17, 1975, it was indicated that of the $100,000,000 increase proposed by sec. 213, $25,000,000 was planned for upgrading work in the Northeast corridor. The Penn Central cash projections did not and do not include any cash expenditures for upgrading the corridor. Consequently, to the extent that such upgrading is to be directed, an additional $25,000,000 would have to be provided.

The CHAIRMAN. The gentleman from New Jersey, Mr. Rinaldo.

Mr. RINALDO. Thank you, Mr. Chairman.

Mr. Blanchette, first of all—I should say I concur completely both in the remarks of the gentleman from California as to the conduct of the Penn Central trustees, and the remarks of my colleague from New York as regards the Congress and the possibility of us staying in session.

I want to get back once again to the tax situation that I discussed yesterday. I would hope before I vote on this measure and before any Member of this Congress votes on this measure, it would be cleared up. The tax question doesn't only affect the city of Elizabeth, it affects many cities in every congressional district in which there is a railroad.

To reiterate: the Central Jersey's tax delinquency to the city of Elizabeth, which dates back to the year 1967, exceeds $1.5 million. Penn Central has been deliquent since 1970, and owes more than $200,000 in back taxes. The interest owed by both railroads in this one city alone amounts to over $445,000.

Now, the city has tried, and I have tried over and over again, in my capacity as a State senator, and since I came to Congress 3 years ago, and we have been unsuccessful in collecting the back taxes because the railroads have been protected from foreclosure of property assets.

As I said yesterday, so that you are completely up to date, because State law requires taxes from railroad property to be carried as anticipated revenue, the city is forced to make up for the unpaid taxes by increasing the local property rate for all property owners. This certainly is a horrible situation.

Let me explain as simply as I can what is unconscionable on the part of the railroads, and in particular Penn Central. In your leases with many tenants you have what is known as a tax escalator clause. Very simply what it means is that in effect, and I am putting this in as sim-

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ple language as I can, the tenant not only pays his rent, but he also pays an additional sum, sometimes I understand by separate check, to cover the taxes due and owing to that municipality, or other unit of government.

What has happened since 1970 in the case of the Penn Central, at least—and I assume this is policy—but at least in the case of the city of Elizabeth—is that every time the tax check is mailed, the Penn Central trustees in effect confiscate, convert, physically take that check and absorb the funds.

This to me is unconscionable. Because what happens is the taxpayer then gets hit twice. The taxpayer in my district, in the city of Elizabeth, are going to pay for their fair share of this bill, but also additional money will be paid in increased local property taxes.

This has to be corrected immediately. It is an emergency situation and cannot continue. These funds are not calculated anywhere in any reports that I have read of the Penn Central, and I have gone over them as carefully as one individual could. They are not calculated as revenue. It doesn't belong to you.

It in effect is given to the trustees as custodians, you might say, for money which legally is owing to the various municipalities, county governments, and State governments. Over and over again, in talks I have had with people from Penn Central and the Central Jersey, I have been told this should not be allowed to continue, and it is going to stop. It has not stopped.

Tomorrow I am going to introduce an amendment to the effect that henceforth any such tax moneys must pass through and be given to the governmental body to which they are legally owed. And I would hope that you would support this kind of an amendment.

Mr. BLANCHETTE. I would like to respond.

The CHAIRMAN. If the gentleman wishes to respond, he might. The gentleman's time has run out.

Mr. BLANCHETTE. I am in perfect, 100 percent accord with the proposition that where a separate check is made by a tenant, specifically attributable and traceable and allocable to taxes, that those taxes should be paid. And it is not right to withhold those payments. At least in the case of Penn Central.

I cannot talk about the other railroads in reorganization. We have done that where we can find situations. We have 19,000 real estate leases, and 80,000 crossing agreements of one kind or another. There are going to be mistakes. I suggest a mistake has been made in your case. When you advised me of this, we will correct that situation.

Mr. RINALDO. I don't believe the escalator, if you will examine it carefully, are included in crossing agreements. Where the agreement is included in a lease, for example for an office building, I respectfully have to disagree with you, when you say when there is a separate check. If there is $50,000 worth of rent due, and maybe $5,000 for taxes due and owing to the municipality, if you were given a check for $55,000 by the tenant, even if it is one check, the $5,000 should be remitted to the proper governmental entity. Even if it is combined.

The CHAIRMAN. The time of the gentleman has expired.

The gentleman from Michigan, Mr. Dingell.

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Mr. DINGELL. Mr. Chairman, I wonder how quickly we can resolve ourselves into executive session to vote Penn Central the money? It occurs to me a $100 million a day increase, we are not going to be able to afford this if we don't hurry up.

I don't think that is at all funny, gentlemen. I happen to be an attorney and a member of the bar. I have served as a trustee and am aware of the responsibilities of the trustees to the creditors, but also am aware of the fact you have a responsibility to the public interest.

I would like to very sadly observe your appearance today gives me the unfortunate opportunity to conclude that you are either probably the most arrogant witness I have seen before this committee in my time here, or perhaps you are the least competent. I must observe regretfully that I have seen so many incompetent witnesses here I have to come to the conclusion you are probably the most arrogant.

I talked to Mr. Gamble here about your communications to the committee, and he advised you at the time you communicated with him you should communicate with Mr. Adams or me, or the chairman. As a member of the Transportation Subcommittee I will tell you I have checked with my office and heard nothing from any of you with regard to the cash crisis that impended.

I can only say to you that this seems to be an almost precise replay of the Penn Central crisis of a few years ago where people came in and said, "You give us $250 million or we will close the thing down."

It strikes me maybe we ought to get ourselves a new set of trustees. You are first of all supposed to report to the ICC. Second of all, you report to the USRA. Third, you keep internal audits to advise the Congress.

I assume none of you are neophytes, and you are aware of the fact that Congress does adjourn, does go home, does meet with the people, come back, and reconstitutes committees. You are aware, I think, or chargeable with an awareness, that Congress does have to reorganize itself, and yet you present yourself before this committee and say "$250 million or we are going to close the railroad down."

It strikes me this is even still more curious, in view of the fact that that figure has grown in a period of less than 24 hours by $100 million. Frankly, gentlemen, I can only come to the conclusion your attitude, I intended to have some questions, but I don't think any questions will respond to the matter, your attitude is like the public be damned attitude, where you come in and say, "Give us the money or we will close the thing down."

It may well be you will get the money, but it may be that the court will be instructed to have some new trustees appointed. I am not satisfied that men who behave like you have are entitled to maintain an estate that so broadly can affect the country that it can cause a havoc in the northeastern United States.

The CHAIRMAN. The gentleman from Indiana.

Mr. SHARP. No questions.

The CHAIRMAN. The gentleman from Connecticut?

Mr. RINALDO. Would the gentleman yield?

Mr. MOFFETT. Certainly.

Mr. RINALDO. I didn't get an answer to that final question, where I

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mentioned the example of the funds being combined in one check, there being an escalator clause, and the funds being combined, the rental and the taxes? Do you or do you not agree the Penn Central trustees should then remit the check with the portion of the funds due in taxes to that municipality?

Mr. BLANCHETTE. Yes, sir.

Mr. RINALDO. Thank you.

I asked that question specifically because in the one case I mentioned, the total tax liability since 1967 now is over $3 million. I don't want to see it continue further. Thank you.

Mr. MOFFETT. Sir, has the Penn Central had any communications regarding this crisis with the shippers in, say, Connecticut?

Mr. BLANCHETTE. In Connecticut? Yes, indeed.

Mr. MOFFETT. What has been the nature of that communication?

Mr. BLANCHETTE. The general course is for our traffic department to advise shippers interested of the problem, and usually that intercourse is accomplished between the traffic officer of the railroad and——

Mr. MOFFETT. Of the problem——

Mr. BLANCHETTE. Of any kind of crisis coming up.

Mr. MOFFETT. Has the Penn Central suggested that the shippers contact Members of Congress?

Mr. BLANCHETTE. I don't know what we have suggested. People have called our traffic officials and said, "Do you have a problem?" And we have said, "Yes".

Mr. MOFFETT. They have called your people?

Mr. BLANCHETTE. They have called us, and we have called them.

Mr. MOFFETT. Have you organized any lobbying effort?

Mr. BLANCHETTE. No.

Mr. MOFFETT. In any way?

Mr. BLANCHETTE. No; we have not organized a lobbying effort, except we have brought some of our local people here, Penn Central people here, to express to the Members of the Congress the problem, make themselves available for questions and answers.

Mr. MOFFETT. How would you describe as best you can the attitude of most of the shippers at this point?

Mr. BLANCHETTE. Concerned.

Mr. MOFFETT. Would you say it is panic?

Mr. BLANCHETTE. No; I don't know if it is panic. No.

Mr. MOFFETT. And would you say the Penn Central has contributed to that concern?

Mr. BLANCHETTE. We have caused it.

Mr. MOFFETT. Have you contributed to it in the sense of your contact with them? Do you feel you have educated them to the problem?

Mr. BLANCHETTE. We have given them in essence the first part of my testimony.

Mr. MOFFETT. Is there any indication that the shippers have begun making plans on a large scale? Other plans?

Mr. BLANCHETTE. I would like Mr. Langdon to answer that question.

Mr. LANGDON. Yes; I think that is right, sir. I think they are making plans as to if the embargo is actually issued, how they will divert the freight.

Mr. MOFFETT. Is there any indication that some of them have already switched to trucks?

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Mr. LANGDON. Yes, sir.

Mr. MOFFETT. How widespread would you say that is?

Mr. LANGDON. I think it is on a small scale, but I think they are ready to make it on a broad scale in the event, depending on what happens here today, largely.

Mr. MOFFETT. Depending on what happens today?

Mr. LANGDON. Yes; in this sense, how this thing is left.

Mr. MOFFETT. What can be resolved today that would change the situation as far as what the shippers are doing in either contemplating or actually shipping?

Mr. BLANCHETTE. I don't think anything can be accomplished today to my knowledge.

Mr. MOFFETT. Now, you and I had a phone conversation and I was appreciative of that, Mr. Blanchette. Have you today testified that if the legislation isn't in fact passed and signed by the President by the middle of the month, the 14th, that you will take steps to close down?

Mr. BLANCHETTE. We will issue the notice of possible future embargo. Immediately we are able to do so, we will lift that embargo, if it has already gone into effect. The vice—I don't disagree, Mr. Moffett, that the Congress will act. The vice of it is, once the embargo goes into effect, damage is done. We will lift that embargo as soon as people can permit us to pay our employees.

Mr. MOFFETT. Damage is already being done——

Mr. BLANCHETTE. In small amounts.

Mr. MOFFETT. In small amounts?

Mr. BLANCHETTE. But we are not going to ask our people to work for nothing. They are already earning the pay that falls due on a payroll on the 25th of February. They are staking us right now.

Mr. MOFFETT. I understand that.

Just one more question. It is my understanding, Mr. Chairman, even if we acted as quickly as we possibly could, under the rules there is no possibility of this coming to the floor before the 14th. Suppose there were no recess?

The CHAIRMAN. We do not come back until the 17th——

Mr. MOFFETT. Suppose we were here. There would be no possibility as I understand it until at least the 14th, isn't that correct?

The CHAIRMAN. It could be possible.

Mr. MOFFETT. I just wanted to say that for the record, because the gentleman from New York seemed to indicate that if we did not take the recess it would somehow expedite this. I am on record as not favoring the recess, but it should be said refusal to take the recess would not in fact expedite this, to my knowledge.

The CHAIRMAN. Under the regular procedure it would be after the 14th before we could do it. But in an emergency we might be able to get some of the rules waived. But under the regular rules—I doubt it.

I would say this to the gentleman from Connecticut, whether we are going to be able to get a quorum tomorrow? I would like to ask those members of the committee who are here today if they will be here tomorrow at 10 o'clock.

All right. That gives us a little something to start off.

Mr. DEVINE. Let the record show there are less than 10 members here.

The CHAIRMAN. That is right. But we are going to poll every member of the committee, because I understood there would be no business

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on the floor. I think we would try to, if we have—I am taking time to explain a little bit, not out of your time, Mr. Moffett, that if we had the time, we would try to get this bill out tomorrow, and get it so we could act as sooon as we came back.

The Speaker called me and said, if we could do it, get everything ready. They would probably have a rules meeting on the 17th and try to act on the 18th. I am giving you that for your benefit. But I doubt it very much under the conditions as they are, and I cannot control those and don't know that any one member can, or two members, or the Speaker.

Mr. BLANCHETTE. We will be delighted at the first opportunity that presents itself for us to discard that embargo.

The CHAIRMAN. A lot of damage is going to be done before that.

Mr. BLANCHETTE. We regret that.

The CHAIRMAN. To the Penn Central and it is already in bad shape.

The gentleman from Connecticut.

Mr. MOFFETT. No further questions.

The CHAIRMAN. The gentleman from Pennsylvania, Mr. Rooney.

Mr. ROONEY. I have read your statement earlier, Mr. Blanchette; and I regret very much that other meetings prevented me from being here during the questioning this morning. If you do impose this embargo on the 14th of February, have you estimated the cost to the Penn Central of shippers shifting the transportation of their goods from railroads to trucks, and remaining with the transportation of their products by truck after the embargo ends?

Mr. BLANCHETTE. It is a very difficult judgment call, but as near as I can answer that is in this way. Between the 14th and the 24th, we would normally earn approximately $90 million. Let us assume now the embargo is put into effect but because of what the Chairman described we are able to lift it on the 24th, and we don't actually shutdown. Some fraction of that $90 million is gone and may be gone forever. It depends on whether shipments that are held back are later rerouted on the Penn Central, and a number of variables. All I can say is that between the 14th and the 24th, we will lose in revenue some portion, some significant portion, of $90 million.

Mr. ROONEY. So you have made a modest estimate for your needs I think. When I left this morning it was $350 million through the first quarter of 1976.

Mr. BLANCHETTE. Yes, sir.

Mr. ROONEY. And now, you indicate you may need more money because you did not take into account the possible additional loss of revenue due to the embargo?

Mr. BLANCHETTE. We did not take into consideration on that $350 million any adverse cash impact resulting from the implementation or the announcement of an embargo.

Mr. ROONEY. I have no further questions.

The CHAIRMAN. Does the gentleman from Texas have any questions? If not, we will proceed to the next witness.

All I must say is I think that before you leave, you gentlemen must take into very, very serious consideration any action that you do, and I think you better consult with the Department of Transportation and the ICC and the Congress before any action is taken.

Mr. BLANCHETTE. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness is the Erie Lackawanna trustee, Mr. Ralph S. Tyler, Jr.

Mr. Tyler.

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STATEMENT OF RALPH S. TYLER, JR., TRUSTEE, ERIE LACKAWANNA RAILWAY CO., AND HARRY G. SILLECK, JR., COUNSEL, ACCOMPANIED BY THOMAS F. PATTON, TRUSTEE; GREGORY W. MAXWELL, PRESIDENT; JOHN L. ALTIERI, JR., COUNSEL; AND RICHARD HAHN, VICE PRESIDENT—FINANCE AND ADMINISTRATION

Mr. TYLER. Mr. Chairman, may I first identify my colleagues. On my immediate right, Mr. Harry G. Silleck, Jr., special counsel to the Trustees. Next to him, Mr. Thomas F. Patton, Trustee, Erie Lackawanna Railway Co. Next to Mr. Patton, Mr. John J. Terry, Jr., also special counsel. On my left, Mr. Gregory Maxwell, president of Erie Lackawanna Railway Co., and next to him Mr. Richard H. Hahn, vice president—finance and administration.

Mr. Chairman——

The CHAIRMAN. Do you have a prepared statement? If you would put that in the record and summarize, we would appreciate it.

Mr. TYLER. Very well, sir. [See p. 207.]

Mr. TYLER. First, may I say we are grateful to you and the members of your committee for the opportunity of meeting with this committee today.

Could I go through a condensation of material previously filed, sir?

The CHAIRMAN. Yes.

Mr. TYLER. Thank you.

Mr. Patton and I as trustees urgently request legislation to provide grants to Erie Lackawanna without which we will be forced to cease operations by the end of February, because cash to meet our payrolls will run out.

We likewise urge the adoption of section 7 of Senate 281 providing for Erie Lackawanna's inclusion as a railroad in reorganization under the 1973 act which is necessary if there is to be any assurance of the preservation of the service now performed by Erie Lackawanna.

The material previously filed sets forth in detail the lengths of our line, the number of employees, 10,000, and the States we serve, as well as our patrons and customers.

If we are forced to close down it would be a tragic addition to the country's economic crisis. This can be averted by an enactment of Senate 281 which would permit Erie Lackawanna to share in the benefits of the Regional Rail Reorganization Act of 1973.

Congress enacted that law to provide a comprehensive plan for the reorganization of all the bankrupt railroads in the Northeast, because Congress believed that the separate reorganization of all those railroads under section 77 of the Bankruptcy Act was impossible.

Erie Lackawanna was then a railroad in reorganization along with the other lines. The Congress provided, however, that if the Reorganization Court supervising the section 77 proceedings found among other things that any such railroad could be successfully reorganized on an income basis within a reasonable time, such reorganization should continue for that railroad instead of reorganization under the 1973 act.

Last April the Federal District Court supervising our section 77 reorganization, based upon evidence submitted by the trustees, con-

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cluded that Erie Lackawanna could reorganize successfully on its own.

I want to point out, Mr. Chairman, contrary to the intimation of some of the statements made yesterday, this was not an optional matter under the statute. We did not make an election.

It involved a judicial determination of a question of fact as the statute required.

Mr. Chairman, the trustees and employees of Erie Lackawanna have worked very hard to accomplish the section 77 reorganization and we are reluctant to seek financial assistance from the Government.

In fact, except for a small Agnes loan of $3.5 billion, this is the first time we have come to the Government for help. However, developments subsequent to the Court's finding have led us to the unhappy conclusion that Erie Lackawanna cannot reorganize on its own and, indeed, is in a desperate cash situation which will force cessation of operations by the end of February unless Government assistance is provided.

These developments include rising costs for labor and materials and a severe downturn in traffic due to the recession.

Even applying all cash management techniques available, we will run out of cash by the end of February. We have already reduced our employment by some 1,600 employees since November 1, so we have exhausted that possibility.

Recognizing the great public interest in keeping the railroad running, we seek immediate financial assistance for the short run and inclusion in the group of railroads to be reorganized under the 1973 act for the longer period.

Senate 281 meets both of these goals.

I want to emphasize that interim financial assistance alone will not solve the problem. Unless we are permitted to become a "railroad in reorganization" under the 1973 act, there is no assurance that any of our properties will continue to be operated after the final system plan becomes effective, nor will there be any assurance that the cost of labor protection benefits of Erie Lackawanna's 10,000 employees will be covered, nor any assurance of assistance to States or local communities which desire to continue rail service by the use of rail subsidies and loans from the Federal Government under the 1973 act.

Yesterday, Mr. Chairman, Mr. Barnum on behalf of the Department of Transportation proposed some amendments to H.R. 2051 in lieu of Senate 281.

His amendments simply do not meet the needs of Erie Lackawanna, or the public interest in assuring continuance of service now performed by Erie Lackawanna.

Let me be specific. In the first place, Mr. Barnum would leave Erie Lackawanna in the anomalous status of a so-called profitable railroad even though it cannot be reorganized.

Yesterday, in response to a question from Congressman Brown, Mr. Barnum said that all that would have to be done would be for the Erie Lackawanna trustees to negotiate with some other railroad for disposition of its properties, and that would be that.

Then Erie Lackawanna properties would be in the final system of roads and the Erie Lackawanna creditors would have gotten fair value. He ignores the fact that it takes two to negotiate a deal, and there is no assurance whatever that the parties could arrive at a deal, and if they don't, the Erie Lackawanna properties will not be in the resulting system of roads under the 1973 act.

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Moreover, the problem is complicated by the necessity under the act, a point stressed by modifications proposed yesterday by Mr. Barnum, that the deal must be arrived at and concluded within 60 days after the effective date of the final system plan.

It is certainly doubtful that this can be done as to all properties as to which Erie Lackawanna might be expected to negotiate.

Without a provision like section 7 of Senate 281, there is just no way that Erie Lackawanna properties can be sure of being in the resulting northeastern system.

Secondly, his proposal on section 213 grants is not workable even to meet the short-term needs of Erie Lackawanna for cash.

As he would rewrite section 213, no money would be available for Erie Lackawanna unless "a substantial portion" of its rail properties is "likely" to be transferred to ConRail or other roads.

How can anyone tell whether that is likely, particularly this month with not even the preliminary system plan released.

Mr. Barnum also purports by another proposal to assure Erie Lackawanna's employees of labor protection. Again, however, this is dependent under his language on a substantial portion of Erie Lackawanna's properties being transferred to ConRail or other roads.

This is no assurance of protection because, as I have said, it depends on one or more voluntary deals being worked out on both sides before 60 days after the final system plan becomes effective.

Now, another important subject, an omission. Mr. Barnum's proposed amendments do not even attempt to deal with the matter of subsidies and loans from the Federal Government to local agencies to carry on any portions of Erie Lackawanna's operations not designated in the final system plan for continued operations.

Yet, unless Erie Lackawanna and either ConRail or other roads agree to and actually conclude the deals or transfers for substantially all of Erie Lackawanna's properties that are designated in the final system plans, there will be no subsidies to local communities to help them take over the rest of Erie Lackawanna's operations.

Mr. Barnum's proposal does not make Erie Lackawanna eligible for section 215 assistance. Yet, if there is a need to start now on buying ties and rails and equipment for Penn Central and other roads in anticipation of the final system plan, there is equal reason to do so in the case of Erie Lackawanna to the extent its properties need modernization.

Why is the Department of Transportation proposing these clearly inadequate amendments? Because, Mr. Barnum says, there is a possibility that the making of Erie Lackawanna a railroad in reorganization under the 1973 Act could reopen the question litigated last year as to the constitutionality and the fairness and equity of the process.

He, frankly, admits such litigation would fail, but fears, he said, the issuance of the injunctions which might delay consummation of the final system plan pending that litigation.

Gentlemen, we think that is entirely specious. I will ask our special counsel, Mr. Silleck, to tell you why.

Mr. SILLECK. Mr. Chairman, as Mr. Tyler said, Mr. Barnum's expressed worry is injunctive relief and the possible delay that might be involved. At this point I see no reason why any creditors would

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even begin to initiate litigation. But assuming that somebody did, it is well-established law that it is not possible to obtain a preliminary injunction unless the plaintiff can show probably success on the merits. Mr. Barnum flatly stated yesterday that any such litigation in his opinion would fail. We gather the ICC and the USRA think it would fail.

The Senate, by passing S. 281 has indicated it thinks it would fail. In view of the Supreme Court's decision, only a couple of months ago, upholding the constitutionality of the 1973 act, it is perfectly clear that such litigation would fail. If that is the case, how can there be any legitimate worry that an injunction would be granted?

Furthermore, where the public interest would be adversely affected by the granting of a preliminary injunction, as it certainly would be in the event of any litigation attacking the legislation which the trustees are here proposing, that would be another reason under decided case law for denying injunctive relief.

Nor would it take very long to decide the question on the merits. Mr. Barnum made reference yesterday to the 11 months which it took to resolve the reorganization case last year. That case took 11 months only because no greater expedition was necessary, as the planning process was still in the early stages and the case raised very serious questions of constitutionality.

The implication that the Federal courts would be so irresponsible as to hold up the implementation of vital legislation and thus hold up the effectiveness of the final system plan hereunder is simply ridiculous.

Certainly in the light of the national crisis presented by the problem of the bankrupt railroads in the East, if any injunction were by mischance granted in lower courts, prompt resolution of the whole subject would be available in the Supreme Court.

We all know that the Supreme Court can act fast when it needs to, as it has in the past.

Mr. Tyler has also referred to the difficulty of working out terms on a negotiated basis within the timeframe of the DOT's proposal. In connection with the matter of delay, I would like to expand on that point.

As the Chairman of USRA, Mr. Lewis, stated yesterday, it is likely that some of EL's properties will be designated for transfer to a truly profitable road. Under section 206 of the 1973 Act, this must be done in the preliminary system plan and within 90 days thereafter the ICC must find that such transactions will be——

The CHAIRMAN. Could I interrupt you one moment?

I wanted to ask one question.

The Chair must leave for an emergency and will be back and I wanted to ask Mr. Tyler this: If we granted an emergency loan or grant under the 1970 Emergency Rail Act, and not under the 1973, could you continue to reorganize under section 77? And if so, what amount would you need to take you through the first quarter of 1976?

Mr. TYLER. May I break that down? Your question related to the 1970 act.

The CHAIRMAN. That is right.

Mr. TYLER. My understanding is that we would not be eligible for a loan under that act because we do not meet one of the terms of the act, namely, viability or survivorship.

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Second, there would also be a problem about the rank and priority of that loan, as a claim against the bankruptcy state.

Going on, our opinion is that our situation has deteriorated so much that a loan almost without regard to size would not make us reorganizable within a reasonable period of time.

The CHAIRMAN. I said loan or grant. Do you know of any other act that we might apply an amendment to this bill under that you could get your money? Any other act that you could still reorganize under?

Mr. TYLER. No.

The CHAIRMAN. Well, I just wonder if there is any way you could work out something? We want to help you. I do, but in light of what Mr. Barnum has said and others said about jeopardizing, and I have been listening to you about not being subject to suit and not being responsible in court, and I know when you get a bunch of lawyers together you can do most anything. So I just kind of discount this a little bit, not saying you are not perfectly honest about what you are telling us. But I know that circumstances change with time. I am just wondering if there is some other way to help you without coming under this act. Put an amendment in this some way.

Mr. TYLER. I believe there is not, Mr. Chairman, we urge upon you the views of Mr. Lewis and the ICC, who are in favor of our going under the 1973 act.

The CHAIRMAN. OK. That is the question.

You may proceed.

Mr. SILLECK. I was referring to the question of delay and trying to work out the inclusion of Erie Lackawanna in the final system plan, if it were to remain as a so-called profitable railroad.

Under section 206, if Erie Lackawanna's properties are to be designated in whole or in part for transfer to a truly profitable railroad, it must be done in the preliminary system plan. And within 90 days thereafter the ICC must find such transactions will be in full accord and comply with the provisions and standards of section 5 of the Interstate Commerce Act.

Under that act the ICC determines whether the terms of any transaction are just and reasonable. If EL is a "railroad in reorganization," there would be a measure of value, to wit, the constitutional minimum language, which the ICC can pass on in determining whether the standard of "just and reasonable" has been met. But without that measure, and there would be no measure in the case of EL, if it is treated as a profitable railroad, you will be forcing the parties immediately to agree on the price so that the ICC can perform its duties under section 206 within 90 days.

This is just not feasible. But even supposing the ICC ignored the whole question of just and reasonable price, there is still the great difficulty in agreeing upon terms within 210 days after the preliminary plan is released, and then having courts determine whether the price is right within 60 days more. You will note that in the case of railroads in reorganization under this act, there is no time limit whatever on determining the very complex issues of valuation that are involved.

Yet, under the DOT's proposal, Mr. Barnum would require that that be determined, approved, agreed upon, and that the transactions be concluded within 270 days.

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Because of that difficulty the Congress cannot reasonably expect that agreements will be reached and concluded within the time required by this act.

Now, what that means is very clear. When the Congress gets down to the point this fall of considering the final system plan, it will have no assurance that EL's rail operations will be continued after the plan becomes effective. We do not believe that Congress would or should approve a final system plan that does not at least provide such assurance.

The chief architect of the planning process, Mr. Lewis, has testified that in order for the final system plan to fulfill the goal of the act, it is essential that EL be subjected to mandatory conveyances. If the plan submitted does not fulfill the goals of the act, there will be real delay inevitably at that point.

The real fears of delay at that point ought to be given far more weight than any theoretical delays caused by some hypothetical litigation.

Mr. TYLER. Mr. Chairman, in conclusion, we can see no basis in fairness or principle for treating Erie Lackawanna any differently from the other railroads which cannot be reorganized.

By this legislation Congress would not do something special for Erie Lackawanna. It would merely be treating Erie Lackawanna in the same manner as the other railroads in reorganization in accordance with Congress' initial intent.

A year ago the economic evidence indicated that Erie could go it alone through a section 77 reorganization. It is because that conclusion is no longer being supportable, that it is now essential to provide for the return of Erie Lackawanna to the status of a railroad in reorganization and for an increase in the authorized amount of section 213 grants in order to continue Erie Lackawanna's operations.

Now, a question that you are thinking about, and I want to answer right now and we will discuss it further later in the question period, is what are our financial requirements, what are we seeking in the way of section 213 grants.

For the first half we estimate that we will require grants of $10 million before giving effect to the loss of revenue from the suspension of the 7 percent rate increase due to go into effect February 5.

To meet that deficiency in revenue we will need in the first half another $6 million. So that makes a total of $16 million during the first half of 1975, the period ending June 30.

For the second half we estimate that our requirements will be $9 million in grants.

Now, I want to recite the three key assumptions we have made in giving those estimates.

As to rate increases, we have assumed that the 7 percent rate increase, suspended on February 5, would become effective on July 1. We further assumed that a 3 percent rate increase, not on the ICC's records, but geared into our forecast, to become effective September 1, would not become effective at all in 1975.

We have made one further principal assumption, and that is that any increases in the cost of oil due to the import fee or other elements, would be compensated for by specific and particular rate increases authorized by the ICC as was the pattern last year.

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So, on those assumptions, it is $25 million that we believe we need through December 31, 1975 [see later dated February 6, 1975, p. —, this hearing].

Mr. Chairman, might I ask that the testimony with the three appendixes we filed on this committee last Friday be incorporated into the record?

Mr. Moss [presiding]. Is there objection to the request?

Hearing none, the material will be incorporated in the record at this point.

[Testimony resumes on p. 216.]

[Mr. Tyler's prepared statement and appendixes follow:]

STATEMENT OF RALPH S. TYLER, JR., CO-TRUSTEE OF ERIE LACKAWANNA RAILWAY COMPANY, DEBTOR

Thomas F. Patton and I are the Trustees of Erie Lackawanna Railway Company ("EL"). We urgently request adoption of S. 281. Without this legislation EL will be forced to cease operations by the end of February, because cash to meet our payrolls will run out.

This means not only that the 10,000 employees of EL may be added to the unemployment rolls but within a few days many shippers on our line may be forced to curtail operations and lay off employees. This impact will be felt not only along the 2,800 miles of EL lines in the States of Illinois, Indiana, Ohio, New York, Pennsylvania and New Jersey but in other sections of the country since EL is an integral part of the national rail network. A more complete description of the services provided by EL is submitted herewith as Appendix A.

The list of 20,000 EL customers who would be adversely affected covers the entire geographic, production and service spectrum of the U.S. economy. Such a disaster, which would be even more tragic in the current economic crisis, can be averted by the enactment of S. 281 which will permit EL to share in the benefits of the Regional Rail Reorganization Act of 1973.

Congress enacted the 1973 Act to provide a comprehensive plan for the reorganization of all the bankrupt railroads in the Northeast because the Congress believed that the separate reorganization of all those railroads under Section 77 of the Bankruptcy Act was impossible. The Congress provided, however, that if the reorganization court supervising the Section 77 proceedings found, among other things, that any such railroad could be successfully reorganized on an income basis within a reasonable time, such reorganization should continue for that railroad instead of a reorganization under the 1973 Act. Such a railroad is not eligible for the financial assistance under the 1973 Act to continue necessary operations which is available to Penn Central and other bankrupt roads reorganizing under the 1973 Act.

Last April, the federal district court supervising EL's Section 77 reorganization proceedings, based on evidence submitted by the Trustees, concluded that EL could reorganize successfully on its own. The Trustees and employees of EL have been working hard to accomplish such a reorganization and EL has been very reluctant to seek financial assistance from the Government. However, developments subsequent to the court's finding have led us to the unhappy conclusion that EL cannot reorganize on its own and indeed is in a desperate cash situation which will force cessation of operations by the end of February unless Government assistance is provided.

These developments include rising costs for labor and materials and a severe downturn in traffic due to the recession. In 1974 EL experienced a loss in net income of about $17.5 million on top of losses of $18.2 million in 1972 and $18.6 million in 1973. The effects of the recession fell heavily on the railroad in November and December and the recession is continuing to plague the railroad.

Our current 1975 forecast projects a loss of $22.6 million for the year. Even that forecast may be unduly optimistic. It assumes a slight upturn in the economy in the second half of the year, but whether this is realistic is becoming more doubtful. The gloomy outlook is further aggravated by the ICC suspension of the 7% rate increase which had been counted on by the nation's railroads to take effect on February 5. The impact on EL will be a drop in revenue from the level forecast of $500,000 in February, $1.3 million in March and, if the suspension lasts the full statutory period of seven months, a total of $8.5 million through September. To the extent these reductions occur there will result a corresponding additional deficit in cash.

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As a result of the 1974 losses and the consequent drain on cash already experienced, maintenance of roadway is being held to the minimum necessary to meet Government safety standards. A year ago only 3% of our main lines were under "slow orders"; now the figure is over 20%. Moreover, the disappointing results for 1974 and the even more disappointing forecast for 1975 have made it impossible for EL to proceed with necessary capital improvements in plant and rolling stock.

A more complete description of the events which have brought us to this point is contained in a memorandum which is submitted herewith as Appendix B.

Even applying all the cash management techniques at its disposal, EL will run out of cash by the end of February. Our employment force has already been reduced by 1,600 employees since November 1. Without assurance of Government financial assistance we will have to begin to embargo traffic before the end of February. Recognizing the great public interest in keeping the railroad running, we seek immediate financial assistance for the short run and inclusion in the group of railroads to be reorganized under the 1973 Act for the longer period. S. 281 meets both of these goals.

It is important to note that interim financial assistance alone will not solve the problem. Unless EL is permitted to become a "railroad in reorganization" under the 1973 Act, there is no assurance that any of EL's properties will continue to be operated after the final system plan becomes effective. Nor will there be any provision to cover the cost of labor protection benefits for EL's 10,000 employees, nor any provision for assistance to states or local communities which desire to continue rail services by the use of rail subsidies and loans from the Federal Government as the 1973 Act provides. Moreover, the Senate Commerce Committee has found that restoration of EL to the status of a "railroad in reorganization" will "alleviate . . . planning problems and streamline the process" under the Act. Appendix C submitted herewith is an analysis in some detail of the legal and public interest considerations involved.

By this legislation, Congress does not do something special for EL. It is merely treating EL in the same manner as the other railroads in reorganization in accord with Congress' initial intention. A year ago the economic evidence indicated that EL could "go it alone" through a Section 77 reorganization. It is because that conclusion is no longer supportable that it is now essential to provide, as does S. 281, for the return of EL to the status of a "railroad in reorganization," and for an increase in the authorized amount of Section 213 grants in order to continue EL's operations.

Appendix A

Description of Erie Lackawanna Railway Company, Its Business and Service

Erie Lackawanna Railway Company has been—and continues to be—an integral part of the transportation system serving the highly industrialized northeastern United States.

Erie Lackawanna operates over 2,800 miles of road in the states of Illinois, Indiana, Ohio, New York, Pennsylvania and New Jersey. Its main line runs between Chicago and New York City, serving Marion, Akron and Youngstown, Ohio; Jamestown, Buffalo, Corning, Elmira and Binghamton, N.Y.; Scranton, Pa.; and Paterson, Newark and Jersey City, N.J. Erie Lackawanna has important branch lines connecting such cities as Cincinnati, Dayton and Cleveland, Ohio, to its main line operations. Branch lines in New York connect Rochester, Syracuse, Utica and Niagara Falls to the main line.

In addition to serving as a direct link for many of the major metropolitan areas in the states served, Erie Lackawanna connects with other railroads which allows its customers to ship to or receive from almost any point in the United States. These important gateways include Chicago with its multiroad connections with most western and southwestern railroads, Cincinnati with its important connections with railroads serving the South, Buffalo with its many connections with other eastern railroads as well as Canadian rails, and several important eastern interchanges providing connections to New England and other eastern destinations.

During the year 1974 Erie Lackawanna handled over 746,000 carloads of freight on its lines and almost 182,000 trailer loads of freight. The trailers of freight are handled on rail cars, usually two per car. For freight service, Erie Lackawanna

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received gross revenues of approximately $282 million last year. In addition, Erie Lackawanna has an extensive commuter train operation in Northern New Jersey and adjacent New York State, handling approximately 40,000 commuters per day. Last year for this service the railroad received over $14 million in revenues and over $13 million under contract with the states involved to bring the operation to a non-profit, break-even level.

Erie Lackawanna required the services of approximately 11,000 employees to produce its total 1974 revenues of $323 million, including the freight and passenger revenues noted above.

Freight cars in Erie Lackawanna ownership totaled almost 20,000 at the end of 1974 and it also owned or leased over 3,400 freight carrying trailers. In addition there were over 500 locomotives owned by railroad at the end of 1974.

Erie Lackawanna's major customer list—those companies which depend on the railroad for a large portion of their total distribution needs—reads like a who's who in United States industry. Republic Steel, United Parcel Service, General Motors, Youngstown Sheet & Tube, Allied Chemical, U.S. Steel and Ford Motor as a group provided almost 28% of Erie Lackawanna's freight business. Other major companies which depend on Erie Lackawanna for rail transportation include Metropolitan Edison of Pennsylvania, Chrysler Corp., International Paper, National Steel, Bethlehem Steel, General Electric, General Foods, Owens-Illinois, General Mills. The list of 20,000 Erie Lackawanna customers covers the entire geographic, production and service spectrum of the U.S. economy. These 20,000 customers ship from or receive at 140,000 locations.

The types of goods carried by Erie Lackawanna are likewise extensive. In 1974 the railroad carried over 50,000 carloads of each of the following commodities: paper and paper products, iron and steel products, automobiles and automobile parts, coal, iron ore and chemicals. This traffic constituted 40% of the total handled in 1974. Much of the traffic moves in rather heavy volume between relatively few points. For example, iron ore mostly moves between the U.S. ports on Lake Erie to the Youngstown and Warren, Ohio, areas as well as Sharon and (via connecting railroads) Pittsburgh, Pennsylvania. Lumber, flour, machinery and beverages added another 10% to the volume of traffic moved over Erie Lackawanna tracks. The other 50% of the traffic was made up of a broad array of commodities from food products to sand and gravel, from ordnance shipments to glass products. Additionally, the railroad handled over 158,000 trailer loads of general merchandise where no commodity identification is available.

Erie Lackawanna's large handling of highway trailers on rail cars makes it a major carrier of this type of freight. With almost 20% of its freight business in trailers, the railroad has developed two large efficient terminals which handle about 80% of its trailers onto and off rail cars. One is located at Chicago and the other in northern New Jersey where not only local New Jersey industry can be served but also customers located at points in New York City, lower Connecticut and Long Island. The volume of this traffic alone indicates shippers' dependence on this type of extremely competitive service.

Over 750,000 cars and trailers, or more than 80% of the total, handled by Erie Lackawanna either originate and/or terminate from customers located on its own lines. Many of these customers do not have alternate rail service available to them.

Some of the larger customers served exclusively by Erie Lackawanna (so far as rail service is concerned) include a General Motors stamping plant at Mansfield, Ohio, a Ford Motor automobile assembly plant at Mahwah, N.J., the Metropolitan Edison generating plant at Portland, Pa., a National Biscuit bakery at Fairlawn, N.J., an FMC chemical plant at Meadville, Pa., and a Packard Electric auto parts plant at Warren, Ohio.

Erie Lackawanna provides the exclusive rail service for 50 firms which move over 500 carloads of freight per year. The need for the essential rail service provided by Erie Lackawanna was evidenced in the hearing held in 1974 pursuant to the Regional Rail Reorganization Act of 1973 before the United States District Court at Cleveland overseeing Erie Lackawanna's reorganization proceedings in which a total of 156 shippers offered exhibits demonstrating the importance of Erie Lackawanna's service to them. The preservation of rail service is also required by industries locating or planning to locate new facilities on Erie Lackawanna's lines. Most notable among these is the new Schlitz plant near Syracuse, N.Y., which will be one of the largest breweries in the United States upon its completion in 1977.

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While Erie Lackawana is greatly dependent on the economy of the northeastern United States, the economy of the northeastern United States is also greatly dependent on Erie Lackawanna. As indicated above, industry in that region relies on Erie Lackawanna to provide an important part of its transportation needs, and many companies have no alternative rail transportation available to them. The economy of the area served by Erie Lackawanna benefits from the existence and preservation of present industry shipping patterns and also because rail service attracts new industry to the area. Moreover, the expenditure last year by Erie Lackawanna of $157 million in wages and salaries and $50 million for the purchase of materials and supplies indicates what a significant contributor the railroad is to the economy of the area in which it operates.

By reason of the substantial volume of traffic it handles in conjunction with other railroads to and from points throughout the United States, Erie Lackawanna's service is an important factor in the national economy.

Appendix B

Memorandum of the Trustees of Erie Lackawanna Railway Company as to (1) Its Inability To Reorganize Under Section 77 of the Bankruptcy Act and (2) Its Urgent Need for Cash To Carry On Its Operations

Erie Lackawanna Railway Company ("EL") has been in reorganization proceedings under Section 77 of the Bankruptcy Act since June 1972.

Early in 1974, pursuant to proceedings required by the Regional Rail Reorganization Act of 1973 (the "1973 Act"), EL was found by the Bankruptcy Court overseeing its reorganization to be reorganizable under Section 77 on an income basis within a reasonable time. However, because heavy operating losses have persisted into the third year of the reorganization proceedings—preliminarily estimated (on a fully accrued basis) to be $17.5 million in 1974—and because the losses are expected to increase substantially in 1975 as a result of present economic conditions, the Trustees of EL concluded early in January, 1975, that such a Section 77 reorganization is not possible.

Furthermore, based on their forecast for 1975 results, EL will need assistance from the Federal Government in an amount of $10 million in order to carry on EL's operations during the first half of 1975, much if not all of which will be required before the end of February. Additional funds may be necessary if the economic downturn is sharper than has been anticipated, or if, as discussed below, expected rate increases to meet increased costs are delayed.

The Court's finding last year that EL, could be reorganized under Section 77 was predicated upon a recommendation by the EL Trustees, whose judgment was based on projections of future operating results ("the 1974 Forecast") arrived at in close consultation with highly competent and experienced railroad consultants and financial advisors. The 1974 Forecast indicated that EL could successfully be reorganized under Section 77 by January 1, 1981.

The 1974 Forecast anticipated a relatively stable economy. At the time, it was concluded by EL's financial consultants that if EL's earnings improved as projected for 1974 and 1975, EL could then anticipate adequate liquidity to meet working capital requirements and sufficient confidence of the private sector in its ability to reorganize which would enable EL to obtain necessary financing for capital improvements. Thus EL was expected to achieve adequate earning power in later years on which to base a fair and equitable capital structure.

Even assuming some way could be found to meet EL's present working capital needs, the reorganization of EL on an income basis within a reasonable time can no longer be regarded as possible, and the financial consultants have so advised the EL Trustees. The considerations involved in arriving at that conclusion include (1) the heavy loss actually experienced in 1974 on top of the losses in 1973 and 1972, and the even greater loss which the Trustees are now compelled to anticipate for 1975, (2) the necessity for a greater improvement in EL's business in subsequent years than can now be realistically expected, and (3) the inability to catch up soon enough on essential maintenance of plant, as well as to make capital improvements which would be necessary to the accomplishment of a Section 77 reorganization but which must now be indefinitely deferred.

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THE LOSSES

Losses from operations during the reorganization years, the results for 1974 and 1975 as anticipated in the 1974 Forecast, and the losses now anticipated for 1975 ("the 1975 Forecast" are set forth below. The letter "D" denotes deficit.

[In millions]

			1974		1975	
	1972	1973	1974 Forecast	Actual[1]	1974 Forecast	1975 Forecast
Income before fixed charges[2]	$6.7D	$6.3D	$0.6	$3.9D	$2.0	$9.0D
Net income (before extraordinary item in 1972 due to "Agnes" storm)	18.2D	18.6D	12.4D	17.5D	10.6D	22.6D

[1] Preliminary; subject to audit and year end adjustments.
[2] Fixed charges include about $4 million of interest, principally on equipment debt, and other items required to be paid during the course of the Section 77 reorganization proceeding. The remaining fixed charges approximate $8 million which is the accrual of interest on funded debt which is not required to be paid during the reorganization proceeding.

As the foregoing shows, the Trustees' 1974 Forecast anticipated an improvement in operating results for 1974 of more than $6 million as compared with the earlier years, whereas the actual improvement in 1974 amounted to only about $1.1 million. Moreover, while a year ago 1975 was anticipated to produce a further improvement, EL must now expect that 1975 will show a loss $4 to $5 million greater than even the losses experienced yearly hertofore in the reorganization period.

The 1974 results are the more disappointing because EL, with the rate increases authorized by the Interstate Commerce Commission, produced about $282 million of freight revenues, up nearly $25 million over 1973, and yet the loss was reduced by only $1.1 million.

Now, because of the accelerating downturn in the general economy in the last months of 1974 which is continuing into 1975, the number of ton miles of freight traffic anticipated to be handled in 1975 is forecast to drop 17% below the volume anticipated for 1975 a year ago.

The 1975 Forecast may in fact be on the optimistic side. For the first six months of 1975 the 1975 Forecast is, as it must be, closely related to the decline in traffic experienced at the end of 1974. The 1975 Forecast then assumes a moderate upturn in the general economy in the last half of the year producing some increase in EL's business. Whether recovery from the recession will be experienced that early now appears to be viewed as more doubtful by many respected economists.

Of great concern now also is the recent suspension by the Interstate Commerce Commission of the 7% rate increase anticipated to become effective on February 5. This will result in estimated reductions of $494,000 and $1.3 million in the February and March revenue projections respectively. If the suspension is effective for seven months as permitted under the law, the aggregate revenue drop compared with EL's projected level is $8.5 million. The 1975 Forecast also assumes a 3% increase in rates in September 1975, which accounts for $3.1 million of the freight revenues projected in the last four months of the year. Whether this will be forthcoming, at least as early as anticipated, now appears doubtful in view of the ICC's suspension of the 7% rate increase.

It should further be kept in mind that experience shows that authorized rate increases intended to offset wage and price increases fall short of doing so because of competitive factors and the time lag between the experiencing of the cost increase giving rise to the rate increases and the implementation of the rate increases.

THE URGENT CASH NEED

Based on the 1975 Forecast of EL's revenues and expenses, EL's cash is expected to slide into a negative figure early in February and the cash deficit will increase to over $8 million by the end of February. During the balance of the year, cash is forecast to have some fluctuation, but to remain throughout the year in a substantial deficit position, exceeding $9 million at the end of September 1975.

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EL is, of course, employing cash management techniques in order to conserve cash required to continue its operations. It is anticipated, however, that even with full implementation of all available cash management techniques EL will not have sufficient cash to meet its operating requirements through February. Clearly, any further downturn in business or severe weather conditions this winter or the failure to obtain the anticipated rate increases, discussed above, would have a disastrous impact on cash.

It is also to be observed that the taking of extraordinary measures to conserve cash will have only a short-term effect.

By reason of EL's critical cash position, maintenance of its physical plant is now being carried on at the absolute minimum required to continue operations in accordance with Government safety standards. Only a year ago the percentage of EL's main line under "slow orders" was as little as 3%; it is now more than 20%. While the 1975 Forecast assumes a significant reduction in the amount of derailment expense ($7 million in 1974), this reduction may not occur in view of the current state of maintenance. If it does not occur, it will be another factor which will increase the anticipated 1975 loss and cash needs beyond those hereinabove described.

EL has also closed its principal car repair facility at Meadville, Pa. Only necessary running car repairs are now being made at line points. Locomotive maintenance has been reduced as much as possible.

Since November 1, 1974, to cut expenses EL has reduced the number of its employees, including seasonal employees, by over 1,600, with the result that there is no further slack to be taken up in this area of expense if EL is to maintain its present level of service. Many of these employees must be rehired in the near future to prevent further deterioration of roadbed and equipment.

As a result of the continuing heavy losses as well as the cash shortage, the EL Trustees have discontinued yard modernization and equipment acquisition programs and are not now making any significant capital improvements beyond those required in connection with environmental protection or other governmental orders.

Appendix C

Legal and Public Interest Considerations Involved in Proposed Amendments of Regional Rail Reorganization Act of 1973 by S. 281

On the date of enactment of the Regional Rail Reorganization Act of 1973 (the "1973 Act"), Erie Lackawanna Railway Company ("EL") was a "railroad in reorganization" within the definition of that term in Section 102(12) of the 1973 Act. Pursuant to Section 207(b) of the 1973 Act, on April 30, 1974, the United States District Court (the "Bankruptcy Court") overseeing the proceedings for EL's reorganization found that EL is reorganizable on an income basis within a reasonable time under Section 77 of the Bankruptcy Act ("Section 77"), and that the public interest would be better served by such a reorganization than by a reorganization under the 1973 Act. That finding having been made within 120 days after the enactment of the 1973 Act, EL thereupon ceased to be a "railroad in reorganization" as defined in Section 102(12).

It is now concluded by the Trustees on the basis of subsequent developments that a reorganization of EL on an income basis within a reasonable time under Section 77 is not possible, and that a substantial infusion of cash is necessary to continue EL's operations.

Section 207(b) of the 1973 Act contains an express finding by the Congress that there is a "strong public interest" in effectuating a reorganization under the Act of all railroads in the region (as defined) undergoing reorganization which are not reorganizable on an income basis within a reasonable time under Section 77. In addition, Section 213 of the 1973 Act authorizes Federal grants of money to "railroads in reorganization" where necessary for the continued provision of essential transportation services. On the other hand, there is no other existing legislation authorizing similar assistance to a railroad in Section 77 proceedings which cannot reasonably be expected to become self-sustaining.

Accordingly, both to assure a reorganization of EL properties which accords with the public interest as thus determined and to make EL eligible for assistance under Section 213 of the 1973 Act, it is necessary that EL be restored to the status of a "railroad in reorganization." Section 7 of S. 281 provides mechanics to achieve this result.

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There are major considerations from the standpoint of the public interest why EL should be reorganized as a "railroad in reorganization" under the 1973 Act rather than continue in the status of a "profitable railroad" under Section 102(9) of that Act.[1]

With EL as a "profitable railroad," while its properties might be designated for transfer under that Act to Conrail, and/or to one or more truly profitable railroads, the making of any such transfer would be optional with EL and could not be compelled under that Act. Likewise, the acceptance of such a transfer would be optional with Conrail and such other profitable railroads. Absent the making of such transfers, there is no assurance under the Act that any EL properties would continue to be operated if EL were to be treated as a "profitable railroad."

Further, the costs of protecting EL employees adversely affected by any such transfer would not be included in the $250 million of Federal Government payments for labor protection provided by Section 509 of the 1973 Act. It is, therefore, doubtful that any transfer of EL properties under the 1973 Act would ever be agreed to if EL is to be treated as a "profitable railroad."

Even in the absence of labor production payments by Federal authorities for EL's employees did not prove an insuperable obstacle to the accomplishment of the transfer of EL's properties if EL were continued within the definition of a "profitable railroad," it certainly cannot be assured that EL and the other profitable railroads or Conrail to which EL's properties might be designated for transfer, or among which it might be proposed in the planning process that they be divided, will in all cases arrive at agreements which can be "concluded" within 60 days after the effective date of the final system plan as required by Section 206(d)(4).

Thus the provisions for local rail service subsidies and loans might well have no application to any of EL's properties. Unless EL, if treated as a "profitable railroad," were to transfer "all or substantially all" of its properties designated in the final system plan for transfer to Conrail or to a "profitable railroad," EL's remaining properties (which might otherwise be abandoned) would not be subject to the provisions of Section 304(c)(2) of the 1973 Act, and the provisions for Federal assistance through rail service continuation subsidies and acquisition and modernization loans referred to in Sections 304, 402 and 403 of the 1973 Act would not be applicable in respect of any of EL's properties.

Since EL cannot be reorganized separately, it is possible that there will be designations of several portions of its properties for transfer to one or more possible recipients and that several other portions will not be designated for transfer to any one. To the extent that state or local authorities or others may be anticipating that they could acquire and operate portions of the EL properties not transferred to a profitable railroad or to Conrail in order to provide service which they regard as essential for local purposes, their expectations of substantial Federal assistance through subsidies and loans to effectuate that result could well be denied fulfillment if EL is not made a "railroad in reorganization" by amendment of the 1973 Act.

In addition to providing appropriate and necessary mechanics to assure the restoration of EL to the status of a "railroad in reorganization," S. 281 would increase the amounts of grants that may be authorized under Section 213 of the 1973 Act to "railroads in reorganization," and thus it provides a means for avoiding the shutdown of operations which otherwise would be necessitated by EL's cash shortage.

In this connection it should be noted that, contrary to the contention of the Department of Transportation before the Senate Commerce Committee, the proposed amendment to Section 211 of the 1973 Act providing for loans to railroads would not take care of EL's cash needs. The language in Section 211(a) now providing for loans under that section to be made "for purposes of assisting in the implementation of the final system plan" would be amended by S. 281 to read "for purposes of achieving the goals of this Act." However, this broadening of the purposes of Section 211, while perhaps desirable for other reasons, is not an adequate substitute for Section 213 grants to a bankrupt railroad which is not reorganizable under Section 77 of the Bankruptcy Act.

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[1] Under the 1973 Act, any railroad which is not a "railroad in reorganization" is by definition a "profitable railroad," even if it is a bankrupt which is not reorganizable under Section 77.

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Section 211(a) of the 1973 Act provides that no loan may be made thereunder unless "where applicable" it is treated as an expense of administration. This provision remains the same in Section 211 as proposed to be amended, and would therefore require that any loan in EL's case be treated as an administration expense with priority over all pre-bankruptcy debt, secured as well as unsecured.

In the event the EL Trustees would seek to make a Section 211 loan for working caiptal needs, it seems certain that a claim of unconstitutional erosion would be advanced by EL pre-bankruptcy creditors. Accordingly, there is substantial doubt whether the Bankruptcy Court overseeing EL's reorganization would authorize the making of such a loan to EL.

As stated by the Special Court in its decision on the "180 day order" in *In re Penn Central Transportation Co., et al.*, — F. Supp. — (Sept. 30, 1974) (slip op. p. 51), "there is no disagreement that . . . accumulation of administration expenses which are entitled to priority over secured creditors" and "the issuance of trustees' certificates with liens superior to those of mortgage bonds" are items which may "constitute unconstitutional 'erosion'." Furthermore, in assaying the fairness and equity of the process of the 1973 Act on Penn Central (and on the other "railroads in reorganization," slip op. p. 26) the Special Court (slip op. p. 51) relied on the provisions of Section 213 (as well as Section 215 relating to assistance for capital improvements), among other factors as indicating that in the case of such railroads there was no convincing evidence that any such erosion items would be likely to develop prior to the effective date of the final system plan on the schedule established in the 1973 Act.

Certainly, loans under Section 211 to a bankrupt road which cannot achieve an income-based Section 77 reorganization could constitute "erosion" which may be claimed to be constitutionally impermissible. This would be fortified, if such a road were treated as a "profitable railroad" for definitional purposes, by the fact that no reorganization of its properties would be assured by the 1973 Act. Rather, as previously indicated, the transfer of any properties of a "profitable railroad" would be optional not only with such railroad but with the designated transferee.

Assuming any such constitutional question were resolved in the courts favorably to the making of such a loan, it is likely that before the loan could in fact be made the EL Trustees would already have been required to commence the shutdown of EL's operations. On the basis of EL's forecast, cash will be required before the end of February to avoid a shutdown of operations. However, so far as EL is aware, the United States Railway Association which administers Section 211 has no regulations on the form and content of applications for loans to implement the final system plan which would be adaptable to a loan necessary to continue essential operations. In addition, Section 211(b) requires publication of any loan application under Section 211, with time required to be given for public comment. Further, the various terms of any loan would require negotiation which would take time before a loan agreement could even be presented to the Bankruptcy Court. Any decision of the Bankruptcy Court would be subject to appeals. These obstacles to obtaining timely assistance would not exist in the case of grants under Section 213 of the 1973 Act.

There also appears to be no basis in fairness or equity for distinguishing as to eligibility for the various types of Government assistance provided in the 1973 Act between bankrupt railroads which cannot be reorganized independently on an income basis under Section 77. Penn Central and other "railroads in reorganization" as defined in the 1973 Act would be eligible not only for loans under Section 211 as proposed to be amended, but also for grants under Section 213 and financial assistance under Section 215. EL should be similarly treated, and this would result from the adoption of Section 7 of S. 281 providing a mechanism for its restoration to the status of a "railroad in reorganization."

[The following letter was received for the record:]

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ERIE LACKAWANNA RAILWAY COMPANY
THOMAS F PATTON and RALPH S TYLER, JR Trustees
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February 6, 1975

Honorable Harley O. Staggers, Chairman
House Committee on Interstate and
Foreign Commerce
2366 Rayburn House Office Building
Washington, D. C.

Dear Mr. Chairman:

This letter is to correct an inadvertent error in my testimony as Trustee of Erie Lackawanna Railway Company before your Committee yesterday afternoon.

I stated that we forcast Erie Lackawanna's requirements for Government cash grants during 1975 total $25 million, including $9 million during the second half of the year, based upon a number of assumptions. These assumptions included the assumption that two freight rate increases would be permitted by the Interstate Commerce Commission to become effective, one of seven percent (suspended by the Commission on January 30, 1975) on July 1, 1975 and another for three percent (for which no application is pending before the Commission) on September 1, 1975. My testimony was in error as to the assumption regarding the latter freight rate increase; Erie Lackawanna's requirements during 1975 for Government cash grants total $25 million, including $9 million during the second half of the year, based upon the assumption that such three percent freight rate increase will not become effective on any date in 1975. The three percent freight rate increase was anticipated in our 1975 forecast made prior to January 30. In view of the Commission's suspension of the seven percent freight rate increase due to become effective on February 5, 1975, it now appears unlikely that the three percent freight rate increase will become effective in 1975.

When the draft of the transcript of my testimony is submitted to me for review and corrections, I shall correct therein the foregoing error.

Very truly yours,

Ralph S. Tyler, Jr.

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Mr. TYLER. Mr. Chairman, we will try to answer your questions.

Mr. Moss. Mr. Devine.

Mr. DEVINE. Thank you, Mr. Chairman.

Mr. Tyler, yesterday when Assistant Secretary Barnum testified before the committee I think, speaking for the Department of Transportation, generally agreed that Erie Lackawanna needed assistance and I think he came up with the answer of $25 million rather than the original figure which Mr. Bill Minshall, who talked to me at great length about this, offered.

And the only question seems to be on whether or not you should come under the same umbrella, and he objected to that on the basis it might stir up litigation and cause further delays and so forth.

He suggested that an amendment be offered that would bring you in and give you $25 million to resolve your problems, and that apparently is not satisfactory to your group.

Would the adoption of this amendment he suggested solve your problems or compound your problems?

Mr. TYLER. No, Mr. Devine, it would not. The $25 million on the assumptions I outlined would keep us alive through 1975. There would be problems not only to us but to USRA in formulating the northeastern railway system if we are not a railroad in reorganization.

There is even a cloud on our ability to get the $25 million by reason of that qualification under section 213 that a railroad such as Erie Lackawanna would be eligible for grants only if it was likely, as I recall, that a substantial portion of the properties would be included in the final system plan.

Mr. DEVINE. You simply then would like to be treated as Penn Central, and you don't hold the same fears he does as to possible litigation?

Mr. TYLER. No.

Mr. DEVINE. That summarizes the differences, does it not?

Mr. TYLER. In short, we don't think we should be penalized for making a good try at reorganizing under section 77, and then find we have been bludgeoned by this unparalleled recession and inflation that kept mounting during the year and then came to a crescendo at the end of the year.

Mr. DEVINE. Thank you.

Mr. Moss. Mr. Dingell.

Mr. DINGELL. No questions, thank you, Mr. Chairman.

Mr. Moss. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

As I understand, Mr. Tyler, some time back when you took over as trustee of the Erie Lackawanna you thought that the Erie Lackawanna would be able to survive and be a competitor for ConRail?

Mr. TYLER. That is right.

Mr. BROWN. Then as a Nation we got into the recession in which we find ourselves today and it was apparent that the Erie wouldn't be able to compete with ConRail.

Is there any chance that it can in the future be a competitive influence to ConRail?

Mr. TYLER. Speaking of properties, I think that is conceivable as part of the planning. But not reorganizing Erie Lackawanna as such under section 77.

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One of the possibilities which I believe has been discussed a number of places, including, I believe, the recent annual report of USRA, was a second ConRail, of which Erie Lackawanna could be a part.

Mr. BROWN. So you think there is no prospect that the present Erie Lackawanna, given the requirements of bankruptcy sections, can put it back on its feet?

Mr. TYLER. No.

Mr. BROWN. So the question is not as I asked the Secretary of the Department of Transportation the other day, not a question of whether, but when, and if eventually, why not now?

Mr. TYLER. Yes.

Mr. BROWN. Now, would you address yourself to that same question, if eventually, why not now. What are the advantages in doing it now over doing it at some later date after the ConRail plan has been formulated without Erie in the operating plan and then folding Erie into that plan at a later date?

The Secretary seemed to feel that there was advantage in deferring inclusion of the Erie until after the plan had been proposed without the Erie—with the Erie's bankruptcy taken into consideration.

I gather this has to do with the disposition of the properties and the rights of the creditors. Can you address those points?

Mr. TYLER. It seems to me, Mr. Brown, that the advantage of doing it now is that USRA will have some known quantities to deal with and can handle them with some certainty.

Our problem came upon us rather suddenly. It was toward the end of December that we saw how our situation deteriorated in 1974. It struck us that we were not going to be able to reorganize.

We formulated a business plan and forecast on January 3 which clearly showed that. That resulted in the trustees reaching the conclusions announced on January 9, (a) that we could not reorganize under section 77 within a reasonable time, and, (b), without Government assistance, we would have to cease operations.

On that date we had a number of meetings in Washington, including a meeting with officers of USRA, Mr. Lewis and Mr. Jordan, also with the Chairman of the Interstate Commerce Commission and also Mr. Tuggle and some of their associates, and then with Mr. Barnum, the Acting Secretary of DOT, and members of his staff as well.

The view was expressed by the USRA that while they were sorry to see us there and regretted the difficulty that brought us there, if we had to come, they were glad we came that day and not later.

That by our problem surfacing, as it were, that early, they would have time to develop a preliminary system plan for issuance on February 26, which would encompass the Erie Lackawanna.

USRA already had given Erie Lackawanna a substantial amount of study, knew a great deal about it. They did not have appraisals, they would not by that date, but those could come later.

So, if it had to be, that was the good time for it. Whereas, if it had come somewhat later, it would have to be handled, and what I am referring to as a jerry built kind of way. So that is what, in my opinion, the Barnum proposals are. They are compromises. Attempts to do something halfway, inspired by what we regard as an unfounded fear of litigation.

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Mr. BROWN. The figure seems to be $25 million that the Government would loan you to keep——

Mr. TYLER. Grant.

Mr. BROWN [continuing]. Grant you, I am sorry, until such time as they are ready to take you into the system, given the testimony of Secretary Barnum.

So what I am really probing for is why is it worth in effect $25 million to the Government to defer taking you in? Is the feeling that the lawsuits that might lie against the Government, if you were taken in now, in excess of this $25 million? I guess maybe that points up the issue?

Mr. TYLER. We have to divide our problem into two parts, I think, Mr. Brown. The $25 million is to keep us operating through December 31, so that we will be available and an operating enterprise to be folded into some kind of a Northeastern plan.

We then get to the situation that we are in, we are to be reorganized by ourselves under section 77, we are going to have to be taken over by ConRail or by profitable railroads, and the most efficient and effective way of doing it, is to make us a full-fledged railroad in reorganization under the act and have the same status as the others.

The CHAIRMAN. The time of the gentleman has expired.

The gentleman from California.

Mr. MOSS. When did this matter which you first told us come to the attention of the trustees? In December, when was it called to the attention of this committee?

Mr. TYLER. Mr. Moss, our first announcement of our two-prong problem, lack of capacity to reorganize and need for Government funds or we would have to cease operations, was first announced here in Washington on January 9 when Mr. Patton and Mr. Maxwell and myself met with the regulatory agencies and advised them that that was the case.

At that time we also issued a press release. So that information became generally available.

I believe it was the following week—we have been in Washington since then for 2 or more days every week, and I think it was the following week we first had conversations with members of the staff of your committee and with one or two members of your committee.

Mr. MOSS. Some time then after mid-January?

Mr. TYLER. Yes. It would be shortly past the middle of January.

Mr. MOSS. That is sufficient for my purpose.

Mr. TYLER. Yes.

Mr. MOSS. Are you going to give a notice of intent to embargo?

Mr. TYLER. Yes. Our situation is this, sir: We, unlike Penn Central, believe that—prefer and even believe—that we need some authority to take this rather drastic action.

Mr. MOSS. You have anticipated my question. That is precisely what I was going to ask you.

Do you concur in the view expressed by the Penn Central trustees as to their ability to act unilaterally without any concurrence by the Interstate Commerce Commission?

Mr. TYLER. I have got enough problems without trying to judge Penn Central. Their status is somewhat different from ours.

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Mr. Moss. In your view then, your powers are not the same as theirs?

Mr. TYLER. Our status is different. You see, we are in this curious situation——

Mr. Moss. Did you feel that the powers are different in the case of your trustees and the trustees of Penn Central?

Mr. TYLER. Our status is different in one respect, sir, certainly, in that we were found by our court to be reorganizable by an order entered April 30. We find that now to be unsupportable, but the order still stands.

Mr. Moss. Is it your opinion, if you were to issue an order of embargo, you would have to have concurrence of the ICC?

Mr. TYLER. No, sir, our intention is to file a petition with our reorganization court. We will seek authority from that source.

Mr. Moss. Only from the court, not the ICC?

Mr. TYLER. That is right.

Mr. Moss. You do not feel it is necessary to seek it from the ICC?

Mr. TYLER. That is right.

The CHAIRMAN. The gentleman from New York, Mr. Hastings.

Mr. HASTINGS. I thank you, Mr. Chairman.

If I understand this situation relating to Erie Lackawanna, DOT is against your inclusion as far as a railroad in reorganization but are sympathetic to your financial needs to keep it in operation.

The one question that, although I think I know the answer, I would like to have on the record, what happens to your labor force in the event you are not included at all?

Mr. TYLER. I might start out by saying that H.R. 2051 is completely silent on the subject. We only get to some of the more serious questions when we get to the amendments proposed by Mr. Barnum in his testimony yesterday.

Mr. HASTINGS. To clarify there, as far as this bill is concerned, the labor force would not be under the labor protective provisions of the Labor Reorganization Act; is that correct?

Mr. TYLER. Under H.R. 2051. Mr. Barnum has amendments which gives a qualified possibility but no assurance of our labor force being protected.

Mr. HASTINGS. And two major issues seem to be—and I think you have outlined them rather well, so I won't dwell on them, the question of litigation raised by Mr. Barnum has been sufficiently answered by yourself and by USRA in my judgment.

The prime question, the right of mandatory conveyance on the part of USRA, becomes critical in importance to Erie Lackawanna. I would frankly say, understanding the problems of both the Penn Central and the Erie Lackawanna, I don't see the difference, why we should treat one one way and the other the other way.

I am beginning to believe unless we do something fairly quickly for all of the railroads, we might just as well consider the next alternative, and that is, nationalize the system of railroads in the Northeast, which I do not endorse. I am very sympathetic to your problem.

Mr. BROWN. Would you yield?

Mr. HASTINGS. Yes.

Mr. BROWN. It seems to me if they are going to be taken in eventually it might be better to take you in now. If they are going to loan you the $25 million one way or another, then the system could see that that $25

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million was directed during that operating period in ways that would conform to what they have and what ConRail has in mind for the Erie system after they are absorbed into the system.

Mr. TYLER. I think that is right. If the Government is going to make grants of $25 million to Erie Lackawanna, it should be in more of a controlled position then—which it would be in if it came under the act. The Government does not have the same controlling position.

Mr. BROWN. I have great respect for you and the circumstances under which you find yourselves and the stewardship of your responsibility, but it seems to me it is good business if it is the Government's $25 million one way or the other, that we give it to you after you are part of the ConRail operation, and we take you in now.

Mr. TYLER. Yes.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. HASTINGS. If I may ask one final question. Has the labor that is now working for Erie, have they taken a position on your inclusion?

Mr. TYLER. Yes. Our—one of the first things we did after our meetings in Washington January 9, Mr. Maxwell had a meeting with the representatives of our employees, advised them with complete candor of what our situation was and what we were trying to do.

One of the purposes of our attempt to get under the act would be to provide them with the protection of title V of the act, just as that available to other railroads.

Mr. MAXWELL. And they have been kept informed since that time also as to the progress of the various hearings and we have been in constant touch with them about that.

So their general feeling is that it coincides with ours, that the company should be included under the status of a railroad in reorganization.

Mr. HASTINGS. Have they taken a solid position?

Mr. MAXWELL. I cannot say they have taken that in writing, no. If I might make one further comment that I think might be helpful, if the company is not taken in as a railroad in reorganization now, we think that it will propose some very serious problems as to branch-line operations and the immediate funding by the States and the Federal Government of those lines that are not included in the final system plan and are released for subsidies by States and municipalities.

And I am sure you are aware of the fact that this is an extremely sensitive subject, particularly when the final system plan comes to the Congress for its approval this fall.

Mr. HASTINGS. I can assure you that is probably the most politically sensitive question that a lot of us with branch-line problems will have.

The CHAIRMAN. The gentleman from Pennsylvania.

Mr. ROONEY. Getting back to your original question as to whether you could go this route alone, and I believe you, Mr. Tyler, said you would not be eligible under the 1970 Rail Services Act, could we not amend that act to include you?

Mr. TYLER. We are not a railroad under reorganization as far as the 1973 act is concerned. You are talking about the Emergency Rail Services Act?

Mr. ROONEY. Right.

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Mr. TYLER. The 1970 act. The problem there, I believe, is that as a condition to obtaining such a loan there must be a finding of viability.

Mr. ROONEY. It seems to me, I think in your statement you said that you lost $18.2 million in 1972, in 1973, $18.6 million, and in the lean year, 1974, you only lost $17.5 million. So you are making some progress.

I would not want to make that kind of progress if I were running a railroad.

Mr. TYLER. Very small progress, sir. The only reason we did as well as $17.4 million, and that is a tentative figure, we may do a shade better than that, is because we had the benefit midyear of a 10-percent rate increase which had not been included in our forecast. Then we are facing in 1975, as our statement sets forth, a loss of some $22.5 million.

Mr. ROONEY. You have asked for a grant of $25 million to carry you through December 31, 1975; is that correct?

Mr. TYLER. Yes.

Mr. ROONEY. ConRail doesn't go into effect until the first quarter of 1976. How much more funds would you need?

Mr. TYLER. You are speaking of the additional money we would need in the first quarter of 1976?

Mr. ROONEY. Yes.

Mr. TYLER. We have not made any real forecast of that. Perhaps Mr. Hahn could speak generally on the subject.

Mr. HAHN. We have not made a forecast into the first quarter, but as indicated this morning by Mr. Blanchette, that is a tight period, the first quarter. It may be we would need several additional millions of dollars.

Mr. ROONEY. How much is several additional millions of dollars?

Mr. HAHN. I can't give a good estimate. Possibly five.

Mr. MAXWELL. Mr. Rooney, I think we should take it through this year and see what we can do to not have to come back for further funds at the end of the year for the first quarter. We would prefer to try it. I realize you don't like to—very properly—having us come back time and again, but I think in this case that because of the very peculiar state of the economy, we would prefer to sit tight on this recommendation to you.

Mr. ROONEY. I have no further questions.

The CHAIRMAN. The gentleman from California, Mr. Moorhead.

Mr. MOORHEAD. Thank you, Mr. Chairman.

I wonder whether there are any other railroads that would be competitive to the new ConRail which are interested in your track or portions of it?

Mr. TYLER. Perhaps you would like to speak to that, Mr. Maxwell.

Mr. MAXWELL. In the area east of Buffalo, we are the only competitor to Penn Central down into the New Jersey area, through Pennsylvania and the lower tier of New York State. West of Buffalo there are other lines that run roughly parallel to one another through to the Chicago area. But each of them has heavy areas of industrial activity. I would say the principal problem is east of Buffalo in the maintenance of competition in that area.

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Mr. MOORHEAD. You think some of the track you have might be sold to other railroads if you were not brought into this plan?

Mr. MAXWELL. I don't know. You will no doubt recall that the USRA in their annual report had five different operations as to what they were considering for their preliminary plan, and it is just not possible at this time to tell what kind of a framework those operations will be.

Mr. MOORHEAD. You have got about 2,000 miles, I understand, altogether of track.

Mr. MAXWELL. 2,800.

Mr. MOORHEAD. How much of that would be useful to the new Con-Rail system and be able to be used in the building of a profitable railroad?

Mr. MAXWELL. I would think a minimum of about 2,500.

Mr. MOORHEAD. You think most of it?

Mr. MAXWELL. Yes; I do.

Mr. MOORHEAD. Why can't you make money on it then with 2,800 miles of track if someone else can make money on 2,500?

Mr. MAXWELL. It depends on the time of framework. If you use one of the operations that are due under ConRail's proposals and set up a second ConRail and provide additional revenue-gathering capacity in the form of additional trackage to the Erie Lackawanna and perhaps some other lines, then I think you can get the earning power that it can stand on its own feet.

Mr. MOORHEAD. What kind of shape is your equipment in, your track, right now?

Mr. MAXWELL. We have had an increase in our slow orders on track. We had been running 2 to 3 percent of our mileage which rose during the middle of the year because of a shortage of materials, ties and rails. At the present time that is running, the total amount under slow order, is running about 30 percent. We have made some progress in reducing that slightly, but it will have to come after the moderation of the weather during the month of April when we can go back to work on it.

The equipment, our bad order situation is too high. We have had some cars that are carried on our bad order that are obsolete in nature. I would say it is on the order of about 10 percent. This is about double what we think it should be.

Mr. MOORHEAD. I would like to assign the rest of my time to Mr. Brown.

Mr. BROWN. Just a couple of questions.

I have some of that Erie track in my district. Thirty percent has to be an optimistic estimate.

Mr. MAXWELL. That is one of the pieces that has to have the additional work done on it.

Mr. BROWN. That is 100 percent in my area. What could you do if you didn't have the problem of maintenance? Would the Erie survive as an independent railroad?

Mr. MAXWELL. As far as I am concerned, I would not say that is the answer. It turns on the rebuilding of terminals and on the greatly increased acquisition of equipment and the ability to service the debt.

Mr. BROWN. It seems to me we are strongheaded in our approach to this problem. I wish instead of having ConRail and the operating responsibility, we had tried to rationalize the system of transporta-

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tion in this country by having the Federal Government, and I would like to have your comment, by having the Federal Government take over and maintain the way on the railroads, the rights-of-way on the railroads, the same as we do on the airlines, for the bargelines, for the trucklines, and the highways.

And if we had that kind of a rationalized system and knew what we were putting into it from the standpoint of Federal dollars, then the Erie might be a successful operating railroad with modern equipment, perhaps some innovative equipment that we don't now have. You could have developed a system that would operate the railroads without the burden of maintaining the rights-of-way.

Would you comment?

Mr. MAXWELL. I think our principal concern with that particular idea is that we look on it as the first step in outright nationalization.

Mr. BROWN. What do call ConRail?

Mr. MAXWELL. Well, it is a compromise.

Mr. BROWN. A compromise of nationalization? That is not the first step?

Mr. MAXWELL. It could be the first step, if ConRail is not successful, yes. On the other hand, I think in this country we deserve every possible effort which the Congress has very rightfully recognized to develop a means of taking an intermediate step and seeing if it can go by itself.

Mr. BROWN. I just observe that the trucklines are not that nationalized, the bargelines are not, we have no ConRail in that area. The only area we are talking about doing this is the rail lines. And it seems to me there is something in that approach that might recommend consideration of it.

The CHAIRMAN. The gentleman from Texas, Mr. Krueger.

Mr. KRUEGER. Thank you, Mr. Chairman.

As I have looked through the testimony for today, I have not seen any genuine forecasts for success for the future. I am wondering, if this infusion of tax money should come to the railroads, what genuine forecasts are there that the railway can be made to operate successfully in the future?

Mr. TYLER. One of the reasons we are here is because we don't see how we can make this railroad operate successfully in the future, which is the conclusion reached by a number of the bankrupt railroads in the Northeast some time ago, and the 1973 act was enacted in order to meet that situation.

We at this point find ourselves in the same or comparable situation with the Penn Central, so we seek to return under the act with the hope and anticipation that USRA, with the help of other Government agencies, will be able to recreate a viable railroad transportation system for the northeastern part of the United States.

Mr. KRUEGER. Is it your judgment you will be able in the areas you serve to compete with other forms of transportation such as trucking and airfreight and so forth? I have not seen those issues addressed either.

Mr. TYLER. I personally can't see that far into the future. It is going to depend on what type of a plan comes out of USRA, what is done in the way of rationalizing rail lines; what is done in the way of increasing productivity of labor; what is done in the way of provid-

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ing Government assistance to build up the equipment needs of railroads; what is done in the way of building up terminals.

Mr. KRUEGER. Would you have any comment on the question earlier, to the possibility of nationalizing the railway itself, as to whether you could consider this a plus or minus for the railroads?

Mr. TYLER. I think it would be a very unfortunate step.

Mr. KRUEGER. Even though it would mean you wouldn't have to pay those taxes?

Mr. TYLER. This attempt of USRA and ConRail is our last chance of avoiding it.

Mr. KRUEGER. And in what way would it be unfortunate? That is what I am not certain about. Suppose we just nationalize the—not the equipment, but just the bed itself, just the line of land?

Mr. TYLER. That is a program that Mr. Brown has been interested in for some time. Mr. Maxwell has expressed the view that could be the first step toward nationalization. There are some differences between a nationalized railroad bed on the one hand and public highways which are used extensively by trucks and other vehicles on the other, and airways that are used by airlines and general aviation, barge lines in rivers that are used by commercial barge lines and others.

There are some differences there. They are not completely the same.

Mr. MAXWELL. In effect you have the individual use of the railroad right-of-way by just the company. The waterways, airways, and highways are used by other parties than transportation of freight. It is a little bit different situation.

Mr. SKUBITZ. Would the gentleman yield?

He has touched on a point I have been interested in for some time, but not from the standpoint of nationalization.

I have thought in terms of lease-back propositions on the railroads, where the Government would take over the maintenance of the roadbeds, charge the costs back in some sort of proportionate share between the use made of the roadbed by the railroads and the use made by passenger service.

In that way we solve two problems. One, the Government would be interested in roadbed repair during slack times. Right now when we are looking for jobs, this would be a place to use people. In turn, the only time the railroads are really interested in maintaining the roadbeds is when they have got some money. And the only time they have got money is when they are operating at full capacity, and then they don't have time for it.

What I am trying to say is it is just in reverse. The Government could take care of it, when we really need to put men to work, and lease back to you or charge back to you what the actual costs are on the basis of what it costs to repair it. That can fluctuate on the amount of traffic that you are carrying over that road.

It would be much easier for us to help a railroad in that way than having you trot back here every 1, 2, or 6 months wanting some more money.

Would you mind commenting on that proposal?

Mr. TYLER. My partner, Mr. Patton, might comment on that.

Mr. PATTON. I would simply say this, sir. That may be something to consider, and it may have merit at a different time. Right now the Congress has set in motion a program which is well on its way to fruition.

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I think it is only fair that the program which is being undertaken by the USRA be completed and be given an opportunity to demonstrate whether or not it can be a successful, profitable road. If it isn't, then I should say that that is one of the alternatives, the one you suggested. That should be fully explored in the handling of the railroad situation in this country.

Mr. SKUBITZ. Will the gentleman yield?

The CHAIRMAN. The gentleman's time has expired.

You may be recognized.

Mr. SKUBITZ. I don't expect to do this overnight, but I think it is time to start thinking in those terms. Corporations, chain organizations and what-have-you, are far more interested in somebody else building the building, and they in turn lease the building and even pay it back in 10 or 15 years in order that they might write it off as a business expense.

This would give the railroads the same opportunity. It would give us an opportunity to get some decent roadbeds. When you read about all the wrecks we are having on the railroad, and about the movement of poisonous gases and very shortly atomic material, I sometimes shudder to think these things are going over the kind of roadbeds we have today. And I think it is about time whether we ought to move in.

Mr. PATTON. I hope there is some group in the U.S. Government making a study of this situation as an alternative, in the event what we are doing now proves not to be successful.

Mr. SKUBITZ. Thank you.

I now yield to the gentleman if he wants some of my time.

Mr. KRUEGER. Thank you very much.

My questions are complete.

The CHAIRMAN. The gentleman from Colorado.

Mr. WIRTH. As I am sure you heard, I will try to boil those down to some kind of simple notion we can get our heads around.

Is there in the railroad industry general rules of thumb that say if you were operating in the optimum conditions and had a pie of 100, and expenses of running your railroad, what percentage of that would go to equipment? What percentage would go to salaries and manpower, and what percentage would go to maintaining a roadbed, of those would be your major expense categories?

Mr. MAXWELL. Well, the percentages vary, and you realize, between various parts of the country.

Mr. WIRTH. Sure.

Mr. MAXWELL. But, in the eastern part of the country the transportation ratio, varies between 45 and 50 percent; 45 to 50 percent of each revenue dollar taken in. The track maintenance runs between 10 and 12 percent. The equipment ratio for both locomotives and freight cars, and if passenger cars are maintained, usually runs on the order of 16 to 18 percent. And the remainder is in general expenses and miscellaneous.

Mr. WIRTH. In other words, if a proposal such as this were followed, we could assume 10 to 12 percent of your dollars might be taken over if the rights-of-way and railbeds were taken over by the Government at some time in some kind of an arrangement?

Mr. MAXWELL. Yes. You have an offset, of course, in the lease costs which the Government, which is perfectly proper, would assess to that roadbed. And you have a partial offset against that 10- to 12-percent figure I mentioned on track maintenance.

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Mr. WIRTH. Sure, I understand that.

Mr. MAXWELL. Yes.

Mr. WIRTH. Thank you.

The CHAIRMAN. Would the gentleman mind repeating those percentages there for me? I didn't get them.

Mr. MAXWELL. The transportation ratio for the eastern lines usually varies between 45 and 50 percent.

The CHAIRMAN. You mean transportation? What do you mean?

Mr. MAXWELL. The expense of running trains, the operation of terminals, the manning of trains, and the various employees engaged in the actual operation of trains.

The CHAIRMAN. OK.

Mr. MAXWELL. The track maintenance and roadway maintenance, the ratio is on the order of 10 to 12 percent, and the equipment ratio for maintenance of cars and locomotives is in the area of 16 to 18 percent. The remaining is in the area of miscellaneous expenses.

Mr. WIRTH. Following up on that briefly, we are talking about 10 to 12 percent for the roadbed, right?

Mr. MAXWELL. Yes.

Mr. WIRTH. Are there savings that would be accrued into the railroads in terms of State and local taxes that you would then pay?

Mr. MAXWELL. Yes, I would expect there would be.

Mr. WIRTH. And what would those be?

Mr. MAXWELL. Those are not included in the figures that I mentioned to you. They are what you would call below the line. And those would be additional savings if the Government owned the right-of-way.

Mr. WIRTH. You would expect that is like 5 percent of the total revenue dollar? Would it be that high or higher than that?

Mr. MAXWELL. No. I would think it would be a much lower figure, probably on the order of about 1 to 2 percent. I am speaking in terms of all the revenues.

Mr. WIRTH. Sure. That would have to be something that if a proposal like this were followed, it would have to be fed back——

Mr. MAXWELL. It might very well offset the leasing costs, as an example, the leasing payments.

Mr. WIRTH. Thank you.

The CHAIRMAN. I want to thank you. Mr. Tyler, and the rest of you that have come and given us the benefit of your views. They will be given careful consideration in the markup of the bill at 10 o'clock in the morning. The committee will stand adjourned.

[The following statements and letters were received for the record.]

STATEMENT OF J. R. SNYDER, NATIONAL LEGISLATIVE DIRECTOR, UNITED TRANSPORTATION UNION

My name is J. R. Snyder. I am appearing today as the National Legislative Director of the United Transportation Union, a union representing some 250,000 railroad workers engaged in operating the nation's trains as Conductors, Engineers, Brakemen, Firemen and Switchmen. I appreciate this opportunity to present our views on the legislation before this Committee, which is designed to prevent a complete or partial shutdown of the Penn Central Railroad System and the Erie-Lackawanna Railroad on or before the end of this month of February.

As the members of this Committee know, the United Transportation Union and its' affiliated organizations in the Congress of Railway Unions strongly and successfully supported the Regional Rail Reorganization Act of 1973, which is

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designed to make possible the successful reorganization of a number of bankrupt railroad systems in the Northeast and Mid-Western sections of the United States. We feel that legislation to prevent a complete financial collapse of Penn Central and Erie-Lackawanna is absolutely necessary to, in turn, prevent further recession of the industry of the entire United States and to avoid endangering the continued functining of the American rail systems.

We are wholeheartedly in support of the bill, S. 281, as passed by the Senate January 29 with one reservation, which would be in the nature of the addition of an amendment changing the language of Section 7, Part 2, to amend the last sentence to read as follows: "The Association shall take any steps it finds necessary, consistent with limitations and other provisions of this Act, to effectuate the consequences of such a revised order, and shall issue, not later than 45 days after the decision of the Reorganization Court, an appropriate supplement to the preliminary system plan." The reason that we request that S. 281 be so amended is simply to make certain that USRA shall include the Erie-Lackawanna Railroad into the final plan. This is made absolutely necessary by the announcement by the Trustees of Erie-Lackawanna that they are unable, because of the present recession, to bring about a reorganization of that railroad under the provisions of Section 77 of the Bankruptcy Act, and, further, that they are without sufficient cash flow, also due to the recession, to continue operations beyond the end of February.

While we suppose that S. 281 may be the bill which will be finally adopted to preserve the Northeast and Mid-West bankrupt railroads and make possible the formation of a successful ConRail when the plans have been finalized, we, of course, support any similar legislation which might be substituted for this bill as a result of hearings, but, in any case, we think that, as a minimum, the language now included in S. 281, with the amendment above suggested, should be incorporated in any legislation which finally deals with this emergency.

It appears from the testimony of various interested parties before the Senate Hearing on S. 281 that there is immediate need for an infusion of funds which will prevent the close down of Penn Central and Erie-Lackawanna with the consequent disastrous effect such closure would have on the employment in the region affected, which stretches from Chicago and St. Louis to Virginia and Maine, and the financial impact of the loss of connecting business on all other railroads in the remainder of the lower 48 States of the United States. Something in excess of 35% of all American rail freight either originates or terminates on the Northeastern rail lines involved in this reorganization. And of the rail lines, the Penn Central and Erie-Lackawanna constitute the overwhelming bulk of the mileage. It is impossible for us to estimate the economic effects of the unemployment, financial failures and transportation chaos which would result if shippers dependent on these railroads are deprived of the service which moves their coal, their raw products used in manufacture, their manufactured products moving to all parts of the country, the foodstuffs, both perishable and staple, which are received by rail in this region, and, in fact, the total impact upon the entire region and its' workers, its' producers, its' financial establishment, its' travelers, its' farmers, laborers and children and aged.

It is also necessary to look at the effect of the cessation of operation of Penn Central upon the movement of passengers by way of Amtrak which would fall a helpless victim as a consequence of the closing down of Penn Central. It would not appear possible that Amtrak could operate over Penn Central under the circumstances, and there is a grave possibility that likewise the commuter operations operated by Penn Central and Erie-Lackawanna could not be operated when these lines are closed down for lack of funds. We are supporting the appropriation of $250 million for Penn Central and $25 million for Erie-Lackawanna, with the requirement that Erie-Lackawanna be included in the Regional Rail Reorganization Act Plan to be drawn up by USRA. We have looked at the situation in every possible light, and while we are aware that there are some who believe that this is another case of "crying wolf" we cannot find, in talking to our members, who are the people who run the trains on these carriers, that there is any other way that they can continue operations unless they should be seized and operated as nationalized railroads by the United States Government.

Obviously we are concerned about the future of our members, who make up a large proportion of the total employees of Penn Central and Erie-Lackawanna. All of them would be thrown into the ranks of the unemployed and immediately begin to constitute a larger drain upon the welfare rolls of the United States. There are some 80,213 employees on the Penn Central Railroad and 11,872 em-

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ployees on the Erie-Lackawanna, which is not an inconsiderable number of people to be affected when it is realized that there are an average of five persons in each family of an employee. There is absolutely no reason that these people should join the ranks of the unemployed because there is a very real need for their services in rail transportation and they will not become unemployed, nor will those people who depend on the railroads that operate for their transportation needs also become members of the unemployed, if this Committee reports out and the House of Representatives adopts and passes this bill.

I have mentioned the form of the shipments which are carried in large quantities by these railroads, and I believe that every member of this Committee has a fair idea of the type and amount of goods which travels over these lines. In this time of winter and fuel shortages, it is perhaps well to mention that coal and fuel oil, and propane gas are all carried in large quantities to supply the heat and energy requirements of this section of the country, and that with spring approaching great amounts of fertilizer are being received over all this area, especially in those parts of the Middle West which have a large and prosperous agricultural production. Both the transportation of food products ready to eat and of feed necessary to raise the broilers and the milk cows of the region are most essential to the health of everyone living in the Northeast—Mid-West Region. We know that efforts could be made to move some of this material by truck, which would result in highway chaos and the use of energy in the form of gasoline and diesel oil in a manner which is the least efficient for transportation purposes of any method known. We think that such a reaction by this Committee and Congress as to allow the shutdown of these carriers to take place and thereby ensure that the entire region would be thrown into a chaotic situation as regards transportation, heating, lighting, food and employment is unthinkable. We feel certain that you will report this bill, or one like it, with the necessary amendments favorable to the Full House and that it will be speedily passed.

In closing, I would like to mention that S. 281 has an amendment to put a ceiling of $90,000 on the salary of the President of Amtrak. Some persons have regarded this as a mistake, but this organization believes, and we believe that the majority of business minded Americans believe, that in a sense "you get what you pay for" and that if Amtrak is to be headed by a knowledgeable and successful chief executive there must be available a salary which is commensurate with first-class ability, because Amtrak must compete with other sections of the railroad industry to obtain a qualified president. We believe that it is time to quit picking a chief executive who has no knowledge of the railroad business and cannot grasp the situation so that Amtrak can be successful. We think there is no substitute for brains *AND* experience for a capable Amtrak executive officer.

I wish to thank you for the opportunity of presenting the viewpoint of the United Transportation Union on this emergency situation, which is now before you.

STATEMENT OF CHARLS E. WALKER, PRESIDENT; CHARLS E. WALKER ASSOCIATES, INC., ON BEHALF OF CERTAIN MAJOR SHIPPERS OF RAIL FREIGHT

Mr. Chairman and distinguished members of the Committee: We appreciate the opportunity to speak on behalf of ten major users of rail freight service on the Northeast railroads. These firms include Aluminum Company of America, Allied Chemical Corporation, Bethlehem Steel Corporation, Ford Motor Company, General Electric Company, General Motors Corporation, National Steel Corporation, Union Carbide Corporation, U.S. Steel Corporation, and Weyerhaeuser Company. These users have manufacturing plants and suppliers located throughout the continental United States as well as in the Northeastern region. They are uniquely acquainted with the operations and interdependence of transportation services in this country. These ten companies alone account for approximately one-half of the total freight moved on Penn Central. Many of the operations of these companies would shut down in five days or less if the Penn Central stops running. Adequate alternatives are not available. The recent coal strike offers a minor but real example of such a result.

We submit this statement on behalf of these companies in support of timely legislative approval of interim financial assistance for the bankrupt railroads in the Northeast in a continuing effort to focus shipper and public attention on the problems of rail freight service in the Northeast. The consequences

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of a shutdown or disruption of freight service on these railroads would hit every person in this country to some degree. These companies alone operate hundreds of plants and employ hundreds of thousands of men and women in the 17-state region served by these railroads. Many plants located outside the region are totally dependent on parts, goods and supplies shipped over the bankrupt railroads in the Northeast region. Many of those operations would have to be sharply curtailed—and some would of necessity shut down completely—within days after interruption of railroad freight service by the Penn Central and Erie Lackawanna railroads. Thus, not only would Penn Central workers become unemployed, but entire plants of other industries would, of necessity, close down with massive unemployment resulting.

It is difficult to conceive of a more inappropriate time for a major railroad stoppage than today. As you know, the nation's gross national product declined at an annual rate of over 9 percent in the final quarter of 1974 and may decline by more in the current quarter—indeed, a major railroad stoppage, even if temporary, would almost guarantee that result. The unemployment figures to be released on Friday will probably show the highest percentage of people out of work since before World War II—a rate that is certain to rise much higher in the event of major rail shutdowns.

A rail stoppage will inevitably erode further the real income of American working men and women, partly because of the drop in employment and income that such a stoppage would cause, and partly because of the impact on the prices of manufactured goods resulting from attempts by producers to ship goods to market by less economical modes of transportation.

To be sure, the revenues of the companies on whose behalf we appear, all of whom are major shippers, will be significantly reduced. But this impact pales in comparison to the impact on workers and their families. The worst recession since World War II will be deepened and perhaps prolonged and prices and the cost of living would rise at the same time. An already bad situation will be made worse.

The railroads of this country are all interdependent. We have a national market place in this country and transportation is the key. One of the most significant market places is the Northeast region. Each Representative is surely aware of the goods moving to the state he or she represents from the Northeast as well as the goods moving from that State to the Northeast. Jobs are directly dependent on those uninterrupted movements. The railroads in the Northeast are a vital part of an integrated transportation system. Other railroads and modes of transportation simply cannot provide the same service without these railroads.

A simple example can illustrate the need for this railroad. Auto parts produced in Ohio are shipped to an assembly plant in Georgia. If those parts do not arrive on time, the whole assembly line shuts down. Coal is shipped from West Virginia to Pennsylvania to produce tin plate to be shipped to a canning plant in California which ships canned goods to New York and Connecticut. In 1974, the Penn Central moved 270 million tons of freight. Of this total, coal, coke, and ore accounted for 46 million tons; iron and steel products were 26 million tons and total movements by the steel industry were approximately 72 million tons.

Inventories of many materials are low. It would take a very short time for the ripple effect to appear in the form of layoffs. It takes more time to get goods moving again through the pipeline.

The present emergency cannot accurately be termed a "new crisis" in a whole series. We are sympathetic with the frustrations of the Congress and the Administration in dealing with these problems, seemingly, over and over again. The timing of this particular cash shortage is a result of the coal strike, huge declines in sales of autos and the general downturn of the economy. But this so-called crisis is really part and parcel of the problem which has developed over the course of twenty years. Mismanagement, poor regulation, labor problems and rising costs all interact.

Why does Penn Central lose so much money? It's not just operation of unprofitable lines. That accounts for only a small portion of the loss. In our judgment, the whole system presently operates at a loss due primarily to the deteriorated condition of plant and equipment. Due to deferred maintenance and failure to modernize, the productivity of the system not only has not kept pace with rising costs but has actually deteriorated while costs were doubling and doubling again. The reasons for deferring maintenance and modernization are useful now only to prevent such a process from repeating itself. The Regional Rail Reorganization Act directly addresses the problems of rebuilding and rationalizing this system. It won't solve all the problems of rail service in this

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country, but the problems cannot be solved without the RRRA and Federal assistance. It is cheaper in the long run to the taxpayer to maintain railroad operation until the planning process is completed and the rebuilding process begun than to permanently subsidize or nationalize an inefficient operation.

The planning process is in mid-stream and must be completed without a shutdown of these railroads if the hope and promise of this massive effort is to ever be realized.

The only feasible solution to the immediate cash problems of the bankrupt railroads is for additional monies to be made available to them. The Department of Transportation has recognized the urgency of the situation and has recommended to the Congress emergency legislation to provide cash resources to enable railroads reorganizing under the Regional Rail Reorganization Act of 1973 to continue essential transportation services during the planning process, and to perform maintenance and improvements which are necessary for safe and efficient operations. The Senate has passed S. 281, with amendments, to provide the necessary funds. The aid contemplated by S. 281 and H.R. 2051 would be designed in such a way as to insure that value added by improvements made therewith would go to Consolidated Rail Corporation after that Corporation is brought into existence at the end of the current planning process.

We cannot overemphasize the critical nature of the increase in Section 215 loans. This money would be used for maintenance, most of the value of which would accrue to ConRail. These loans, under RRRA, would be repaid at little or no cost to the taxpayers. This program would release cash to Penn Central for operations thus reducing the total amount of Section 213 grants necessary.

Finally, the authority of the ICC to order profitable railroads to operate over lines of the bankrupts is not a feasible solution on a system as vast as Penn Central. The problems of compensation to the profitable roads are insoluble. For example, these railroads could operate over Penn Central lines only with the use of the Penn Central crews. These crews would have to be paid, presumably out of the assets of the profitable railroads. This would be an intolerable burden. Furthermore, since such roads would not be compensated until after expiration of the order, it would amount to a forced loan from profitable to bankrupt lines, possibly jeopardizing the operations of the former.

We urge prompt passage of this legislation. Thank you.

STATEMENT OF DAVID L. FOSTER, SALEM, VA.

My name is David L. Foster and I reside at Route 5, Box 472, Salem, Virginia I have a BA degree in economics from Bates College, and hold an MBA in transportation from Wharton School of Finance and Commerce, University of Pennsylvania. I am employed by the Norfolk and Western Railway in Roanoke, Virginia, where I do economic research. This statement is my own and represents my personal views, not those of my employer.

I am opposed to the Senate-passed bill granting $275,000,000 in aid to the bankrupt Penn Central Railroad, and for the following reasons I urge the House Commerce Committee not to report out such a bill to the House of Representatives:

(1) *The Penn Central is not a necessary company.* Attached as Exhibit 1 to this statement is a document compiled by the United States Railway Association (USRA).[1] This document contains a listing of those portions of the present Penn Central, and in some cases other Eastern bankrupt carriers as well, that are desired by connecting or parallel rail carriers in the East and Midwest. If your staffers were to sit down with a system map of Penn Central and mark on it the lines wanted by other railroads as shown in the USRA planning document, virtually every line of any significance would be spoken for; and many would be desired by two or three carriers. Surprising to me were the number of lines listed in this document that are often thought of as branch lines. So service continuance over most of the present Penn Central System would be continued if these tentatively-proposed acquisitions were to be consummated.

(2) *Liquidation much cheaper to taxpayers.* Since even Penn Central ceases to exist as one company, service would be continued by other railroads over virtually all of its lines of any importance, a much more economical and practical government approach to the situation would be to grant much more

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[1] EDITOR'S NOTE.—Document may be found in committee files.

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limited aid over a period of months during which time the Penn Central would be divided up ("auctioned off", as some have phrased it) among other solvent carriers. This approach offers the twin advantages of securing for Penn Central's creditors the maximum value for their properties and at the same time limiting government financing and other involvement in the railroad's operation to a minimum.

(3) *Government funds for special interests.* I oppose granting government money to special interests of any kind. Special interests are continually turning to the Federal Treasury for their protection, whether they be Lockheed Aircraft, food stamp recipients, maritime unions, or moribund railroads. This cannot be allowed to continue. The taxpayers of the nation are called upon to pay the bills of such *special interests*, while no one looks out for the *general interest* of the public or its ability to pay higher and higher sums necessary to sustain the heavier and heavier burdens of special interest financing. Aid in the amount of $275,000,000 to Penn Central, apart from being unnecessary, would not be nearly sufficient to restore the health of that dying giant. It would buy nothing beyond the perpetuation of the status quo for a year or so, but then the problem would arise anew and the taxpayer would again be asked to shoulder more massive special interest financing. The $275 million is just a start. *Billions* of dollars would be required to save the Penn Central, and the Congress *must* consider where its policies will lead in a year or two as it contemplates its current response.

(4) *Disaster for other solvent railroads.* A series of cash infusions of hundreds of millions of dollars to the Penn Central, if continued to the point where they did foster and sustain renewed viability for that company, would be detrimental to the privately-financed competing railroads in the East and Midwest, for no private company can compete against the power of the Federal Treasury. Herein lies the potential for an even larger problem for Congress in the years ahead. If one railroad after another is pushed into bankruptcy and is judged to be vital to the National Economy and thus becomes eligible for Federal backing, the spectre of owning and operating a Nationalized Railroad System becomes very real.

That preservation of Penn Central as a company is vital to the National Economy, or even to the Northeastern regional economy, is false. Senator Hartke, in pushing for the passage of the $275 million aid bill in the Senate said that compared to a Penn Central closedown, last year's Arab oil embargo would "seem like a summer picnic in which we have rainbows dancing around our hearts." Such emotional pleas are without reason, although many more will likely be made before your Committee and before the House of Representatives. Appending PC's various lines to healthy trunk-line railroads, supplemented by shipper- and municipally-owned short lines that would surely arise, would ensure continuance of service at a level adequate to sustain the shipping needs of the National and regional economies. Such a plan would require only limited government financing during the period necessary to accomplish orderly transition of lines to alternative ownership and operation, rather than an ever-growing commitment *beginning* with hundreds of millions of dollars annually.

GORDON P. MACDOUGALL,
WASHINGTON, D.C.,
February 6, 1975.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

Re H.R. 2051 and S. 281.

DEAR MR. STAGGERS: Attached hereto is the presentation of Governor Milton J. Shapp, made during the course of the consideration of this legislation by the Senate Committee on Commerce.

If you deem it appropriate, it is requested that this statement be considered by your committee and included in the record.

Thank you.

Very truly yours,

GORDON P. MACDOUGALL,
Special Assistant Attorney General,
Commonwealth of Pennsylvania.

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STATEMENT OF GOVERNOR MILTON J. SHAPP, COMMONWEALTH OF PENNSYLVANIA

S. 281, Regional Rail Reorganization Act Amendments of 1975 was introduced on January 21, 1975, by Senator Vance Hartke for himself and Senator James B. Pearson, by request, and was scheduled for hearing the following day by the Subcommittee on Surface Transportation of the U.S. Senate Committee on Commerce.

S. 281 would amend certain provisions of Regional Rail Reorganization Act of 1973, enacted January 2, 1974. (P.L. 93-246). The need advanced by the Ford Administration for emergency consideration is the threat advanced by the trustees of Penn Central Transportation Company to embargo shipments beginning in mid-February, and to shutdown railroad operations at the end of that month. Penn Central testified that it faces wage payments of over $14 million on February 25-27-28, 1975, and that it will not have the money to pay its employees on those dates.

Section 213 of the Act presently authorizes $85 million to be appropriated for emergency grants to railroads, pending implementation of the final system plan under the Act, for the continued provision of essential transportation services. It is proposed to increase this sum by $100 million, to the level of $185 million.

Section 215 of the Act authorizes the issuance of $150 million in obligations for the acquisition, maintenance, or impovement of railroad facilities and equipment necessary to improve property that will be in the final system plan. It is proposed to increase this sum by $150 million, to the level of $300 million.

There remains about $4.4 million in funds uncommitted under section 213, and some $146.6 million under section 215. However, the balance of the section 215 obligations have recently been earmarked by the United States Railway Association (U.S.R.A.) for specific projects.

The preliminary system plan is to be released by U.S.R.A. on February 26, 1975, and the final system plan on July 26, 1975.

Penn Central is vital to the economy of the Northeast and to the nation. Suspension of operation, particularly at this time, would be catastrophic and in all probability would plunge the nation deeper into economic recession while cutting off vital supplies of fuel, food and manufactured goods to the nation's most densely populated area.

Nevertheless, the Congress and the American public should not be pressured in to approving such huge sums as Penn Central now seeks without careful scrutiny. The $250 million sought by the Administration is presented as needed to keep the Penn Central and other Northeast railroads in operation through the current calendar year. During this period, the needs of the railroads may change. More money may be requested.

Meanwhile, U.S.R.A. must meet its February 26 and June 26 deadlines. It is still too early to determine whether the U.S.R.A. plan will be accepted, rejected, returned for modification, or whether entirely new legislation will be needed. Present indication is that the the latter course will be required.

Penn Central states that it requires $14 million to meet its payroll through February. It is my suggestion, therefore, that these funds and subsequent funds for the current fiscal year be made by the Congress as needs are discerned. Everyone, in the meantime, should have sufficient time to review railroad needs during the period for which the $250 million is now requested.

I opposed enactment of Regional Rail Reorganization Act of 1973. See: Hearings on S. 1031, S. 2188 and H.R. 9142, *Northeastern and Midwestern Railroad Transportation Crisis*, before Surface Transportation Subcommittee of the Committee on Commerce, U.S. Senate, 93rd Cong., 1st Sess., Ser. No. 93-8, at pp. 161-204 and 832-44 (1973). At the same time I stated, and I again urge that—

> "Interim funds should be made available to the distressed railroads to guarantee the operations during the period of time necessary to complete the study."

I would only emphasize that present services must be continued during the planning process and beyond.

The Administration's request follows the 7-2 decision of the U.S. Supreme Court, rendered on December 16, 1974, which opens the U.S. Treasury to deficiency judgments as high as $10-$12 billion, for "taking" of railroad properties under the Act. A group of U.S. Congressmen, headed by Mr. Brock Adams, filed an amicus curiae brief to the Court, opposing such a construction of the Act. The Commonwealth of Pennsylvania, in its separate amicus curiae brief, had urged that the Act be invalidated and returned to the Congress.

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S. 281 goes far beyond the provision of funds until completion of the preliminary plan on February 26, or the final system plan on July 26. The purpose of the legislation is to enable funding through the first quarter of 1976.

It may very well be that the entire concept of the Regional Rail Reorganization Act will require revision after release of the preliminary system plan next month, or the final system plan in June. It would seem unwise to legislate certain funds at this time when the preliminary system plan is forthcoming in the very near future.

Moreover, evaluation of needs is being hampered by U.S.R.A. itself. Personnel from the Commonwealth of Pennsylvania, and from other States, are being denied access to important studies and reports which have been compiled by U.S.R.A. at public expense, and which are critical to an evaluation of the railroad reorganization process and to the necessity for funding. In response to our written request from our Department of Justice, we were advised by press release on January 21 that these important sources of information would be available only *after* release of the preliminary system plan on February 26. A copy of the U.S.R.A. press statement, which is wholly unsatisfactory to us, is attached.

Accordingly, I urge that funds be provided, but only such funds as to continue essential operations at this time during the planning process. Any funds for maintenance or acquisition should clearly make certain that payment is not made twice for the same facilities.

ERIE-LACKAWANNA

The trustees of the Erie-Lackawanna Railway Company (E-L) request that they be given federal financial assistance in the amount of apx. $10 million to guarantee operations through the first half of 1975, and that this assistance be given in the form of permitting E-L's reorganization court to reverse its previous determination to reorganize outside of the Act.

We do not oppose such assistance to E-L as may be required. We vigorously oppose, at least until the plans required from U.S.R.A. can be evaluated, any inclusion of E-L as a "railroad in reorganization" so as to qualify E-L for compulsory conveyance of its properties to Consolidated Rail Corporation or to other railroads. In short, E-L should not be legislated into the Act at this time, other than for the purposes of financial assistance.

Commonwealth of Pennsylvania supported the decisions of the Erie-Lackawanna and Boston & Maine reorganization courts, rendered on or about May 2, 1974, that the respective roads be reorganized outside of the Act.[1] Inclusion of E–L and B&M in Conrail would diminish competitive rail service in Pennsylvania and would also be harmful to a major railroad, Delaware & Hudson, which is not in reorganization. For these and other reasons, Pennsylvania participated in the E-L and B&M "120-day" court cases. These court decisions, in my opinion, should not be upset by Congress at this time. Particularly would it be inappropriate so soon before the preliminary system plan is made known.

However, it is my suggestion that the Congress consider amendments to the Act at this time which would permit assistance to E-L without changing its present court-determined status of May 2, 1974. This would seem possible by amendments to sections 211, 213 or 215, and without disturbance with section 207.

I do not believe that the U.S. Supreme Court's construction of the Act in December, 1974, or the present downturn in the economy, should provide justification for any additional raid on the Treasury.

[Press release, United States Railway Association, Jan. 21, 1975]

USRA To Make Reports Available

Copies of studies done for the United States Railway Association will soon be available for public inspection in a reading room being set up for that purpose at the Association's headquarters.

These consultant reports are those which the Association commissioned for its use in the formulation of the preliminary system plan for restructuring bankrupt railroads in the Northeast and Midwest. They will be made available following publication of the prelimary system plan late in February.

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[1] *In re Boston & Maine Corporation*, 378 F. Supp. 68 (D. Mass. 1974). The Erie-Lackawanna's court decision is not yet reported.

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Arthur D. Lewis, Chairman of the Board, United States Railway Association, announced that the public will be able to read or to copy the reports in a special reading room to be established by the Association.

Copying facilities will be provided as a part of the public service, with the actual cost of copying to be paid by the user. Copies of the reports also will be furnished on request, with a fee arrangement to cover the cost of reproduction and mailing on each order.

The United States Railway Association is the government corporation established under the Regional Rail Reorganization Act of 1973 to reorganize the bankrupt railroads in the 17-states comprising the Northeast and Midwest region of the United States. The six railroads now involved in that reorganization are the Penn Central, Reading, Lehigh Valley, Lehigh and Hudson River, Ann Arbor and the Central of New Jersey. A seventh carrier, the Erie-Lackawanna, has recently requested to be included in the reorganization.

Plans call for the reading room to be established on February 26 in the library, Room 2605, at the Association's headquarters in the Transport Building, 2100 Second Street S.W., Washington, D.C. 20595.

NATIONAL COUNCIL OF FARMER COOPERATIVES,
WASHINGTON, D.C.,
January 29, 1975.

Hon. HARLEY O. STAGGERS,
Chairman, House Committee on Interstate and Foreign Commerce
Rayburn House Office Building
Washington, D.C.

DEAR CONGRESSMAN STAGGERS: The National Council of Farmer Cooperatives is concerned over recent reports of an imminent shutdown of the Penn Central system due to lack of operating capital. Such a shutdown would seriously harm farmer cooperatives and their patrons who depend upon Penn Central not only for through service, but also for pick-up and delivery service at thousands of origin and destination points located throughout the Midwest and Northeast regions.

The Senate Commerce Committee earlier this week favorably reported S. 281, a bill to amend the Regional Rail Reorganization Act of 1973 to increase emergency financial assistance to railroads in reorganization. A similar bill H.R. 2051 was introduced in the House and referred to the Committee on Interstate and Foreign Commerce for consideration.

On behalf of the members of the National Council of Farmer Cooperatives, I respectfully request your Committee to give this matter the utmost priority. While we urge a careful and complete review of the request for supplemental appropriations, we believe the review should be conducted as expeditiously as possible, so as to be concluded in advance of the threatened embargo date of February 14. Expedited action by your Committee will avoid unnecessary disruption of rail service that might result if this legislation is not considered prior to the 10-day Congressional recess scheduled to commence February 7.

Yours truly,

KENNETH D. NADEN,
President.

DOW CHEMICAL U.S.A.,
WASHINGTON, D.C.,
February 4, 1974.

Re H.R. 2051 and S. 281—Increased Funding For Northeast Railroads.

Hon. HARLEY O. STAGGERS,
Chairman Committee on Interstate and Foreign Commerce
U.S. Congress, Washington, D.C.

DEAR MR. STAGGERS: While The Dow Chemical Company abhors government subsidies for transportation, it is imperative that appropriations for the aid of the bankrupt Northeast Railroads be forthcoming until the reorganization plan specified under the Regional Railroad Reorganization Act of 1973 can be accomplished. The country cannot tolerate the complete shutdown of the Penn

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Central Railroad; and the Penn Central cannot continue to operate under its present circumstances without financial assistance until it is restructured. Therefore, the necessity for interim funding (as called for under the two bills above and possibly other future appropriations requests) is obvious.

We urge that your committee recommend that these funds be made available and that the loans be guaranteed. We ask that you include this statement in the Record on your hearings regarding H.R. 2051 and S. 281.

Sincerely yours,

RICHARD M. PATTERSON,
Government Relations Manager.

[Whereupon, at 4 p.m., the committee was adjourned.]



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FEDERAL COMMUNICATIONS COMMISSION OVERVIEW

HEARING

BEFORE THE

SUBCOMMITTEE ON COMMUNICATIONS

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

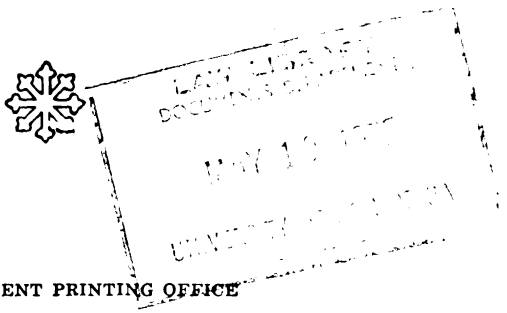
ON

THE FUNCTIONS AND DUTIES OF THE FEDERAL COMMUNICATIONS COMMISSION

MARCH 11, 1975

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FEDERAL COMMUNICATIONS COMMISSION OVERVIEW

TUESDAY, MARCH 11, 1975

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON COMMUNICATIONS,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2325, Rayburn House Office Building, Hon. Torbert H. Macdonald [chairman] presiding.

Mr. MACDONALD. The subcommittee will come to order, please.

This morning, the Subcommittee on Communications meets for the purpose of overview hearings involving the Federal Communications Commission. I would like to welcome the members of the Commission and their staff.

At the outset, let me explain the intent of this subcommittee in proceeding with its oversight responsibilities in the area of communications. It is my desire to effect some major changes in the way in which we discharge our oversight function. In the past, this subcommittee had the additional responsibility of dealing with complicated matters of energy policy. If you recall, this subcommittee was the Subcommittee on Communications and Power. However, now we may focus our attention on a broad range of communications matters.

As the members of this subcommittee know, I envision a very active and productive year during this first session of the 94th Congress.

The purpose of these overview hearings are to provide the members of this subcommittee, many of whom are new to the communications area, with an opportunity to discuss with the Commission their concerns and to learn how the Commission functions and what its primary responsibilities are. In addition, these hearings will enable members of the Commission and their staff to familiarize themselves with matters that concern the members of this Subcommittee.

These overview hearings will be followed later in the year by full and extensive oversight hearings. It is my hope that these oversight hearings will provide a model for effective legislative oversight of the regulatory agencies. These oversight hearings will involve extensive preparation by the staff of the subcommittee, and by the members of this subcommittee, working closely with the staff and the members of the Commission, and will enable this subcommittee to take much a more exhaustive look at the FCC and how it operates than has ever been possible before. I might add that we are enlarging our staff with an eye toward assisting us in pursuing this very important objective.

I realize that Chairman Wiley is completing his first year as Chairman of the FCC, and I welcome him and the other Commissioners here this morning. I would like to say that there are many areas in which I

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feel the Commission is doing a good job and, quite candidly, other areas where I feel the Commission's record is far less commendable. I suspect that this subcommittee will continue to have its differences with the Commission in terms of both procedure and policy, but I can assure the Commissioners and their staff that at least there will be increased dialog between the Congress and the FCC; that is, if the FCC answers its phone.

Chairman Wiley, I appreciate your condensing your opening remarks. We will receive your entire statement into the record as if read, without objection, and you may proceed, now. Actually, we have your rather lengthy statement, and the compression of it, which still seems to me to be a little lengthy—maybe you can even verbally condense that, because it offers matters that are familiar to many of us, and actually, this morning, I would like to get on with the questioning as quickly as possible because I have some things in mind, and I know other members of the committee do as well, that have been sort of fermenting if that is a good choice of words, in my mind, dealing with the FCC. I can't think of a better time to get some answers than this morning, when, as I see, you have got the whole Commission here.

STATEMENT OF HON. RICHARD E. WILEY, CHAIRMAN, FEDERAL COMMUNICATIONS COMMISSION, ACCOMPANIED BY COMMISSIONERS ROBERT E. LEE, CHARLOTTE T. REID, BENJAMIN L. HOOKS, JAMES H. QUELLO, ABBOTT WASHBURN, AND GLEN O. ROBINSON; WALTER R. HINCHMAN, CHIEF, COMMON CARRIER BUREAU; AND DAVID D. KINLEY, CHIEF, CABLE TELEVISION BUREAU

Mr. WILEY. Yes; we do.

Mr. MACDONALD. For which we thank you. You may proceed.

Mr. WILEY. Thank you very much, Mr. Chairman and members of the subcommittee. I appreciate this opportunity to review with you significant activities of the FCC during the past year. As you suggest, I have with me my colleagues, Mr. Robert E. Lee, our veteran on the Commission; Charlotte T. Reid; and Benjamin L. Hooks. Additionally, we have our trio of newcomers, Commissioners James Quello, Abbott Washburn, and Glen O. Robinson. Additionally, we also have our top personnel on hand.

As you suggest, I have submitted a lengthy statement covering a wide variety of major matters, and I also have a shorter statement from which I am going to read, and I will try to abide by your request to cut it down some.

While broadcasting and its associated problems are often considered the glamorous portion of the Commission's broad regulatory scope, increasing attention has been focused in recent years on the Commission's activities dealing with communications common carriers. I would like to begin our review by discussing telephone rate regulation, especially our February 27 decision to permit the Bell System to file tariffs which would increase interstate revenues by $365 million annually.

Accordingly, I would like to proceed by going to our A.T. & T. rate case. A.T. & T., through its Bell System, handles some 80 percent of all telephone service in the United States. For many years, the regu-

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latory approach of the Commission was to set interstate and foreign telephone rates through a combination of rulemaking and a process of continuous surveillance. In 1971, despite the vast effort required, the FCC embarked upon an in-depth examination of the telephone ratemaking process.

In phase 1 of this investigation, the Commission sought to determine the just and proper rate of return for the Bell System. The investigation went into the Bell System's embedded cost of debt, cost of new debt, debt/equity ratio, and cost of equity. The investigation required many days of hearings and hundreds of exhibits. In November 1972, the investigation was completed, and we prescribed the allowable rate of return for the Bell System as 8.5 percent. We held, however, that A.T. & T. could increase its earnings up to 9 percent, through more efficient operations and increased productivity under the tariffs then in effect, without seeking authority from the Commission. It was felt that such an incentive for the Bell System would be desirable and in the public interest.

Hearings are now being conducted on phase II of the rate case, involving an examination of the costs and expenses of the Bell System, including the reasonableness of Western Electric's prices for equipment to the Bell operating companies, the amounts claimed by Bell for investment and operating expenses, and the lawfulness of the overall internal rate structure of the message toll service. The hearings are expected to be completed by midyear, and we should have a final decision some time in 1976.

We now go to the A.T. & T. rate filing of January 1975. On January 3, 1975, A.T. & T. submitted to the Commission a proposed new tariff seeking increased revenues for the Bell System's interstate services in the amount of $717 million per year, effective March 4, 1975. The proposed rate adjustments were designed to produce an interstate rate of return of 10½ percent to 11 percent on investment. A.T. & T. contended that this rate of return was required to sustain the financial integrity of the Bell System and to attract necessary debt and equity capital under prevailing conditions in the money markets.

Upon the filing of the new tariff, the Commission basically had three alternatives under present law: (1) To allow the entire $717 million tariff to go into effect after a 90-day suspension period; (2) to reject the tariff in its entirety; or (3) to modify our prescription to take into consideration economic changes which were uncontested. We had to act before March 4, which was the effective date of the tariff.

On February 27, the Commission rejected Bell's request for an annual increase in revenues of $717 million. Recognizing, however, that it was uncontested that Bell's capital structure had changed and that the embedded cost of debt had risen almost a full percentage point, the Commission, in accordance with the recommendations of our Common Carrier Bureau, modified Bell's prescribed rate of return to cover these known changes. This action increased Bell's allowable rate of return from 8.5 percent established in the phase 1 case, to 8.74 percent, and allowed Bell an annual increase in revenues of $365 million. Without a hearing, however, the Commission was unable to determine Bell's cost of equity. Thus, this matter was set

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for an expedited hearing to be concluded within 9 months. At the end of this proceeding, Bell's rate of return will be modified appropriately.

Our actions in response to any tariff filing, as indicated previously, are severely limited by the existing statute. At the same time, our tariff submissions continuously grow more complex due to new monopoly and competitive services now being considered. It is for this reason that we will shortly propose new legislation to provide the Commission more latitude and flexibility in dealing with these complex matters. Specifically, we are seeking authority, among other things, to suspend for up to 9 months, which with expedited hearing procedures we recently have initiated, should be sufficient to complete hearings on even more complex filings. Additionally, we want to be able to grant partial or temporary increases where indisputable evidence exists to support such grants. In our recent decision, we were able to accomplish this result only because of the previous prescription of a rate of return.

Let me turn now to the *Private Line Rate* case, docket No. 18128. There, we hope to establish guidelines for the assignment of Bell System revenue requirements among its principal competitive and monopoly interstate and foreign services. Proposed findings and conclusions have been filed, and in a few weeks there will be a recommended decision.

In January 1974, the "Hi-Lo" private line service tariff revisions were filed by the Bell System. These tariffs would, for the first time, significantly depart from the concept of nationwide rate averaging by seeking to price private line telephone service according to whether high or low density facilities are involved, with reduced rates applying over allegedly lower cost high density routes. They raise a number of substantial questions, including the proper allocation of direct and common costs, and thus were suspended and designated for a hearing.

Another important proceeding before the Commission involves appropriate regulatory policies concerning resale and shared use of common carrier services and facilities. There is growing interest in the communications industry in establishing middlemen or "brokers" to obtain transmission capability from established carriers and then to provide new or more economical communications service to the public. At present, the tariffs of the established carriers restrict these operations. We are now engaged in a full hearing to determine if such restrictions serve a valid public policy.

Moving now to interconnection, we also are involved in a number of proceedings dealing with the interconnection of separate systems or facilities with the nationwide communications network of the established common carriers. Recently, our staff recommended a new FCC certification program for interconnection equipment to a Federal/State joint board. We believe that effective coordination between Federal and State regulators is very important in these areas. However, we have also ruled that a State may not take action which would thwart Federal policy on customer interconnection, a decision which has been appealed to the U.S. Court of Appeals for the Fourth Circuit.

During the past year, we also implemented the interconnection policies adopted in our specialized carrier and domestic satellite proceedings. These decisions held that new terrestrial specialized carriers and new domestic satellite carriers should have nondiscriminatory

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access to the monopoly facilities of the telephone companies. In September of last year, our ruling was upheld by the Court of Appeals for the Third Circuit.

Going to specialized carriers, requests for authority to extend the geographic coverage of the newly authorized specialized carriers continue to be processed by the Commission. Approximately 200 cities will be covered by presently filed applications. Two carriers are on the way to promote coast to coast service in the near future. The U.S. Court of Appeals for the Ninth Circuit affirmed our basic Specialized Common Carrier decision. You will notice my statement sets forth information on these particular systems.

Proceeding now to domestic satellites, in the newly developing realm of domestic satellites, the Commission completed its policymaking proceedings in December 1972. Since then, we have authorized five of the seven satellite proposals initially received, together with several experimental earth stations. The advent of domestic satellite communications provides an opportunity to integrate service between the 48 contiguous States and Alaska, Hawaii, and Puerto Rico. We are currently evaluating carrier proposals in this regard.

I should also mention that, very recently, the Commission rejected a specific joint proposed arrangement between IBM and Comsat but indicated other options for independent or coordinated service which we would approve.

We turn now very quickly to international telecommunications. This area continues to be the fastest growing segment in the entire telecommunications field. During 1973, we authorized a new cable system in the Pacific Region—Transpac II—and it was partially completed in 1974. Rate reductions have resulted from this system. In the Atlantic region, Earth stations were authorized to expand to handle increased traffic and to provide for diversity of their satellite traffic capability. Furthermore, Comsat was authorized to participate with its partners in Intelsat to construct three new satellites, the so-called Intelsat IV–A satellite series. A number of international matters, however, still remain to be resolved. For example, we are reexamining the relationship between the international record carriers and Western Union in the pickup and delivery of international telegram traffic in the Continental United States. We have also set for hearing the question of whether Western Union is entitled to an increase in the per word charge for the carriage, within the mainland, of inbound and outbound international public message telegram traffic. And a U.S.-European-Canadian meeting in Munich in October 1974, established a continuing consultative process among these countries in planning future transmission facilities in the North Atlantic.

I should also like to add that the Commission is currently engaged in a proceeding to determine whether Comsat's tariffs are in the public interest. The hearing record was closed on December 1, 1974, and a decision by the Commission is anticipated by June 1, 1975.

Finally, let me call your attention to another important proceeding which we initiated last year: A major study of the economic factors and interrelationships of the common carrier industry in docket 20003. A major objective of this effort is to determine the economic effects of our policies relating to competition, interconnection, various

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ratemaking practices and the allocation of common plant expenses and revenues to interstate rather than intrastate operations.

I turn now quickly to our activity in the broadcast area. One of our major concerns at the commission during the past year has been TV programing for children. I am proud of the considerable progress we have made in this sector of our broadcast regulatory activity.

On October 24, 1974, the Commission concluded a study of children's television by issuing its Children's Television Report and Policy statement. This report established a series of guidelines for programing and advertising designed for the child audience. In concluding this 4-year-old proceeding, the Commission was aware of the tension between its duty to regulate the medium in the public interest and its corresponding obligation, under the first amendment and section 326 of the Communications Act, to avoid regulations which might constitute censorship. Traditionally, the Commission has resolved this dilemma by establishing general guidelines and avoiding excessive governmental interference in specific program decisions. This traditional approach was followed in the Children's Television Report.

The report reached a number of conclusions. In general these can be summarized by stating two guidelines. First, TV stations should provide a reasonable amount of programing for children, including educational material and material designed particularly for younger children, and the scheduling of such programing should be made more diversified. Second, the level of advertising during these programs should be reduced and a clear separation between program material and commercials should be established.

To implement this policy, the Commission amended its TV license renewal form to obtain information on programs for children, and on past and proposed commercial practices during these programs. The Commission, however, declined to adopt rules to enforce its policy since the broadcast industry, after extensive discussions with me, adopted commercial time standards comparable to those the FCC would have considered. The amended license renewal form, however, will enable us to determine whether TV licensees are complying with the industry standards, and to evaluate whether self-regulation is effective.

On February 19, 1975, the Commission issued another report regarding children and television entitled, "Report on the Broadcast of Violent, Indecent and Obscene Material." The report was in response to requests from the Congress, studies on the harmful effects of televised violence on children, and a growing number of complaints concerning this type of programing.

The report focused on two questions, namely, what steps might be taken to prohibit the broadcasting of obscene and indecent material, and what could be done to protect children from other sexually oriented or violent material which might be inappropriate for them. With regard to the first question, direct Government action is required. The Commission has responded by issuing a recent declaratory order which clarifies the use of the term "indecent" in 18 U.S.C. 1464—A statute which forbids the broadcast of profane, indecent or obscene language. Specifically, we held that certain words describing sexual or excretory organs or activities—broadcast in midafternoon by a New York City radio station—were covered by the statute.

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The Commission, moreover, intends to recommend to the Congress, an amendment to 18 U.S.C. 1464, which would eliminate the uncertainty regarding whether visual depiction of prohibited matter is included within the law. Accordingly, it covers cable television, as well as radio.

With respect to the broader question of what is appropriate for TV viewing by children, the Commission believes that industry self-regulation is preferable to Government standards. Our preference is based on a concern that the Commission could become too deeply involved in programing judgments which would raise serious legal and constitutional questions. Therefore, I initiated a series of meetings with executives of the three major television networks and of the National Association of Broadcasters to explore the possibility of meaningful solutions in the private sector. As a result of these meetings, the networks and the NAB's code review board adopted the following guidelines to be presumably effective this September.

(1) The first hour of network programing in prime time and the preceding hour is to be designated as a family viewing period. This means, generally, 7 to 9 p.m. eastern time.

(2) Viewer advisories will be broadcast in audio and video form to warn parents if programs during the family viewing period occasionally have material unsuitable for children. Viewer advisories will also be used later in the evening if programs have material that might be disturbing to significant portions of the audience.

(3) Broadcasters will attempt to notify publishers of TV program listings which programs will contain advisories.

The Commission believes that these guidelines are commendable, and will provide considerable aid to parents for the protection of children from violent and obscene material. A meaningful evaluation of these guidelines, however, must wait until it is possible to observe how they are interpreted and applied by broadcasters. Ultimately, their success will depend on the reasonableness and good faith of the broadcast industry.

Turning to another major decision of the Commission, this year we adopted newspaper broadcast cross-ownership rules on January 28. These rules prohibit the multiple ownership of AM, FM, and television broadcast stations. Divestiture is required by January 1, 1980.

Moving on to license renewals, I think this committee is very well informed on this subject. The Commission is working on developing its own package in this area. I think, in the near future, we will finalize our ascertainment. We are also working on a new comparative renewal policy statement and an improved system of staff delegations to improve the speed of our processing capability and to allow us to spend more time on those applications that require remedial action.

Going to the fairness doctrine, we reaffirmed the need for the fairness doctrine, which requires that broadcasters devote a reasonable percentage of time to coverage of public issues and that such coverage provide an opportunity for the presentation of contrasting viewpoints.

The Supreme Court in the landmark *Red Lion* decision upheld the constitutionality of the fairness doctrine, which is mandated in section 315 of the act.

On July 12, 1974, we released our fairness report which was the end result of a 3-year relook at the doctrine in light of developing contro-

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versies in areas such as counter commercials and applicability of the doctrine to political broadcasts. Our report basically reaffirmed the need for the fairness doctrine, as I indicated.

Let me turn now to the prime time access rule. The prime time access rule, as the committee knows, basically limits the networks to 3 hours of prime time programing during the evening.

In October 1972, we initiated an inquiry to examine the effectiveness of the rule and decided to modify it. However, our modification was stayed by the Court of Appeals for the Second Circuit, and they suggested additional inquiry. We made that inquiry, and this year we reaffirmed our original decision to lessen network control over the selection of prime time programing, and we made modifications primarily to exempt documentary, public affairs, and children's programing. Once again it was appealed to the courts and was reargued last Friday. We expect the rule to be implemented this September, but this will depend on the ultimate decision of the court.

The Commission has been active in other broadcast matters, which, for the sake of brevity, I shall only touch upon. We have notified broadcasters of athletic events that they must disclose during broadcasts any arrangements whereby sports announcers have been selected by someone other than the broadcaster. To the extent consistent with international agreements, we have allowed daytime-only licensees an additional hour of operation during the presunrise period in order to mitigate problems caused by the earlier effective date of daylight saving time.

The Commission is also examining several issues such as the use of reruns during prime time on TV, and the feasibility of making additional VHF television channel assignments through drop-ins at shorter mileage separations from other stations. We are still involved in reregulation and, during 1974, 261 rules were modified to meet current needs. Finally, an interesting and worthwhile innovation has been a series of regional meetings where various Commissioners, key staff members and myself met face-to-face with broadcasters and the general public.

Let me turn now to the emerging area of cable television. Our new cable regulatory program is entering its fourth year, and we are undertaking a comprehensive review of some key elements of that program.

This review is being conducted by two task forces, and through the process of several major rulemakings. The cable reregulation task force, similar to the work we have done in broadcasting—is reviewing all of our cable rules, forms, and procedures to modify and simplify them, particularly for the smaller cable operator. The Commission will be reviewing the work and recommendations of this task force later this month. I anticipate changes in the future.

A second task force, known as the 1977 task force, is studying the problems faced by the Commission and the industry as the March 31, 1977, deadline approaches for full compliance with our 1972 rules. As a result of this staff effort, the Commission has recently proposed for public comment a postponement of the deadline for certain of our channel capacity requirements. These requirements would apply to many older systems which would have to be completely rebuilt to comply. We hope to initiate another proceeding this month to inquire substantively into these requirements.

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In addition, the Commission has almost completed major revisions to our antisiphoning rules for movies, sports, and series programing on pay cable. We would hope to finalize these rules this week or next. Likewise, in the area of our network program exclusivity or nonduplication rules, the Commission has decided on major revisions. The staff is now in the process of drafting the final documents, which should be issued in the next several weeks.

We are also examining our policy regarding divestiture when there is cross-ownership of cable TV systems and co-located TV stations, a proposed sports blackout rule for cable systems (a proceeding which, I might add, has been pending since February of 1972), our standards for cable franchises, and proposed legislation for cable television drafted by the Office of Telecommunications Policy.

During the past year, through staff growth and efficiencies, we have made a 40-percent reduction in cable applications backlog and a sizable decrease in average case processing time. We are determined to modify our regulatory framework to accommodate the public interest in developing this emerging communications service to the American people.

We have covered, now, common carrier, broadcast, and cable TV. Let me mention several other areas. One of the most important decisions concerning land mobile spectrum relief in the last 25 years was taken last year in Docket 18262, the so-called 900 MHz proceeding. Our action provides for expanded private systems of communication in the public safety, industrial, and land transportation radio services and also makes possible the eventual establishment of a nationwide, compatible, mobile radiotelephone and limited dispatch service. We will complete our final reconsideration of this matter this month, paving the way for the development of the new services contemplated. In another docket, we have extended to three additional cities the opportunity for land mobile sharing of TV channels 14–20. Additionally, the needs of emergency medical services were afforded relief by our June action in Docket 19880, creating a new communications category in the special emergency radio service. We have also adopted interim rules (Docket 18302) to provide for automatic vehicle location and monitoring systems, important to police, fire, transit, and other public services.

I will skip over some of the material on page 22, but I commend it to your attention. I might say that in the amateur and citizens radio service, we are considering four interrelated proceedings: A creation of a new class E citizens service, an expansion of class D stations, a restructuring of amateur radio operator licenses (to permit a no-code license) and an initiation of automatic identification requirements for the citizens band.

Let me conclude my verbal statement to you by briefly mentioning the final two topics in the complete statement, namely, fees and our backlog reduction and management improvement program. In March 1974, the Supreme Court, in *National Cable Television Association* v. *United States*, held that the Commission's annual fee for cable TV systems had not been formulated in accordance with existing law. We are now in the court of appeals regarding our new fee schedule, and we suggested, in our statement, the Congress may wish to consider clarifying legislation in this entire area.

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Mr. Chairman, as should be evident from my full statement, it has been a busy year with many accomplishments. While we are pleased with some of our progress, we recognize much remains to be done. As more of the pressing major policy matters are resolved, we hope soon to be able to focus increased attention on ways to reduce the backlog of applications and other matters being processed.

Mr. Chairman, that concludes my statement. We will be pleased to respond to your questions.

[Chairman Wiley's prepared statement follows:]

STATEMENT OF RICHARD E. WILEY, CHAIRMAN, FEDERAL COMMUNICATIONS COMMISSION

Mr. Chairman and Members of the Subcommittee: Thank you for the opportunity to review with you significant activities of the Federal Communications Commission during the past year. I have with me my colleagues, Commissioners Robert E. Lee, Charlotte T. Reid, Benjamin L. Hooks, James H. Quello, Abbott Washburn and Glen O. Robinson.

While broadcasting and its associated problems are often considered the glamorous portion of the Commission's broad regulatory scope, increasing attention has been focused in recent years on the Commission's activities dealing with communications common carriers. I would like to begin our review by discussing telephone rate regulation, especially our February 27 decision to permit the Bell System to file tariffs which would increase interstate revenues by $365 million annually.

COMMON CARRIER

AT&T Rate Case

For the benefit of some of the new members of the Subcommittee, a little background may offer some perspective. AT&T, through its Bell System, handles approximately 80% of all telephone service in the United States. For many years, the regulatory approach of the Commission was to set interstate and foreign telephone rates through a process of rulemakings and continuous surveillance. In 1971, despite the vast effort required, the Commission undertook an in-depth examination of the telephone ratemaking process in Docket 19129—the AT&T Rate case.

In Phase I of this investigation, the Commission sought to determine the just and proper rate of return for the Bell System. The investigation went into the Bell System's embedded cost of debt, cost of new debt, debt/equity ratio, and cost of equity. The investigation required many days of hearings and hundreds of exhibits. In November, 1972, the investigation was completed and we prescribed the allowable rate of return for the Bell System as 8.5%. We held, however, that AT&T could increase its earnings up to 9% through more efficient operation and increased productivity under the tariffs then in effect, without seeking authority from the Commission. It was felt that such an incentive for the Bell System would be desirable and in the public interest.

The remaining issues in Phase II of the rate case call for an examination of costs and expenses of the Bell System, including the reasonableness of Western Electric's prices on equipment sold to Bell operating companies, the amounts claimed by Bell for investment and operating expenses, and the lawfulness of the overall internal rate structure of the Message Toll Service. As we reported last year, Phase II unfortunately had a slow start because of difficulties in recruiting qualified personnel to conduct a meaningful examination of the issues, and because of procedural problems with AT&T, particularly involving staff access to needed information from Western Electric. These problems, however, were resolved in 1973 and the evidentiary hearings began on May 13, 1974. The examination of AT&T's direct case, which was submitted in November, 1973, was completed in November, 1974. The Trial Staff has now offered its testimony, and it is now being tested by the other parties. The hearings are expected to be completed by mid-year but, due to the complexities of the issues involved, a final decision is not anticipated until sometime in 1976.

AT&T Rate Filing of January 1975

On January 3, 1975, AT&T submitted to the Commission a proposed new tariff seeking increased revenues for the Bell System's interstate services in the amount of $717 million per year, effective March 4, 1975. The proposed rate adjustments were designed to produce an interstate rate of return of 10½ to 11% on investment.

AT&T contended that this rate of return was required to sustain the financial integrity of the Bell System and to attract necessary debt and equity capital under prevailing conditions in the money markets.

Upon the filing of the new tariff, the Commission basically had three alternatives under present law: (1) to allow the entire $717 million tariff to go into effect after a ninety-day suspension period; (2) to reject the tariff in its entirety; or (3) to modify our prescription to take into consideration economic changes which were uncontested. To prevent the tariff from going into effect, it was necessary for us to take appropriate action prior to March 4 (the effective date of the tariff).

On February 27, in accordance with the recommendations of the Common Carrier Bureau, the Commission rejected Bell's request for an annual increase in revenues of $717 million. Recognizing, however, that it was uncontested that Bell's capital structure had changed and that the embedded cost of debt had risen almost a full percentage point, the Commission modified Bell's prescribed rate of return to cover these known changes. This action increased Bell's allowable rate of return from 8.5%, established in the Phase I case, to 8.74%, and allowed Bell an annual increase in revenues of $365 million. Without a hearing, however, the Commission was unable to determine Bell's cost of equity. Thus, this matter was set for an expedited hearing to be concluded within nine months. At the end of this proceeding, Bell's rate of return will be modified appropriately.

The instant case highlights the need for the Commission to have greater flexibility and authority in dealing with tariff filings, and illustrates how such flexibility and authority could be employed in the public interest. As you are aware, Mr. Chairman, the law presently allows a carrier to file a tariff seeking increases in rates on 60 days' notice. In most instances, the Commission can only prevent the tariff from going into effect after the notice period by suspending it for a period up to ninety days. Thus, the staff has only the notice period of 60 days to determine the facts and make recommendations to the full Commission on the proposed disposition of the tariff. Due to the ever increasing complexities of our present day tariffs, it is often difficult to make a thorough evaluation in this time period. For that reason, we are proposing a legislative change to extend these periods. In addition, it traditionally has taken from one to two years, or more, to complete a hearing on the lawfulness of the tariff. This has resulted in tariffs being in effect for a minimum of 9 months before their lawfulness could be determined. We recently have instituted an expedited hearing procedure, relying heavily on written rather than oral examination, by which we expect to reduce the hearing time to 9 months in most cases. However, under the present statute, tariffs still will go into effect months before the question of their lawfulness has been resolved.

We are proposing legislation which would extend the 60-day notice period to 90 days and make it applicable to all tariff filings, including those involving no rate increase. We are also proposing that we be authorized to suspend for up to 9 months, by which time we would expect to complete a hearing on even the most complex filings. Finally, we are asking authority to suspend in part and grant in part. Another problem with the present statute is that any suspension must apply to the entire tariff. Thus, even where the Commission is convinced by the uncontroverted evidence that the carrier is entitled to at least a portion of the increase sought (as in the present case), we lack authority to approve such a partial increase.

In the recent decision, we were able to accomplish many of the objectives of our legislative recommendation only because the Commission had previously prescribed a rate of return and, thus, could reject the tariff filing as a violation of that prescription. However, because of the uncontested evidence of Bell's increased debt cost and changes in the capital structure, the Commission could justifiably modify its previous prescription and allow Bell a new rate of return to cover the increased costs. In addition, we were able to defer the effective date of the full increase sought pending a full adjudication of its lawfulness. However, I must emphasize that this is the exception rather than the rule with respect to our ability to handle such cases.

Private Line Rate Cases

Proposed findings and conclusions have been filed in the *Private Line Rate Case* (Docket 18128), and there will be a Recommended Decision in a few weeks from the Chief of our Common Carrier Bureau. Following further comment and exceptions by all parties on that recommendation, the Commission expects to reach a final decision before the end of the year. In this proceeding, we hope to establish guidelines for the assignment of Bell System revenue requirements among its principal interstate and foreign services. This includes not only the monopoly

Message Toll Service and WATS services but also the private line services of the Bell System where they compete now in this rapidly expanding market with the newly specialized communications carriers.

In January, 1974, we suspended for the statutory limit of 90 days the "Hi-Lo" private line service tariff revisions filed by the Bell System and ordered a hearing on the lawfulness of the tariffs (Docket 19919). In its filings, AT&T departed from nationwide costs and rate averaging, which it had previously applied to interstate services, and instead priced private line service according to whether high or low density facilities were involved. Reduced rates would apply over alledgedly lower-cost high density routes and increased rates would apply over allegedly higher-cost low density routes. These "Hi-Lo" tariffs raise a number of substantial questions including the proper allocation of direct and common costs for specific services. We entered an accounting order to provide for possible refunds and set forth procedures requiring a paper hearing which will allow for an expedited resolution. The record was closed in July, 1974, and oral argument was held before the Commission on November 5. We anticipate a decision in June of this year.

Another important area of private line service involves the resale and shared use of common carrier services and facilities (Docket 20097). There is growing interest in the communications industry in establishing middle men or "brokers" to obtain bulk transmission capability from established carriers so that they, in turn, can provide new or more economical communications services to the public. We have previously authorized three firms—Telenet, Graphics, and Packet Switch—to engage in selected types of brokerage. The tariffs of established carriers have historically limited such operations. For that reason, we are undertaking an inquiry to determine the potential need for such services; the extent to which these new entities should be able to obtain communications services from the established carriers; and what regulation of these operations would be in the public interest. A Notice of Inquiry and Proposed Rulemaking was issued in July, 1974, inviting comments by interested persons on the many interrelated issues to be considered by the Commission in developing policy in this area. Comments of the parties have been received and are now under study by the staff.

Interconnection

We also are involved in a number of proceedings dealing with the interconnection of separate systems or facilities with the nationwide communications network of the established common carriers. Interconnection involves two basic areas: customer/carrier interconnection, namely, connection of customer-provided private systems and facilities to the facilities of common carriers; and carrier/carrier interconnection involving the connection of the facilities of one carrier to the facilities of another carrier.

Interconnection of customer-provided equipment through the use of a special interface or coupling arrangement is now permitted under telephone company tariffs, pursuant to the Commission's *Carterfone* decision. Following *Carterfone*, the Commission undertook to determine whether it would be feasible and in the public interest to require that some customer-provided equipment be allowed direct interconnection with the network, thus eliminating both a cost and operational deterrent contained in the present tariffs. After extensive staff work, independent studies, and comments by interested parties, our staff recently recommended a certification program for such equipment to be administered jointly by our Common Carrier Bureau and Office of Chief Engineer. This proposal was considered by a Federal-State Joint Board on March 3, and we have scheduled a further meeting on the subject for April 24. Meanwhile, our staff is undertaking discussions with the staff of the National Association of Regulatory Utility Commissioners (NARUC) on this and related subjects.

I believe that effective coordination and cooperation between Federal and State regulators is very important in areas such as this, and I have pledged the Commission's best efforts to meet our share of that responsibility.

In January, 1974, we issued an important ruling on customer interconnection in Docket 19808. Noting that interstate and foreign communication services depend vitally on plant facilities and operations which are inextricably interwoven with intrastate services, we ruled that this fact does not permit conflicting state and Federal policies to exist with respect to interconnection of customer-provided equipment and that, consistent with judicial precedent, Federal policy must prevail. Accordingly, we ruled that a state may not take any action that would thwart Federal policy on customer interconnection. This decision was recently appealed by the North Carolina Regulatory Commission to the U.S. Court of Appeals for the 4th Circuit.

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With regard to carrier/carrier interconnection, our main regulatory activities in the past year have been to implement the interconnection policies that we adopted in our *Specialized Carrier* and *Domestic Satellite* proceedings. Those decisions held that new terrestrial specialized carriers and new domestic satellite carriers should have non-discriminatory access to the monopoly facilities of telephone companies in order to provide authorized services to their customers. To implement this holding, we ruled that the leasing of facilities or services by one carrier to another for interstate or foreign communications must be governed by tariffs filed with the FCC rather than by private contract. Bell appealed both these principles. In September, 1974, the U.S. Court of Appeals for the Third Circuit affirmed the Commission's rulings.

Separations

You may recall that, last year, I discussed the continuing problem of jurisdictional separations. Jurisdictional separations involve the allocation, for ratemaking purposes, of investment and costs of telephone plant and operations between interstate service and local exchange and intrastate toll service. This allocation is becoming quite controversial in light of generally increasing costs and rates, particularly for local exchange service, and the state regulatory bodies are focusing their attention more and more on this problem. The Commission adopted rules after a Federal-State Joint Board proceeding to provide guidelines in making these allocations. A petition filed by the National Association of Regulatory Utility Commissioners (NARUC) is now pending before the Commission urging changes in the current separations formula. If these changes are adopted, interstate operations would have to bear an additional $575 million of revenue requirements, shifted from intrastate operations.

We are aware of the problems faced by the states regarding further intrastate rate increases. Accordingly, we have suggested to NARUC that joint studies be undertaken to determine whether the judicious use of usage-sensitive pricing for local telephone service, instead of traditional flat-rate pricing, would lead to more efficient use of the communications network. If this occurred, the investment required by telephone companies for local exchange service, and the need for rate increases, would be reduced. Experiments in usage-sensitive pricing are being conducted in a few local areas, and we are closely following the results of these experiments.

Specialized Common Carriers

In 1973, AT&T filed a petition requesting that we reverse our 1971 decision allowing specialized common carriers to enter the common carrier communications field. AT&T requested that we discontinue all further grants to competitors pending the outcome of an evidentiary hearing on its petition.

In December, 1973, we denied this petition (FCC 73–1298) on the ground that a re-examination of the policies formulated by our decision would be unwarranted and premature. We held that AT&T had not advanced any significant arguments that were not carefully considered by the Commission at the time of its decision, and that there had been no changes in circumstances or unanticipated developments since our decision which might require reexamination. The U.S. Court of Appeals for the 9th Circuit on January 20, 1975 affirmed our *Specialized Common Carrier* Decision.

Since the 1971 decision, we have issued a large number of construction authorizations and operating licenses for various types of specialized carrier systems. Two carriers have now been authorized coast-to-coast systems and are in the final stages of construction. Several carriers have large partial systems in operation. The total applications filed cover services to more than 200 cities in the United States.

Domestic Satellites

The Commission completed its domestic satellite policy-making proceeding in December, 1972. Since then, we have authorized five of the seven domestic satellite proposals initially received, together with several experimental earth stations.

Western Union Telegraph Company launched two of its three satellites last year and has been providing service since July. The Communications Satellite Corporation (COMSAT) has formed a subsidiary, Comsat General, to own and operate four satellites authorized to provide satellite services for the seven authorized AT&T earth stations.

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General Telephone and Electronics (GT&E) was authorized to establish a separate system to provide message telephone and other services, through a lease arrangement with National Satellite Services, Inc. (a Hughes Aircraft subsidiary). This authorization was appealed to the Court of Appeals by AT&T. Subsequently, GTE and AT&T determined through negotiations to merge their efforts. Accordingly, GTE has requested authorization to drop its plans for a separate system in favor of owning 3 of the 7 earth stations proposed for a joint AT&T/GTE system. This request has been set for hearing.

In addition to these three systems, interim operations have been authorized to American Satellite Corporation and RCA Global Communications, Inc./RCA Alaska Communications, Inc. The RCA system is now providing service to Alaska and the lower 48 states, temporarily using the Canadian or the Western Union Satellite System until they launch their own "bird" in 1975. American Satellite presently leases satellite transponders on the Western Union system to provide service via its own earth stations. In addition to the carrier-owned earth stations associated with these systems, the Commission has authorized several experimental earth stations to General Electric, TelePrompTer, Scientific Atlanta, and American Satellite.

COMSAT/IBM

In 1972, the Commission approved in principle the establishment of a joint venture in domestic satellite services by Comsat, MCI, and Lockheed. Each partner was to have a 33% interest in the resultant CML Corporation. Due to changed economic circumstances, MCI and Lockheed decided not to proceed with an operational program, Comsat and IBM recently proposed a new arrangement in which they would purchase the MCI and Lockheed interests, with IBM retaining a 55% ownership and Comsat a 45% ownership in CML. Numerous objections were raised in comments filed concerning this proposed merger, and a full-day oral argument was held on Novemer 25, 1974.

After carefully scrutinizing the issues raised, the Commission determined that there should be no absolute bar to Comsat and IBM entering the domestic satellite business, either separately or together, but that their specific joint proposal arrangement should be rejected. Accordingly, the Commission gave them the option of proceeding independently of one another, of proceeding under a lessor/lessee arrangement, or of finding a third partner having at least a 10% ownership share in order to prevent total dominance by any of the partners involved.

Another significant domestic satellite decision was our approval of an arrangement whereby an entire transponder in an Intelsat satellite over the Pacific basin was leased to the voice and record carriers by Comsat. Since an entire transponder was leased, the rate per circuit was substantially reduced. In approving the transponder lease, the Commission required most of the savings to be passed on to the public. The term of the lease was restricted to allow future potential competitors for mainland/Hawaii satellite service an opportunity to bid against Comsat for the provision of such service in 1975.

The advent of domestic satellite communications service between the 48 continguous states and Alaska, Hawaii and Puerto Rico provides an opportunity for the integration of these areas into the uniform domestic rate pattern. For that reason, we have required certain carriers to submit proposals for integrating these rates. Responses and further information have been submitted and are presently under evaluation.

International Telecommunications

In the international sphere, revenues have continued to grow at a rate well in excess of 15% annually during the past several years, making this the fastest growing segment in the entire common carrier field. This growth pattern has brought with it many urgent problems which have been further complicated by the pace of technological advances in international telecommunications, and by the competing demands made upon the Commission by satellite interests, terrestrial interests, AT&T and the international record carriers for rulings and policy statements more clearly defining their respective areas of service.

As a consequence of increasing demand, the Commission has authorized several high capacity cable and satellite facilities. During 1973, the Commission granted a cable landing license and issued authorizations to AT&T, Hawaiian Telephone Company, ITT World Communications, Inc., RCA Global Communications, Inc. and Western Union International, Inc., for a new cable system in the Pacific region. This cable system, referred to as Transpac II, will have three segments,

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with a capacity of 845 circuits. The first segment between the Mainland and Hawaii is presently operational, and the remaining two segments (between Hawaii and Guam and between Guam and Okinawa) should be completed this year.

The international satellite field has also grown rapidly. Comsat was authorized last year to participate with its partners in INTELSAT in the construction of three new satellites, the so-called INTELSAT IV–A satellite series. These satellites would have a capacity of between 5,500 and 6,500 circuits plus television, depending upon the operational requirements and frequency configuration. The first INTELSAT IV–A satellite is scheduled for operation in mid-1975, and will be used initially in the Atlantic region.

There have also been changes in international rates, mostly in the form of reductions. AT&T is continuing to work with our staff in devising new rate structures for international message telephone calls to take account of economies made available by improvements in technology, lower labor costs, and increased reliance on direct dialing and the availability of high capacity communication facilities to all parts of the world.

Maritime and Aeronautical Satellites

Communication via satellite is broadening to encompass services not previously provided by commercial satellite facilities. The Commission has approved a joint venture of Comsat General Corporation, RCA Global Communications, Inc., Western Union International, Inc. and ITT World Communications, Inc. to participate in the joint ownership of a maritime satellite system, and to individually market maritime communications satellite services. This is a developmental program which materialized from a communications requirement of the U.S. Navy Department with the majority of the communications capacity required to serve such needs. The additional capacity not required to satisfy the Navy's requirements will provide a means for initial commercial maritime satellite requirements to be met.

In addition to the maritime satellite system just described, the Commission is involved in developing U.S. views and establishing an international maritime satellite system. An international conference is now scheduled for April, 1975 to consider the establishment of an organization for international maritime satellite service.

An aeronautical satellite system (AEROSAT) is being planned with ownership of several European countries, Canada and the United States. The Commission will have the responsibility of approving and licensing the U.S. carrier participation and the regulatory aspects of the operation and services to be provided. The initial system will be experimental in nature and is intended to bridge the gap between experimental effort and an operational satellite capability. The purposes of the AEROSAT system are to provide experience in technical, operational, economic and managerial areas required in advance of a fully operational capability. It appears now that the first operational capability of the system will be in late 1978.

Comsat Rate Case

For some time, we have been engaged in a comprehensive proceeding to determine whether the charges, classifications, regulations and practices in the tariffs of the Communications Satellite Corporation are just and reasonable. These tariffs authorize Comsat to provide satellite channels to international carriers for voice and record services to the public. The hearing record in this proceeding was closed in December and proposed findings were filed on February 18, 1975. A decision by the Commission is anticipated by this summer.

International Policy Matters

There have been a number of developments in the area of international communications policy during the past year. Perhaps foremost among these is the effort we have launched with respect to the planning of future satellite and cable facilities for international communications. As you may know, determination of the appropriate mix of these facilities has been and continues to be a subject of intense interest and concern among the U.S. carriers, their foreign counterparts, and foreign administrations. It is also, of course, of great concern to the Commission since the investments in these facilities are ultimately borne by the rate-payer.

In recognition of these concerns, and of the growing complexity of international communications networks, we met with representatives of some 16 European telecommunications administrations in Munich last October, for the purpose of establishing a continuing consultative process on trans-Atlantic facility needs

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and options. The first meeting on substantive matters, following up on the understanding reached in Munich, should be held later this Spring. The Commission will serve as the focal point for U.S. participation in this effort, which will involve other government agencies, all the U.S. carriers, user interests, and other interested parties. We expect to coordinate fully and frequently with the Office of Telecommunications Policy and the Department of State to ensure that the U.S. presents a well thought out, unified approach to this vital planning effort.

In furtherance of these broad objectives, the Commission in February released a Notice of Inquiry to help determine a policy for future licensing of facilities for overseas communications. We anticipate this proceeding will be an evolving process working toward the continuing refinement of the Commission's guidelines for the future planning of facilities. With the increasing complexity of communications systems, and the continuing growth in communication requirements, the Commission must constantly review relevant information to establish and refine guidelines so that the planning and implementation of needed communications facilities may proceed on a timely basis during the next decade. The Commission's basic policy is one of concern for adequate diversity, redundancy and flexibility, and the availability of sufficient capacity to meet all reasonable requirements for this nation's international communications services.

Also in the area of international communications policy, we are reexamining the relationship between international record carriers and Western Union created by Section 222 of the Act. Major issues here include various proposals by the international record carriers to establish new gateway cities for international record traffic, bypassing Western Union's domestic network; Western Union's desire to participate in the furnishing of new and different services among all States of the Union including Hawaii and Alaska; the proper division of unrouted international telegraph traffic picked up by WU, among the several international record carriers; and the proper landline haul charge which WU should receive for handling such international traffic.

In early, 1974, the Commission also initiated a proceeding to determine whether the basis for regulating rates for international leased channel service should be changed. At present, these rates are established and justified on a route-by-route basis. The Commission is considering whether those rates should be on an area-by-area basis, or perhaps removed altogether from cost-of-service/rate of return regulation so that they may be determined by the competitive environment.

As is evident, the Commission is now being required to reallocate significant resources to the international area. In recognition of this fact, we have recommended that a new position of Assistant Chief/International be created in the Common Carrier Bureau to help coordinate international matters. Specifically, he and his staff will be responsible for coordinating efforts of the staff, industry, and other agencies in developing and presenting the Commission's views and policies on such matters as transatlantic facility planning, World Administrative Radio Conferences, maritime and aeronautical satellite programs, and related items.

Economic Inquiry

Finally, I should like to call your attention to another important common carrier study which is underway. In recognition of the growing complexity of the telecommunications industry's structure, technological operations, service offerings, rate structures, interstate/intrastate jurisdictional separations, and related issues, the Commission decided, in April 1974, to undertake a major study of the economic factors and interrelationships of the common carrier industry. A major objective of this study is to determine the economic effects of policies relating to competition, interconnection of customer-provided equipment and multiple communications networks, various rate-making practices (including usage-sensitive vis-a-vis flat rate pricing), and the allocation of common plant expenses and revenues to interstate instead of intrastate operations.

This proceeding (Docket 20003) is designed as a fact-finding inquiry rather than a vehicle to adopt specific rules or policies. The economic factors being examined are so interrelated that we consider it essential that a fact-finding inquiry occur before reaching a decision on several outstanding petitions for review on economic grounds of Commission policies and industry practices.

BROADCAST

Children's Television Programming and Advertising

On October 24, 1974, the Commission concluded an extensive study of children's television by issuing its *Children's Television Report and Policy Statement.*

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The *Report* established a series of guidelines for programming and advertising designed for the child audience.

In setting up guidelines concerning children's programming practices, the Commission was mindful of the fact that there is a tension between its duty to regulate the medium in the "public interest" and its corresponding obligation, under the First Amendment and Section 326 of the Communications Act, to avoid regulations which might constitute "censorship". In all cases where the Commission is involved in the regulation of program content, it must walk a tightrope between saying too much and saying too little. Traditionally, the Commission has resolved this dilemma by establishing general guidelines and avoiding excessive governmental interference in specific program decisions. This traditional approach was followed in the *Children's Television Report.*

The *Report* recognizes that programs designed for general audiences are not adequate to serve the special needs of children. Because of their immaturity, children require programs which are specifically designed for them. The *Report,* therefore, requires television stations to provide diversified programming designed to meet the particular needs of the child audience. It is also made clear that a reasonable amount of this programming should be designed to contribute to the child's cultural and intellectual development—and not simply to entertain. The Commission stated that this educational programming need not take the form of dull "classroom" instruction. Rather, it was pointed out that there are many exciting ways in which the medium can be used to further a child's understanding of history, music, the arts, and the world around him.

The Commission's *Report* noted that pre-school children differ markedly from older children in their level of intellectual development and that some programming should be particularly designed for the younger children in the audience. In addition, the Commission found that the practice of many broadcasters in relegating all children's programs to just one or two days of the week is unreasonable. The *Report* stated that considerable improvement is expected in scheduling practices in the future.

With regard to the related problem of advertising on children's programs, the *Report* clarified the division of responsibility between the FCC and the Federal Trade Commission (FTC). The FCC has a responsibility to see that the amount of advertising is not excessive and that broadcasters maintain a clear separation between program material and advertising. Other areas of concern about advertising for children, including deceptive or misleading advertising practices, are within the Jurisdiction of the FTC.

The FCC considered and rejected suggestions that advertising be banned completely from children's television. It was recognized that advertising is the sole economic foundation of the American commercial broadcasting system. It would be unrealistic, on the one hand, to expect licensees to improve significantly their program services to children and, on the other hand, to withdraw the principal source of funding for this effort.

The Commission's studies indicated, however, that existing levels of advertising to children were in excess of the amount needed to support good program service. Following extensive discussions with me, the National Association of Broadcasters responded to these findings by amending its code to limit non-program material on children's programs to nine minutes and thirty seconds per hour on weekends and twelve minutes during the week by 1976. The Association of Independent Television Stations (INTV) agreed to reduce advertising to the same levels.

The advertising levels adopted by these industry associations are comparable to levels which the Commission would have considered adopting by rule in the absence of effective self-regulation by broadcasters. Accordingly, the Commission has endorsed the industry's action and will carefully examine the renewal applications of stations which exceed the agreed levels. Such licensees will be expected to make a substantial and well-documented showing to justify their advertising policies. The Commission has recently acted to amend the television renewal form to provide detailed information on the children's advertising practices of each station.

The *Children's Television Report* also recognizes the fact that young children have considerable difficulty in distinguishing advertising and programming material. The *Report* requires stations to take special precautions to insure that there is a clear separation between the two. In addition, the *Report* prohibits the use of a program host, or other program personality, to sell to children. The Commission found that one effect of "host selling" is to interweave program and commercial material, exacerbating the difficulty children have in distinguishing the two. In

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addition, it was found that the host, as a result of his special relationship with the audience, was in a position to take unfair commercial advantage of the trust which children place in program personalities.

Violent, Indecent and Obscene Material

In response to Congressional directives, the Commission has considered the problem of sex and violence on television with special emphasis on the goal of protecting children. A *Report on the Broadcast of Violent, Indecent and Obscene Material* was forwarded to the Congress on February 19, 1975.

This *Report* focused on two areas of inquiry: (1) what steps might be taken to prohibit the broadcasting of obscene and indecent material; and (2) what steps might be taken to protect children from other sexually oriented or violent material which might be inappropriate for them.

With regard to the first question, the Commission believes that existing statutory authority embodied in Section 1464 of the Criminal Code is adequate as a safeguard against obscene and indecent language. On February 12, 1975, the Commission issued a declaratory order designed to clarify the term "indecent" as used in the statute and to make it known that certain words describing sexual or excretory organs or activities are covered by the statute. The related problem of video or pictorial presentation of such material is not specifically covered by the statute and the Commission will propose legislation to clarify any uncertainty in this area.

The Commission also considered the broader question of material which—although not legally obscene or indecent—may nevertheless be inappropriate for viewing by children. The Commission believed that this problem should most appropriately be handled through self-regulation rather than through the establishment of government standards. The reason for this preference is that decisions concerning what is appropriate are highly subjective. Thus, attempts to regulate in such an area could lead the Commission too deeply into programming judgments, raising serious constitutional questions.

With these considerations in mind, I initated a series of meetings with the executives of the three major television networks to explore the possibility of industry self-regulation. In suggesting these meetings, I sought to serve as a catalyst for the achievement of meaningful reform within the industry. As a result of these meetings, the networks and the National Association of Broadcasters' Code Review Board adopted the following guidelines:

(1) Two hours in the early evening (generally 7:00 to 9:00 PM Eastern Time) will be set aside as a "Family Viewing" period. Programs presented during this period will be appropriate for viewing by the entire family including younger children.

(2) "Viewer advisories" will be broadcast in audio and video form to warn parents when there is an occasional exception to this Family Viewing principle. Viewer advisories will also be used later in the evening if programs have material which might be disturbing to significant portions of the audience.

(3) Broadcasters will attempt to notify publishers of *TV Guide* and other program listings so that the viewer advisories will be printed with these listings.

It is obvious, of course, that these guidelines will not guarantee that every child will be protected from objectionable material. Children watch television in varying numbers during all hours of the broadcast day and not just during the 7:00 to 9:00 PM period. Some, who are not properly supervised, will undoubtedly be exposed to programs which responsible adults would consider to be inappropriate. Nevertheless, we believe that the industry reforms strike an appropriate balance between two conflicting objectives. On the one hand, it is necessary that the industry aid concerned parents in protecting their childred from objectionable material; on the other hand, it is important that the medium have an opportunity to develop artistically and to present themes which are appropriate and of interest to an adult audience. In essence, the balance decided on by the industry is to divide prime time in half.

In the final analysis, the success of these new guidelines will depend on the reasonableness and good faith of the broadcast industry. The new standards will only be accepted by the American people if broadcasters are responsible in their day-to-day administration of the program.

Cross Ownership

On January 28, 1975, the Commission adopted the final order in Docket 18110 bringing to an end and the proceeding begun in 1968 relating to the multiple ownership of AM, FM and Television Broadcast Stations. In some areas of media

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cross ownership, the existing rules continue in effect and, in other areas, new rules have been adopted.

In the area of TV-radio combinations, no divestiture of existing combinations is required, and the present rules adopted in an earlier phase of this proceeding remain in effect. This means that a licensee of a VHF television station may not build or acquire a radio station (AM, FM, or AM-FM) in the same market, and that the licensee of an AM station, an FM station, or an AM-FM combination may not build or acquire a VHF station in the same market. Although existing combinations are not required to divest, if the owner of a VHF-radio combination sells, he must sell the TV station to one party and the radio station to a different party. Applications involving UHF-TV and radio station combinations are handled on a case-by-case basis.

AM-FM combinations also are not required to divest, and existing rules continue in effect. This means that the licensee of an AM station may build or acquire an FM station in the same market and vice versa. Moreover, AM-FM combinations may be sold to a single party. The present rules governing duplication of programming by AM-FM combinations will be considered in pending Docket 20016.

New rules were adopted, however, concerning cross-ownership of a newspaper and either a television station or radio station in the same market. Prospectively, the formation of new newspaper-broadcast station combinations in the same market is barred. Divestiture is required by January 1, 1980, by television stations in seven communities where the only general circulation newspaper in the community and the only television station placing a city-grade signal over the entire community are under common ownership. Similar divestiture is required in the case of nine radio-newspaper combinations where there is common ownership of the only general circulation daily newspaper in the community and the only radio station placing a city-grade signal over the entire community in daytime hours. Waivers may be available upon a proper showing.

License Renewals

The subject of broadcast license renewal continues to generate interest and controversy. During calendar 1974, 2,571 AM, FM and TV stations (out of approximately 8,500 total stations) applied for renewal of their authorizations to broadcast. In that same time span, 2,531 renewals were granted, some of these having been applied for prior to 1974. A total of 112 petitions to deny license renewals were filed in that year, as well as a substantial number of informal objections and complaints.

The Commission has made a number of internal adjustments and improvements to meet the renewal workload. A task force of attorneys has been placed on temporary assignment to the Renewal Branch, chiefly to deal with contested applications. Reorganization of certain record-keeping functions, and closer internal coordination are beginning to speed the flow of paper. And conversion of certain broadcast data from manual to computer format has added greatly to the efficiency of research on renewal policies.

A number of broadcast policies have been opened for inquiry. Perhaps closest to resolution is Docket 19715, Ascertainment of Community Problems. As you may recall, the Commission's four-year-old *Primer* on ascertainment was prepared for use by new applicants and was made applicable to license renewals only as an interim measure until other guidelines could be developed to recognize the importance of the renewal applicant's actual performance during the preceding license term.

The Commission also sought comment concerning "continuous" versus fixed-period ascertainment, and whether survey requirements should differ according to the kind of broadcast service (radio, television), station size, market size, and other factors.

Many of the comments the Commission received in this matter stated that the present application of the *Primer* requirements to renewal applicants was burdensome, restrictive, arbitrary, and method-centered. A significant number of these same comments, however, acknowledged that the *Primer* introduced a degree of certainty into the ascertainment process, and conceded the value of the contacts between the broadcaster and the community made obligatory by the *Primer*.

The Commission now is considering a series of staff recommendations and alternatives for resolution of the ascertainment inquiry. Although it would be premature to speculate upon the outcome, I think it is fair to state that the Commission approaches its task highly conscious of at least these three concerns: (1)

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the burden upon the small broadcaster of a highly formalized process which inordinately consumes his time and his comparatively meager resources; (2) the desirability of a means to insure "continuity" of community ascertainment by the broadcast licensee throughout his license term; and (3) the value of systematic contacts between the broadcaster and the community in the development of a continuing "dialogue."

Another outstanding inquiry, now scheduled for early resolution by the Commission, is Docket 19154. This proceeding concerns the standards for evaluating and comparing in the context of a comparative hearing a renewal application and one or more competing applications for the same frequency. Specifically, we have sought comment on whether to establish quantitative standards for local and informational programming which would give a *prima facie* indication of substantial service warranting a "plus of major significance"—to use the Court of Appeals' phrase—in a comparative renewal hearing.

Besides ascertainment and comparative renewal policy, several other important renewal topics are on the Commission's schedule for the January-March quarter. These include the development of a "short form" for certain radio license renewals and a re-examination of the "delegations" policy which guides the staff in determining whether a renewal application should be approved by the Commission or may be approved at the Bureau level.

The Commission places great importance on the efforts by broadcasters and their listeners and viewers to resolve differences and problems through discussion on the local level. In this connection, the Commission is considering a policy statement to clarify the appropriate role of broadcaster-citizen agreements.

Fairness Doctrine

In 1949 the Commission adopted a policy which has become known as the fairness doctrine and which subsequently received statutory recognition. The fairness doctrine requires that broadcasters devote a reasonable percentage of time to coverage of public issues and that such coverage provide an opportunity for the presentation of contrasting viewpoints.

The Supreme Court in the landmark *Red Lion* decision upheld the constitutionality of the fairness doctrine. The Court declared that because the number of licenses available is necessarily limited, a licensee must act as a public trustee to present those views and voices which are representatives of his community.

Because of the passage of time since adoption of the policy and the emergence of many new problems regarding its application, the Commission in 1971 began an inquiry directed toward reassessment and clarification of the policy. The product of this proceeding, in which the public, the broadcasting industry and the Commission played active roles, was the Commission's Fairness Report, released on July 12, 1974. Four areas of inquiry were examined: the fairness doctrine generally; access to the broadcast media as a result of the presentation of commercial announcements; access, generally, for discussion of public issues, and application of the doctrine to political broadcasts. In each of these areas the Report clarified the Commission's application of the fairness doctrine. It also explained more fully our procedures for processing fairness complaints and the requirements placed upon both complainants and licensees with respect to filing and answering such complaints. In conclusion, the Commission reaffirmed the need for the fairness doctrine and said that strict adherence to the doctrine was perhaps the single most important requirement of operation in the public interest.

Political Broadcasting

The Commission also clarified its position concerning political broadcasting. In a Public Notice of June 5, 1974 (47 FCC 2d 516) the Commission stated that a right of access to *prime time* by Federal candidates is inherent within the meaning of "reasonable access" required by section 312(a)(7) of the Communications Act. A broadcast licensee, therefore, may not deny candidates access to time periods of greatest audience potential, such as "prime time" on television or "drive time" on radio. The Commission further stated that if a broadcast licensee sells spot announcements to legally qualified candidates for public office, it would be contrary to the congressional objective of putting candidates in the same position as the most favored commercial advertisers to deny them the opportunity to purchase spot announcements of the same length and type available to commercial advertisers.

Combination Rates and Joint Sales Practices

On January 29, 1975, the Commission issued its First Report and Further Notice of Proposed Rule Making in response to a 1973 Notice of Inquiry and

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Notice of Proposed Rule Making regarding policies on combination advertising rates—the rates offered advertisers by two or more separately owned stations serving substantially the same area—and other joint sales practices involving broadcasters and cable television systems. The Commission emphasized in its 1973 action that it was seeking to maintain a healthy, competitive economic environment for broadcasting consistent with the public interest and the policies underlying the antitrust laws. The basic policy is that of promoting "arms length" competition among broadcast stations.

The Commission's First Report (1) re-affirms existing policy which prohibits separately owned stations serving the same market from using combination rates or joint sales practices; (2) makes more inclusive a previously-enunciated policy prohibiting a sales representative organization owned by a licensee from representing a competing station in the same area; (3) reverses a policy which permitted certain FM stations serving the same area to use combination rates; (4) permits an independent sales representative organization (i.e., one not owned by a licensee in the community) to represent more than one station in a community provided that the stations are not sold in combination. For example, a representative of two stations in a community will be required to enter into separate contracts with advertisers for each station and to leave all decisions as to contracting for the sale of time, including rates, to the individual licensees.

The Commission in its recent action also proposed a new rule that would codify the policy prohibiting combination sales by separately owned stations and specify the signal contours of stations to which the prohibition would apply. The proposed rule also would prohibit combination sales by separately owned stations and TV cable systems if the specified contour of the station overlapped the area served by the cable system. Finally, the proposed rule would prohibit combination sales by *commonly* owned television and aural stations if there were an overlap of contours.

Practice of Licensees and Networks in Connection With Broadcasts of Sports Events

On July 31, 1974, the Commission notified broadcasters of athletic events that they must disclose "clearly, publicly, and prominently" during broadcasts any arrangements in which sports announcers have been directly or indirectly selected, paid, approved or removed by parties other than the licensee or network broadcasting the event. This action resulted from proceedings initiated by a Notice of Inquiry released June 26, 1973, in which the Commission sought comment on a variety of alleged practices by networks and individual licensees in the broadcast of sports events. Comments showed that non-broadcast organizations such as sports leagues and individual teams exercised a high degree of control over the selection and retention of sportscasters. The Commission found that allowing sports organizations a voice in the selection of personnel to announce their events did not, in itself, necessarily result in the abdication of a licensee's responsibilities. The licensee, if it insists, can still retain effective control over programming.

The Commission found, however, that the public interest would best be served by requiring licensees to disclose the existence of such arrangements during broadcasts. Disclosure would prevent deception as to possible lack of objectivity because of the private interest of the sports announcer. Although we did not inhibit the role which third parties played in the selection of sports announcers, we stressed that it was the licensee's responsibility to "refrain from engaging in or permitting others to engage in, deliberate falsification, distortion or suppression of facts." In this regard, the Commission noted that many of the allegations of distortion or suppression outlined in the Notice of Inquiry went far beyond general home-team bias on the part of the announcer.

Special Subcarrier Service for the Blind

On November 6, 1974, the Commission issued a declaratory ruling which for the first time enabled a licensee of an educational station to use its FM Subsidiary Communications Authorization (SCA) for special programming to serve the blind. The licensee had requested a declaratory ruling as to the applicability of the fairness doctrine and sections 315 (equal opportunities for political candidates) and 317 (prohibition of editorializing and endorsement of political candidate) of the Communications Act to its FM SCA programming to serve the blind by reading articles, feature stories, editorials and advertisements from newspapers. Special subcarrier radio receivers for reception of the SCA broadcasts were to be furnished to the blind.

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Prime Time Access Rule

The prime time access rule, which first became effective in October of 1971, provided that broadcast stations in the top-50 markets could present no more than three hours of network programming during prime time each evening. (Prime Time is defined as the four-hour period between 7 and 1 p.m., E.T. and P.T., 6–10 p.m., C.T. and M.T.) The one hour of time "cleared" of network programming by the rule could not be filled with either off-network material (programs previously shown by any of the three major networks) or feature-length films exhibited within a top-50 market during the past two years.

In October of 1972, the Commission initiated an inquiry to examine the overall effectiveness of the rule; to resolve manifold problems in administering the rule; and to consider modification or repeal if warranted. After extensive comment and oral argument on the subject, the Commission issued a decision sometimes referred to as PTAR II. Without ruling on the merits of that decision, the U.S. Court of Appeals for the Second Circuit nevertheless enjoined the Commission from putting its rule changes into effect before September of 1975, and suggested that additional inquiry be made with respect to particular parties and groups.

Pursuant to the court's instructions, the Commission obtained and evaluated further comment and, in January of this year, issued a decision which had a three-fold objective: (1) re-affirm our original decision to lessen network control over the selection of prime time programming and encourage local licensees to make such judgments as well as to continue to encourage alternate, independent sources of programming; (2) avoid a growing number of complex difficulties in administering the rule; and (3) create a special exemption so that the rule would no longer work to inhibit the presentation of certain network programming of unique public interest value, specifically documentary, public affairs and children's programming. In the last connection, it is believed important to encourage children's programming at an early evening hour which the rule has tended to inhibit in practice. The Commission believes that it would be inconsistent to take strong and affirmative action in our *Children's Television Report and Policy Statement* (Docket No. 19142) encouraging the presentation of more children's programming, and then to ignore the apparent effects of the prime time access rule to lessen the likelihood of such programming. In the Commission's judgment, creating a special exemption to the prime time access rule would greatly serve one public interest objective without significantly undercutting another.

As you may already know, Mr. Chairman, this matter was again taken on appeal and argued before the court just last week. The Commission is confident, however, that our recently adopted decision serves the needs of the public and we look forward to its implementation in September of this year.

"Re-runs" in Prime Time Television Programming

During the last decade, there has been a substantial increase each year in "re-runs". For example, a TV station might repeat (usually during the spring and summer months) episodes of programs previously shown. This practice resulted in a substantial amount of public complaint, and in 1972 a petition was filed asking the Commission to adopt rules limiting prime time re-runs to 25% of a broadcast year (the equivalent of the "39-13" ratio of new and "re-run" material which prevailed years ago). This type of rule has been opposed by the networks on the ground that the already high and increasing costs of program production require cost saving measures such as the use of re-runs. The networks further argue that if the number of re-runs were restricted, they would, of necessity, turn to less expensive programming. On the other hand, Hollywood guilds and union groups have vigorously supported regulation to limit the use of re-runs.

On October 3, 1974, the Commission issued a Notice of Inquiry concerning the use of re-runs in regular network program series. The Commission is seeking to answer certain questions regarding current programming trends and to determine whether they serve the public interest. For example, to what extent does the welfare of the U.S. program production industry, and employment in that industry, afford a basis for Commission regulation; is government regulation appropriate or necessary; and what would be the economic and programming consequences of restricting the use of re-runs. Comments, have been received and are now under study by the staff.

VHF Television Channel Drop-Ins

In October, 1973, the Office of Telecommunications Policy (OTP) prepared a Technical Analysis of VHF Television Broadcasting Frequency Assignment Criteria. Based on their own analysis, approximately 62 new VHF Television

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channel assignments could be made in the United States provided the Commission hereafter assigned channels geographically closer than under present rules. In March 1974, the Commission received a petition from the United Church of Christ, asking that we add as many new VHF television broadcasting channels as are technically feasible and that we consider the 62 new channels mentioned in the OTP analysis. That petition also seeks preferences under certain conditions for non-commercial educational operations and minority ownership. The New Jersey Coalition for Fair Broadcasting also filed a petition requesting that the Commission "drop in" a VHF television channel in the state of New Jersey. Although the OTP analysis did not specifically suggest a New Jersey drop-in, the New Jersey Coalition based its proposal on the OTP criteria; namely, the assignment of channels geographically closer than permitted under present FCC rules.

The Commission responded to the petition from the New Jersey Coalition by adopting a Notice of Inquiry and Proposed Rule Making to examine the feasibility of reducing the spacing between co-channel and adjacent TV channel assignments, reallocating TV channels from adjoining states to New Jersey, or authorizing hyphenated or dual community assignments with the main studio installed in New Jersey.

In March of last year, OTP re-evaluated its 1973 analysis and prepared a further study. This study suggested 83 VHF drop-in assignments among the top 100 markets.

OTP also suggested what criteria might be used to assign new VHF television channels. These criteria include reducing the mileage spacing between existing co-channel and adjacent channel stations from present rule requirements, and abandoning the concept that a television station's maximum service area should remain protected until it can achieve full operating power and facilities.

The "drop-in" proposals raise difficult technical as well as policy questions. Nevertheless, we believe that the issue of VHF television drop-in assignments should be re-examined and we anticipate issuing inquiry and rule-making proceedings in the very near future.

Daylight Saving Time Impact

As previously reported, the enactment in late 1973 of year-round daylight saving time (P.L. 93-182) resulted in serious dislocations throughout the AM broadcast industry, particularly among the more than 2,000 stations licensed for daytime-only operation. In winter, most stations were still in pre-dawn hours after much of their listening audiences had left for work or school. During the 1973–74 winter season, the Commission attempted to deal with this problem by adopting a series of emergency orders to allow a minimum of an additional hour of operation during the pre-sunrise period with a power of a least 50 watts, except where precluded by international agreement.

This situation improved when year-round daylight saving time was abandoned in the fall of 1974 (P.L. 93-434). During 1975, however, the onset of advanced time occurred on February 23 rather than on the traditional last Sunday in April. We are, therefore, left with a two-month period during which daytime stations will suffer varying degrees of loss of early morning "drive time" broadcast service. This was particularly noticeable during the last week in February when advanced time went into effect.

In recognize of this problem, the Commission issued an Order reinstating last year's temporary pre-sunrise operating benefits flowing from international agreements reached with Canada and the Commonwealth of the Bahamas during the past four months.

Re-Regulation of Radio and Television Broadcasting

The Commission announced the formation of the Re-regulation Task Force on April 6, 1972. The purpose of the Task Force is to undertake a continuing study of the broadcast rules concerning AM, FM and TV service. It is composed of three staff members—an engineer, an attorney and a broadcast specialist.

By the end of 1974, the work of the Task Force resulted in modifications to 261 rules. It also completed special studies (e.g., "Energy Usage by the Broadcasting Industry"), and special projects (e.g., Regional Meetings in Atlanta, Chicago, and Washington).

Numerous other projects are in progress. They include modifying additional rules; developing new policies regarding the ascertainment by broadcast licensees of community problems, needs and interests; Notice of Rulemaking modifying and amending program logging rules; and analyzing the feasibility of relying on automatic, unattended transmission systems for broadcast stations; proposing new

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short-form radio license renewal procedures; and planning more regional meetings with licensees and members of the public.

Regional Meetings

An interesting and worthwhile innovation to which I just referred was undertaken this year by the Commission. A series of Regional Meetings were held where the Chairman, various Commissioners and key staff members met face-to-face with broadcasters and the general public. Each meeting was divided into two parts, one for broadcasters and another for the public, although each group was encouraged to attend both meetings to gain insight into each other's problems, needs and interests.

The first meeting was in Atlanta on May 23 and 24, 1974. Broadcasters and the public from Alabama, Florida, Georgia, South Carolina and Tennessee met with members of the Commission on the Georgia Tech campus. The second regional meeting convened in Chicago on October 30 and 31 for the five states of Illinois, Indiana, Ohio, Michigan and Wisconsin. On January 8 and 9, 1975, a third meeting was held in Washington, D.C. covering Delaware, Maryland, Virginia, West Virginia, Kentucky, North Carolina, and the District of Columbia. These meetings, we believe, lead to better understanding, better regulation, and better and more responsive broadcasting and we plan to continue this series of meetings throughout the country in the next few years.

CABLE TELEVISION

Regulatory Program

In the cable television area, the Commission's "new" cable regulatory program is entering its fourth year, and we are undertaking a comprehensive review of some key elements of that program. This review is based on three years of operational experience, and on suggestions for changes made by advisory committees, Commission task forces, and industry and public spokesmen.

Advisory Committees

Last year I briefly described the work of the Federal-State/Local Advisory Committee and the Cable Technical Advisory Committee. In response to this group's final report, the Commission, during 1974, issued a clarification of the cable rules and eight rulemaking proposals. Perhaps the most critical of these is one which looks into the problem of multiple levels of regulation over cable television systems. The Commission's concern in this proceeding is to avoid unnecessary duplication of regulatory efforts.

The Technical Advisory Committee's work continues, and the final report of its Steering Committee and most of its panels should be ready shortly. We are hopeful that the work produced by this panel of experts will significantly aid us in understanding and regulating the technical aspects of system operation. The Committee's report should prove useful in identifying those areas in which further technical standards are necessary and in developing performance test procedures useful not only to us but to the industry itself.

Rule Makings

Several other rulemaking matters deserve brief mention. As you know, the Commission prohibits cross-ownership of cable television systems with co-located television stations. Prohibited existing interests are required to be divested by August 10, 1975. An analysis, however, of the numerous requests for waiver of the divestiture requirement, and a desire to put cable cross-ownership limitations on a similar policy footing with the newly adopted rules limiting broadcast and newspaper cross-ownership, have caused us to re-examine the present cable rule. Accordingly, we are initiating a further rulemaking proceeding and during this period will suspend the August, 1975 divestiture date. As to newspaper and cable cross-ownership, available information has not revealed the need for remedial action at this time. We will, however, continue to study this matter.

A Commission proposal, under consideration since February 1972, to impose sports black-out rules comparable in scope to those permitted professional sports leagues by P.L. 87-331, is being restudied in light of the 1973 amendment to the Communications Act, which prohibits league home game blackouts of professional football, baseball, hockey and basketball games if the games are sold out 72 hours in advance. New data and rulemaking comments are being received concerning the cable blackout question.

Over the course of the year we have concluded a rulemaking proceeding designed to increase the diversity of programming cable systems may deliver by permitting the carriage of distant late night television programming. By amending our franchise standards relating to line extensions and complaint procedures, we

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have also attempted to insure that cable service is uniformly available in communities where it operates and that cable subscriber complaints are properly dealt with. We have acted to pre-empt local and state technical standards inconsistent with our own. Our mandatory program origination rules, stayed since the Supreme Court considered our jurisdiction to impose them, were re-evaluated and altered in significant respects. Continuing consideration is being given to the difficult problem of what role the Commission should play in regulating the utility pole attachment practices of telephone and electric utility companies whose poles must be used by cable television operators.

We have recently given staff instructions for the resolution of two of the more controversial rulemaking matters left pending. The first of these relates to pay cable and over-the-air subscription television operations. This proceeding was opened for further written comment last fall, followed by two days of oral arguments and panel discussion concerning the nature of the rules that should govern these services. We have had a very real concern, as you know, that these new pay operations if not properly regulated could cause a loss of programming from conventional "free" over-the-air television stations—the program siphoning effect. We have been particularly concerned with the possibility that this would happen to sports programming and feature films which are mainstays of the conventional broadcast service. We have given the staff instructions for writing final rules in the pending proceeding which we think provide solid assurance that program siphoning will not occur. At the same time, we have no desire to stifle this new service to the public. I believe we have found an appropriate balance of these concerns. We do, however, intend to keep this proceeding open so that we will be in a position to act without delay if experience under revised rules shows that to be necessary.

The second of these major proceedings which is nearing completion has also generated much interest from the public, the cable and broadcast industries, and the Congress. It concerns the network program exclusivity or non-duplication rules that presently apply to cable television. The present proceeding seeks to re-examine the existing rules and gather statistical data concerning their operation. Here again, we have recently given the staff instructions for revising the rules. We think these rules are an important part of our cable program. However, we are considering possible rule change, to make non-duplication more equitable, less inconvenient to cable subscribers and not unduly burdensome to smaller cable systems.

Task Forces

In April 1974, I announced the creation of two special task forces within our Cable Television Bureau—the "1977 Task Force" and the "Cable Re-regulation Task Force." The 1977 Task Force is studying the problems faced by the Commission, franchising authorities, and the cable television industry as cable systems prepare to meet the March 31, 1977, deadline for uniform compliance with our cable rules on franchise, access, and technical standards. The Task Force is also considering, in light of Commission experience and present economic conditions, whether some of the uniform compliance requirements should be dropped or at least postponed beyond March 31, 1977. With the recommendations of this Task Force in hand, the Commission recently issued a Notice of Proposed Rule Making looking toward a suspension of a number of the requirements of the rules that would have required substantial rebuilding of existing cable television systems by March 31, 1977. A further Notice looking toward a substantive re-evaluation of some of the rules should be released shortly.

The Re-regulation Task Force is reviewing our experience with cable television rules and forms with a view toward eliminating unnecessary regulations, procedures, and paperwork and simplifying the rules. Each rule is being analyzed to determine its continuing validity and whether it should be retained, modified or deleted. Particular attention is being directed toward relief for the small cable television system operator. Task Force recommendations may result in either clarification orders or formal rulemaking proceedings.

Service to the Public

During 1974, the Commission received about 1,300 applications for new or increased cable television service, and a total of 1,950 pending applications were processed. The resulting 40% reduction in the cable applications backlog and a sizeable decrease in average case processing time are largely attributable to a substantial increase in the staff of our Cable Television Bureau during 1974, and to completion and implementation of the Bureau's organization framework.

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Finally, in a further effort to serve the public, a Cable Complaint Service was established in the Cable Bureau in 1974. The Service has three main functions: it attempts to clear up misunderstandings between subscribers and systems regarding the Commission's Rules; it deals with complaints about a system's quality of service by resolving disputes informally, and, when merited, by instituting formal action; and it helps the cable industry and local or state governments to develop procedures for the expeditious resolution of complaints at the local level.

Proposed Legislation

Finally, the Commission over the course of the last year has submitted formal comments to the Office of Management and Budget on two drafts of cable television legislation prepared by the Office of Telecommunications Policy. While our comments have reflected some fundamental philosophical differences with the Office of Telecommunications Policy, particularly as to the degree of administrative flexibility which the Commission should have in regulating the cable television industry, we fully concur with their view that some additional legislation, at least in certain specific areas, would be desirable. In this connection, we are developing our own draft legislation which should be completed within the next several months. While this more comprehensive look at statutory changes relating to the industry is under consideration, I would like to reaffirm my support for a more narrow action which we have proposed in the past—that is, to give the Commission forfeiture authority with respect to cable television systems similar to our existing authority with respect to broadcasters and other radio licensees. Without such authority, we have no effective enforcement tool for minor infractions of our rules which do not warrant an order directing total cessation of operations.

SPECIAL RADIO SERVICES

Land Mobile Radio Services

The next area I will review for you involves special radio services. A major part of this area is concerned with land mobile radio.

Land mobile spectrum relief has been a matter of top priority in 1974. In what may well be the most important Commission decision concerning land mobile spectrum relief over the past 25 years, major long term relief was provided through our action in Docket No. 18262 in which frequencies in the 900 MHz band were made available for land mobile use. Our action makes possible the eventual establishment of a nationwide, compatible, mobile radiotelephone and limited dispatch service. This is, according to our plan, to be made available to the public through common carrier enterprises.

Further, our action in this Docket provides for much expanded private systems of communication at 900 MHz in the Public Safety, Industrial, and Land Transportation Radio Services. The new spectrum allocated to these services can accommodate from 30,000 to 60,000 mobile units in each major area or region of the Nation, and reuse of the frequencies will be possible at distances ranging from 60 to 100 miles.

In taking this action in Docket No. 18262, we also made provision for new licensing procedures and for innovative systems designs. These will enable us to increase the efficiency and effectiveness of land mobile use of the radio spectrum. The new techniques mentioned include licensing of specialized mobile radio systems and "cellular," "trunked," and "multiple access" methods of operations. We believe that these measures, as an ancillary benefit, will lead to large scale opportunities for employment in the development and establishment of these new land mobile modes of communication and open up opportunities for growth and expanded availability of competitive systems of communication and competitive land mobile radio equipment. Our decision in this Docket is being reviewed in the light of petitions for reconsideration filed in the proceeding and we expect to reach a final determination in the matter within a month's time.

In Docket 18261, which provides for sharing of television channels 14–20 by the land mobile radio services, added land mobile relief was achieved by extending the sharing plan to Dallas-Fort Worth and Houston, Texas; and Miami, Florida. Thirteen major urban areas now have some use of channels in the 470–512 MHz band for land mobile purposes. Actual assignments, however, in Detroit and Cleveland are still pending the completion of agreements with Canada. In the eleven cities where authorizations are being issued, the growth has been from 450 system assignments and 128 applications pending in 1973 to 978 system authorizations and 151 pending applications in 1974.

The Emergency Medical Services communications needs, which we reported last year, have been afforded relief by our June action in Docket 19880 creating a new medical service communications category in the Special Emergency Radio

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Service. This action made certain frequencies available exclusively for ambulance-to-hospital and ambulance-to-doctor medical telemetry and medical voice uses. More than forty EMS communication system plans have been filed.

Rulemaking to improve the regulatory framework for private microwave systems was also issued in 1974. In the near future, we expect to issue new microwave rules which will affect the entire range of our licensees.

In 1974, we also adopted interim rules (Docket 18302) to provide for automatic vehicle location and monitoring systems. Police and fire departments, transit systems, trucking companies and others are expected to implement these systems to automatically keep track of the location of their vehicles.

Amateur and Citizens Radio Services

Regulatory activity has also been occurring in the amateur and citizens radio services. A Notice of Proposed Rulemaking and Inquiry adopted on June 6, 1973, concerned the possibility of reallocating the 224–225 MHz band to Citizens Radio for the creation of a new Class E Citizens radio service.

Rulemaking notice for revision of the operating rules for Class D stations in Citizens Radio was adopted on July 23, 1974, and remained open for comments until January 30, 1975, and for replies until March 14. Significant aspects of the proposal include the doubling of frequency space available to Class D stations, changing equipment technical standards to require use of single sideband equipment, simplification of station identification requirements, and changes in the permissible communications rules for clearer understanding. It is hoped that these proposals, if adopted, will promote a higher degree of voluntary rule compliance by licensees.

The Commission further adopted a Notice of Proposed Rulemaking on December 4, 1974, to restructure the various classes of amateur radio operator licenses. This proceeding proposes to create a new communicator class of license with operating privileges in the 220–225 MHz band. A code examination would not be required for this license.

These three rulemaking proceedings involve related issues. Principal among these is the amount and location of spectrum space that should be allocated to meet the personal and business radio communication needs of the general public. Moreover, further discussions are needed with Canada concerning Class E frequencies along our border. Accordingly, we are deferring action regarding the creation of a new Class E Citizens radio service until later in 1975 to permit us to fully develop the requirements and alternative solutions we feel are needed. It is our firm intention, however, to reach a conclusion in this matter as quickly as possible.

In the Citizens Band area, we amended our rules, effective January 23, 1975, to prohibit the marketing of single band external radio frequency power amplifiers (commonly known as linears) capable of operation with Class D radio equipment, and, as further clarification of what was already illegal, specifically to proscribe their use at a Class D Citizens radio station. A power amplifier's only function at a Class D station is to boost the power of the station beyond permissible levels. These devices could significantly interfere with other radio and TV reception. Strict enforcement of the new rules is expected.

Aviation and Marine Radio Services

The aviation and marine radio services also have been active during the past year. The Commission is continuing its efforts to improve Public Coast Radiotelegraphy in the Maritime Service. Several applications to close some radiotelegraph stations have resulted in interim denials unless service by the remaining stations to the maritime industry is improved. The Commission's inquiry into this subject continues in Docket 19544.

The Maritime Satellite Panel of Experts completed its work in 1974 in preparation for the Meeting of Governments in April, 1975. The purpose of this meeting is to agree on institutional arrangements and technical specifications for a Maritime Satellite System. The FCC will be represented at the Meeting of Governments.

The Commission has released a Notice of Inquiry soliciting the public's views in preparation for the 1977 meeting of the Aeronautical World Administrative Radio Conference. The purpose of this meeting will be to establish technical requirements and a frequency allotment plan for the Aeronautical Mobile (R) Band for aeronautical communications.

The exchange of instruments of ratification for the "Agreement Between the United States of America and Canada for Promotion of Safety on the Great Lakes by Means of Radio, 1973", took place on May 6, 1974. The Agreement will enter

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into force on May 6, 1975, and will affect shipping on the Great Lakes. The Agreement will terminate the 1952 Agreement, and requires all vessels covered by the Agreement to have VHF radiotelephone equipment operating in the band 156–162 MHz, and designates the frequency 156.8 MHz as the distress, safety and calling frequency. Medium frequency radio operations will be improved by the introduction of single sideband equipment. The technical regulations of the new Agreement are more specific and conform more with modern practices than the 1952 Agreement. The Commission is currently updating its regulations to implement the agreement.

General International Radio Matters: Preparation for the 1979 World Administrative Radio Conference (WARC 79)

The Commission is preparing for the International Telecommunications Union (ITU) 1979 World Administrative Radio Conference. The importance of this conference cannot be over emphasized. The outcome may determine various allocation matters involving almost all of the radio services administered by the Commission for the remainder of the century. The necessary internal organization that will spearhead the Commission's preparations for this WARC 79 has been established. This group will coordinate with industry and the public to establish non-government radio frequency requirements. It will also coordinate its efforts with similar on-going efforts of the Office of Telecommunications Policy which is handling federal government radio requirements. The FCC industry effort was announced in a Public Notice released January 31, 1975, calling for a public meeting to be held on February 21, 1975. At that meeting, the role of public participation was outlined and active participation was invited. During the meeting, the FCC preparatory structure was described in detail. The first of a series of inquiries into WARC 79 has been relased in Docket 20271. This inquiry seeks comments and views of interested parties.

FIELD OPERATIONS

Citizens Radio Enforcement

In the area of field operations, during 1974, our Citizens Radio Service enforcement effort in the southeast United States was expanded by the activation of our fourth Special Enforcement Facility at Powder Springs, Georgia. In Iowa we carried out two major enforcement efforts to curb violations of the Commission's rules. The field staff also carried out a nationwide educational campaign to notify truckers of the rules governing the use of citizens radio. As a result of our efforts in Iowa, 29 illegal users of citizens radio equipment were found in violation—27 of whom entered guilty pleas and 2 were found guilty after trial in a U.S. District Court.

In enforcing the Commission's rules, however, we have experienced difficulty regarding sanctions. Monetary forfeitures for violation of our rules may be readily imposed on licensed radio stations but are not available against unlicensed stations. This results in large numbers who simply do not obtain licenses and presents us with a major enforcement problem. We are seeking to remedy this situation through proposed legislation which will enable the Commission to impose forfeitures on such unlicensed operations.

Operator Examinations

A new examination for operators at broadcast stations is being placed into use nationwide. The number of questions has been increased from 20 to 40 so that the applicant will have a better chance of passing without restricting the scope of the exam. Questions are designed to determine the applicant's practical knowledge of the Commission's Rules and operating requirements as they pertain to his duties.

The Commission also has contracted with the Civil Service Commission for their examiners to conduct FCC operator examinations in five pilot areas of the country. The experimental program ends in September, 1975, Evaluations are being made to determine cost effectiveness and whether the increased number of examination locations in the pilot areas is beneficial to the public. If the results of the program are satisfactory it would be expanded nationwide.

ENGINEERING MATTERS

National Spectrum Management Program

In the Office of the Chief Engineer, the Spectrum Management Task Force continues to evaluate and improve a regional program for spectrum management that was established in 1971. The purpose of the Force is to make more efficient

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use of a limited resource, namely the radio spectrum. The Chicago Regional Office is now processing applications by computer and issuing frequency recommendations based on computerized engineering models that reference the most extensive data base ever available to the Commission in the land mobile services.

The Spectrum Management Task Force is now within reach of its objective of improving spectrum utilization throughout the mobile radio services by limited relaxation of the traditional block allocation scheme. In the coming months, the Task Force intends to validate the monitoring data base that it has been constructing over the last three years, and to establish the new criteria necessary for the sharing of under-utilized frequencies.

The Office of the Chief Engineer is, moreover, considering the possibility of reducing the spectrum required for UHF–TV service by examining the spacing between co-channels. A Notice of Inquiry regarding this is being prepared. Other steps to save spectrum include the preparation of a work statement for a contract to develop an improved TV receiver, and the completion of a computer program to increase the efficiency of UHF–TV assignments on a compressed spectrum.

FEES

The original goal of the Commission's fee collection program was to recover from licensees as close to 100% of the Commission's annual appropriation as possible. A fee schedule was established in 1970, and for three years between 60 and 80% of the budget was recovered. During 1974, however, the fee schedule has been a continuing source of Commission concern. On March 4, 1974, the Supreme Court, in *National Cable Television Association* v. *United States*, held that the Commission's annual fee for cable television systems had not been formulated in a manner consistent with Title V of the Independent Offices Appropriation Act of 1952. The Court interpreted Title V as allowing the Commission to collect from the recipients of its benefits some of the Commission's costs based on the "value to the recipient" standard in Title V rather than on the basis of total recovery of the Commission's annual budget.

Immediately following the Supreme Court's decision, the Commission suspended the collection of the broadcast and cable television annual fees. In August, 1974, we issued a Further Notice of Proposed Rulemaking for a new schedule of fees consistent with the Court's holding, and on January 15, 1975, adopted a Report and Order establishing new fees effective March 1. This schedule is designed to recover the Commission's costs in processing applications and granting authorizations. It will recover approximately $16.5 million, or 35.3%, of the Commission's fiscal year 1975 budget.

In December, 1974, we concluded that all fees should be refunded to cable television systems that had paid fees under the 1970 schedule. Although the Commission believed it could recalculate the proper fee for the period following 1970, it decided against this because of the substantial administrative burden, and the small amount of fees that could be retained. On January 20, 1975, refund requests of other parties were denied because they had not exhausted their judicial remedies by filing a petition with the Supreme Court for a writ of certiorari, and the period for Commission reconsideration or judicial review of their fees had passed. Petitions to review the Commission's orders denying refunds and establishing the new fee schedule have been filed in the United States Court of appeals for the District of Columbia Circuit.

BACKLOG REDUCTION AND MANAGEMENT IMPROVEMENT PROGRAM

Backlog Reduction

As should be evident from my statement, it has been a busy year with many accomplishments. Any observer of the Commission is aware of the accelerated pace of our activities. I believe we are making real progress in many major areas. However, much remains to be done. We hope soon to be able to focus increased attention on the backlog of items awaiting action.

In October, 1973, the Commission initiated a comprehensive program to eliminate application processing delays and backlogs caused by obsolete rules, out-of-date forms and inefficient procedures. The program is developing simple, clear, user-oriented rules and forms to aid the public in preparing more complete and accurate applications and other filings, thus expediting action by our staff.

The cable television rules, for example, were amended in November, 1973, to allow cable systems to furnish the FCC and local television stations a simple notice when they plan to add certain signals to an existing system instead of filing a formal

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application for a certificate of compliance. In December, 1974, a proceeding was initiated to revise and clarify rules for the common carrier mobile and microwave services to minimize petitions. A notice of proposed rulemaking also has been issued regarding a single license to cover all the remote pick-ups of a broadcast station instead of individual licenses. By the end of 1974, the Commission had completed 14 rules and forms revision projects. Twenty-six additional projects are planned for completion during FY 1975 or FY 1976.

Management Improvement

An executive team made up of the Chairman and the Bureau and Office Chiefs has been formed and meets weekly to plan the Commission's agenda and to establish priorities in connection with its work load. The Commission, during the last seven months, has worked under a publicly released meeting schedule which has assisted the staff and the Commission in discharging its responsibilities.

As part of the program to eliminate backlogs, the Commission is seeking to end internal procedural bottlenecks, improve manpower utilization, and increase productivity. Comprehensive management surveys of two backlog areas (common carrier radio and industrial and public safety radio), and an analysis of the Commission's agenda process were completed in July, 1974. As a result of these surveys, internal improvements have been implemented.

Two new management studies were initiated in September, 1974. An analysis of broadcast complaints and compliance activities seek to expedite processing of complaints and investigations of rule violations. A study of administrative services operations seeks to improve the support provided to program managers.

In conjunction with these studies, the Commission' management staff has been examining the interrelated problems of training, job satisfaction, leadership style and other factors affecting productivity. A pilot project was started in 1974 to evaluate the effectiveness of "job enrichment" or designing jobs to make them more challenging and to improve individual development and performance.

To provide a top level forum to monitor these activities, the Commission established a Backlog Control Committee chaired by a Commissioner. The Committee met nine times during 1974 to review backlog reduction plans and goals, and to provide an interchange of ideas in the Commission.

Current Backlog Status

These management improvement efforts together with additional manpower authorized by Congress last year have enabled the Commission to increase output to reduce a number of critical backlogs, in some cases despite substantial increases in workload. For example, Safety and Special Radio receipts increased 45% during 1974, but they were processed more quickly than in 1973. The average time required to handle these applications in 1973 ranged from 21 to 74 days, and in 1974 it was reduced to 14 to 40 days.

Progress in the Cable Television Bureau has also been excellent. Disposals increased substantially in all categories—69% for Community Antenna Relay Applications, 67% for Certificates of Compliance, and more than double for Special Relief Petitions.

The number of pending Common Carrier microwave applications for new service and transfers or assignments has been reduced from 3,513 to 2,195—a 38% improvement. Normal applications are now processed in about four months which is considered reasonable for licenses of this complexity. The Domestic Public Land Mobile backlog has been stable during the past year (around 1,800), but we anticipate improvement during 1975 as a relatively new staff gains experience.

The Broadcast situation is mixed. The Bureau achieved a dramatic improvement in the processing of assignment and transfer application. In the area of new AM service and major changes, processing increased 37%, but receipts were up 42%, and consequently the backlog increased. There were reductions, however, in the number of pending TV and FM applications for new service or major changes. The renewal backlog increased slightly during 1974 because of more petitions to deny from public interest groups. A number of administrative steps have been initiated to reverse this trend, and reductions are expected in the coming months.

Mr. Chairman, that concludes my statement. We are all prepared to answer questions, and to provide further information.

Mr. MACDONALD. Thank you very much, Mr. Wiley.

I must say that the report sounds a little more self-satisfying on the work of the Commission than perhaps everybody else in the country feels about it, including this committee, and including this

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Member of Congress, but as one who runs for office myself, and one who has heard many, many others run, it doesn't set me off. That is all a bit self-congratulatory.

In your report, I think that is only human, and I think the Commission, and especially yourself, is to be commended for many things that it has done, or attempted to do, and maybe the rest of the Commission won't like this, but I think one of the best things you have done is to get everyone to stay in Washington for at least 3 days a week, and get them all together so you can get on with the public's and your business.

I am a little surprised, Mr. Wiley, that you would raise the A.T. & T. rate filing as a matter that you feel the Commission did a terrific job on. I would like to ask some questions about that and then come up with a suggestion that goes beyond A.T. & T., and I think you will be very interested in my questioning.

You know that I had been pressing you a little bit concerning the A.T. & T., and their request for $717 million, and I heard nothing much about many hearings or decisions concerning it until suddenly my phone rang one day. I think it was shortly after the decision had been reached by the Commission on the A.T. & T., informing me of what you had done, even though you were very well aware as to how interested the Congress was in this entire matter, and especially what we could do to be of assistance to the FCC. It is obvious A.T. & T. is a large company, and it would take all of our coordinated efforts to try to keep what they say, and what is the fact, exactly in line. Even with our coordinated efforts, we could do that, so I was very surprised, indeed, not to hear it from the FCC, but to hear it from somebody who knew somebody who worked for A.T. & T., and who, in turn, knew somebody at the FCC. All of which brings me directly to the point I have in mind.

Inasmuch as the FCC meetings are sort of like a sieve, nothing ever gets kept quiet very long, although the A.T. & T. decision set a new world record, as far as I am concerned, as far as speed is concerned, and it set a personal record for surprise, and, at first, indignation. I figured it was not the day to call you directly because I was afraid I might blow off at you and then regret doing that, but I do not regret calling it to your attention. I think that something the FCC could do very easily, that we have done here in the Congress, and it seems to me to be the best way of doing the publics' business and to set an example for many of the other agencies here in Washington—would be to hold these executive sessions in public. This committee holds its executive sessions in public unless a majority votes to close the executive session to the public. We are always presented with something from the FCC saying, this is what we have done, and we have to get a crystal ball out to figure out why it was done. Sometimes, there are those that agree with what was done, and sometimes, obviously, there are those that disagree on any given subject, but, at least, if the executive sessions were open, and the public's business was done in public, I think it would put to rest a lot of rumors concerning the agencies—I am not just now talking about yours—although I am talking specifically about yours in this case, but I think it is also true of other agencies here in town, and to stop the criticism about the agencies being run by the people that they are supposed to regulate.

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Now, I am not suggesting A.T. & T. runs the FCC. What I am more than suggesting is that I think that it would be a very good move on your part to see to it that the Congress and the public become as well informed on the workings of the Commission as are some of the segments of the industry over which you have jurisdiction and over which you impose regulation. We here have done the same thing. We have opened up our meetings to the public. If it was a very sensitive matter or adjudicatory matter, either one or both, that affected national security or our relationships with other countries—in the field of international satellites, for example—I think that no one would particularly raise any objections to those executive sessions being closed, but I think it would be a very good thing for the Commission to make all of your deliberations open to the public. You have made a good deal in your statement to us of taking the Commission to the various places in the country to hear from the public. I think that in your markups and the decisionmaking, the people, especially the Congress, have the right to know who is voting how and why, and what are the reasons that the decision was reached, so I would urge—I don't like to make a formal request as of yet, because I know, perhaps it is a new thought to you—but I would like to urge, at this point, Commissioner Wiley, that you take a good look at this and take steps to open up your executive sessions to the public, and have a public vote, on which members should be recorded, so that we, in the Congress, and those who have appointed the various members, know who is doing their job well, and who is just going through the motions—if, indeed, there are any such people, which I sometimes hear about. If you have any response to that suggestion, Mr. Wiley, at this point, I would like to hear it.

Mr. WILEY. I would like to make several comments, if I might, concerning the remarks you made. Number one, I don't think there is anything in my statement which indicates that we felt—to use your phrase—that our decision in the case was terrific. I don't think there was anything in the decision to be either commended or condemned, we were simply doing our job and sometimes it is difficult. I do apologize, as I have told you personally, for not advising the chairman of this committee in advance of the Commission's decision.

I would like to say, as far as the speed of the decision goes, we made it prior to March 4, because it had to be made prior to March 4. We released the public announcement that day and I resist any suggestion that there was anything clandestine about the Commission's decision.

Mr. MACDONALD. I said a closed session; now, we can play semantics all morning, if you want to. Anything that is closed is not clandestine in the sense that nobody knows it is going on. The public may know that a meeting is taking place, but they don't know what is happening in the meeting, unless they are well acquainted with somebody in the FCC who leaks to them immediately when the meeting is over. I swear to you that I had knowledge of what you had done within several hours after it was done. Even though you finally decided, apparently, to put out a press release, and you put out a very short release saying what you had done later in the afternoon; then I was notified by someone at the FCC. I was not there at the time, but my office tells me I was notified at 5:30 on the same day, while the people who have an in at the FCC, private individuals working

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for private companies, were telling a friend of mine, who was telling me, about what was happening. Now, that is not right.

Mr. WILEY. If I may respond. As I say, we did release our decision on the very day it was made. I have had a group of staff looking into the whole question of opening meetings for some time. There are considerations with a regulatory commission which takes in proprietary information, which makes decisions affecting stock of various companies we regulate, which must be considered in the overall decision. I am only saying to you, Mr. Chairman, this is not a question that I find should not be considered, and we are considering it. I would like to say, the question of leaks from the Commission concerns me very much. I think it is not appropriate for members of our Commission or staff members to tell regulated industries or other friends of theirs of the private negotiations of the Commission, as has been going on. I think the basic answer to what you are saying is the integrity of its members. I think the decision——

Mr. MACDONALD. I have to interrupt you at this point, Mr. Chairman, because I in no way am questioning the integrity of anyone. The Congress, this subcommittee, opened up its hearings, not because anybody on the subcommittee or full committee challenged the integrity of any member, but just to insure the freedom of information, the right of the public to know what is going on in their Government and you, yourself, have indicated how important the decisions that you make are, so integrity has got nothing much to do with it.

Mr. WILEY. It has this to do with it. As you suggest, and others have suggested, sometimes regulatory agencies seem to have a closer association with those they regulate than is appropriate. I think that does bear on the basic integrity of the Commission, its members and decisions, and I must say I respectfully resist that.

Mr. MACDONALD. You can resist all you want. It doesn't change the point of the fact that somebody that works for A.T. & T. told somebody who told me about your decision several hours before you did.

Mr. WILEY. There may be Commission leaks——

Mr. MACDONALD. As far as the stock market goes, as long as the insiders know, and so long as you keep it from the public, it would seem to me to have much more tendency for some insider to take a flyer on the stock market on information they have that the rest of the public does not have, so I think your argument on that point is self-defeating.

Mr. WILEY. Let me say again, we don't keep things from the public. We try to release our decisions as quickly as possible. In the meantime, if someone within the Commission releases information, I think that is inappropriate. As for the question of open meetings, I think that is a serious and complex matter, and something I am having looked into because I am for as open a government as possible. We will have to consider whether such openness will assist the delicate considerations we have and lead to the kind of exchanges we have in a collegial body, that make good policy. If it would prohibit that kind of free and open exchange among the Commissioners, I would have to question it. I think the Congress is looking into this same question, because I have read a variety of testimony on the Government in the Sunshine legislation—I have seen a variety of viewpoints suggested on testimony

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on that subject. I think it is an important issue that must be looked into and I agree with you to that extent.

Mr. MACDONALD. Do you agree with me to the extent you are thinking seriously of opening your executive sessions to the public?

Mr. WILEY. I am having a staff look into it to make recommendations on it. I don't think this is the place to comment on that. My personal opinion is that there are some aspects of our meetings that could be made public. There are others that, perhaps, opening them to the public would not be in the public interest.

Mr. MACDONALD. When it was first suggested 2 years ago that we open up our markup sessions, I resisted, myself, thinking that there would be people playing demagogue, who would be appealing to the masses, rather than getting the business of the committee done. But I assure you that has not happened on this committee, so I have become a believer that once you get involved in something complex, you know, you forget anybody else is there.

Mr. WILEY. We have mentioned several times the fact that if everyone is going to know what we are doing in any case, it may be appropriate to simply have the meetings in the open. I would have no problem with that, personally. I think some considerations have to be given to the kind of proprietary information we deal with, the effect it may have on the stock market and what have you.

Mr. MACDONALD. I think it is more deleterious to free trading to have just a few insiders have quick access to what the Commission has done.

Mr. WILEY. I have often found inside information is not always as accurate as it might be.

Mr. MACDONALD. I haven't been privy to much of it because, for some reason, the people I know privy to the information don't give it to me except that on this A.T. & T. thing, I heard about it more quickly than I know for sure what is going to come up on the Floor of the House this afternoon, and it would seem to me—I don't want to go over the same arguments—your argument of the stock market is fallacious.

Another matter, you are talking about what you are going to do with the CATV and the rules you are thinking about. If you want to be an insider, all you have got to do is buy Television Digest, which I agree doesn't always have all proper information, or Broadcasting Magazine, about which I would have to say the same thing. They have about 2½ or 2 pages just full of changes that the FCC made in a closed meeting last week.

Mr. WILEY. It is for that very reason I asked the staff to look into this very question several months ago but——

Mr. MACDONALD. Wouldn't it all be alleviated if you had the meetings in public?

Mr. WILEY. The other side of it is—would you have the same kind of frank and open discussion? Would Commissioners suggest a number of things which, in the full light of day might not appear too good, but are necessary for the Commission to get the full range of options? I don't know.

Mr. MACDONALD. Now, you are questioning the integrity of your Commission. It isn't me, it is you.

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Mr. WILEY. I don't think that is integrity. I think that is courage. I believe Commissioner Lee wants to add something.

Mr. MACDONALD. Before you say that, discretion is the better part of valor, but as far as I know, the members, unless they do something outrageous, only have to please one man, and that is the President, and get approved by the Senate, and there you are. You don't have to be a profile in courage on every issue. Mrs. Reid has been both places, and I am not going to put her on the spot but I am sure—well, if it isn't out of line, I think, after we finish this—you say you think it is a good idea from your point of view, but you are not sure about the others.

Mr. WILEY. I say it is a good idea, there are some concerns.

Mr. MACDONALD. I want to go down the line and ask them what they think.

Mr. WILEY. I do commend to your attention some of the debate that has gone on with respect to the Government in the Sunshine bill. The American Bar Committee has been studying that and I am on the council——

Mr. MACDONALD. Studies—every subject you have has been studied to death. A number of the things you are talking about originated back in 1971, and they are still unresolved and you are complimenting the Commission for coming to grips and coming out with some ruling. I don't know what they have been doing since 1971. You have only been Chairman for a year, so you are not supposed to be responsible for everything but I think it is a good suggestion. But, of course, we are just at the talking stage now. I think the FCC is an arm of the Congress—if the Congress tells you to do it and takes further action, you are going to have to do it. I always believe in doing things the easiest way possible just as long as they are done properly, and I would think that perhaps a trial period even—if you found out that all of your Commissioners, or the majority of them lack courage, which I find hard to believe—they have to run the gauntlet, in the first place, over in the Senate, to come here, which takes a good deal of courage for some people, I would think. I wholeheartedly subscribe to it. I hope that you get moving on it.

Mr. LEE. I have one small observation on that point, as an observer on the scene for a long time. It is difficult to say that everything shouldn't be public. I think, for the most part, that is in the public interest. There are some areas, however, that I would question, and this is one. The reason I say that is, that you would not have what we sometimes refer to as the full, robust, open debate among Commissioners to achieve a point. I think it is somewhat analogous to the appropriation process up here, perhaps it has changed recently—I worked up here years ago and we used to sit in on these markups involving money. I worked for an old gentleman—you probably refer to him by the name of John Tabor, and sitting in these little conferences—he would throw out a figure—somebody else threw out a figure, and sometimes he would lean over and say, "that is only the asking price."

I think there are places where you need that exchange, and some reporter isn't going to pick up a remark you made and go out and print it before he gets a chance to understand why you made it. Per-

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haps you are testing—you want a reaction. I think this particular area—I am not saying we shouldn't do it, but I want to move very carefully.

Mr. MACDONALD. I think the Commission has been in existence for an awful lot of years. It has never been tested, and I, for one, think it is time to have it tested. Mrs. Reid, you wanted to say something?

Mrs. REID. I had the same thought, having served on the Appropriations Committee, and even though I think some of our meetings could be open, many of the meetings do remind me of the meetings we had in Appropriations, particularly in markup. There are exchanges that would probably be inhibited if this kind of meeting were open, and I think we would have to look at that very carefully.

Mr. MACDONALD. I agree, but if you have a lack of courage to face displeasure, you are in the wrong job, just as I would be if I was scared of the press. What can they do? They can twist facts sometimes, but they don't twist them all of the time, and a good reporter doesn't even try to twist facts to make a pretty good story out of not much of a story. Cutting A.T. & T's. request in half looked to me like a trade off. They asked for $717 million, you gave them $365 million. Well, I see the Chairman shaking his head, no, but I only think that because I am not privy to what happened at that markup session to which I would have access if it were public.

Mr. WILEY. My full report clarifies completely where we picked $385 million. I don't think that is a fair statement.

Mr. MACDONALD. I have used up my time for the first round, and we will go on. Mr. Carney would be next, but we have adopted some new rules.

Mr. CARNEY. Mr. Chairman, I will humbly await my turn.

Mr. MACDONALD. Mr. Byron.

Mr. BYRON. Yes, Mr. Chairman, I have one or two small questions here. I concur with our Chairman. I don't think openness is half as bad as it seems. The water is a little cold when you put your foot in but in the long run it is probably better.

I had a couple of questions on your remarks on that cable television. I just want to address myself to that, if I could.

You say you are holding hearings now on the question of cable TV and the sports blackout question. Have these hearings progressed or is that just beginning?

Mr. WILEY. Well, this question——

Mr. BYRON. I think that is on page 19.

Mr. WILEY. This question of distant signal sports has been pending in the Commission since February of 1972. The Commission put out a rulemaking in this entire area and said it would decide this matter expeditiously. However, 3 years later, we have not decided it and I put it on my publicly announced schedule for a meeting with the Commissioners to reach a decision on the issue. Many of our Commissioners are new and have not been introduced to this problem before. We also put it out for further comments to update the record. The Commission has not yet had this discussed with them, but it is going to be coming up in the near future when the date for filling comments has expired. We extended time at the request of the cable industry to sometime in April, and therafter the Commission will consider it. What the rulemaking is looking to is whether or not the

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Commission should give some credence to the apparent intent of Congress, Public Law 87–33, relative to this area. This is an area of great controversy to the cable industry and sports interest as well, and the Commission has got to decide where its regulatory responsibilities lie in this area and simply has not done so at this point.

Mr. BYRON. You don't plan to treat CATV any differently than in the past, until you have arrived at some decision on this issue?

Mr. WILEY. On this issue, what will happen is that after the comments have been completed, the staff will come forward and discuss it with the Commission, and we will make a determination as to whether or not there should be any kind of oral proceeding in the area. We have had one oral argument back in 1972. That is quite old, and we must decide whether or not some action may be appropriate in this area.

The Commission has had no discussion of it. We haven't made a decision whether we are going to do what is proposed in the rules, something less than that, or nothing.

I know Members of Congress have received input on this, and I can only say, at this time, it is somewhat premature.

Mr. BYRON. We have millions of subscribers around the country, and that is a tremendous hornet's nest, it seems to me. You remember how quickly the bill went through here several years ago. I think it was 3 days, Mr. Chairman, and there is a great deal of public interest in sports television.

Mr. WILEY. I agree with you.

Mr. MACDONALD. Will the gentleman yield?

Mr. BYRON. Yes.

Mr. MACDONALD. Mr. Wiley, don't you think it would be well to distinguish, for the benefit of the newer members, of which Mr. Byron is not one, the difference between importation of distant signals and the antiblackout law itself?

Mr. WILEY. What we are talking about is distant signal importation of sports events. The Commission put out a proposed rule which would seem to track Public Law 87–331. Say we have a professional game in the four major sports—then when they are playing at home, no cable system located within the grade B contour could carry, without the consent of that team, a television broadcast of a professional game of the same sport, without consent of the local television station. That is one thing we are talking about on cable. There is also a sports blackout bill which much was involved in relative to home games on TV, sporting events. We are not referring to that.

Mr. BYRON. How about the question of pay television. I notice you are having hearings on that?

Mr. WILEY. That is a separate question, somewhat related, but the Commission has just about finished a revision, major revision of our antisiphoning rules. Those are not out, so I will only speak for myself. I think it very likely the Commission will continue to believe that some antisiphoning regulations are necessary, the concern being there is a public interest associated with conventional over-the-air television system, and major sporting events and feature films should not be siphoned off to a pay form. I think we are going to give more opportunity to pay television to develop. It is highly controversial and I expect, within a week or two, we will have a set of revised rules you

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can review and determine whether or not you feel they do meet the public interest.

Mr. BYRON. You are not going to make any major change?

Mr. WILEY. I think there will be major changes but I think the basic concept of antisiphoning will continue in terms of allowing pay television to feature sporting events to give this choice to the American people who want to pay for it while maintaining the basic system for the mass of the people.

Mr. MACDONALD. I can point out, whatever action they take along those lines, that will be thoroughly explored by this subcommittee just as soon as they do it.

Mr. WILEY. We welcome that.

Mr. BYRON. The problem of cross-ownership there is sort of a growing area of newspaper—CATV ownership. Does that concern the Commission at all?

Mr. WILEY. We have taken action in the newspaper-television, and in the newspaper-radio areas recently. We have taken revised action in the CATV-television cross-ownership area. On the question of newspaper-cable ownership, the Commission tentatively has decided it will continue to watch that matter but does not feel a rule prohibiting future co-located situations is necessary at this time. We don't know how cable will develop and we don't know if there would be concern that would require regulation.

Mr. BYRON. You do compile information on it, though?

Mr. WILEY. We are watching it carefully and revising our reporting to keep up on what are the patterns in this area.

Mr. MACDONALD. Mr. Frey.

Mr. FREY. First, let me say I am delighted to be back on the subcommittee and look forward to working with the chairman, who has worked for years in this area and done so much for it. The ability of this committee to focus completely on this issue, on a continuing basis, is going to be a benefit to the committee, and we hope, to the country.

I might say, we don't have any problem of leaks up here. The decisions are out before we even know they are being made. We understand the problem. I am delighted you are meeting 3 days a week. I hope the Congress catches up to you.

I do have some things in my mind. I would like to echo what the gentleman from Maryland said about this whole area of pay TV, and especially the sports area. I am concerned with it and I am delighted the chairman has indicated we are studying it very closely.

I have a couple of general questions on my mind. I think you said, or someone from the Commission said, you had questions about competition always being in the best interest. I think you said in front of the committee—competition not always being in the public interest, and I think I am not sure whether I share your views or don't or whether you said it or not. What I am trying to say is I do have a basic question about competition in some of these areas.

Let's take, for instance, the area generally of A.T. & T. and the problems of the skimming off of some of the businesses that have been claimed. We get many people in my State who are angry about the phone bills and power bills, and everything like that. I would like your thoughts generally on this subject.

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Mr. WILEY. What I did say was that I felt competition, after all, is the basic economic concept in our society. I generally agree it is in the public interest in terms of providing more diversified service, offering to the public lower cost innovation, what have you. What I am saying is the Commission's statutory mandate is to regulate in the public interest. The courts have told us competition is in the public interest. Generally speaking, we have introduced the thrust of competition, over the last several years, into the common carrier area. We have done this in specialized common carrier decisions, in the interconnection area, and also we have introduced sort of open-skies competition theory in domestic satellites. I generally think these decisions are going to prove to be in the public interest. We are looking at the question of whether or not it will have an adverse public effect on the telephone system in the country or any deleterious effect. Those questions are being carefully studied in 2 dockets I mentioned in my statement. We are working with the Federal-State joint board docket, which is looking to the——

Mr. FREY. When are you going to get the answers?

Mr. WILEY. To date, I have not seen the evidence that would convince me, the decisions we made to date are not in the public interest. I think, frankly, we have not seen the evidence of technological harm to the basic system. We have not seen the evidence of harm, to turn away from our basically procompetitive system.

Mr. FREY. Let me give you a hypothetical. If the phone bill of people in my State doubles, should I tell them it is in their best interest?

Mr. WILEY. One of the things, perhaps, one would look at is whether we are pricing our telephone services in the right way. You pay for most utilities by reason of usage, whereas, for telephone service, we have had flat rates. The Commission has suggested the usage should be considered. I agree the economic impact on the American public is something that has to be looked at to determine if competition is in the public interest.

Mr. FREY. You mentioned something about satellites. You rejected a proposed arrangement, other options you are considering. What are those other options?

Mr. WILEY. You mean in the Comsat–IBM matter?

Mr. FREY. Yes.

Mr. WILEY. Comsat–IBM brought to us a proposal for a joint communications domestic satellite service. We rejected the precise plan they gave us but we provided them with 3 options—either to enter the market independently of each other—to enter jointly with a third party that would have to own at least 10 percent of the stock, or Comsat to provide leased space service to IBM much as it does to A.T. & T.

Mr. FREY. Speaking generally, are you going to propose certain options, that others, who were interested, could take in the future?

Mr. WILEY. We already have. We came out with a major domestic satellite decision which is spelled out in my statement. We currently have the Western Union, which is broad——

Mr. FREY. Any new options—because, as I read your statement, you are talking about new options or new ways to do it. I was interested in what they might be.

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Mr. WILEY. I think the innovation, now, in new services and technologies will have to come from the public sector. I think the entry of IBM must be watched in terms of——

Mr. FREY. Are you satisfied with the cooperation of the commissioner of football, in that report you put out last October?

Mr. WILEY. I think, in our first report to Congress, we did not receive, initially, the kind of cooperation we had hoped for. Subsequently, through correspondence I had with Mr. Rozelle, I think we worked out our problems. It is a question of initiating the kind of information we needed, having them understand what we required, and I think, this year, we will be able to give you, the Congress, a more meaningful report.

Mr. FREY. I hope so because that first one wasn't really a record setter.

I know you have some statistics about what you are doing to update the Commission, but just for the record, how many dockets are pending in the licensing area? How many applications?

Mr. WILEY. In broadcast licensing, 8,000 commercial radio and television licenses have to be renewed each year—that is about 2,700 a year. It is complicated by petitions to deny and comparative filings authorized by the statute. We have several hundred of those applications, of those challenges, backlogged at the Commission. That is why we have put a new task force into the renewal branch and put more people in there to try to adopt some new procedures to get from underneath this backlog.

Mr. FREY. What has been the average time?

Mr. WILEY. It is difficult to give you an average. If it is an uncontested filing, it will go through very quickly. If it has EEOC problems, promise versus performance problems, if there is a station challenging it, it can be held up for a long time. This is a concern both to the industry and the Commission, and I think it was to the Congress, because, of course, you considered license renewal legislation last year.

Mr. FREY. Maybe we will get back to that. I am delighted to see you are working on a way to separate the smaller broadcasters from the others—we are getting killed with the paperwork.

One last comment. I read your report on, the just recent one, on obscenity, and that is a most interesting legal area. Your definition, I guess, of obscenity relates—and you have made it as specific as possible, in terms of the thrust of that case. I have also been interested, over a period of years, in the problem of the children's programing broadcasting, and at times I find myself in a quandary, as I suppose you do, in the need to preserve, in essence, the first amendment, and what I think at times is the overuse, for instance, in the advertising area. I have five children—whether I like it or not I get to see some of it. Your method seems to be to throw out a suggestion, and then negotiate with the industry. Is that a fair statement?

Mr. WILEY. Not completely, Mr. Frey. On the question of children's television, this has been a proceeding which had been at the Commission for a long time. I made a speech indicating I specifically felt the time had come for Government action—commercials should be reduced. The industry came to see me and suggested they were going to take action in this area to limit commercials. I said I would see what they had in mind, but it had to cover not only code stations

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but all stations. Subsequently, the NAB did take action. The independent television stations took action to reduce commercials along the lines I had in mind. We then put a statement on the renewal form and we will be able to monitor it to see whether self-regulation will be workable. I would like to facilitate and encourage that wherever I can. If it is not meaningful, we will have to take action. I think we have shown that in the past.

Mr. MACDONALD. Mr. Carney, a new, welcome addition.

Mr. CARNEY. Mr. Wiley, in your testimony, you say that the Commission believes industry self-regulation is preferable to Government standards, and so on. That might be a nice theory, but I understand your Commission was set up because of the fact when institutions do not practice restraint, then the people expect the Government to step in and make regulations. Isn't that right?

Mr. WILEY. You take this particular statement out of context, if I may say so. That is an area where we are touching very delicate first amendment problems. In dealing with the question of violence and sexual material on television, we are in a sensitive area. I felt, if the industry could take action in this area, that would be preferable to a rigid set of Government standards. If that doesn't turn out to protect the public, we will have to take a look at what our regulations will be. It will be a very complex area which may require additional legislation.

Mr. CARNEY. I appreciate that, but my mail, and every Congressman's mail, is consistent. Over the years, my mail has been consistent from housewives and people complaining about violence and, also, they contend, immoral or frank discussion.

I think anybody that observes TV can see, in the last 2 or 3 or 4 years, every week, some network will do something more explicit. The next week another network does it. I think people should have the right to choose what they want to read or go to see. This is something going over the airwaves, and the airwaves are owned by the people of this country. I think the people have some right to reasonable regulation.

Mr. WILEY. Let me say this—I strongly agree with your basic view that broadcasting is different than other entertainment forms. It goes directly into the home. We can expect different standards than that of motion pictures. That is why I took the initiative of meeting with the network officials to explore whether or not some meaningful self-regulation could be achieved. The steps that the networks and the NAB Committee Review Boards have taken to date give some promise of this occurring and, at the same time, allow television to continue to cover sensitive subjects for mature audiences at times when adult audiences may be interested. Of course, even those should be done with taste and decency. We have assurances from the networks, and we will wait and see if these people mean what they say.

Mr. CARNEY. The product doesn't show it. They may be giving you assurances. I will tell my friends in the broadcasting industry, unless they show they mean what they are saying, they are going to get regulations they might not like. I am saying this publicly because I agree with you in theory—self-regulation is the best. One of the things about this country, if you don't do self-regulation, and the people control the Government, they go too far, people have a way of kicking back and that always isn't good. Somethimes they kick too hard.

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I commend you and your committee for trying to do something about this, but I want to say publicly to the members of the industry, they better start showing discretion, if my mail means anything.

About cable TV, one of the complaints I am getting in my district, and one of the reasons I wanted to be on this subcommittee, was frankly, I want to say it bluntly—you are allowing too narrow licenses for too narrow districts. In my district—and I have pretty good grounds on this—these fly-by-night operators, who aren't financially sound, are going out and inducing city councils and government bodies, township trustees, to grant them a license. They are not producing on this. They want to sell the paper to somebody that is a bigger operator. They have got a few thousand dollars invested, and they sell these cable TV licenses for, in some instances, 50 and 100 times what they have put into it, without doing anything of a constructive nature to build the industry. Have you any rules or regulations to control that?

Mr. WILEY. When we embarked on our cable regulatory program, because cable has different characteristics in the sense of making use of the local streets and properties, we embarked on a joint regulatory program with State and local communities. The selection of the franchisee is primarily a matter not for Federal but local franchising authorities. At the same time, the Commission does have concern about some of the points you have mentioned, and we are currently looking at a possible new proceeding on transfers of cable operations, but I would have to say that some of the concerns you express lie at the door of local governmental bodies.

Mr. CARNEY. Have you put any thought to maybe some Government control to make it a broader licensing basis? Local bodies don't give TV and radio stations out; you do it. Why shouldn't the same apply to cable TV?

Mr. WILEY. The reason we have a national plan in broadcasting is because it is over the air. Cable is a wire situation that has to use the local streets and has incidents of local ownership and concern. We have attempted to have a sharing of the regulatory concern. If we were not going to do that, we would have to have a much larger FCC. I am not certain Congress would support that because, frankly, we don't have the manpower to franchise all of these various merging cable systems, and I am not really sure it ultimately would be in the public interest. At the same time, it seems to me those franchising authorities must go through certain requirements that we establish. For example, a public proceeding. People can come in and make their views known. They must meet certain Federal standards we have set up. I am not saying it is a perfect system, but I do feel it has some advantages because of cable's peculiar characteristics.

Mr. CARNEY. Do you think we should leave this, the license or franchising, to local authorities, or do you think there should be some reasonably broad governmental regulations everyone that wants a license should comply with—financial liabilities, how long they should keep the license after they get it, the terms they can transfer or sell that property to someone else? It seems to me there should be some regulation on this. Have you put any thought to this?

Mr. WILEY. Yes. We have had a Federal, State, and Local Advisory Committee working for several years. We are studying part II of the FSLAC report. We have limited the time a local franchise authority

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can grant a franchise to 15 years. We have preempted technical standards. We are going to make decisions in the near future as to how much the Federal Government should do and how much the State and local authorities can do. It is not an easy area, but I am satisfied careful study is being made of this entire problem.

Mr. CARNEY. I hope you will make a study and make sound regulations in the public interest.

I have one more question. You point out here in the fee schedule that you will recover $16½ million or 35 percent of the Commission's fiscal year budget. That $16½ million, what licenses do you cover there?

Mr. WILEY. We cover practically all of our services in which there is some value to the recipient. That is the standard the Supreme Court requires. Before, under congressional directive, we tried to take our entire budget and divide it among the various things we regulate. The Court said that is not proper. We have gone back and made a complicated breakdown. We are now only going to recover 35 percent of our budget, where previously we were trying to recover as close to 100 percent as we could.

Mr. CARNEY. Is that all forms of licensees or cable TV?

Mr. WILEY. Oh, no. Down to citizen band radio.

Mr. CARNEY. I was in Ohio State Legislature many years and we expected the Public Utilities Commission of Ohio to make sure the public utilities were assessed enough to pay for that service. Why should the Government pay 65 percent, which would be over $35 million, when these commercial people are making money on it?

Mr. WILEY. I can only repeat what the Supreme Court told us in March of last year, the whole concept of regulation is in part service to the public, and that service to the public is supposed to be paid out of the tax revenues, so we had to go back and compute a new fee schedule based on value to the recipient. At the time of our last fee decision I put out a separate statement, in which all of the Commissioners joined, suggesting this whole area cries out for additional congressional guidance. We are now in court on almost every aspect of this fee schedule. If the Commission is to continue to be a Federal Communications Commission and not a Fee Commission I suggest respectfully the Congress might wish to reevaluate this entire area.

Mr. MACDONALD. If the gentleman from Ohio would yield for a brief moment. I would also like to point out that next to filling out an IRS form, the rules and regulations governing CATV, as of now, are just about as confusing to me, and I would guess to the average cable operator, certainly to the average investor, thinking about going into CATV, as the Internal Revenue forms. Some day, when we have more time, I am going to discuss with you all of the rules, because some of them seem terribly unnecessary and others seem unnecessarily complex.

Mr. WILEY. I couldn't agree with you more. I have said publicly I think the set of cable rules is perhaps one of the most complicated ever devised. We have had almost a year, already, a task force working to simplify those rules.

Mr. CARNEY. No more questions.

Mr. MACDONALD. Mr. Madigan.

Mr. MADIGAN. I have some questions which your former law partner wanted me to ask you but since they relate more to your

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efficiency as a Little League coach than they do to the Commission, I think I will not ask you those right now.

I am interested in the area Mr. Frey opened up, and I wonder were you a member of the Commission when the decisions were made about telephone company competition, the point to point communications and the interchange of equipment for those kinds——

Mr. WILEY. I was probably General Counsel when some of those decisions were made. It has been evolving over the last few years since 1968, and I joined the Commission in 1970 as General Counsel, so I don't think I participated as a Commissioner in the Common Carrier decision, but I have more recently in the extensions of those basic decisions.

Mr. MADIGAN. I want to see if my understanding of the background for the charges made by a company like Bell, is the same understanding you have. What I have read about this, both in court decisions and in decisions through the years made by State regulatory agencies, it seems to me the intent has always been to weigh the cost of the telephone company doing business to the commercial or industrial use for the purpose of providing telephone service to the residential user at the cheapest possible price. Is that the general impression you have?

Mr. WILEY. There has probably been some of that aspect in Bell's general costing of its services. Whether or not that is an appropriate action or whether or not some small businessmen should subsidize, for example, more wealthy residential users, to take the worst situation—we normally think about the small man subsidizing a large commercial businessman. You can think of the reverse situation also—whether or not any subsidies in this area are appropriate, is something I think should be looked at.

Mr. MADIGAN. Have there not been decisions made by State agencies that had, as their basis, that understanding or that thrust—they were trying to provide telephone service to residential users cheaply by having the telephone company weight the charge for equipment rental?

Mr. WILEY. I assume so.

Mr. MADIGAN. It seems to me, with that history, that the recent decisions by your Commission then enable these new competitors to effectively undercut companies like Bell because Bell has these inflated charges on the basis of these prior corrections given them. We allow people to come in and compete with them, charging a lesser amount of money, but those new people coming in are not under any obligation to provide residential or rural or long-line service, any of the more costly things. I wonder how you justify that?

Mr. WILEY. In the economic inquiry I mentioned, docket 20003, we are looking into the question of economic effects of our policies. However, it is difficult to draw the extreme conclusion in this area that the mere fact we have introduced competition into some aspects of Bell's overall services, will cause, for example, the residential user, the rural homeowner, the urban homeowner to pay more money, and if so, are there other ways to solve that? I think it is a very complex area. I have not seen evidence myself sufficient to suggest the Commission's policies, which introduce some competition into this entire monopoly area, are not in the public interest today.

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Mr. MADIGAN. While this subcommittee doesn't get into it, this full committee gets into other types of business endeavors and the use and regulations that relate to them, and the problems other business entities have.

I would like to draw an analogy for you between railroads and telephone companies. Railroads, for the most part, in the United States, are bankrupt, are in a bankrupt situation, except for some of the Western and Southwestern routes. Through the years, railroads have been regulated. They do not have the flexibility to charge their customers on the basis of what the service should actually cost. They were regulated and told what they could transport, where, and what they could charge for it. There has always been a weighting in the railroad industry for providing cheap transportation for agricultural products, and making up the money by charging more for industrial goods. The truck companies and other carriers have come in and taken away from the railroads the industrial transportation business and left them only with the things they were doing cheaply. It seems inconsistent to me that the Interstate Commerce Commission could cause that kind of problem in the American transportation industry, and then your Commission would come along and move in the direction you are moving, which, ultimately could create the same kind of problem for the telephone company.

Mr. WILEY. I am not sure the analogy is proper. I say our regulation of the Bell System has been an indication of effective, successful regulation because here we have a viable service to the American people, a company which has been successful. One of the reasons it has been successful is the Commission and the State regulatory commissions have had the courage to provide unpopular rate increases, as we did in this last one, where the public interest would require it, and the company would need it. I am not convinced the introduction of competition, in some aspects of this very, very large empire of services, is necessarily going to lead to the kind of disastrous effect you suggest. However, because it is a possibility, and there are concerns about the economic industry by not only the Bell System, but hundreds of independent telephone companies, the Commission has instituted this very, very complex and far-reaching inquiry, which will examine all aspects of this area, and I must say we are working closely with State regulatory commissions which have a legitimate concern in this same area. I assure you this is something the Commission is going to continue to monitor carefully because we don't want another Penn Central in the telephone service. We have the finest telephone service in the world, and I think the companies are to be commended. The only question is whether or not, in the light of the national interest in providing competition, certain aspects of that service should be completely inhibited because of our success to date with a monopolistic service. I don't think the evidence suggests it should, at this point.

Mr. MADIGAN. Before we move away from that, I want to leave you with this one observation. At the same time your Commission has been moving in the direction it has, people with as diversified backgrounds and ideologies as Attorney General Saxbe and the former chairman of President Johnson's Council of Economic Advisers, have been recommending American railroads should be set up by the

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Government on a basis like Bell telephone. That is their recommendation. At the same time, you are moving in the opposite direction, so I am delighted you are undertaking this study, and I hope it will be done in a timely fashion, and will be a comprehensive thing.

Mr. WILEY. One thing you must understand—the competition we have introduced has been in the private line and not the message toll service, which is the basic service we have been talking about to the resident. However, I think your point is that it might have an effect on the economic viability of this other service and that is what we are examining.

Mr. MADIGAN. We can talk about the business customers subsidizing wealthy residential users. There are a lot of residential users we can put in a cate_ory other than wealthy.

Mr. WILEY. Absoutely.

Mr. MADIGAN. Increase in cost for residential telephone service would be absolutely terrible—people would have to do without.

I want to make this final observation about obscenity. I served as the vice president of the obscenity commission, and we did draft legislation, quickly undone by the courts. You and I might not agree on a definition of obscenity, but I think the fact you have attempted to do something is laudatory and I praise you for that, whether or not we are in agreement. I think it is an area something has to be done by people like yourself. I want to commend you.

Mr. WILEY. Thank you. I also share your concern about the rates which the residential telephone user pays and might pay, and we are looking into all aspects of that, I assure you.

Mr. MACDONALD. I would like to get back to what I think, perhaps, is my underlying discontent with the report which you filed on television violence and that mainly I would think, deals with your optimism concerning the industry's willingness for self-regulation. I, perhaps, don't go quite as far as Mr. Carney did in his questioning, but I must say that the industry, as far as I am concerned, in my experience with them, and I have many good friends in the industry, and secretly—I don't know if they will admit it to me, but secretly I know they must admit it to themselves—they have one motivation and that is the bottom line. They don't care what they put on that screen as long as the ratings show that it is attracting a vast majority of Americans to watch it. I know you have been with the Commission since 1970, so you can't be naive about what motivates the broadcasting industry as a whole, and therefore, when you say that this whole thing is going to depend on their reasonableness and their good faith, that is, in my judgment, like writing a letter to Santa Claus. They have made so little progress, but for the amount of progress they have made, I would like to congratulate you. I think you and this subcommittee have been hammering along about children's programing and there have been some active groups, including one called ACT, which has done very well in this field. But as far as sex and violence are concerned, and as far as your hoping that the good faith and reasonableness of the networks is going to take care of violence and sex on TV programing, I think you are whistling Dixie.

Mr. WILEY. If I may respond to that——

Mr. MACDONALD. If you will pardon me——

Mr. WILEY. Your concern is an honest one, I am sure, and one shared by many people. At the same time, one has to remember, we

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do have a first amendment, and a no-censorship provision in the Communications Act.

Now, we have the networks having made public, policy statements about what they plan to do in this area.

Mr. MACDONALD. If I could interrupt. They made the same promises to me when the license renewal bill was being considered, and I was trying to drive topless radio off the air. We were successful but that was just a series of happenstances among which was the happenstance that their license renewal bill was pending. And as far as their good faith is concerned ,the license renewal bill is an example. I felt a 3-year license was enough but I agreed to 4 years just to get a bill out and through, because there were inequities going on and still are, in this field and Mr. Frey has mentioned some of them. Then the broadcasters broke their word and went for 5 years on the floor, and of course got it, and that killed the entire bill.

How long have we been after the networks about sex and violence? They get worse and worse. They don't get better and better. When did you have this great conversation with them where they promised to do this and that to clean up television? They were going to cut back on violence?

Mr. WILEY. I just had these meetings in November and January.

Mr. MACDONALD. The programing gets worse all the time. You turn on the TV, any given night, and that is all you can see, after about 8 p.m., is a new way to kill somebody. It is done under the guise of cops and robbers and sure, the bad guy always gets caught, but in the meantime, there is blood all over the streets, blood every place. Guys are getting beaten up. The violence, I think, is much worse on our children than any of the obscenities. Some of the obscenity isn't as bad as they hear at their own school, but some of that violence is incredible.

Mr. WILEY. I have spoken out vigorously on this same subject. I agree with your views.

Mr. MACDONALD. Why say, "Now it is up to their good faith and reasonableness," when they have demonstrated their lack of good faith and reasonableness in this field?

Mr. WILEY. If the Congress has any ideas they would like to suggest for further action or further legislation, I would be glad to consider them, but I think this program goes as far as the Commission can go under the current law and is a good step in the public interest.

Mr. MACDONALD. I agree, the Commission is in a tough position in light of the first amendment. But exposing everybody in the family to burning someone alive—they caught five kids in the city of Boston sometime ago, who set fire to a woman—threw gasoline over her, lit her with a match. They got them down to the police station and no one could believe kids their age would do it. "Where did you get that idea?" they asked. "We saw it on a TV program." The TV programs haven't ceased one iota in violence. It seems to me they keep pushing and pushing to see how far they can go before somebody really cracks down on them. I would think, without touching the first amendment, in the license renewal process, this could be a fair part of ascertainment, because, are they serving the public interest of the communities they are licensed to service by showing all of this sex and violence? That, in no way would abridge the first amendment.

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Mr. WILEY. I think they are getting the message from the comments you have made and other Members of the Congress have made, and the Commission has made, and I have made. Starting in the fall, I think a parent can be assured, prior to 9 p.m., at least, there isn't going to be any programing in prime time that would be offensive to younger children, without specific advisories. I think it is always going to be subjective. We are dealing with a system Congress set up—placed the public interest in private hands.

Mr. MACDONALD. I know you are not suggesting we nationalize?

Mr. WILEY. No, not in the slightest. I am satisfied with the current system. I think the current system can work. It has to have continual oversight. That is what we are going to do, not only in that area, but all areas.

Mr. MACDONALD. I agree. I don't envy you your job. Nobody ever promised you a rose garden when you took the job you are in. I think this violence thing is the worst thing to hit the United States since the plague, since now, on the news, the kids see live war in Southeast Asia with blood and guts all over the streets, and then we go *from* there into blood and guts all over our streets under the heading of action—"SWAT" is a new one. Each of the new programs outdoes the other. You can take a postgraduate course on how to kill somebody in "Hawaii Five O". You don't have to go to school any more to learn tricks of the trade. You can turn on your TV. That is what makes me—not laugh—I am not laughing at you—I sympathize with you a good deal, but when you talk about the family television hour, *it* sounds like something like "Over the Hill to Grandmother's House." I don't know any family that has got an hour's family viewing time, do you?

Mr. WILEY. It is 2 hours, first of all. It is the first half of prime time.

Mr. MACDONALD. There are so many things we can get into, since you refer to prime time access. That period was reserved for local programing. All we got was reruns of "Lucy," "Dragnet," or something like that. The amount of new local programing is still zilch, so I, for one, think that has been a failure except there has been some expanded local news—but outside of that, there is no more local programing than there ever was, in my judgment.

Second, you talk about eastern time and 7 to 9 being set aside. How about central, Rocky Mountain, west coast?

Mr. WILEY. West Coast would be the same. I suggested to the networks they have 9 across the country, much as they do in Europe and France, where you have a one time zone country. They suggested this would be economically not feasible and their programs therefore do vary by the time zone. The proposal I put to them was 9 origination time.

Mr. MACDONALD. It is an effort, I suppose, but I don't have too much hope, because kids watch TV from morning until night, especially if you have got two TV's in the house—you have to run a border patrol to see what they are watching upstairs. You can't watch what you want to yourself—I went through that stage.

We have two new members that have not been heard from, but I would like to sound off through you to the industry, that while you may be relying on their good faith and reasonableness, this subcom-

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mittee is not, as far as its chairman is concerned. I will believe it when I see the performance, not just on conversations. I have had a million conversations and it turns out it gets worse instead of better.

We have two very new members—no newer than anyone else when they first came here, but new to the subcommittee—Mr. Wirth and Mr. Brodhead. I don't know if you are sitting in seniority.

Mr. Brodhead, do you have any questions?

Mr. BRODHEAD. Yes; I do.

Mr. Wiley, I would like to pursue much the same line of questioning as Mr. Madigan. When the FCC made the original decision to allow these specialized common carriers to compete with the Bell System, wasn't that done on the basis that they were going to be providing new and different services?

Mr. WILEY. I think largely that is true, and I have not been totally satisfied with their performance to date in terms of providing something different, new, to the public that the Bell System hadn't performed. The response I get, when I raise those points, is that they have to get started, have to get developed, and this is going to come when they become viable.

Mr. BRODHEAD. Then, what you are saying is, up to this point there hasn't been any significantly new or different services these companies have provided?

Mr. WILEY. There have been some, but, as I say, more can be done in this area, and I feel, in time, more may well be done. We are learning as we go along in this area. This is a new thrust.

Mr. BRODHEAD. Could you be a little more specific with respect to what services they are providing, that the Bell System or the standard telephone companies cannot or have not been providing?

Mr. WILEY. Let me ask Mr. Hinchman, the Chief of our Common Carrier Bureau, if he would like to elaborate.

Mr. HINCHMAN. If you are talking about new transmission services, they all transmit information by microwave and that is the same kind of system Bell has used, but in terms of tailoring of services to fit particular customers' needs to provide terminal equipment at customer locations, to provide new forms of switch service for private networks, they are providing new services. I think it is a matter of definition what you call a new service. They are offering something which, apparently, those customers are finding attractive, economical, providing, to that extent, new services. They are not providing something which was unheard of in terms of television transmission service that we didn't have before, but in terms of the overall end to end service, they are providing, there are new service offerings. They have tariffs that do not match the type of service the Bell System provides and they are finding customers for their services.

Mr. BRODHEAD. I am deeply concerned about the effect of this policy on the average telephone subscriber. If the Bell System is losing business, if their rates are being undercut, the extent to which they are going to have to compensate for this by raising the cost of the telephone service for the average residential subscriber. Residential telephone service today is a necessity, and we are in a very tight inflationary period. Considering that the costs people have to pay for basic utilities are rising very fast, I am concerned this policy is going to have that kind of impact. I therefore question whether or not it is in the public interest.

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Mr. WILEY. I would refer back to some of the responses I gave to Congressman Madigan. This is an issue under consideration by the Commission. There are a variety of answers to it other than simply the fact the residential phone bills are going to have to go up. There are possible alternative ratemaking practices, including usage-sensitive pricing. Not only do I think we have to look at possible alternatives in terms of pricing, concerning usage-sensitive pricing, as I said, but we have to look at the size of the market we are talking about and really what portion of it has been open to competition. The private line market is relatively miniscule in terms of the market we are talking about. The Commission recognizes the concerns you express.

Mr. BRODHEAD. Have you addressed the question of needless duplication of services; that is, if there are existing lines or systems that can carry this business and then somebody else, another company makes another system to carry the traffic that could be carried by an existing system. If the problem is that the existing system is inadequate or the rates are unfair, that could be dealt with by the appropriate regulatory agencies. But in case of duplication, eventually, these costs are passed along to the public and the people end up paying for it. If this competition is going to provide lower prices and benefits to the public, I can see it. However, it would appear to me, at least at this early stage, there has been some aspect of needless duplication of service with additional costs to be passed on to the consumer.

Mr. WILEY. I don't agree that has happened to date. I think the Commission has long agreed that two telephone poles in the back yard, to take a classic case, would be needless duplication and wastefulness. I am not so sure that is true in some aspects of the common carrier; for example, private line. There can be different services that members of the public, businessmen, may want to pay for and receive. I think competition can make existing companies more responsive, more innovative. I think that is in the best interest of the American public. We are monitoring this new policy very carefully. The Commission is going to continue to study it. To date, in my view, it has been in the public interest.

Mr. BRODHEAD. Thank you, sir.

Mr. MACDONALD. Mr. Wirth?

Mr. WIRTH. I am sorry I was not here for your discussion of open meetings earlier, but I would like to add my input, and I think that of probably most of the new Members of the Congress, about the whole notion of Government conducting its sessions in secrecy, staff notwithstanding. I think, what you do want to do is have those as open as possible. I don't see any great reason for holding them in closed session, unless national security is at stake.

Mr. WILEY. As I said, shortly after the first of the year, I was thinking of that issue because of some professional association work looked at the Government in the sunshine bill. The staff is studying this matter, and some time in the future we will have this discussed with the Commission and determine whether or not there are portions of our meetings that could be open.

Mr. WIRTH. We have had a sunshine law in the State of Colorado, which has worked very well. In balance, it is in favor of that. I came in this morning, really concerned about cable in our rural areas. I guess some of my enthusiasm for that subject may have been gutted

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by the discussion of blood and guts on television. Assuming there can be a good product that can be felt out, I would like to focus a few minutes on that. As I understand it, there are literally thousands of households that have no access to television reception.

Mr. WILEY. I think television basically covers 98 percent of the country.

Mr. WIRTH. I think cable is a way of providing additional service to the American people. Have you seen the service commissioned by OTP and done by the Denver Research?

Mr. WILEY. Yes; we are examining that.

Mr. WIRTH. What is the FCC doing to stimulate cable television in our rural areas?

Mr. WILEY. I will ask Mr. David Kinley to comment on that.

Mr. KINLEY. Congressman Wirth, there is nothing in the way of funding that we have undertaken. We have no funds under our appropriation, of course, to foster the development of technology such as cable TV. What we have tried to do is tailor the signal carrying rules in such a fashion that it would make it economically feasible for private operators to undertake cable operations in rural areas. This is particularly true in areas, what we call, outside all markets, cable areas in which no grade B contour television station reaches that area. In those situations, under our rules, the cable system can carry any signal they desire. This is the means by which we have tried to foster the development.

Mr. WIRTH. The DRI study contains two specific recommendations as to what could be done, that do not require the kind of print-in money you are talking about.

That report also talks about the possibility of various proposals for liens that might be provided by the Federal Government to stimulate rural cable growth.

Mr. WILEY. The entire report is being reviewed by the Cable Bureau to see whether or not there is a regulatory aspect to it which we should be involved with.

Mr. WIRTH. I am sure there is and I wanted to continue our discussions. I will be back on that. There are a lot of people in various areas of the country that are concerned about their lack of access to television.

Mr. WILEY. Thank you.

Mr. MACDONALD. We have a vote going on in the House, and we thank you very much for coming here and bringing everyone else with you. We never got a chance to take a crack at a couple of questions that I have. We will have you back as soon as feasible on both sides. We have much more time. You probably have a little less. We will be seeing more of you. It is nice to see you. Thank you.

[The following correspondense was received for the record:]

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C., March 19, 1975.

Hon. RICHARD E. WILEY,
Chairman, Federal Communications Commission,
Washington, D.C.

DEAR MR. CHAIRMAN: I was unable to attend hearings before the Communications Subcommittee of the House Interstate and Foreign Commerce Committee last Tuesday, March 11, due to a meeting of another committee of which I am also a member. As I did not have the opportunity to ask certain questions of you at that time, I am now submitting them to you in writing

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and the questions and the answers will become a part of the permanent hearing record of that day. I would appreciate it if you would answer the following questions and submit the answers to me as soon as your time permits.

1. I understand that the original subscription television rules were established in an effort to regulate the assignment of the limited over-the-air frequencies. If this is correct, how does the FCC understand its rationale for regulating pay cable where there is an abundance of channel space?

2. Many of my constituents would be interested in seeing movies in the comfort of their own homes. Pay cable endeavors to offer this opportunity, I understand. The FCC rules limit the amount of product available to the pay cable interests but do nothing to assure that network television will continue to provide same. Can you explain this?

3. Further, my understanding of the existing rules tells me that a broadcaster might contract for a new, successful movie soon after its release, and then hold that movie for five to seven years. This "warehousing" of product denies the public the right to see the movies. Why is there no provision in the new rules to prohibit such an occurrence?

Do you believe it is fair for the broadcaster to acquire an exclusive contract on a film and then not show it for many years?

4. I understand that the impact of the proposed sports black out rule would be to force people to attend sporting events in person that they had previously enjoyed on television. I cannot understand why the FCC would be interested in sporting events gate receipts. Could you please explain this?

5. As you are aware, the Congress will be reviewing Public Law 93-107 concerning sports black out this spring, and you are also aware that in 1973 we rejected the black out policy advocated by sports leagues. Why is the FCC looking at the same issue when there is a Public Law on the books?

I look forward to hearing your response to these questions.

With kind regards.

Sincerely,

JOHN M. MURPHY,
Member of Congress.

FEDERAL COMMUNICATIONS COMMISSION,
Washington, D.C., April 7, 1975.

Hon. JOHN M. MURPHY,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN MURPHY: This is in response to your letter of March 19, 1975, in which you listed several questions that you did not have an opportunity to ask when I testified before the Communications Subcommittee of the House Interstate and Foreign Commerce Committee on March 11, 1975. Your questions and my responses thereto are set forth below.

1. "I understand that the original subscription television rules were established in an effort to regulate the assignment of the limited over-the-air frequencies. If this is correct, how does the FCC understand its rationale for regulating pay cable where there is an abundance of channel space?"

When the over-the-air subscription television rules were adopted by the Commission in 1968, at least two primary public interest considerations were deliberated. The threshold question was whether limited broadcast frequencies should be allotted for the delivery of subscription programming. This having been answered in the affirmative, the Commission went on to consider whether program restrictions were required in the public interest to ensure that the type of programming traditionally brought to the public by conventional television would not be "siphoned" away from that source to subscription operations. This second question does not concern only the use of broadcast frequencies by subscription television; it also relates to the nature of conventional television broadcasting and the effect that subscription television, in all of its forms, will have on the conventional service. Having found that subscription program restrictions are in the public interest, and having adopted appropriate rules applicable to over-the-air subscription operations, these same rules were later applied to subscription cable television operations. The rules are applied to both over-the-air and cable subscription operations not because both services utilize broadcast frequencies, which cable need not do, but because both services impact upon the conventional television structure.

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2. "Many of my constituents would be interested in seeing movies in the comfort of their own homes. Pay cable endeavors to offer this opportunity, I understand. The FCC rules limit the amount of product available to the pay cable interests but do nothing to assure that network television will continue to provide same. Can you explain this?"

I am confident that you would agree that the Commission should not mandate the provision of specific programs by conventional television. Such action would be contrary to our system of privately operated broadcasting. The subscription rules seek to maintain the sources of programming now generally delivered by conventional television so that the American public continues to have an opportunity to view that programming free of direct charges. To the extent that subscription television supplements conventional television by offering an alternative form of television entertainment, its growth and development promises many benefits to the public. By adopting the subscription program rules, we have sought to provide for the development of subscription television without undermining the ability of the public to view popular programs on conventional television. Where it is determined that a program is not desired for conventional telecast the rules allow for the program's subscription exhibition, *e.g.*, older feature films not broadcast in the market for three years may be exhibited on a subscription basis. With regard to relatively recent feature films (those less than three years old) which are not generally televised, the rules do not prohibit their subscription exhibition.

"Further, my understanding of the existing rules tells me that a broadcaster might contract for a new, successful movie soon after its release, and then hold that movie for five to seven years. This 'warehousing' of product denies the public the right to see the movies. Why is there no provision in the new rules to prohibit such an occurrence?"

The record is not clear as to whether "warehousing" actually takes place, or, if it does, as to the nature and extent of the practice. When the new subscription rules were adopted on March 20, 1975, we noted the lack of factual information on this issue, despite our previous specific request for such information, and commenced a new inquiry looking into the warehousing question. Additionally, we stated that the concepts integrated into the new subscription feature film rule suggest the need for an overall assessment of exclusivity practices *vis-a-vis* conventional and subscription television operations, and we questioned whether rules are needed to limit the degree of program exclusivity for which either form of television service may contract. On the basis of our inquiry into the subject, should the evidence demonstrate that measures are required to prevent unreasonable restraints on the program product available to the subscription television industry, we will consider adopting new rules designed to limit or remove such restraints.

3. "Do you believe it is fair for the broadcaster to acquire an exclusive contract on a film and then not show it for many years?"

Clearly, where demands for exclusivity amount to a predatory practice, they are both unfair and a violation of the anti-trust laws. Some exclusivity against subscription television may be reasonable to protect the legitimate business interests of conventional broadcasters. Few would suggest that some program exclusivity among broadcast stations in the same market is not fair, or even necessary. At this time, we do not have enough information to determine what degree of program exclusivity against subscription operations is "reasonable," or whether restraints on the practice of contracting for exclusivity are required. We hope to find answers to these questions as we proceed with our inquiry into the subject of program exclusivity which I mentioned in my answer to the previous question.

4. "I understand that the impact of the proposed sports blackout rule would be to force people to attend sporting events in person that they had previously enjoyed on television. I cannot understand why the FCC would be interested in sporting events gate receipts. Could you please explain this?"

The Commission's pending cable television sports blackout rule making is grounded upon the Congressional policy established in Public Law 87-331. The first section of that statute provides an exemption from the anti-trust laws to permit the professional football, basketball, baseball and hockey leagues to pool the individual television rights of its member clubs and to sell those rights as a package. The second section of that law provides for television blackouts of games in the home territory of a team when it is playing at home. It is argued by sports interests and others that cable television systems, by carrying sports events

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televised by distant broadcast stations, threaten to undermine the Congressional intent of Public Law 87-331, and that the Commission should follow the established Congressional policy by adopting a rule which would proscribe the carriage of distant signal sports events on cable television systems in a manner consistent with the policy underlying Public Law 87-331.

5. "As you are aware, the Congress will be reviewing Public Law 93-107 concerning sports blackout this spring, and you are also aware that in 1973 we rejected the blackout policy advocated by sports leagues. Why is the FCC looking at the same issue when there is a Public Law on the books?"

Public Law 93-107 requires that the local blackout provided for by Public Law 87-331 be lifted if the game to be played is sold out 72 hours prior to game time. Since the proposed cable television blackout rule would affect only sports programming carried over distant teleivision signals, the rule would have no effect upon the operation of Public Law 93-107. Where the local blackout is lifted pursuant to that statute, and the game is televised locally, cable television subscribers will be able to veiw the game on the local television station which is carried by the cable television system.

I trust that the foregoing is responsive to your questions. If you desire additional information, do not hesitate to contact me.

RICHARD E. WILEY, *Chairman.*

[Whereupon, at 12:25 p.m., the hearing was adjourned.]

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HEALTH MANPOWER PROGRAMS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

ON

H.R. 2956, H.R. 2957, H.R. 2958, and H.R. 3279 (and all identical and similar bills)

BILLS TO AMEND THE PUBLIC HEALTH SERVICE ACT TO REVISE AND EXTEND THE PROGRAMS OF ASSISTANCE FOR TRAINING IN THE HEALTH AND ALLIED HEALTH PROFESSIONS, FOR NURSE TRAINING, TO REVISE THE NATIONAL HEALTH SERVICE CORPS PROGRAM AND THE NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP TRAINING PROGRAM, AND FOR OTHER PURPOSES

FEBRUARY 20 AND 21, 1975

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ORGANIZATIONS REPRESENTED AT HEARINGS

American Association of Colleges of Osteopathic Medicine, A. Archie Feinstein M.D., assistant dean for clinical training, Pennsylvania College of Osteopathic Medicine.
American Nurses Association:
Daggett, Susan, R.N.P.
Holleran, Connie, R.N.
Association of American Medical Colleges:
Cooper, John A. D., M.D., president.
Fentress, Charles.
Sherman, John, M.D.
Coordinating Council on Medical Education:
Cooper, John A. D., M.D., president, Association of American Medical Colleges.
Fenninger, Leonard D., M.D., secretary, Advisory Committee on Graduate Medical Education, Committee on Education, American Medical Association.
Gehrig, Leo J., M.D., vice president, American Hospital Association.
Hanlon, C. Rollins, M.D., F.A.C.S., president, Council on Medical Specialty Societies.
Holden, William D., M.D., immediate past president, American Board of Medical Specialties, and chairman, Committee on Physician Distribution, CCME.
Nesbitt, Tom E., M.D., speaker, House of Delegates, American Medical Association.
Ruhe, C. H. William, M.D., director, Division of Medical Education, American Medical Association, and secretary, CCME.
Federation of Associations of Schools of the Health Professions:
Bates, James E., D.P.M., president, Pennsylvania College of Podiatric Medicine and vice chairman of the Federation.
Cotton, Raymond D., Association of Schools of Public Health.
Filerman, Gary L., M.D., Association of University Programs in Health Administration.
Oaks, Howard, D.D.S., American Association of Dental Schools, and vice president for health sciences, State University of New York at Stony Brook.
Wallis, Norman E., O.D., Association of Schools of Colleges of Optometry.
Wandelt, Mabel A., National League for Nursing.
Health, Education, and Welfare Department:
Altman, Stuart, M.D., Deputy Assistant Secretary for Health Planning and Analysis.
Cooper, Theodore, M.D., Acting Assistant Secretary for Health.
Endicott, Kenneth M., M.D., Administrator, Health Resources Administration.
Kurzman, Stephen, Assistant Secretary for Legislation.
Weinberger, Hon. Caspar W., Secretary.
National Association of Physician Assistants Program, Donald Fisher, M.D., executive director.

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HEALTH MANPOWER PROGRAMS

THURSDAY, FEBRUARY 20, 1975

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

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will come to order, please.

This morning the subcommittee begins 2 days of hearings on important measures which would revise this Nation's Federal initiatives on health manpower and nurse training for 3 years.

We will consider H.R. 2956, the Health Manpower Act of 1975, a bill identical to legislation that passed the House of Representatives last December; and H.R. 2957, the Nurse Training Act of 1975, which passed both bodies last year but was vetoed following adjournment; and all other related bills.

Because health manpower and nurse training legislation was not enacted last year despite considerable congressional activity, serious national issues remain unaddressed. These issues include the financial dependence of most health professions schools on direct Federal assistance, shortages of health professionals, acute specialty maldistribution within the medical profession, a widening geographic maldistribution of health professionals, particularly physicians, and the problems of quality and international equity which have arisen from the rapid influx of foreign medical graduates into this country within the past decade.

The problems that are a product of these issues—widely acknowledged by government, within academic institutions, and by practicing health professionals—will not be resolved without legislative direction. In my view, it is incumbent upon this committee to develop legislation that will address all of these issues.

Without objection, the text of H.R. 2956, H.R. 2957, H.R. 2958, H.R. 3279, and a list of all other identical and similar bills to be considered by the subcommittee will be printed at this point in the record.

[Testimony resumes on p. 308.]

[The bills and listing referred to follow:]

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94TH CONGRESS
1ST SESSION

H. R. 2956

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 6, 1975

Mr. ROGERS (for himself, Mr. PREYER, Mr. SYMINGTON, Mr. CARNEY, Mr. SCHEUER, Mr. WAXMAN, Mr. HEFNER, Mr. FLORIO, Mr. CARTER, Mr. HASTINGS, and Mr. HEINZ) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Public Health Service Act to revise and extend the programs of assistance under title VII for training in the health and allied health professions, to revise the National Health Service Corps program and the National Health Service Corps scholarship training program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as the "Health Manpower Act of 1975".

(b) Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a sec-

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tion or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

TITLE I—GENERAL PROVISIONS

SEC. 101. (a) Sections 701 through 711 are repealed.

(b) Sections 724, 725, 799, and 799A are transferred to part A of title VII and are redesignated as sections 701, 702, 703, and 704, respectively.

(c) Section 701 (as so redesignated) is amended—

(1) by striking out "As used in this part and parts C, E, and F—" and inserting in lieu thereof "For purposes of this title:";

(2) by inserting "or an equivalent degree" after "degree in public health" in paragraph (4); and

(3) by adding at the end the following new paragraphs:

"(7) The term 'program for the training of physician assistants' means an educational program which has as its objective the education of individuals who will, upon completion of their studies in the program, be qualified to effectively provide primary health care under the supervision of a physician and which meets guidelines prescribed by the Secretary. Such guidelines shall be prescribed on or before March 1, 1975, after consultation with appropriate professional organizations and

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shall, as a minimum, require that such an educational program (A) have (i) a program of classroom instruction and supervised clinical practice directed toward preparing students to deliver primary health care and (ii) a minimum course of study of one academic year, and (B) have an enrollment in each year of not less than twenty-five students.

"(8) The term 'program for the training of nurse practitioners' means an educational program which has as its objective the education of professional nurses who will, upon completion of their studies in the program, be qualified to effectively provide primary health care and which meets the guidelines prescribed by the Secretary. Such guidelines shall be prescribed on or before March 1, 1975, after consultation with appropriate professional organizations and shall, as a minimum, require that such an educational program (A) have (i) a program of classroom instruction and supervised clinical practice directed toward preparing nurses to deliver primary health care and (ii) a minimum course of study of one academic year, and (B) have an enrollment in each year of not less than twenty-five students.

"(9) The term 'program for the training of expanded function dental auxiliaries' means an educa-

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tional program which has as its objective the education of individuals who will, upon completion of their studies in the program, be qualified to effectively provide primary dental care under the supervision of a dentist and which meets guidelines prescribed by the Secretary. Such guidelines shall be prescribed on or before March 1, 1975, after consultation with appropriate professional organizations and shall, as a minimum, require that such an educational program (A) have (i) a program of classroom instruction and supervised clinical practice directed toward preparing students to deliver primary dental care and (ii) a minimum course of study of one academic year, and (B) have an enrollment in each year of not less than twenty-five students."

(d) (1) (A) The second sentence of subsection (a) of section 702 (as so redesignated) is amended to read as follows: "Of the appointed members of the Council (1) twelve shall be representatives of the health professions schools assisted under programs authorized by this title, including at least six persons experienced in university administration and at least one representative of schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, and public health, and entities which may receive a grant under section 791, (2) two shall be full-

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time students enrolled in health professions schools, and (3) six shall be members of the general public.".

(B) The amendment made by subparagraph (A) with respect to composition of the National Advisory Council on Health Professions Education shall apply with respect to appointments made to the Council after the date of the enactment of this Act, and the Secretary of Health, Education, and Welfare shall make appointments to the Council after such date in a manner which will bring about, at the earliest feasible time, the Council composition prescribed by the amendment.

(2) Section 702 (as so redesignated) is amended by striking out "E, and F" in subsection (a) and inserting in lieu thereof "E, F, and G".

(3) Section 702 (as so redesignated) is amended by striking out "parts A and G" in subsections (b) and (c) and inserting in lieu thereof "part II".

(c) Section 703 (as so redesignated) is amended to read as follows:

"ADVANCE FUNDING

"SEC. 703. An appropriation under an authorization of appropriations for grants or contracts under this title for any fiscal year may be made at any time before that fiscal year and may be included in an Act making an appropriation

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under such authorization for another fiscal year; but no funds may be made available from any appropriation under such authorization for obligation for such grants or contracts before the fiscal year for which such appropriation is authorized.".

(f) Part A of title VII is amended by adding after section 704 (as so redesignated) the following new sections:

"RECORDS AND AUDITS

"SEC. 705. (a) Each recipient of a grant or contract under this title shall keep such records as the Secretary may prescribe, including records which fully disclose the amount and disposition by such recipient of the funds paid to it under such grant or contract, the total cost of the project or undertaking for which such grant or contract is made, and the amount of the portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

"(b) Each recipient of a grant or contract under this title shall provide for an annual financial audit of any books, accounts, financial records, files, and other papers or property which relate to the disposition or use of the funds received under such grant or contract. For purposes of assuring accurate, current, and complete disclosure of the disposition or use of the funds received under such a grant or contract, each such audit shall be conducted in accordance with such requirements concerning the individual or agency which con-

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ducts the audit and the standards applicable to the performance of the audit as the Secretary may by regulation provide. The report of each such audit shall be filed with the Secretary at such time and in such manner as he may by regulation prescribe.

"(c) The recipient of a scholarship or traineeship under this title or a grant under subsection (f) or (g) of section 747 shall not with respect to the scholarship, traineeship, or grant be required to keep the records prescribed under subsection (a) or provide the audit prescribed by subsection (b).

"DELEGATION

"SEC. 706. The Secretary may delegate the authority to administer any program authorized by this title to the administrator of a central or regional office or offices in the Department of Health, Education, and Welfare, except that the authority—

"(1) to review, and prepare comments on the merit of, any application for a grant or contract under any such program for purposes of presenting such application to the National Advisory Council on Health Professions Education, and

"(2) to make such a grant or enter into such a contract,

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shall not be delegated to any administrator of, or officer in, a regional office or offices.".

(g) (1) The heading for part A of title VII is amended to read as follows:

"PART A—GENERAL PROVISIONS"

(2) The heading for part II of title VII is repealed.

SEC. 102. Section 212 is amended by adding after subsection (d) the following new subsection:

"(e) Active service of commissioned officers of the Service shall be deemed to be active military service in the Armed Forces of the United States for the purposes of all rights, privileges, immunities, and benefits now or hereafter provided under the Soldiers' and Sailors' Civil Relief Act of 1940 (50 App. U.S.C. 501 et seq.).".

TITLE II—ASSISTANCE FOR CONSTRUCTION OF TEACHING FACILITIES

SEC. 201. Section 720 is amended to read as follows:

"GRANT AUTHORITY; AUTHORIZATIONS OF APPROPRIATIONS

"SEC. 720. (a) The Secretary may make grants to assist in the construction of teaching facilities (including teaching hospitals) for the training of physicians, dentists, pharmacists, optometrists, podiatrists, veterinarians, and professional public health personnel.

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"(b) There are authorized to be appropriated $25,000,000 for fiscal year 1975, $25,000,000 for fiscal year 1976, and $25,000,000 for fiscal year 1977, for grants under this part.".

SEC. 202. (a) (1) Subsection (a) of section 722 is amended to read as follows:

"(a) The amount of any grant under this part for construction of a project shall be such amount as the Secretary determines to be appropriate after obtaining advice of the Council, except that no grant for any project may exceed 80 per centum of the necessary costs of construction, as determined by the Secretary of such project. In determining the portion of the construction costs to be covered by a grant under this part for a construction project for teaching facilities for the training of physicians located in a State which has no such facilities, the Secretary shall provide that the grant for the project cover 80 per centum of its construction costs unless he determines a grant for such portion of such costs is not needed.".

(2) The amendment made by paragraph (1) shall take effect with respect to grants made under part B of title VII of the Public Health Service Act from appropriations under section 720 of such Act for fiscal years beginning after June 30, 1974.

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(b) Subsection (d) of section 722 is amended by striking out "(within the meaning of part A of this title)".

(c) Subsection (e) of section 721 is amended by adding at the end the following new sentence: "In considering applications submitted for a grant under this part for the cost of construction of teaching facilities for the training of physicians, the Secretary shall give special consideration to projects in States which have no such facilities.".

SEC. 203. (a) Subsections (a) and (b) of section 729 are each amended by striking out "1974" and inserting in lieu thereof "1977".

(b) The second sentence of section 729 (e) is amended by striking out "and" after "June 30, 1973," and by striking out the period at the end thereof and inserting in lieu thereof a comma and the following: "$2,000,000 for fiscal year 1975, $3,000,000 for fiscal year 1976, and $3,000,000 for fiscal year 1977.", and the fourth sentence of such section is amended by inserting a period after "Treasury" the second time it appears in that sentence and by striking the remainder of that sentence.

(c) (1) The third sentence of section 729 (a) is amended to read as follows: "No such loan guarantee may, except under special circumstances and under such conditions as are prescribed by regulations, apply to any amount which, when added to any grant under this part or any other

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law of the United States, exceeds 90 per centum of the cost of the construction of the project.".

(2) The amendment made by paragraph (1) shall apply with respect to loans guaranteed under section 727 (a) of the Public Health Service Act (as redesignated by section 204 (b) of this Act) after the date of the enactment of this Act.

(d) Subsections (a) and (b) of section 729 are each amended by inserting "or the Federal Financing Bank" after "non-Federal lender".

SEC. 204. (a) Section 721 (c) is amended—

(1) by striking out "section 770 (f) of this Act" in paragraph (2) and inserting in lieu thereof "section 771";

(2) by striking out the sentence at the end of paragraph (2);

(3) by striking out paragraph (5) and redesignating paragraphs (6) and (7) as paragraphs (5) and (6), respectively;

(4) by striking out "and" at the end of paragraph (5) (as so redesignated), by striking out the period at the end of paragraph (6) (as so redesignated) and inserting in lieu thereof "; and", and by inserting after paragraph (6) the following:

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"(7) the application contains or is supported by adequate assurance that any laborer or mechanic employed by a contractor or subcontractors in the performance of work on the construction of the facility will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a–276a–5, known as the Davis-Bacon Act).

The Secretary of Labor shall have with respect to the labor standards specified in paragraph (7) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c)."; and

(5) by striking out "725" in the last sentence and inserting in lieu thereof "702".

(b) Sections 726, 727, 728, and 729 are redesignated as sections 724, 725, 726, and 727, respectively.

TITLE III—STUDENT ASSISTANCE; NATIONAL HEALTH SERVICE CORPS

SEC. 301. (a) Subsection (a) of section 740 is amended by striking out "or veterinary medicine" and inserting in lieu thereof "veterinary medicine, or public health".

(b) (1) Subsection (b) of section 740 is amended (A) by striking out "and" at the end of paragraph (4), (B) by

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redesignating paragraph (5) as paragraph (6), and (C) by inserting after paragraph (4) the following new paragraph:

"(5) provide that the school shall advise, in writing, each applicant for a loan from the student loan fund of the provisions of section 741 under which outstanding loans from the student loan fund may be paid (in whole or in part) by the Secretary; and".

(2) Paragraph (4) of such subsection (b) is amended by striking out "veterinary medicine or an equivalent degree," and inserting in lieu thereof "veterinary medicine or an equivalent degree or to a graduate degree in public health or an equivalent degree,".

(c) Subsection (a) of section 741 is amended to read as follows:

"(a) Loans from a student loan fund established under an agreement under section 740 may not exceed for any student for any academic year (or its equivalent) the sum of—

"(1) the cost of tuition for each year at the school for which such fund was established, and

"(2) $2,500."

(d) Subsection (b) of section 741 is amended by striking out the period at the end and inserting in lieu thereof "or to a graduate degree in public health or an equivalent degree.".

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(e) Subsection (c) of section 741 is amended by striking out "or veterinary medicine" and inserting in lieu thereof "veterinary medicine, or public health".

(f) (1) Subsection (c) of section 741 is amended by striking out "3 per centum" and inserting in lieu thereof "7 per centum".

(2) The amendment made by paragraph (1) shall apply with respect to loans made after the date of the enactment of this Act from student loan funds established under section 740 of the Public Health Service Act.

(g) Subsection (f) (1) of section 741 is amended—

(1) by inserting before the semicolon at the end of subparagraph (A) the following: "or a graduate degree in public health or an equivalent degree"; and

(2) by striking out "or podiatry" in subparagraph (B) and inserting in lieu thereof "podiatry, or public health".

(h) In the case of any individual who, on or after November 18, 1971, and before the date of the enactment of this Act, met the requirements of subparagraphs (A) and (B) of section 741 (f) (1) of the Public Health Service Act and who practiced his profession in an area described in subparagraph (C) of such section (as in effect before the date of the enactment of this Act) while a member of the National Health Service Corps or as an officer of the Regular or

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Reserve Corps of the Public Health Service or as a civilian employee of the Public Health Service, the individual shall, for purposes of section 741 (f) of such Act, be deemed to have entered into the agreement required by such subparagraph (C) with respect to that practice.

(i) Effective with respect to appropriations under section 742 of the Public Health Service Act for fiscal years beginning after June 30, 1975, subsection (a) of section 742 is amended to read as follows:

"(a) For the purpose of making Federal capital contributions into the student loan funds of schools which have established such funds under an agreement under section 740, there are authorized to be appropriated $30,000,000 for fiscal year 1976, and $30,000,000 for fiscal year 1977. For the fiscal year ending June 30, 1978, and each of the two succeeding fiscal years there are authorized to be appropriated such sums as may be necessary to enable students who have received a loan under this part for any academic year ending before July 1, 1977, to continue or complete their education."

(j) Section 743 is amended by striking out "1977" each place it occurs and inserting in lieu thereof "1980".

(k) (1) Section 744 is repealed.

(2) The health professions education fund created within the Treasury by section 744 (d) (1) of the Public Health

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Service Act shall remain available to the Secretary of Health, Education, and Welfare for the purpose of meeting his responsibilities respecting participations in obligations acquired under section 744 of such Act. The Secretary shall continue to deposit in such fund all amounts received by him as interest payments or repayments of principal on loans under such section 744. If at any time the Secretary determines the moneys in the fund exceed the present and any reasonable prospective future requirements of such fund, such excess may be transferred to the general fund of the Treasury.

(3) There are authorized to be appropriated without fiscal yar limitation such sums as may be necessary to enable the Secretary to make payments under agreements entered into under section 744(b) of the Public Health Service Act before the date of the enactment of this Act.

(4) Section 742(b) is amended (1) by striking out ", and for loans pursuant to section 744" in paragraph (1); and (2) by striking out "(whether as Federal capital contributions or as loans to schools under section 744)" in paragraph (3).

(l) (1) Section 746 is repealed.

(2) Section 740 is amended (A) by striking out "of Health, Education, and Welfare" in subsection (a); and

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(B) by striking out ", except as provided in section 746," in paragraphs (2) and (3) of subsection (b).

(3) Section 745 is redesignated as section 744.

(m) (1) The heading for part C of title VII is amended to read as follows:

"PART C—STUDENT ASSISTANCE".

(2) The heading for subpart I of part C of title VII is amended to read as follows:

"Subpart I—Student Loans".

SEC. 302. (a) Subparts I, II, and III of part F of title VII are repealed.

(b) The Secretary of Health, Education, and Welfare during the period beginning July 1, 1974, and ending September 30, 1977, may (1) make grants to public and nonprofit private schools of medicine, oseopathy, dentistry, veterinary medicine, optometry, podiatry, and pharmacy to enable such schools to continue making payments under scholarship awards to students who initially received such awards out of grants made to the schools under section 780 of the Public Health Service Act for fiscal years ending before July 1, 1974, and (2) makes scholarship grants under section 784 of such Act (as in effect before the date of the enactment of this Act) to individuals who initially received such grants before July 1, 1974.

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SEC. 303. Part C of title VII is amended by adding at the end of the following new subpart:

"Subpart III—Traineeships for Students in Schools of Public Health

"TRAINEESHIPS

"SEC. 751. (a) The Secretary may make grants to schools of public health for traineeships to train students enrolled in such schools.

"(b) (1) No grant for traineeships may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain such information, as the Secretary by regulation may prescribe. Traineeships under such a grant shall be awarded in accordance with such regulations as the Secretary shall prescribe. The amount of any such grant shall be determined by the Secretary and payments under such a grant may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

"(2) Traineeships awarded under grants made under subsection (a) shall provide for such stipends and allowances (including travel and subsistence expenses and dependency allowances) for the trainees as the Secretary may deem necessary.

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"(c) For the purposes of making payments under grants under subsection (a), there are authorized to be appropriated $6,000,000 for fiscal year 1975, $6,000,000 for fiscal year 1976, and $6,000,000 for fiscal year 1977.".

SEC. 304. (a) Section 329 is amended to read as follows:

"NATIONAL HEALTH SERVICE CORPS

"SEC. 329. (a) There is established, within the Service, the National Health Service Corps (hereinafter in this section referred to as the 'Corps') which shall consist of those officers of the Regular and Reserve Corps of the Service and such other personnel as the Secretary may designate and which shall be utilized by the Secretary under this section to improve the delivery of health services to medically underserved populations.

"(b) (1) The Secretary shall designate the medically underserved populations in the States. For purposes of this section, a medically underserved population is the population of an urban or rural area (which does not have to conform to the geographical boundaries of a political subdivision and which should be a rational area for the delivery of health services) which the Secretary determines has a critical health manpower shortage or a population group determined by the Secretary to have such a shortage; and the term 'State' includes Guam, American Samoa, and the Trust Ter-

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ritory of the Pacific Islands. In designating medically underserved populations, the Secretary shall take into account (A) the recommendations of the entities responsible for the development of the plans referred to in section 314(b) which cover all or any part of the areas in which populations under consideration for designation reside, and (B) in the case of any such area for which no such entity is responsible for developing such a plan, the recommendations of the agency of the State (or States) in which such area is located which administers or supervises the administration of a State plan approved under section 314(a).

"(2) Any person may apply to the Secretary (in such manner as he may prescribe) for the designation of a population as a medically underserved population. In considering an application under this paragraph, the Secretary shall, in addition to criteria utilized by him in making a designation under paragraph (1), take into account the following:

"(A) Ratios of available health manpower to the population for which the application is made.

"(B) Indicators of the population's access to health services.

"(C) Indicators of the health status of the population.

"(D) Indicators of such population's need and demand for health services.

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"(3) The Secretary shall (A) provide assistance to persons seeking assignment of Corps personnel to provide under this section health services for medically underserved populations, and (B) conduct such information programs in areas in which such populations reside as may be necessary to inform the public and private health entities serving those areas of the assistance available to such populations by virtue of their designation under this section as medically underserved.

"(c) (1) (A) The Secretary may assign personnel of the Corps to provide, under regulations prescribed by the Secretary, health services for a medically underserved population if—

"(i) the State health agency of each State in which such population is located or the local public health agency or any other public or nonprofit private health entity serving such population makes application to the Secretary for such assignment, and

"(ii) the

"(I) local government of the area in which such population resides, and

"(II) any State and district medical, osteopathic, or dental society for such area, or any other appropriate health society (as the case may be) for such area,

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certify to the Secretary that such assignment of Corps personnel is needed for such population.

"(B) The Secretary may not approve an application under paragraph (1) (A) (i) for an assignment unless the applicant agrees to enter into an arrangement with the Secretary in accordance with subsection (e) (1) and has afforded—

"(i) the entity responsible for the development of the plans referred to in section 314 (b) which covers all or any part of the area in which the population for which the application is submitted resides, and

"(ii) if there is a part of such area for which no such entity is responsible for developing such plans, the agency of the State in which such part is located which administers or supervises the administration of a State plan approved under section 314 (a),

an opportunity to review the application and submit its comments to the Secretary respecting the need for and proposed use of the manpower requested in the application. In considering such an application, the Secretary shall take into consideration the need of the population for which the application was submitted for the health services which may be provided under this section; the willingness of the population and the appropriate governmental agencies or health entities serving it to assist and cooperate with the

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Corps in providing effective health services to the population; and recommendations from medical, dental, or other health societies or from medical personnel serving the population.

"(C) If with respect to any proposed assignment of Corps personnel for a medically underserved population the requirements of clauses (i) and (ii) of subparagraph (A) are met except for the certification by a State and district medical, osteopathic, or dental society or by any other appropriate health society required by clause (ii) (II) and if the Secretary finds from all the facts presented that such certification has clearly been arbitrarily and capriciously withheld, the Secretary may, after consultation with appropriate medical, osteopathic, dental, or other health societies, waive the application of the certification requirement to such proposed assignment.

"(2) (A) In approving an application submitted under paragraph (1) for the assignment of Corps personnel to provide health services for a medically underserved population, the Secretary may approve the assignment of Corps personnel for such population during a period (referred to in this paragraph as the 'assistance period') which may not exceed four years from the date of the first assignment of Corps personnel for such population after the date of the approval of

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the application. No assignment of individual Corps personnel may be made for a period ending after the expiration of the applicable approved assistance period.

"(B) Upon expiration of an approved assistance period for a medically underserved population, no new assignment of Corps personnel may be made for such population unless an application is submitted in accordance with paragraph (1) for such assignment. The Secretary may not approve such an application unless—

"(i) the application and certification requirements of paragraph (1) are met;

"(ii) the Secretary has conducted an evaluation of the continued need for health manpower of the population for which the application is submitted, of the utilization of the manpower by such population, of the growth of the health care practice of the Corps personnel assigned for such population, and of community support for the assignment; and

"(iii) the Secretary has determined that such population has made continued efforts to secure its own health manpower, that there has been sound fiscal management of the health care practice of the Corps personnel assigned for such population, including efficient collection of fee-for-service, third-party, and other funds available to such population, and that there has

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been appropriate and efficient utilization of such Corps personnel.

"(3) Corps personnel shall be assigned to provide health services for a medically underserved population on the basis of the extent of the population's need for health services and without regard to the ability of the members of the population to pay for health services.

"(4) In making an assignment of Corps personnel the Secretary shall seek to match characteristics of the assignee (and his spouse (if any)) and of the population to which such assignee may be assigned in order to increase the likelihood of the assignee remaining to serve the population upon completion of his assignment period. The Secretary shall, before the expiration of the last nine months of the assignment period of a member of the Corps, review such member's assignment and the situation in the area to which he was assigned for the purpose of determining the advisabilty of extending the period of such member's assignment.

"(5) To assist in the recruitment of health manpower, the Secretary shall provide technical assistance to all medically underserved populations to which are not assigned Corps personnel. The Secretary shall also give such populations current information respecting public and private programs which may assist in securing health manpower for them.

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"(d) (1) In providing health services for a medically underserved population under this section, Corps personnel shall utilize the techniques, facilities, and organizational forms most appropriate for the area in which the population resides and shall, to the maximum extent feasible, provide such services (A) to all members of the population regardless of their ability to pay for the services, and (B) in connection with (i) direct health services programs carried out by the Service; (ii) any direct health services program carried out in whole or in part with Federal financial assistance; or (iii) any other health services activity which is in furtherance of the purposes of this section.

"(2) (A) Notwithstanding any other provision of law, the Secretary (i) may, to the extent feasible, make such arrangements as he determines necessary to enable Corps personnel in providing health services for a medically underserved population to utilize the health facilities of the area in which the population resides and if there are no health facilities in or serving such area, the Secretary may arrange to have Corps personnel provide health services in the nearest health facilities of the Service or the Secretary may lease or otherwise provide facilities in such area for the provision of health services, (ii) may make such arrangements as he determines are necessary for the use of equipment and supplies of the Service and for the lease or acqui-

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sition of other equipment and supplies, and (iii) may secure the temporary services of nurses and allied health professionals.

"(B) If such area is being served (as determined under regulations of the Secretary) by a hospital or other health care delivery facility of the Service, the Secretary shall, in addition to such other arrangements as the Secretary may make under subparagraph (A), arrange for the utilization of such hospital or facility by Corps personnel in providing health services for the population, but only to the extent that such utilization will not impair the delivery of health services and treatment through such hospital or facility to persons who are entitled to health services and treatment through such hospital or facility.

"(3) The Secretary may make one grant to any applicant with an approved application under subsection (c) to assist it in meeting the costs of establishing medical practice management systems for Corps personnel, acquiring equipment for their use in providing health services, and establishing appropriate continuing education programs and opportunities for them. No grant may be made under this paragraph unless an application therefor is submitted to, and approved by, the Secretary. The amount of any grant shall be determined by the Secretary, except that no grant may be made for more than $25,000.

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"(4) Upon the expiration of the assignment of Corps personnel to provide health services for a medically underserved population, the Secretary (notwithstanding any other provision of law) may sell to the entity which submitted the last application approved under subsection (c) for the assignment of Corps personnel for such population equipment of the United States utilized by such personnel in providing health services. Sales made under this paragraph shall be made for the fair market value of the equipment sold (as determined by the Secretary).

"(e) (1) The Secretary shall require as a condition to the approval of an application under subsection (c) that the entity which submitted the application enter into an appropriate arrangement with the Secretary under which—

"(A) the entity shall be responsible for charging in accordance with paragraph (2) for health services by the Corps personnel to be assigned;

"(B) the entity shall take such action as may be reasonable for the collection of payments for such health services, including if a Federal agency, an agency of a State or local government, or other third party would be responsible for all or part of the cost of such health services if it had not been provided by Corps personnel under this section, the collection, on a fee-for-service or other basis, from such agency or third party the portion.

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of such cost for which it would be so responsible (and in determining the amount of such cost which such agency or third party would be responsible, the health services provided by Corps personnel shall be considered as being provided by private practitioners); and

"(C) the entity shall pay to the United States as prescribed by the Secretary for each calendar quarter (or other period as may be specified in the arrangement) during which any Corps personnel are assigned to such entity the sum of—

"(i) the pay (including amounts paid in accordance with subsection (f)) and allowances of such Corps personnel for the portion of such quarter (or other period) during which assigned to the entity;

"(ii) if such entity received a grant under subsection (d)(3) for the assistance period, an amount which bears the same ratio to the amount of such grant as the number of days in such quarter (or other period) during which any Corps personnel were assigned to the entity bears to the number of days in the assistance period after such entity received such grant; and

"(iii) if during such quarter (or other period) any member of the Corps assigned to such entity is

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providing obligated service pursuant to an agreement under the Public Health and National Health Service Corps Scholarship Training Program, for each such member an amount which bears the same ratio to the amount paid under such Program to or on the behalf of such member as the number of days of obligated service provided by such member during such quarter (or other period) bears to the number of days in his period of obligated service under such Program.

The Secretary may waive in whole or in part the application of the requirement of subparagraph (C) to an entity if he determines that the entity is financially unable to meet such requirement or if he determines that compliance with such requirement would unduly limit the ability of the entity to maintain the quality of the services it provides. The excess (if any) of the amount collected by an entity in accordance with subparagraph (B) over the amount paid to the United States in accordance with subparagraph (C) shall be used by the entity to expand or improve the provision of health services to the population for which the entity submitted an application under subsection (c) or to recruit and retain health manpower to provide health services for such population. Funds received by the Secretary under such an arrangement shall be deposited in the Treasury as miscellaneous re-

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ceipts and shall be disregarded in determining the amounts of appropriations to be requested under subsection (i) and the amounts to be made available from appropriations made under such subsection to carry out this section.

"(2) Any person who receives health services provided by Corps personnel under this section shall be charged for such services on a fee-for-service or other basis at a rate approved by the Secretary, pursuant to regulations, to recover the value of such services; except that if such person is determined under regulations of the Secretary to be unable to pay such charge, the Secretary shall provide for the furnishing of such services at a reduced rate or without charge.

"(f) (1) The secretary shall conduct at medical and nursing schools and other schools of the health professions and at entities which train allied health personnel, recruiting programs for the Corps. Such programs shall include the wide dissemination of written information on the Corps and visits to such schools by personnel of the Corps.

"(2) The Secretary may reimburse applicants for positions in the Corps for actual expenses incurred in traveling to and from their place of residence to an area in which they would be assigned for the purpose of evaluating such area with regard to being assigned in such area. The Secretary shall not reimburse an applicant for more than one such trip.

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"(3) Commissioned officers and other personnel of the Corps assigned to provide health services for medically underserved populations shall not be included in determining whether any limitation on the number of personnel which may be employed by the Department of Health, Education, and Welfare has been exceeded.

"(4) The Secretary shall, under regulations prescribed by him, adjust the monthly pay of each physician and dentist member of the Corps who is directly engaged in the delivery of health services to a medically underserved population as follows:

"(A) During the first thirty-six months in which such a member is so engaged in the delivery of health services, his monthly pay shall be increased by an amount (not to exceed $1,000) which when added to the member's monthly pay and allowance will provide a monthly income competitive with the average monthly income from an established practice of a member of such member's profession with equivalent training.

"(B) During the period beginning upon the expi-

"(B) During the period beginning upon the expi-ration of the thirty-six months referred to in subparagraph (A) and ending with the month in which the member's monthly pay and allowances is equal to or exceeds the monthly income he received for the last

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of such thirty-six months, the member shall receive in addition to his monthly pay and allowances an amount which when added to such monthly pay and allowances equals the monthly income he received for such last month.

For purposes of subparagraphs (A) and (B), the term 'monthly pay' includes special pay received under chapter 5 of title 37 of the United States Code. In the case of a member of the Corps who is directly engaged in the provision of health services to a medically underserved population in accordance with a service obligation incurred under the Public Health Service and National Health Service Corps Scholarship Training Program, the provisions of this paragraph shall apply to such member upon satisfactory completion of such service obligation and the first thirty-six months of his being so engaged in the delivery of health care shall, for purposes of this paragraph, be deemed to begin upon such satisfactory completion.

"(g) The Secretary shall report to Congress no later than May 15 of each year—

"(1) the number and identity of all medically underserved populations in each of the States in the calendar year preceding the year in which the report is made and the number of medically underserved popu-

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lations which the Secretary estimates will be designated under subsection (b) in the calendar year in which the report is made;

"(2) the number of applications filed in such preceding calendar year for assignment of Corps personnel under this section and the action taken on each such application;

"(3) the number and types of Corps personnel assigned in such preceding year to provide health services for medically underserved populations, the number and types of additional Corps personnel which the Secretary estimates will be assigned to provide such services in the calendar year in which the report is submitted, and the need (if any) for additional personnel for the Corps;

"(4) the recruitment efforts engaged in for the Corps in such preceding year, including the programs carried out under subsection (f) (1) and the number of qualified persons who applied for service in the Corps in each professional category;

"(5) the total number of patients seen and patient visits recorded during such preceding year in each area where Corps personnel were assigned;

"(6) the number of health personnel electing to remain after termination of their service in the Corps to

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provide health services to medically underserved populations and the number of such personnel who do not make such election and the reasons for their departure;

"(7) the results of evaluations made under subsection (c) (2) (B) (ii), and determinations made under subsection (c) (2) (B) (iii), during such preceding year; and

"(8) the amount (A) charged during such preceding year for health services by Corps personnel, (B) collected in such year by entities in accordance with arrangements under subsection (e) (1), and (C) paid to the Secretary in such year under such arrangements.

"(h) (1) There is established a council to be known as the National Advisory Council on the National Health Service Corps (hereinafter in this section referred to as the 'Council'). The Council shall be composed of fifteen members appointed by the Secretary as follows:

"(A) Four members shall be appointed from the general public to represent the consumers of health care, at least two of whom shall be members of a medically underserved population for which Corps personnel are providing health services under this section.

"(B) Three members shall be appointed from the medical, dental, and other health professions and health teaching professions.

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"(C) Three members shall be appointed from State health or health planning agencies.

"(D) Three members shall be appointed from the Service, at least two of whom shall be members of the Corps directly engaged in the provision of health services for a medically underserved population.

"(E) One member shall be appointed from the National Advisory Council on Comprehensive Health Planning.

"(F) One member shall be appointed from the National Advisory Council on Regional Medical Programs.

The Council shall consult with, advise, and make recommendations to, the Secretary with respect to his responsibilities in carrying out this section, and shall review and comment upon regulations promulgated by the Secretary under this section and section 747.

"(2) Members of the Council shall be appointed for a term of three years and shall not be removed, except for cause. Members may be reappointed to the Council.

"(3) Appointed members of the Council, while attending meetings or conferences thereof or otherwise serving on the business of the Council, shall be entitled to receive for each day (including traveltime) in which they are so serving the daily equivalent of the annual rate of basic pay

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in effect for grade GS–18 of the General Schedule, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 (b) of title 5 of the United States Code for persons in the Government service employed intermittently.

"(i) (1) To carry out the purposes of this section, there are authorized to be appropriated $25,000,000 for fiscal year ending 1975; $36,000,000 for fiscal year 1976; and $45,000,000 for fiscal year 1977.

"(2) An appropriation under an authorization under paragraph (1) of his subsection for any fiscal year may be made at any time before that fiscal year and may be included in an Act making an appropriation under an authorization under paragraph (1) for another fiscal year; but no funds may be made available from any appropriation under such authorization for obligation under this section before the fiscal year for which such appropriation is authorized.".

(b) (1) The Secretary of Health, Education, and Welfare shall report to Congress (1) not later than three months after the date of the enactment of this Act, the criteria used by him in designating medically underserved populations for purposes of section 329 of the Public Health Service Act, and (2) not later than six months after the date of the enactment

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of this Act, the identity and number of medically underserved populations in each State meeting such criteria.

(2) The Secretary of Health, Education, and Welfare shall conduct or contract for studies of methods of assigning under section 329 of the Public Health Service Act National Health Service Corps personnel to medically underserved populations and of providing health care to such populations. Such studies shall be for the purpose of identifying (A) the characteristics of health manpower who are more likely to remain in practice in areas in which medically underserved populations are located, (B) the characteristics of areas which have been able to retain health manpower, (C) the appropriate conditions for assignment of nurse practitioners, physician's assistants, and expanded function dental auxiliaries in areas in which medically underserved populations are located, and (D) the effect that primary care residency training in such areas has on the health care provided in such areas and on the decisions of physicians who received such training respecting the areas in which to locate their practice.

(c) (1) The amendment made by subsection (a) which changed the name of the advisory council established under section 329 of the Publci Health Service Act shall not be construed as requiring the establishment of a new advisory council under that section; and the amendment made by such subsection with respect to the composition of such

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advisory council shall apply with respect to appointments made to the advisory council after the date of enactment of this Act, and the Secretary of Health, Education, and Welfare shall make appointments to the Advisory Council after such date in a manner which will bring about, at the earliest feasible time, the Advisory Council composition prescribed by the amendment.

(2) (A) Section 741 (f) (1) (C) is amended by striking all that follows after "in a State" and inserting in lieu thereof "in which is located a medically underserved population designated under section 329 (b) ;".

(B) The amendment made by subparagraph (A) shall apply with respect to agreements entered into under section 741 (f) of the Public Health Service Act after the date of the enactment of this Act.

SEC. 305. (a) Section 747 is repealed and effective July 1, 1975, section 225 is transferred to subpart II of part C of title VII, is redesignated section 747, and is amended to read as follows:

"PUBLIC HEALTH AND NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP TRAINING PROGRAM

"SEC. 747. (a) The Secretary shall establish the Public Health and National Health Service Corps Scholarship Training Program (hereinafter in this section referred to as the 'Program') to obtain trained physicians, dentists, and

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nurses and, if needed by the Corps or other unit of the Service, podiatrists, optometrists, pharmacists, graduates of schools of public health, graduates of programs in health administration, and other health-related specialists.

"(b) To be eligible for acceptance in the Program, an applicant for the Program must—

"(1) be accepted for enrollment, or be enrolled, as a full-time student (A) in an accredited (as determined by the Secretary) educational institution in a State and (B) in (i) a course of study offered by such institution and approved by the Secretary which leads to a degree in medicine, osteopathy, dentistry, nursing, or other health-related specialty as determined by the Secretary or (ii) a program offered by such institution for the training of physician assistants, expanded function dental auxiliaries, or nurse practitioners;

"(2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Service; and

"(3) agree in writing to serve, as prescribed by subsection (d) of this section, in the Commissioned Corps of the Service or as a civilian member of the Service.

To remain in the Program an individual must pursue at such

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an institution such an approved course of study or such a program and maintain an acceptable level of academic standing in it.

"(c) (1) (A) Each participant in the Program shall receive a scholarship for each approved academic year of training, not to exceed four years. A participant's scholarship shall consist of (i) an amount equal to the basic pay and allowances of a commissioned officer on active duty in pay grade O–1 with less than two years of service, and (ii) payment of the tuition expenses of the participant and all other reasonable educational expenses incurred by the participant, including fees, books, and laboratory expenses.

"(B) The Secretary may contract with an institution in which participants in the Program are enrolled for the payment to the institution of the tuition and other educational expenses of such participants. Payment to such insitution may be made without regard to section 3648 of the Revised Statutes (31 U.S.C. 529).

"(2) When the Secretary determines that an institution has increased its total enrollment for the sole purpose of accepting members of the Program, he may provide under a contract with such an institution for additional payments to the institution to cover the portion of the increased costs of the additional enrollment which are not covered by the institution's normal tuition and fees.

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"(d) (1) Each participant in the Program shall provide service as prescribed by paragraph (2) for a period of time (hereinafter in this section referred to as a 'period of obligated service') prescribed by the Secretary which may be not less than—

"(A) one year of such service for each academic year of training received under the Program, or

"(B) two years.

For persons receiving a degree from a school of medicine, osteopathy, or dentistry, the commencement of a period of obligated service shall be deferred by the Secretary, at the request of the participant, for the period of time required to complete internship, residency, or other advanced clinical training. For persons receiving degrees in other health professions the obligated service period shall commence upon completion of their academic training. Periods of internship, residency, or other advanced clinical training shall not be creditable in satisfying a service obligation under this subsection.

"(2) (A) Except as provided in subparagraphs (B), (C), and (D), an individual obligated to provide service on account of his participation in the Program shall provide such service for the period of obligated service applicable to him as a member of the National Health Service Corps or

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the Indian Health Service in the clinical practice of his profession.

"(B) If at the time an individual is required by the Secretary to begin his period of obligated service neither the National Health Service Corps nor the Indian Health Service has a position available for a member of the profession for which such individual was trained, such individual shall serve as a member of the Service in the clinical practice of his profession in connection with the delivery of health services under the authority of section 321 (relating to hospitals), 322 (relating to care and treatment of seamen and others), 323 (relating to care and treatment of Federal prisoners), 324 (relating to examination and treatment of certain Federal employees), 325 (relating to examination of aliens), or 326 (relating to services to certain Federal employees) or part D of title III (relating to services for persons with Hansen's disease).

"(C) If at the time an individual is required by the Secretary to begin his period of obligated service—

"(i) the Corps and the Indian Health Service have no positions available for a member of the profession for which such individual was trained, and

"(ii) the Service has no need for such individual in

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connection with the delivery of health services under the authorities referred to in subparagraph (B),

such individual shall serve in the clinical practice of his profession for such period in a medical facility of a State correctional facility, State mental hospital, community mental health center, migrant health center, community health center, or other medical entity designated by the Secretary as having a priority need for health personnel.

"(D) If at the time an individual is required by the Secretary to begin his period of obligated service—

"(i) the Corps and the Indian Health Service have no positions available for a member of the profession for which such individual was trained,

"(ii) the Service has no need for such individual in connection with the delivery of health services under the authorities referred to in subparagraph (B), and

"(iii) no entity designated under subparagraph (C) has positions available for a member of the profession for which such individual was trained,

such individual shall serve for such period as a member of the Public Health Service in such unit of the Department as the Secretary may prescribe.

"(e) If, for any reason, a person fails to either begin his service obligation under this section in accordance with subsection (d) or to complete such service obligation, the

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United States shall be entitled to recover from such individual an amount determined in accordance with the formula

$$A = 2\phi\left(\frac{t-s}{t}\right)$$

in which 'A' is the amount the United States is entitled to recover, 'ϕ' is the sum of the amount paid under this section to or on behalf of such person and the interest on such amount which would be payable if at the time it was paid it was a loan bearing interest at the maximum legal prevailing rate; 't' is the total number of months in such person's service obligation; and 's' is the number of months of such obligation served by him in accordance with subsection (d). Any amount which the United States is entitled to recover under this subsection shall, within the three-year period beginning on the date the United States becomes entitled to recover such amount, be paid to the United States.

"(f) (1) (A) The Secretary shall release any participant in the Program from his service obligation under subsection (d) if such participant enters into a written agreement with the Secretary to engage on a full-time basis in the private practice of his profession—

"(i) in an area in a State in which is located a medically underserved population designated under section 329 (b) ; and

"(ii) for a period of—

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"(I) one year for each academic year of training received under the Program, or

"(II) two years,

whichever is greater.

"(B) An agreement described in subparagraph (A) shall—

"(i) provide that during the period of private practice by a participant pursuant to the agreement—

"(I) any individual who receives health services provided by the participant in connection with such private practice will be charged for such services at the usual and customary rate prevailing in the area in which such services are provided, except that if such individual is unable to pay such charge (as determined in accordance with regulations prescribed by the Secretary) such individual shall be charged at a reduced rate or not charged any fee; and

"(II) the participant in providing health services in connection with such private practice shall not discriminate against any individual on the basis of such individual's ability to pay for such services or because payment for the health services provided to such individual will be made under the insurance program established under part A or B of title

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XVIII of the Social Security Act or under a State plan for medical assistance approved under title XIX of such Act; and

"(ii) contain such additional provisions as the Secretary may require to carry out the purposes of this subsection.

"(2) (A) The Secretary may make one grant to any participant—

"(i) who has entered into an agreement under paragraph (1), and

"(ii) who has agreed to extend the period of practice under such agreement by a period of not less than one year,

to assist such participant in meeting the costs of beginning the practice of his profession in accordance with such agreement, including the costs of acquiring equipment and renovating facilities for use in providing health services, and of hiring nurses and other personnel to assist in providing health services. No such grant may be used for the purchase or construction of any health care facility.

"(B) The amount of the grant to any participant under subparagraph (A) shall be—

"(i) $12,500, if such participant agrees to extend the period of practice under the agreement under para-

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graph (1) for a period of at least one year but less than two years; or

"(ii) $25,000, if such participant agrees to extend the period of practice under the agreement under paragraph (1) for a period of at least two years.

"(3) The Secretary may not enter into any agreement under paragraph (1) or make any grant under paragraph (2) unless an application therefor has been submitted to, and approved by, the Secretary.

"(4) (A) The Secretary shall pay, as soon as practicable after the close of each calendar quarter, to each participant who entered into an agreement under paragraph (1) an amount which is equal to the excess (if any) of—

"(i) the amount of basic pay and allowances which such participant would have received for the period—

"(I) in which he practiced his profession in accordance with the agreement under paragraph (1), and

"(II) which is in the calendar year in which such calendar quarter occurs and ends at the close of such calendar quarter,

(which period is hereafter in this paragraph referred to as the 'service period') if during his service period he was a commissioned member of the National Health

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Service Corps providing service during a period of obligated service under subsection (d), over

"(ii) the sum of the net income (as determined under regulations prescribed by the Secretary) derived by such participant during his service period from the private practice of his profession and the amount (if any) paid before the close of such calendar quarter to such participant under this paragraph with respect to the portion of his service period which ended at the close of the preceding calendar quarter.

"(B) If after the close of any calendar year—

"(i) the amount described in subparagraph (A) (ii) which was received by the participant for the period in such year in which he practiced his profession in accordance with an agreement under paragraph (1), exceeds

"(ii) the amount of basic pay and allowances which the participant would have received for such period if during such period he was a commissioned member of the National Health Service Corps providing service during a period of obligated service under subsection (d),

the Secretary shall be entitled to recover from the participant an amount equal to the lesser of the amount of such excess or the amount paid to the participant under subparagraph

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(A) for the period in such year in which he practiced his profession in accordance with an agreement under paragraph (1).

"(C) The Secretary may not make any payment to any participant under subparagraph (A) unless—

"(i) an application therefor has been submitted to the Secretary in such manner and containing such information as he shall by regulation prescribe; and

"(ii) such participant keeps such records as the Secretary may prescribe and makes such records available to the Secretary for any examination he may require.

"(g) (1) The Secretary may make one grant to any individual (other than an individual who entered into an agreement under subsection (f) (1))—

"(A) who has completed his period of obligated service under the Program, and

"(B) who has agreed in writing to engage on a full-time basis in the private practice of his profession in accordance with subsection (f) (1) for the period of not less than one year,

to assist such individual in meeting the costs of beginning the practice of his profession in accordance with such agreement, including the costs of acquiring equipment and renovating facilities for use in providing health services, and of hiring

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nurses and other personnel to assist in providing health services. Such grant may not be used for the purchase or construction of any health care facility.

"(2) The amount of the grant under paragraph (1) to any individual shall be—

"(A) $12,500, if such participant agrees to practice his profession in accordance with subsection (f) (1) for a period of at least one year but less than two years; or

"(B) $25,000, if such participant agrees to practice his profession in accordance with subsection (f) (1) for a period of at least two years.

"(3) The Secretary may not make a grant under paragraph (1) unless an application therefor has been submitted to, and approved by, the Secretary.

"(h) If the Secretary determines that an individual has violated an agreement under subsection (f) (1) or (g) (1) (B), he shall, as soon as practicable after making such determination notify the individual of such determination. If within one hundred and twenty days after the date of giving such notice, such individual is not practicing his profession in accordance with the agreement under subsection (f) (1) or (g) (1) (B), as the case may be, and has not provided assurances satisfactory to the Secretary that he will not knowingly violate such agreement again, the United States shall be entitled to recover from such individual an

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amount determined under subsection (e), except that in applying the formula contained in such subsection—

"(1) in the case of an agreement under subsection (f) (1), 'ϕ' shall be the sum of the amount paid under this section (other than any amount paid under subsection (f) (4)) to or on behalf of such person and the interest on such amount which would be payable if at the time it was paid it was a loan bearing interest at the maximum legal prevailing rate, 't' shall be the number of months that such individual agreed to practice his profession under such agreement, including the number of months that the period of practice under such agreement was extended under subsection (f) (2) (A), and 's' shall be the number of months that such individual practiced his profession in accordance with such agreement; or

"(2) in the case of an agreement under subsection (g) (1) (B), 'ϕ' shall be the sum of the amount of the grant made under subsection (g) to such person and the interest on such amount which would be payable if at the time it was paid it was a loan bearing interest at the maximum legal prevailing rate, 't' shall be the number of months that such individual agreed to practice his profession under such agreement, and 's' shall

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be the number of months that such individual practiced his profession in accordance with such agreement.

"(i) (1) When a person undergoing training in the Program is academically dismissed or voluntarily terminates academic training, he shall be liable for repayment to the Government for an amount equal to the scholarship which he received under the Program.

"(2) (A) Any obligation of any individual under paragraph (1) or under subsection (e) or (h) shall be canceled upon the death of such individual.

"(B) The Secretary shall by regulation provide for the waiver or suspension of any obligation under paragraph (1) or under subsection (e) or (h) applicable to any individual whenever compliance by such individual is impossible or would involve extreme hardship to such individual and if enforcement of such obligation with respect to any individual would be against equity and good conscience.

"(j) Notwithstanding any other provision of law, persons undergoing academic training under the Program shall not be counted against any employment ceiling affecting the Department of Health, Education, and Welfare.

"(k) The Secretary shall issue regulations for the implementation of this section.

"(l) To carry out the Program, there are authorized to

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be appropriated $80,000,000 for fiscal year 1976, and $120,000,000 for fiscal year 1977.".

(b) Effective July 1, 1975, the heading for subpart II of part C of title VII is amended to read as follows:

"Subpart II—Student Scholarships".

TITLE IV—GRANTS FOR HEALTH PROFESSIONS SCHOOLS

SEC. 401. (a) Subsection (a) of section 770 is amended to read as follows:

"(a) GRANT COMPUTATION.—The Secretary shall make annual grants to schools of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, and podiatry for the support of the education programs of such schools. The amount of the annual grant to each such school with an approved application shall be computed for each fiscal year as follows:

"(1) Each school of medicine and osteopathy shall receive—

"(A) $2,100 for each full-time student enrolled in such school in such year; and

"(B) $650 for each student who is enrolled in such year on a full-time basis in such school in a program for the training of physician assistants (as defined by section 701 (7)).

"(2) Each school of dentistry shall receive—

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"(A) $2,100 for each full-time student enrolled in such school in such year; and

"(B) $650 for each student who is enrolled in such year on a full-time basis in such school in a program for the training of expanded function dental auxiliaries (as defined by section 701(9)).

"(3) Each school of public health shall receive $1,500 for each full-time student enrolled in such school in such year.

"(4) Each school of veterinary medicine shall receive $1,500 for each full-time student enrolled in such school in such year.

"(5) Each school of optometry shall receive $700 for each full-time student enrolled in such school in such year.

"(6) Each school of pharmacy (other than a school of pharmacy with a course of study of more than four years) shall receive $700 for each full-time student enrolled in such school in such year. Each school of pharmacy with a course of study of more than four years shall receive $700 for each full-time student enrolled in the last four years of such school. For purposes of sections 771, 772, and 782, a student enrolled in the first year of the last four years of such school shall be considered a first-year student.

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"(7) Each school of podiatry shall receive $1,500 for each full-time student enrolled in such school in such year.".

(b) Subsection (c) of section 770 is amended to read as follows:

"(c) APPORTIONMENT OF APPROPRIATIONS.—If the total of the grants to be made in accordance with subsections (a) and (b) for any fiscal year to schools of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, or podiatry with approved applications exceed the amounts appropriated under subsection (f) for such grants, the amount of the grant for that fiscal year to a school which may not because of such excess receive for that fiscal year the amount determined for it under such subsections shall be an amount which bears the same ratio to the amount so determined for it as the total of the amounts appropriated for that year under subsection (f) for grants to such schools bears to the amount required to make grants in accordance with subsections (a) and (b) to such schools.".

(c) (1) Subsections (d), (e), (f), and (g) of section 770 are repealed.

(2) Subsection (h) of section 770 is (A) redesignated as subsection (d), and (B) is amended to read as follows:

"(d) ENROLLMENT DETERMINATIONS.—

"(1) For purposes of this section and sections 771

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and 772, regulations of the Secretary shall include provisions relating to the determination of the number of students enrolled in a school or in a particular year-class in a school on the basis of estimates, on the basis of the number of students who in an earlier year were enrolled in a school or in a particular year-class, or on such other basis as he deems appropriate for making such determination, and shall include methods of making such determination when a school or a year-class was not in existence in an earlier year at a school.

"(2) For purposes of this section and sections 771, 772, and 782 the term 'full-time students' (whether such term is used by itself or in connection with a particular year-class) means students pursuing a full-time course of study leading to a degree of doctor of medicine, doctor of dentistry or an equivalent degree, doctor of osteopathy, bachelor of science in pharmacy or an equivalent degree, doctor of optometry or an equivalent degree, doctor of veterinary medicine or an equivalent degree, or doctor of podiatry or an equivalent degree or to a graduate degree in public health or equivalent degree. In the case of a training program of a school designed to permit the students enrolled in such program to complete, within six years after completing secondary school, the requirements for degree of doctor of medicine, doctor

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of dentistry or an equivalent degree, or doctor of osteopathy, the term 'full-time students' shall only include students enrolled on a full-time basis in the last four years of such program and for purposes of sections 771, 772, and 782, students enrolled in the first of the last four years of such program shall be considered as first-year students.".

(3) Subsection (i) of section 770 is (1) amended by inserting ", public health" after "osteopathy", and (2) redesignated as subsection (e).

(4) Subsection (j) of section 770 is redesignated as subsection (f) and is amended to read as follows:

"(f) AUTHORIZATIONS OF APPROPRIATIONS.—

"(1) (A) There are authorized to be appropriated $165,000,000 for fiscal year 1975, $170,000,000 for fiscal year 1976, and $167,000,000 for fiscal year 1977, for payments under grants under this section to schools of medicine, osteopathy, and dentistry based on the number of full-time students enrolled in such schools.

"(B) There are authorized to be appropriated $3,500,000 for fiscal year 1975, $4,000,000 for fiscal year 1976, and $4,500,000 for fiscal year 1977, for payments under grants under this section to schools of medicine, osteopathy, and dentistry based on the number of students enrolled in such schools in programs for the

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training of physician assistants and programs for the training of expanded function dental auxiliaries.

"(2) There are authorized to be appropriated $6,000,000 for fiscal year 1975, $6,750,000 for fiscal year 1976, and $7,500,000 for fiscal year 1977, for payments under grants under this section to schools of public health.

"(3) There are authorized to be appropriated $9,250,000 for fiscal year 1975, $9,750,000 for fiscal year 1976, and $10,500,000 for fiscal year 1977, for payments under grants under this section to schools of veterinary medicine.

"(4) There are authorized to be appropriated $21,700,000 for fiscal year 1975, $22,600,000 for fiscal year 1976, and $23,500,000 for fiscal year 1977, for payments under grants under this section to schools of optometry and pharmacy.

"(5) There are authorized to be appropriated $2,800,000 for fiscal year 1975, $3,100,000 for fiscal year 1976, and $3,200,000 for fiscal year 1977, for payments under grants under this section to schools of podiatry.

"(6) No funds appropriated under any provision of this Act (other than this subsection) may be used to make grants under this section."

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(d) For the fiscal year ending June 30, 1975, and for each of the next two fiscal years, there are authorized to be appropriated such sums as may be necessary to continue to make annual grants to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, and podiatry under section 770(a) of the Public Health Service Act (as in effect before the date of the enactment of this Act) based on the number of enrollment bonus students (determined in accordance with subsections (d) and (e) of section 770 of such Act (as so in effect)) enrolled in such schools who were first-year students in such schools for school years beginning before June 30, 1974, except that the amount of any grant made to such a school from sums appropriated under this subsection may not exceed the amount of the grant the school received in the fiscal year ending June 30, 1974, based on the number of such students enrolled in it.

(e) Effective with respect to fiscal years beginning after June 30, 1976, paragraphs (1)(A) and (2)(A) of section 770(a) are each amended by striking out "$2,100" and inserting in lieu thereof "$2,000".

(f) The heading for part E of title VII is amended to read as follows:

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"PART E—GRANTS AND CONTRACTS TO IMPROVE THE QUALITY OF SCHOOLS OF MEDICINE, OSTEOPATHY, PUBLIC HEALTH, DENTISTRY, VETERINARY MEDICINE, OPTOMETRY, PHARMACY, AND PODIATRY".

SEC. 402. Part E of title VII is amended (1) by redesignating section 771 as section 772, and (2) by adding after section 770 the following new section:

"ELIGIBILITY FOR CAPITATION GRANTS

"SEC. 771. (a) IN GENERAL.—The Secretary shall not make a grant under section 770 to any school in a fiscal year beginning after June 30, 1974, unless the application meets the following requirements:

"(1) The application shall contain or be supported by reasonable assurances satisfactory to the Secretary that the first-year enrollment of full-time students in the school in the school year beginning after the fiscal year in which the grant applied for is to be made will not be less than the first-year enrollment of such students in the school in the preceding school year.

"(2) The application of each school shall contain or be supported by reasonable assurances satisfactory to the Secretary that the applicant will expend in carrying out its functions as a school of medicine, osteopathy,

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dentistry, public health veterinary medicine, optometry, pharmacy, or podiatry, as the case may be, during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the amount of funds expended by such applicant for such purpose (excluding expenditures of a nonrecurring nature) in the fiscal year preceding the fiscal year for which such grant is sought.

"(3) (A) The application of each school shall contain or be supported by reasonable assurances satisfactory to the Secretary that the school (i) will enter into a legally enforceable agreement with each student enrolled in the school in a school year beginning after June 30, 1976, under which the student agrees to pay, in equal annual installments in accordance with subparagraph (B), to the United States an amount equal to the amount which the school received under section 770 because of the enrollment of the student in the school in school years beginning after such date, and (ii) will make annual reports to the Secretary respecting the amount owed under such agreements.

"(B) (i) A student subject to an agreement entered into with a school pursuant to subparagraph (A) shall pay to the United States in equal annual

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installments an amount equal to the total amount received by the school after June 30, 1976, under section 770 on account of the enrollment of the student in school years beginning after such date. The number of annual installments shall be equal to the number of fiscal year (beginning after June 30, 1976) in which the school received a grant under section 770 on account of the enrollment of the student in school years beginning after such date.

"(ii) The first annual installment under an agreement under subparagraph (A) shall be paid in the first calendar year which begins more than eleven months after the month in which the student subject to the agreement completed or terminated his course of study at the school, except that—

"(I) if the course of study was terminated in connection with a transfer to another school to pursue the same course of study and the transfer was made within twelve months of the termination date, the first annual installment shall be paid in the first calendar year which begins more than eleven months after the date the student completes his course of study at the school to which he transferred; or

"(II) if the student begins an internship, residency, or other advanced clinical training within

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six months after the month in which he completed his course of study, the first annual installment shall be paid in the first calendar year which begins more than eleven months after the month in which such internship or residency training ends.

No installment shall be required to be paid in a calendar year in which more than six months is spent in an internship or in residency training.

"(C) For each year that an individual subject to such an agreement—

"(i) provides service during a period of obligated service in accordance with section 747 (d) or practices his profession in accordance with an agreement entered into under section 747 (f) ; or

"(ii) in the case of an individual who is not providing service during a period of obligated service in accordance with section 747 (d), practices his profession—

"(I) as a member of the National Health Service Corps in an area in which is located a medically underserved population designated under section 329 (b), or

"(II) as a member of the Indian Health Service;

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the individual shall be relieved of his liability to pay one annual installment.

"(D) The obligation of an individual under an agreement shall be canceled upon his death. The Secretary shall by regulation provide for the waiver or suspension of such an obligation whenever compliance by the individual subject to it is impossible or would involve extreme hardship to such individual and if enforcement of such obligation with respect to him would be against equity and good conscience.

"(b) SCHOOLS OF MEDICINE, OSTEOPATHY, AND DENTISTRY.—

"(1) The Secretary shall not make a grant under section 770 to any school of medicine, osteopathy, or dentistry in a fiscal year beginning after June 30, 1974, unless the following requirements are met:

"(A) The application for such grant shall contain or be supported by reasonable assurances satisfactory to the Secretary that—

"(i) for the second school year beginning after the close of the fiscal year in which such grant is made and for each school year thereafter beginning in a fiscal year in which such a grant is made the first-year enrollment of

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full-time students in such school will exceed the number of such students enrolled in the school year beginning during the fiscal year ending June 30, 1974—

"(I) by 10 per centum of such number if such number was not more than one hundred, or

"(II) by 5 per centum of such number, or ten students, whichever is greater, if such number was more than one hundred; or

"(ii) for the second school year beginning after the close of the fiscal year in which such grant is made and in each school year thereafter beginning in a fiscal year in which such a grant is to be made the school, if it is a school of medicine or osteopathy, it will offer a program for the training of physician assistants or, if the school is a school of dentistry, it will offer a program for the training of expanded function dental auxiliaries.

"(B) (i) In the case of an application for a grant to be made in a fiscal year beginning after June 30, 1975, the applicant shall submit to the Secretary and have approved by him before the

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grant applied for is made, a plan to train, in the school year beginning after the close of the fiscal year in which the grant is made and in each school year thereafter beginning in a fiscal year in which such a grant is made and in areas geographically remote from the main site of the teaching facilities of the applicant (or any other school of medicine, osteopathy, or dentistry which has joined with the applicant in the submission of the plan), full-time students and students enrolled in programs of the applicant for the training of physician assistants and expanded function dental auxiliaries.

"(ii) More than one applicant may join in the submission of a plan described in clause (i). No plan may be approved by the Secretary unless—

"(I) the application for a grant under section 770 of each school which has joined in the submission of the plan contains or is supported by reasonable assurances satisfactory to the Secretary that each such school will obligate to implement the plan an amount equal to not less than 25 per centum of the amount received under such grant;

"(II) the application for a grant under section 770 of each school which has joined in the

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submission of the plan contains or is supported by reasonable assurances satisfactory to the Secretary that all full-time students enrolled in such school will receive a majority of their training at the main site of the training facilities of the school and at least six weeks (in the aggregate) of training in an area geographically remote from such site during the last two years of enrollment in such school and that, in the case of a school of medicine or osteopathy, all students enrolled in its programs (if any) for the training of physicians' assistants and, in the case of a school of dentistry, all students enrolled in its program (if any) for the training of expanded function dental auxiliaries, will receive at least six weeks (in the aggregate) of training in an area geographically remote from such main site at any time during such program;

"(III) the plan contains a list of the areas where the training under such plan is to be conducted, a detailed description of the type and amount of training to be given in such areas, and provision for periodic review by experts in medical, osteopathic, or dental education (as may be appropriate) of the desirability of pro-

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viding training in such areas and of the quality of training rendered in such areas;

"(IV) the plan contains a specific program for the hiring, as members of the faculty of the school or schools submitting the plan, of practicing physicians or dentists (as appropriate) to serve as instructors in the training program in areas geographically remote from the main site of the teaching facilities of such school or schools; and

"(V) the plan contains a plan for frequent counseling and consultation between the faculty of the school or schools at the main site of their training facilities and the instructors in the training program in the areas geographically remote from such site.

"(2) The Secretary may waive (in whole or in part) the requirement of paragraph (1) (A) with respect to any school of medicine, osteopathy, or dentistry if he determines, after consultation with the National Advisory Council on Health Professions Education, that, because of limitations of physical facilities available to the school for training or because of other relevant factors—

"(A) such school cannot increase its first-year

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enrollment of full-time students in accordance with clause (i) of such paragraph; and

"(B) such school cannot offer a program for the training of physican assistants or a program for the training of expanded function dental auxiliaries to comply with clause (ii) of such paragraph;

without lowering the quality of education provided in such school.

'(c) SCHOOLS OF PUBLIC HEALTH.—

"(1) The Secretary shall not make a grant under section 770 to any school of public health in a fiscal year beginning after June 30, 1974, unless the application for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that for the second school year beginning after the close of the fiscal year in which such grant is made and for each school year thereafter beginning in a fiscal year in which such a grant is made the first-year enrollment of full-time students in such school will exceed the number of such students enrolled in the school year beginning during the fiscal year ending June 30, 1974—

"(A) by 10 per centum of such number if such number was not more than one hundred, or

"(B) by 5 per centum of such number, or ten

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students, whichever is greater, if such number was more than one hundred.

"(2) The Secretary may waive (in whole or in part) the requirements of paragraph (1) with respect to any school if he determines, after consultation with the National Advisory Council on Health Professions Education, that such school, because of limitations of physical facilities available to the school for training or because of other relevant factors, cannot increase its first year enrollment in accordance with such paragraph without lowering the quality of education provided in such school.

"(d) SCHOOLS OF VETERINARY MEDICINE, OPTOMETRY, PHARMACY, AND PODIATRY.—

"(1) SCHOOLS OF VETERINARY MEDICINE.—The Secretary shall not make a grant under section 770 to any school of veterinary medicine in a fiscal year beginning after June 30, 1974—

"(A) unless the application for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that for the second school year beginning after the close of the fiscal year in which such grant is to be made and for each school year thereafter beginning in a fiscal year in which such a grant is made the first year enrollment of full-

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time students in the school making the application will exceed the number of such students enrolled in the school year beginning during the fiscal year ending June 30, 1974—

"(i) by 10 per centum of such number if such number was not more than one hundred, or

"(ii) by 5 per centum of such number, or ten students, whichever is greater, if such number was more than one hundred; or

"(B) unless the application for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that at least 20 per centum of the first year enrollment of full-time students in the school making the application will for the second school year beginning after the close of the fiscal year in which the grant applied for is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made be comprised of students who are residents of States in which are not located any accredited school providing the training provided by the school making the application.

"(2) SCHOOLS OF OPTOMETRY.—The Secretary shall not make a grant under section 770 to any school of optometry in a fiscal year beginning after June 30,

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1974, unless the application for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that for the second school year beginning after the close of the fiscal year in which such grant is to be made and for each school year thereafter beginning in a fiscal year in which such a grant is made the first year enrollment of full-time students in the school making the application will exceed the number of such students enrolled in the school year beginning during the fiscal year ending June 30, 1974—

"(A) by 10 per centum of such number if such number was not more than one hundred, or

"(B) by 5 per centum of such number, or ten students, whichever is greater, if such number was more than one hundred.

The Secretary may waive (in whole or in part) the requirements of this paragraph with respect to any school if he determines, after consultation with the National Advisory Council on Health Professions Education, that such school, because of limitation of physical facilities available to the school for training or because of other relevant factors, cannot increase its first year enrollment in accordance with such paragraph without lowering the quality of education provided in such school.

"(3) SCHOOLS OF PHARMACY.—The Secretary

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shall not make a grant under section 770 to any school of pharmacy in a fiscal year beginning after June 30, 1974—

"(A) unless the application for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that for the second school year beginning after the close of the fiscal year in which such grant is to be made and for each school year thereafter beginning in a fiscal year in which such a grant is made the first year enrollment of full-time students in the school making the application will exceed the number of such students enrolled in the school year beginning during the fiscal year ending June 30, 1974—

"(i) by 10 per centum of such number if such number was not more than one hundred, or

"(ii) by 5 per centum of such number, or ten students, whichever is greater, if such number was more than one hundred; or

"(B) unless the school has submitted to and had approved by the Secretary a plan for the establishment, expansion, improvement, or operation, in the second school year beginning after the fiscal year in which the grant applied for is to be made and in

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each school year thereafter beginning in a fiscal year in which such a grant is made, of at least two of the following programs: (i) a program to teach pharmacy in a hospital, extended care facility, or other clinical setting, (ii) a program of training in clinical pharmacology, or (iii) a program to train pharmacists to assist physicians and counsel patients on the appropriate use and reactions to drugs.

"(4) SCHOOLS OF PODIATRY.—The Secretary shall not make a grant under section 770 to any school of podiatry in a fiscal year beginning after June 30, 1974—

"(A) unless the application for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that for the second school year beginning after the close of the fiscal year in which such grant is to be made and for each school *year thereafter beginning in a fiscal year in which* year thereafter beginning in a fiscal year in which such a grant is made the first year enrollment of full-time students in the school making the application will exceed the number of such students enrolled in the school year beginning during the fiscal year ending June 30, 1974—

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"(i) by 10 per centum of such number if such number was not more than one hundred, or

"(ii) by 5 per centum of such number, or ten students, whichever is greater, if such number was more than one hundred; or

"(B) unless the application for such grant contains or is supported by reasonable assurances satisfactory to the Secretary that at least 40 per centum of the first year enrollment of full-time students in the school making the application will for the second school year beginning after the close of the fiscal year in which the grant applied for is to be made and in each school year thereafter beginning in a fiscal year in which such a grant is made will be comprised of students who are residents of States in which are not located any accredited school providing the training provided by the school making the application.".

SEC. 403. (a) Section 772 (a) (1) (as so redesignated) is amended by striking out "or dentistry" and inserting in lieu thereof: ", dentistry, public health, veterinary medicine, optometry, pharmacy, or podiatry".

(b) Section 772 (a) (4) (as so redesignated) is amended by striking out "or dentistry" and inserting in lieu

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thereof "dentistry, public health, veterinary medicine, optometry, pharmacy, or podiatry".

(c) Section 772(a)(6) (as so redesignated) is amended to read as follows:

"(6) There are authorized to be appropriated $5,000,000 for fiscal year 1975, $5,000,000 for fiscal year 1976, and $5,000,000 for fiscal year 1977, for payments under grants under this subsection. Sums appropriated under this paragraph shall remain available until expended."

(d) Section 772(b)(2) (as so redesignated) is amended (1) by striking out "1974" and inserting in lieu thereof "1977", and (2) by striking out "1975" and inserting in lieu thereof "1978".

SEC. 404. (a) Subsection (a) of section 773 is amended to read as follows:

"(a) There are authorized to be appropriated $5,000,000 for fiscal year 1975, $5,000,000 for fiscal year 1976, and $5,000,000 for fiscal year 1977, for payments under grants under this section."

(b) Section 773 is amended by inserting "public health," after "dentistry," in subsections (b) and (d).

SEC. 45. (a) Section 775 is redesignated section 774 and is amended—

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(1) by striking out "770, 771, 772, or 773" each place it occurs and inserting in lieu thereof "770, 772, or 773";

(2) by inserting ", public health" after "dentistry" in subsection (b);

(3) by striking out "this part" in subsection (c) and inserting in lieu thereof "section 770, 772, or 773";

(4) by striking out "770, 771, or 773" in subsection (d) (1) and inserting in lieu thereof "770, 771, 772, or 773" and

(5) by amending subsection (d) (3) to read as follows:

"(3) provides for such fiscal control and accounting procedures and reports, including the use of such standard procedures for the recording and reporting of financial information as the Secretary may prescribe, and access to the records of the applicant, as the Secretary may require to enable him to determine the costs to the applicant of its program for the education or training of students."

(b) The section heading of section 774 (as so redesignated) is amended by striking out "SPECIAL PROJECT".

SEC. 406. Sections 312 and 313 are repealed.

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TITLE V—SPECIAL PROJECT GRANTS AND CONTRACTS

SEC. 501. (a) Section 767 (entitled "GRANTS FOR TRAINING, TRAINEESHIPS, AND FELLOWSHIPS IN FAMILY MEDICINE") is transferred to part F of title VII and redesignated as section 781.

(b) Section 781 (as so redesignated) is amended as follows:

(1) Such section is amended by striking out "and" after "1973," and by inserting after "1974," the following: $40,000,000 for fiscal year 1975, $40,000,000 for fiscal year 1976, and $40,000,000 for fiscal year 1977,".

(2) Such section is amended by inserting "(a)" before "There are" and by inserting at the end thereof the following:

"(b) Sums appropriated under subsection (a) may be used by the Secretary to make grants to any public or nonprofit private school of dentistry or accredited postgraduate dental training institution—

"(1) to plan, develop, and operate an approved residency program in the general practice of dentistry; and

"(2) to provide financial assistance (in the form of

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traineeships and fellowships) to residents in such a program who are in need of financial assistance and who plan to specialize in the practice of general dentistry.".

(3) The title of such section is amended by inserting after "FAMILY MEDICINE" the following: "AND IN THE GENERAL PRACTICE OF DENTISTRY".

SEC. 502. Section 772 (as in effect before the date of the enactment of this Act) is transferred to part F of title VII, is redesignated section 782, and is amended to read as follows:

"ASSISTANCE TO INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS

"SEC. 782. (a) (1) For the purpose of assisting individuals from disadvantaged backgrounds, as determined in accordance with criteria prescribed by the Secretary, to undertake education to enter a health profession, the Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, public health, dentistry, veterinary medicine, optometry, pharmacy, and podiatry and other public or private nonprofit health or educational entities to assist in meeting the costs described in paragraph (2).

"(2) A grant or contract under paragraph (1) may be used by the health or educational entity to meet the costs of—

"(A) identifying, recruiting, and selecting individ-

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uals from disadvantaged backgrounds, as so determined, for the education provided by a health professional school,

"(B) facilitating the entry of those individuals into such a school,

"(C) providing counseling or other services designed to assist those individuals to complete successfully their education at such a school,

"(D) providing, for a period prior to the entry of those individuals into the regular course of education of such a school, preliminary education designed to assist them to complete successfully such regular course of education at such a school, or referring such individuals to institutions providing such preliminary education, and

"(E) publicizing existing sources of financial aid available to persons enrolled in the education program of such a school or who are undertaking training necessary to qualify them to enroll in such a program.

"(3) No grant may be made or contract entered into under paragraph (1) to a school of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, or podiatry unless its application for such grant or contract contains or is supported by assurances satisfactory to the Secretary that in the second school year beginning after

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the close of the fiscal year for which such grant is made or contract entered into, such school will enroll in its first-year class a number of full-time students from disadvantaged backgrounds, as determined in accordance with criteria prescribed by the Secretary, which is at least equal to the lesser of—

"(A) 5 per centum of the number of full-time first-year students enrolled in the school in the preceding school year, or

"(B) ten.

"(b) There are authorized to be appropriated $20,000,000 for fiscal year 1975, $20,000,000 for fiscal year 1976, and $20,000,000 for fiscal year 1977, for payments under grants and contracts under subsection (a).".

SEC. 503. (a) Section 774 (as in effect before the date of the enactment of this section) is transferred to part F of title VIII, is redesignated section 783, and is amended to read as follows:

"AREA HEALTH EDUCATION CENTERS

"SEC. 783. (a) For the purpose of improving the distribution, supply, quality, utilization, and efficiency of health personnel in the health services delivery system and for the purpose of encouraging the regionalization of educational responsibilities of the health professions schools, the Secretary may make grants and enter into contracts for projects for area health education centers—

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"(1) to conduct programs to alleviate shortages of health personnel in rural areas with sparse populations or urban areas with unusually dense populations through training or retraining of health personnel in community hospitals and other facilities located in such areas including training of students enrolled in residency programs in family medicine, general internal medicine, general pediatrics, psychiatry, and obstetrics and gynecology) or to otherwise improve the distribution in such areas of health personnel by area or by specialty group;

"(2) to provide training programs in such areas leading to more efficient utilization in such areas of health personnel, emphasizing multidisciplinary and interdisciplinary patterns of undergraduate, graduate, and continuing education of health personnel; and

"(3) to provide education programs for the general populations of such areas regarding the appropriate use of health services, the availability of health services in such areas (including services provided under federally funded programs), and the contribution each individual can make to the maintenance of his own health.

"(b) (1) The costs for which a grant or contract under this section may be made may include such stipends and allowances (including travel and subsistence expenses and dependency allowances) for the students in such programs

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as the Secretary may deem necessary and costs of construction of new primary care facilities and of medical school facilities necessary for the administration of the training program for which the grant or contract is made.

"(2) An applicant for a grant or contract under this section shall be a public or nonprofit private educational entity which has, or which is affiliated with, at least three degree or diploma granting health professions education programs (of which at least one shall be a program offered by a school of medicine or osteopathy). No application for a grant or contract may be approved unless the application—

"(A) contains assurances satisfactory to the Secretary that, to the maximum extent feasible, the project of the applicant will be conducted in conjunction with (including the sharing of faculty and facilities with) the projects (if any) of any schools of medicine or osteopathy participating in the project of the applicant for the remote site training of undergraduate students of medicine or osteopathy conducted pursuant to plans approved under section 771 (b) (1) (B);

"(B) contains a designation of the geographic boundaries of the areas to be served by area health education centers established under the project;

"(C) contains a list of the manpower needs of the areas to be served by area health education centers estab-

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lished under the project, the relative order in which those needs should be addressed, a detailed description of the types of programs to be carried out by the area health education centers and provision for periodic review and evaluation of such programs by experts in medical or osteopathic or other health professions education (as may be appropriate);

"(D) contains assurances that each medical and osteopathic school participating in the project will provide not less than six weeks of training per year in area health education centers for at least 50 per centum of the students enrolled in such schools in residency programs in family medicine, general internal medicine, general pediatrics, psychiatry, obstetrics, and gynecology;

"(E) contains assurances satisfactory to the Secretary that each participant in the project will contribute a significant portion of its faculty to serve as instructors in graduate training and continuing education programs in areas served by the area health education centers;

"(F) contains a specific program for multidisciplinary and interdisciplinary training programs both at the main site of the training or clinical facilities of the applicant and in area health education centers established under the project;

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"(G) contains a plan for frequent counseling and consultation between the faculty of the applicant at the main site of its training or clinical facilities and instructors and other appropriate participants in the applicant's programs in the areas served by the area health education centers;

"(H) contains a detailed plan for frequent consultation and coordination of the applicant's project with appropriate local, regional, State, and Federal agencies in order to exchange information, and avoid unnecessary duplication of programs; and

"(I) contains assurances that the applicant will designate a local advisory board for each area health education center.

Each advisory board for an area health education center shall be comprised of consumers of health services residing in the area and shall, as a group, represent the residents of that area taking into consideration the employment, age, sex, race, place of residence, and other demographic characteristics. The advisory board shall meet on a regular basis (not less than twice a year) for purposes of determining the project's responsiveness to the health manpower needs of the area and making recommendations to the area health education centers with respect to the provision of health manpower in the area.

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"(3) The amount of any grant or contract under this section shall be determined by the Secretary, except that no grant or contract for any project may exceed 75 per centum of the costs, as determined by the Secretary, of such project.

"(c) There are authorized to be appropriated $15,000,000 for fiscal year 1975, $20,000,000 for fiscal year 1976, and $25,000,000 for fiscal year 1977, for payments under grants and contracts under this section."

(b) For the fiscal year ending June 30, 1975, and for each of the next two fiscal years there are authorized to be appropriated such sums as may be necessary to continue payments to entities under contracts entered into under section 774 of the Public Health Service Act (as in effect before the date of the enactment of this Act) for projects for area health education centers, except that no payment shall be made to an entity under such a contract unless the entity provides assurances satisfactory to the Secretary that not later than January 1, 1976, the project for which the payment is to be made will be a project described in subsection (a) of section 783 of such Act and the entity and its application will meet the requirements of subsection (b)(2) of such section. Such payments may only be made from such sums for the periods and the amounts specified in such contracts.

(c) On and after January 1, 1976, the Secretary of

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Health, Education, and Welfare shall assess the program of grants under section 783 of the Public Health Service Act to determine the effect of the projects funded under such grants on the distribution of health manpower and on the access to and quality of health care in the areas in which such projects are located. Not later than January 1, 1977, the Secretary shall submit to the Congress a report on the assessment conducted under this subsection.

SEC. 504. Part F of title VII is amended by adding after section 783 the following new section:

"PROJECT GRANTS AND CONTRACTS FOR SCHOOLS OF OPTOMETRY, PHARMACY, AND PODIATRY

"SEC. 784. (a) SCHOOLS OF OPTOMETRY.—The Secretary may make grants to and enter into contracts with schools and optometry to meet the costs of projects to assist in—

"(1) the affiliation between optometric training programs and medical, osteopathic, and other health professions training programs and academic institutions,

"(2) establishing cooperative arrangements between optometric training programs and medical, osteopathic, and other health professions training programs and academic institutions,

"(3) planning, developing, and operating residency training programs in special optometric services

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or in meeting the optometric needs of special populations, or

"(4) planning, developing, and operating educational programs which provide training in the early detection and diagnosis of health problems which are accompanied by visual or ocular symptoms.

"(b) SCHOOLS OF PHARMACY.—

"(1) The Secretary may make grants and enter into contracts with schools of pharmacy to meet the costs of projects to assist in—

"(A) the affiliation between clinical pharmacy training programs and medical, osteopathic, and other health professions training programs and academic institutions, or

"(B) establishing cooperative arrangements between clinical pharmacy training programs and medical, osteopathic, and other health professions training programs and academic institutions.

"(2) The Secretary may make grants to and enter into contracts with schools of pharmacy to meet the costs of projects to establish, expand, or improve—

"(A) programs for the teaching of pharmacy in hospitals, extended care facilities, and other clinical settings,

"(B) clinical pharmacology training, and

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"(C) programs to train pharmacists to assist physicians and counsel patients on the appropriate use and effects of and reactions to drugs.

"(c) SCHOOLS OF PODIATRY.—The Secretary may make grants to and enter into contracts with schools of podiatry to meet the costs of projects to assist in—

"(1) the affiliation between podiatric training programs and medical, osteopathic, and other health professions training programs and academic institutions, or

"(2) establishing cooperative arrangements between podiatric training programs and medical, osteopathic, and other health professions training programs and academic institutions.

"(d) TECHNICAL ASSISTANCE.—If the Secretary does not approve an application for a grant or contract under this section, he shall advise the applicant of the reasons for disapproval of the application and provide the applicant such technical and other nonfinancial assistance as may be appropriate to enable the applicant to submit an approvable application.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $5,000,000 for fiscal year 1975, $5,000,000 for fiscal year 1976, and $5,000,000 for fiscal year 1977, for payments under grants and contracts under this section.".

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SEC. 505. (a) Section 769A (entitled "GRANTS FOR COMPUTER TECHNOLOGY HEALTH CARE DEMONSTRATION PROGRAMS") is transferred to part F of title VII, inserted after section 784, and redesignated as section 785.

(b) Section 785 (as so redesignated) is amended (1) by striking out "and" after "1973,", and (2) by inserting after "1974," the following: "$3,000,000 for fiscal year 1975, $3,000,000 for fiscal year 1976, and $3,000,000 for fiscal year 1977,".

SEC. 506. (a) Section 766 (entitled "TRAINING IN EMERGENCY MEDICAL SERVICES") is transferred to part F of title VII, inserted after section 785, and redesignated as section 786.

(b) Section 786 (as so redesignated) is amended by striking out subsections (b), (c), (d), and (e) and inserting in lieu thereof the following:

"(b) No grant or contract may be made or entered into under this section unless the applicant therefor is a public or nonprofit private entity. Grantees and contractees under this section shall make such reports at such intervals, and containing such information, as the Secretary may prescribe.

"(c) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $7,000,000 for fiscal year 1975, $7,000,-

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000 for fiscal year 1976, and $7,000,000 for fiscal year 1977.".

Section 507. Part F of title VII is amended by adding after section 786 the following new section:

"EDUCATION OF RETURNING UNITED STATES STUDENTS FROM FOREIGN MEDICAL SCHOOLS

"SEC. 787. (a) The Secretary may make grants to schools of medicine and osteopathy in the United States to plan, develop, and operate programs—

"(1) to train United States citizens who have been enrolled in medical schools in foreign countries before July 1, 1975, to enable them to meet the requirements for enrolling in schools of medicine or osteopathy in the United States as full-time students with advanced standing; or

"(2) to train United States citizens who have transferred from medical schools in foreign countries in which they were enrolled before July 1, 1975, and who have enrolled in schools of medicine or osteopathy in the United States as full-time students with advanced standing.

The costs for which a grant under this subsection may be made include the costs of identifying deficiencies in the medical school education of the United States citizens who have been enrolled in foreign medical schools, the development of

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materials and methodology for correcting such deficiencies, and specialized training designed to prepare such United States citizens for enrollment in schools of medicine or osteopathy in the United States as full-time students with advanced standing.

"(b) More than one school of medicine or osteopathy may join in the submission of an application for a grant under subsection (a).

"(c) The Secretary may not approve an application for a grant under subsection (a) (1) unless such application contains assurances satisfactory to the Secretary, to the maximum extent feasible, that every individual who—

"(1) satisfactorily completes the training program for which such grant is to be made, and

"(2) is qualified to be accepted for enrollment in the school or schools which submitted such application as a full-time student with advanced standing,

will be accepted for enrollment as a full-time student with advanced standing in the school, or in one of the schools, which submitted such application.

"(d) Any school of medicine or osteopathy which receives a grant under subsection (a) for the final year ending June 30, 1975, shall submit to the Secretary before January 1, 1976, a report on the deficiencies (if any) identified by the school in the foreign medical education of the students

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trained by such school under the program for which such grant was made. The Secretary shall compile the reports submitted under the preceding sentence, and before July 1, 1976, submit to the Congress his analysis and evaluation of the information contained in such reports.

"(e) There are authorized to be appropriated $2,000,000 for fiscal year 1975, $3,000,000 for fiscal year 1976, and $4,000,000 for fiscal year 1977, for payments under grants under subsection (a).".

SEC. 508. Part F of title VII is amended by adding after section 787 the following new section:

"PROJECT GRANTS FOR INSTRUCTION IN FAMILY MEDICINE

"SEC. 788. (a) The Secretary may make grants to schools of medicine and osteopathy to meet the costs of projects to establish and maintain academic administrative units (which may be departments, divisions, or other units) to provide clinical instruction in family medicine.

"(b) The Secretary may not approve an application for a grant under subsection (a) unless such application contains—

"(1) assurances satisfactory to the Secretary that the academic administrative unit with respect to which the application is made will (A) be comparable to academic administrative units for other major clinical spe-

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cialties offered by the applicant, (B) be responsible for directing an amount of the curriculum for each member of the student body engaged in an education program leading to the awarding of the degree of doctor of medicine or doctor of osteopathy determined by the Secretary to be comparable to the amount for other major clinical specialties in the school, (C) have a number of full-time faculty which is determined by the Secretary to be sufficient to conduct the clinical instruction required in clause (B) and to be comparable to the number of faculty assigned to other major clinical specialties in the school, and (D) have control over a three-year approved or provisionally approved graduate training program in family practice or its equivalent as determined by the Secretary which shall have the capacity to enroll a total of no less than twelve interns or residents per year; and

"(2) such other information as the Secretary shall by regulation prescribe.

"(c) There are authorized to be appropriated $10,000,000 for fiscal year 1975, $15,000,000 for fiscal year 1976, and $20,000,000 for fiscal year 1977, for payments under grants under subsection (a).".

SEC. 509. (a) Section 769B is transferred to part F of title VII, inserted after section 788, and redesignated as section 789.

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(b) Section 789 (as so redesignated) is amended—

(1) by striking out "grant may be made under sections 767, 769, and 769(A)" in subsection (a) and inserting in lieu thereof "grant may be made or contract entered into under this part";

(2) by adding at the end of subsection (a) the following: "The Secretary may not approve or disapprove any application for a grant or contract under this part except after consultation with the National Advisory Council on Health Professions Education.";

(3) by striking out "grants under sections 767 and 769(A)" in subsection (b) and inserting in lieu thereof "grants or contracts under this part"; and

(4) by striking out subsection (c) and inserting in lieu thereof the following:

"(c) The amount of any grant or contract under this part shall be determined by the Secretary. Payments under such grants may be made in advance or by way of reimbursement, at such intervals and on such conditions, as the Secretary finds necessary. Contracts may be entered into under this part without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).".

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SEC. 510. Section 768 (entitled "GRANTS FOR SUPPORT OF POSTGRADUATE TRAINING PROGRAMS FOR PHYSICIANS AND DENTISTS") and section 769 (entitled "GRANTS FOR TRAINING, TRAINEESHIPS, AND FELLOWSHIPS FOR HEALTH PROFESSIONS TEACHING PERSONNEL") are repealed.

SEC. 511. The heading for part F of title VII is amended to read as follows:

"PART F—SPECIAL PROJECT GRANTS AND CONTRACTS".

TITLE VI—PUBLIC AND ALLIED HEALTH PERSONNEL

SEC. 601. (a) Part G of title VII is amended to read as follows:

"PART G—TRAINING PROGRAMS FOR PUBLIC AND COMMUNITY HEALTH PERSONNEL

"DEFINITION

"SEC. 790. For purposes of this part, the term 'public and community health personnel' means individuals who are engaged in—

"(1) the planning, development, monitoring, or management of health care or health care institutions, organizations, or systems,

"(2) research on health care development and the

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collection and analysis of health statistics, data on the health of population groups, and any other health data,

"(3) the development and improvement of individual and community knowledge of health and the health care system, or

"(4) the planning and development of a healthful environment and control of environmental health hazards.

"INSTITUTIONAL GRANTS FOR GRADUATE PROGRAMS IN HEALTH

"SEC. 791. (a) From funds appropriated under subsection (d), the Secretary shall make annual grants to public or nonprofit private educational entities (except schools of public health) to support the graduate educational programs of such entities in health administration, hospital administration, or health planning.

"(b) The amount of the grant for any fiscal year under subsection (a) to an educational entity with an application approved under subsection (c) shall be equal to the amount appropriated under subsection (d) for such fiscal year divided by the number of educational entities which have applications for grants for such fiscal year approved under subsection (c).

"(c) (1) No grant may be made under subsection (a) unless an application therefor has been submitted to the Secretary before such time as he shall by regulation pre-

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scribe and has been approved by the Secretary. Such application shall be in such form, and submitted in such manner, as the Secretary shall by regulation prescribe.

"(2) The Secretary may not approve an application submitted under paragraph (1) unless—

"(A) such application—

"(i) contains assurances satisfactory to the Secretary that in each academic year (as defined in regulations of the Secretary) for which the applicant receives a grant under subsection (a)—

"(I) at least twenty-five individuals will complete the graduate educational program of the entity for which such application is submitted; and

"(II) such entity will expend or obligate at least $100,000 in funds from non-Federal sources to conduct such programs;

"(ii) contains such assurances as the Secretary shall by regulation prescribe respecting one or more of the following: Increases in overall enrollment in the programs for which such application is submitted and increases in enrollment in programs for the training of needed types of public and community health personnel; and

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"(iii) contains such other information as the Secretary may by regulation prescribe; and

"(B) the programs for which such application was submitted have been accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education and meet such other quality standards as the Secretary shall by regulation prescribe.

The Secretary may not approve or disapprove such an application except after consultation with the National Advisory Council on Health Professions Education.

"(d) There are authorized to be appropriated for payments under grants under this section $1,750,000 for fiscal year 1975, $2,000,000 for fiscal year 1976, and $2,500,000 for the fiscal year 1977.

"TRAINEESHIPS

"SEC. 792. (a) The Secretary may make grants to public or nonprofit private educational entities eligible for grants under section 791 for traineeships to train public and community health personnel for which the Secretary determines there is unusual need.

"(b) (1) No grants for traineeships may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain such information, as the Secretary by regulation may

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prescribe. Traineeships under such a grant shall be awarded in accordance with such regulations as the Secretary shall prescribe. The amount of any such grant shall be determined by the Secretary and payments under such grant may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

"(2) Traineeships awarded under grants made under subsection (a) shall provide for such stipends and allowances (including travel and subsistence expenses and dependency allowances) for the trainees as the Secretary may deem necessary.

"(c) For the purposes of making payments under grants under subsection (a), there are authorized to be appropriated $2,500,000 for fiscal year 1975, $2,500,000 for fiscal year 1976, and $2,500,000 for fiscal year 1977.

"STATISTICS AND ANNUAL REPORT

"SEC. 793. (a) The Secretary shall, in coordination with the National Center for Health Statistics, continuously develop, publish, and disseminate on a nationwide basis statistics and other information respecting public and community health personnel, including—

"(1) detailed descriptions of the various types of activities in which public and community health personnel are engaged,

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"(2) the current and anticipated needs for the various types of public and community health personnel, and

"(3) the number, employment, geographic locations, salaries, and surpluses and shortages of public and community health personnel, the educational and licensure requirements for the various types of such personnel, and the cost of training such personnel.

"(b) The Secretary shall submit annually to the Committee on Interstate and Foreign Commerce of the House of Representatives and to the Committee on Labor and Public Welfare of the Senate a report on—

"(1) the statistics and other information developed pursuant to subsection (a); and

"(2) the activities conducted under this part, including an evaluation of such activities.

Such report shall contain such recommendations for legislation as the Secretary determines is needed to improve the programs authorized under this part. The Office of Management and Budget may review such report before its submission to Congress, but the Office may not revise the report or delay its submission beyond the date prescribed for its submission and may submit to Congress its comments respecting such report. The first report under this subsection shall be submitted not later than September 1, 1975."

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(b) Title VII is amended by adding at the end the following new part:

"PART H—TRAINING PROGRAMS FOR ALLIED HEALTH PERSONNEL

"DEFINITION

"SEC. 795. For purposes of this part, the term 'allied health personnel' means individuals with training and responsibilities for (1) supporting, complementing, or supplementing the professional functions of physicians, dentists, and other health professionals in the delivery of health care to patients, or (2) assisting environmental engineers and other personnel in environmental health control activities.

"PROJECT GRANTS AND CONTRACTS

"SEC. 796. (a) The Secretary may make grants to public and nonprofit private entities and enter into contracts with individuals and public and private entities to assist in meeting the costs of planning, study, development, demonstration, and evaluation projects undertaken with respect to one or more of the following:

"(1) Methods of coordination, management, and articulation of education and training at various levels for allied health personnel within and among educational institutions and their clinical affiliates.

"(2) Methods and techniques for State and regional

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coordination and monitoring of education and training for allied health personnel.

"(3) Educational programs (including programs in a junior college) which lead to—

"(A) a baccalaureate degree, an associate degree, or the equivalent of either degree, or

"(B) a higher degree,

in medical technology, opthalmic dispensing, dental hygiene, or such other of the curricula for the training of allied health personnel as the Secretary may by regulation specify, and other methods and curricula (including model curricula) for training various types of allied health personnel.

"(4) Programs, or means of adapting existing programs, for training as allied health personnel special groups such as returning veterans, the economically or culturally deprived, and persons reentering any of the allied health fields.

"(5) New roles and functions for allied health personnel and methods for increasing the efficiency of health manpower through more effective utilization of allied health personnel in various practice settings.

"(6) New methods of credentialing allied health personnel, including techniques for appropriate recognition (through equivalency and proficiency testing or

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otherwise) of previously acquired training or experience, developed in coordination with the Secretary's program under section 1123 of the Social Security Act.

"(7) Methods of recruitment and retaining of allied health personnel.

"(8) Meaningful career ladders and programs of advancement for practicing allied health personnel.

"(9) Continuing education programs for practicing allied health personnel.

"(b) (1) No grant may be made or contract entered into under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

"(2) Contracts may be entered into under subsection (a) without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(3) The amount of any grant under subsection (a) shall be determined by the Secretary. Payments under such grants may be made in advance or by way of reimbursement, and at such intervals and on such conditions as the Secretary finds necessary.

"(c) For the purpose of making payments under grants and contracts under subsection (a), there are authorized to

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be appropriated $20,000,000 for fiscal year 1975, $20,000,000 for fiscal year 1976, and $20,000,000 for fiscal year 1977.

"TRAINEESHIPS FOR ADVANCED TRAINING OF ALLIED HEALTH PERSONNEL

"SEC. 797. (a) The Secretary may make grants to public and nonprofit private entities for traineeships provided by such entities for the training of allied health personnel to teach in training programs for such personnel or to serve in administrative or supervisory positions.

"(b) (1) No grant may be made under subsection (a) unless an application therefor has been submitted to and approved by the Secretary. Such application shall be in such form, submitted in such manner, and contain such information as the Secretary shall by regulation prescribe.

"(2) Payments under such grants (A) shall be limited to such amounts as the Secretary finds necessary to cover the cost of tuition and fees of, and stipends and allowances (including travel and subsistence expenses and dependency allowances) for, the trainees; and (B) may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

"(c) For the purposes of making payments under grants under subsection (a), there are authorized to be appropriated $6,000,000 for fiscal year 1975, $6,000,000

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for fiscal year 1976, and $6,000,000 for fiscal year 1977.

"GRANTS AND CONTRACTS TO ENCOURAGE FULL UTILIZATION OF EDUCATIONAL TALENT FOR ALLIED HEALTH PERSONNEL TRAINING

"SEC. 798. (a) The Secretary may make grants to and enter into contracts with State and local educational agencies and other public or nonprofit private entities—

"(1) to (A) identify individuals of financial, educational, or cultural need who have a potential to become allied health personnel, including individuals who are veterans of the Armed Forces with military training or experience similar to that of allied health personnel, and (B) encourage and assist, whenever appropriate, the individuals described in clause (A) to (i) complete secondary school, (ii) undertake such postsecondary training as may be required to qualify them to undertake allied health personnel training, and (iii) undertake postsecondary allied health personnel training; and

"(2) to publicize existing sources of financial aid available to individuals undertaking allied health personnel training.

"(b) (1) No grant may be made or contract entered into under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and

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contain such information, as the Secretary shall by regulation prescribe.

"(2) Contracts may be entered into under subsection (a) without regard to section 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(3) The amount of any grant under subsection (a) shall be determined by the Secretary. Payments under such grants may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary.

"(c) For payments under grants and contracts under subsection (a) there are authorized to be appropriated $1,000,000 for fiscal year 1975, $1,000,000 for fiscal year 1976, and $1,000,000 for fiscal year 1977.

"STATISTICS AND ANNUAL REPORT

"SEC. 799. (a) The Secretary shall, in coordination with the National Center for Health Statistics, continuously develop, publish, and disseminate on a nationwide basis statistics and other information respecting allied health personnel, including—

"(1) detailed descriptions of the various types of such personnel and the activities in which such personnel are engaged,

"(2) the current and anticipated needs for the various types of such health personnel, and

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"(3) the number, employment, geographic locations, salaries, and surpluses and shortages of such personnel, the educational and licensure and certification requirements for the various types of such personnel, and the cost of training such personnel.

"(b) The Secretary shall submit annually to the Committee on Interstate and Foreign Commerce of the House of Representatives and to the Committee on Labor and Public Welfare of the Senate a report on—

"(1) the statistics and other information developed pursuant to subsection (a); and

"(2) the activities conducted under this subpart, including an evaluation of such activities.

Such report shall contain such recommendation for legislation as the Secretary determines is needed to improve the programs authorized under this part. The Office of Management and Budget may review such report before its submission to Congress, but the Office may not revise the report or delay its submission beyond the date prescribed for its submission and may submit to Congress its comments respecting such report. The first report under this subsection shall be submitted not later than September 1, 1975.".

(c) Section 704 (as so redesignated) is amended (1) by striking out "any training center for allied health personnel" and inserting in lieu thereof "an entity for the

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training of public and community health personnel or allied health personnel", and (2) by striking out "or training center" each place it occurs and inserting in lieu thereof "or entity".

TITLE VII—MEDICAL RESIDENCY TRAINING PROGRAMS

SEC. 701. The Public Health Service Act is amended by adding at the end the following new title:

"TITLE XVII—MEDICAL RESIDENCY TRAINING PROGRAMS

"FIRST-YEAR POSITIONS IN MEDICAL RESIDENCY TRAINING PROGRAMS

"SEC. 1701. (a) (1) (A) The number of first-year positions in any accredited medical residency training program in the United States which may be made available in a calendar year beginning after calendar year 1977 may not exceed such number as may be established for such calendar year for such program under section 1703; and the aggregate number of first-year positions in all accredited medical residency training programs in the United States which may be made available in a calendar year beginning after calendar year 1977 to graduates of schools of medicine and osteopathy may not exceed 125 per centum of the estimated number of graduates from accredited schools of medicine in the preceding calendar year.

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"(B) The Secretary shall prepare by October 1 of each calendar year an estimate of the number of graduates that there will be from accredited schools of medicine in the succeeding calendar year, and shall by that date report the estimate to the agency designated or established under section 1703.

"(2) For purposes of this title, the term 'medical residency training program' means a program which trains graduates of schools of medicine and schools of osteopathy in a medical specialty recognized by the Liaison Committee for Specialty Boards established jointly by the American Board of Medical Specialties and the Council on Medical Education of the American Medical Association (or any successor of such Committee) and which provides the graduate education required by the specialty board (recognized by such Liaison Committee) for certification in such specialty. Such term does not include a residency training program in an osteopathic hospital.

"(b) (1) No entity which is engaged in business as a health care facility may include in any charge (or otherwise collect) for the provision in any calendar year of any health service by any physician in a medical residency training program an amount which is attributable to compensation paid to the physician by the health care facility in connection with such program unless the medical

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residency training program has been accredited under section 1702 for such calendar year and the number of first-year positions in such program made available in such calendar year does not exceed the number prescribed for such program under section 1703. Any entity which makes a charge or collection prohibited by this paragraph shall for each such charge or collection be subject to a civil penalty of not more than $5,000. Such penalty shall be assessed by the Secretary and may be collected in a civil action brought by the United States in a United States district court under section 1355 of title 28, United States Code.

"(2) If the Secretary determines that an entity is—

"(A) operating a medical residency training program which has not been accredited under section 1402, or

"(B) operating a medical residency training program with a number of first-year positions which exceeds the number established for that program under section 1403,

the Secretary shall notify the entity of his determination, shall publish the determination in the Federal Register, and shall not make any grant or to enter into any contract with such entity under this Act for the fiscal year beginning after the date the Secretary publishes such determination in the Federal Register.

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"MEDICAL RESIDENCY TRAINING PROGRAM ACCREDITING AGENCY

"SEC. 1702. (a) (1) For the purpose of accrediting the medical residency training programs for which first-year positions may be authorized under section 1403, the Secretary shall in accordance with subsection (b) designate or establish a medical residency training program accrediting agency (hereinafter in this section referred to as the 'accrediting agency').

"(2) The accrediting agency shall review, in accordance with procedures established and published by the agency and made available to the public, each medical residency training program in the United States and shall either accredit or disapprove such program. Each such program shall be reviewed at least every three years and an accreditation of a program shall be in effect for three years unless the accrediting agency terminates the accreditation before the expiration of three years. During the three-year period beginning January 1, 1976, the accrediting agency may accredit such a program on the basis of an accreditation granted such program by an entity generally recognized by the medical profession for purposes of accrediting such a program, except that an accreditation made under this sentence may not be in effect after January 1, 1979.

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"(3) The accrediting agency shall submit to the agency designated or established under section 1403 and keep current for it a list of the medical residency training programs the accreditations of which are in effect.

"(b) (1) Not later than March 31, 1975, the Secretary shall prescribe and publish in the Federal Register requirements which must be met by an entity before it may be designated as the accrediting agency for purposes of this title. Such requirements shall provide that an entity—

"(A) have a governing body which is comprised of representatives of the medical profession, medical specialty boards, medical specialty societies, hospitals, schools of medicine, and the general public; and

"(B) meet the criteria established by the Secretary for recognition of nationally recognized accrediting agencies and associations.

"(2) (A) An entity which seeks designation as the accrediting agency shall submit an application to the Secretary not later than August 31, 1975. If such an application has been submitted to the Secretary by the Liaison Committee for Graduate Medical Education of the Coordinating Council for Medical Education before such date, and—

"(i) if the Secretary determines that the Liaison Committee meets the requirements prescribed under

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paragraph (1), he shall approve such application and designate it as the accrediting agency; or

"(ii) if the Secretary finds that the Liaison Committee does not meet such requirements, he shall provide it with such technical and other nonfinancial assistance as may be appropriate to enable it to meet such requirements, and if the Secretary determines not later than October 31, 1975, that it meets such requirements, he shall designate it as the accrediting agency.

"(B) If, by October 31, 1975, the Secretary has not designated the Liaison Committee as the accrediting agency he shall consider other applications for such designation and shall if he determines that an entity under such an application meets the requirements prescribed under paragraph (1) and that such entity is otherwise qualified to accredit medical residency training programs, designate, not later than January 1, 1976, such entity as the accrediting agency.

"(3) (A) A desgination of the accrediting agency shall be in effect for three years unless the Secretary terminates such designation before the expiration of three years upon a determination by the Secretary (after notice and reasonable opportunity for a public hearing) that the agency no

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longer meets the requirements of paragraph (1) or is not qualified to accredit medical residency training programs. A designation may, upon application, be renewed for a period of three years.

"(B) If the Secretary terminates a designation or determines a designated accrediting agency is not qualified to have its designation renewed, the Secretary shall publish notice of such termination or determination and solicit application from other entities for designation as the accrediting agency.

"(4) (A) If—

"(i) by January 1, 1976, the Secretary determines that no entity which has applied for designation meets the requirements prescribed under paragraph (1) or is otherwise qualified to accredit medical residency training programs or if by such date no entity has applied for designation, or

"(ii) upon the expiration of a designation under this section, the Secretary determines that the designated agency is not qualified to have its designation renewed and that there are no other qualified applicants for designation, or upon the termination of such a designation, the Secretary determines that there are no qualified applicants for designation,

the Secretary shall, within three months of the determination, establish an accrediting agency for purposes of this title.

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"(B) An accrediting agency established by the Secretary under subparagraph (A) shall meet the criteria established by the Secretary for recognition of nationally recognized accrediting agencies and associations and the membership of which shall be fairly representative of the medical profession, medical specialty boards, medical specialty societies, hospitals, schools of medicine, and the general public. Members of the agency shall carry out the functions of the agency in accordance with this title. While away from their homes or regular places of business in the performance of services for the agency, members of the agency shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 (b) of title 5 of the United States Code. The agency may appoint, without regard to the provisions of title 5, United States Code, respecting appointments in the competitive service, and pay, without regard to the provisions of such title respecting rates of pay, such personnel as it deems necessary for the agency to carry out its functions.

"(C) The establishment of an accrediting agency under subparagraph (A) shall be for such period (but not more than three years) as the Secretary prescribes. If an accrediting agency has been established by the Secretary an

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entity may apply for designation as such agency upon the termination of the period for which the accrediting agency was established. If no entity submits an approvable application for designation before the date of such termination, the Secretary shall renew the authority of the established accrediting agency for a period not to exceed three years.

"ESTABLISHMENT OF POSITIONS

"SEC. 1703. (a) (1) The number of first-year positions in each medical residency training program, accredited under section 1702, in the United States which may be made available in any calendar year beginning after calendar year 1977 shall be established by an agency designated or established under this section by the Secretary.

"(2) The aggregate number of such positions which may be established by the designated or established agency for any calendar year may not exceed the limit prescribed by section 1701 (a) (1). In determining the number of such positions in any such accredited program the designated or established agency shall—

"(A) take into consideration the report made with respect to the study conducted under section 15 (c) of the Act of December 31, 1973 (Public Law 93-233), and the report made with respect to the study conducted under section 801 of the Health Manpower Act of 1975;

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"(B) insure that first-year positions in medical residency training programs are distributed equitably throughout various geographical areas of the United States;

"(C) afford special consideration to first-year positions in medical residency training programs maintained in conjunction with area health education centers under section 783 of this Act; and

"(D) afford particular attention to the need for medical residency training programs in the primary care specialties of general internal medicine, general pediatrics, family medicine, and obstetrics and gynecology.

"(3) The agency designated or established under this section shall, by April 1, 1977, establish (and publish in the Federal Register) the number of first-year positions to be made available in calendar year 1978 by accredited medical residency training programs and shall give to each entity which maintains such a program written notice of the number of first-year positions which it may make available in such program. The number of positions established for any calendar year thereafter shall be published in the Federal Register not later than April 1 of the preceding calendar year and each entity which maintains an accredited medical residency training program shall be given written notice by such

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date of the number of first-year positions which may be made available in such program.

"(b) (1) Not later than March 31, 1975, the Secretary shall prescribe and publish in the Federal Register requirements which must be met by an entity before it may be designated as the agency to establish the number of first-year positions which may be made available in accredited medical residency training programs. Such requirements shall provide that an entity have a governing body which is comprised of the Secretary (or his delegate) and representatives of the medical profession, medical specialty boards, medical specialty societies, hospitals, schools of medicine, and the general public.

"(2) (A) An entity which seeks designation under this section shall submit an application to the Secretary not later than August 31, 1975. If such an application has been submitted to the Secretary by the Coordinating Council for Medical Education before such date, and—

"(i) if the Secretary determines that the Coordinating Council meets the requirements prescribed under paragraph (1), he shall approve such application and designate it; or

"(ii) if the Secretary finds that the Coordinating Council does not meet such requirements, he shall provide it with such technical and other nonfinancial as-

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sistance as may be appropriate to enable it to meet such requirements, and if the Secretary determines not later than October 31, 1975, that it meets such requirements, he shall designate it.

"(B) If, by October 31, 1975, the Secretary has not designated the Coordinating Council for Medical Education, he shall consider other applications for such designation and shall if he determines that an entity under such an application meets such requirements and is otherwise qualified to establish the number of first-year positions in medical residency training programs, designate such entity not later than January 1, 1976.

"(3) (A) A designation of an agency under paragraph (2) shall be in effect for three years unless the Secretary terminates such designation before the expiration of three years upon a determination by the Secretary (after notice and reasonable opportunity for a public hearing) that the agency no longer meets the requrements of paragraph (1) or is not qualified to establish the number of first-year positions in accredited medical residency training programs. A designation may, upon application, be renewed for a period of three years.

"(B) If the Secretary terminates a designation or determines a designated agency is not qualified to have its designation renewed, the Secretary shall publish notice of such

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termination or determination and solicit applications from other entities for designation under this section.

"(4) (A) If—

"(i) by January 1, 1976, the Secretary determines that no entity which has applied for designation meets the requirements prescribed under paragraph (1) or is not otherwise qualified to establish the number of first-year positions in accredited medical residency training programs or if by such date no entity has applied for designation, or

"(ii) upon the expiration of a designation under this section, the Secretary determines that the designated agency is not qualified to have its designation renewed and that there are no other qualified applicants for designation, or upon the termination of such a designation, the Secretary determines that there are no qualified applicants for designation,

the Secretary shall, within three months of such determination, establish an agency to establish the number of first-year positions in accredited medical residency training programs.

"(B) The membership of an agency established by the Secretary under subparagraph (A) shall be fairly representative of the medical profession, hospitals, schools of medicine, medical specialty boards, medical specialty soci-

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eties, and the general public. Members of the agency shall carry out the functions of the agency in accordance with this title. While away from their homes or regular places of business in the performance of services for the agency, members of the agency shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 (b) of title 5 of the United States Code. The agency may appoint, without regard to the provisions of title 5, United States Code, respecting appointments in the competitive service, and pay, without regard to the provisions of such title respecting rates of pay, such personnel as it deems necessary for the agency to carry out its functions.

"(C) The establishment of an agency under subparagraph (A) shall be for such period (but not more than three years) as the Secretary prescribes. If an agency has been established by the Secretary an entity may apply for designation as such agency upon the termination of the period for which the agency was established. If no entity submits an approvable application for designation before the date of such termination, the Secretary shall renew the authority of the established accrediting agency for a period not to exceed three years.

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"(5) The Secretary may make grants to agencies designated under this section for their costs in carrying out their functions under this section. A grant to an agency under this paragraph shall be made for its costs incurred under this section during a period not to exceed one year after the date the grant was made. No single grant to an agency may exceed $300,000.".

TITLE VIII—MISCELLANEOUS

STUDY OF DISTRIBUTION OF PHYSICIANS

SEC. 801. (a) The Secretary of Health, Education, and Welfare shall, within ninety days after the date of the enactment of this Act, contract for the conduct of a study for the following purposes:

(1) To analyze the current distribution of physicians by specialty. In making such analysis—

(A) the geographical distribution of medical and osteopathic physicians by specialty and subspecialty and by geographic area shall be determined, and in connection with such determination physician specialties and subspecialties shall be defined in a manner consistent with recognized categories and geographical areas shall be defined as reasonable medical trade areas for each specialty or subspecialty; and

(B) special attention shall be given to de-

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termining (i) the percentage of time physicians in each specialty and subspecialty spend in primary care activities and in other activities unrelated to their specialty training, and (ii) the percentage of time primary care physicians spend in specialty care.

(2) To project the expected distribution of physicians by specialty and subspecialty by geographic area in the years 1980, 1985, and 1990. Such projection shall be based on current trends in physician specialty training and choice of practice sites, the activities of various specialty boards and other organizations, and the retirement-death rate of physicians by specialty and subspecialty.

(3) To examine and evaluate the various methodologies for estimating the optimal distribution of physicians by specialty and subspecialty by geographic area controlling the supply of specialists and subspecialists. Methodologies examined and evaluated shall include (A) methodologies utilized by foreign countries, and (B) consideration of the use of nonphysicians to perform functions normally performed by physicians.

(4) To develop a reliable and appropriate methodology to establish the optimal distribution of physicians by specialty and subspecialty by geographic area. Utiliz-

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ing such methodology, projections shall be made for the optimal number of physicians by specialty and subspecialty by geographic area for the years 1980, 1985, and 1990.

(b) The organization selected by the Secretary to conduct the study required by subsection (a) shall—

(1) have a national reputation for objectivity in the conduct of studies for the Federal Government;

(2) have the capacity to readily marshal the widest possible range of expertise and advice relevant to the conduct of such study;

(3) have a membership and competent staff which have backgrounds in government, the health sciences, and the social sciences;

(4) have a history of interest and activity in health policy issues related to such study; and

(5) have extensive existing contracts with interested public and private agencies and organizations.

(c) An interim report providing a plan for the study required by subsection (a) shall be submitted by the organization conducting the study to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate by October 31, 1975; and a final report giving the results of the study shall be submitted by such organiza-

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tion to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate by October 31, 1976.

QUALITY ASSURANCES RESPECTING EDUCATION AND TRAINING OF ALLIED HEALTH PERSONNEL

SEC. 802. The Secretary of Health, Education, and Welfare shall within one year of the date of the enactment of this Act (1) submit to the Congress a report which identifies and describes each of the programs which he administers under which the costs of programs of education and training for allied health personnel (as defined in section 795 of the Public Health Service Act) are directly or indirectly paid (in whole or in part); and (2) take such action as may be necessary to require that such assistance is provided only those programs which meet such quality standards as the Secretary may by regulation prescribe.

ALLIED HEALTH PERSONNEL STUDY

SEC. 803. (a) (1) The Secretary of Health, Education, and Welfare shall, in accordance with paragraph (2) arrange for the conduct of studies—

(A) to identify the various types of allied health personnel and the activities in which such personnel are engaged and the various training programs currently offered for allied health personnel;

(B) to establish classifications of allied health per-

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sonnel on the basis of their activities, responsibilities, and training;

(C) using appropriate methodologies, to determine the cost of educating and training allied health personnel in each classification; and

(D) to identify the classifications in which there are a critical shortage of such personnel and the training programs which should be assisted to meet that shortage.

(2) (A) The Secretary shall request the National Academy of Sciences to conduct such studies under an arrangement under which the actual expenses incurred by such Academy in conducting such studies will be paid by the Secretary. If the National Academy of Sciences is willing to do so, the Secretary shall enter into such an arrangement with such Academy for the conduct of such studies.

(B) If the National Academy of Sciences is unwilling to conduct one or more such studies under such an arrangement, then the Secretary shall enter into a similar arrangement with other appropriate nonprofit private groups or associations under which such groups or associations will conduct such studies and prepare and submit the reports thereon as provided in subsection (b).

(b) The studies required by subsection (a) shall be completed within the two-year period beginning on the date of

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the enactment of this Act; and a report on the results of such study shall be submitted by the Secretary to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate before the expiration of such period.

(c) Within six months after the date prescribed for the completion of the studies under subsection (a), the Secretary of Health, Education, and Welfare shall transmit to Congress such recommendations for legislation as he determines is necessary to provide appropriate support for the training programs referred to in subsection (a) (1) (D).

SEC. 804. If, within twenty years (or ten years in the case of a facility constructed under funds paid under part A of title VII of the Public Health Service Act (as in effect before the date of the enactment of the Health Manpower Act of 1975)) after completion of the construction of any facility for which funds have been paid under such part A (as so in effect) or under part D of such title VII (as in effect before July 1, 1967)—

(1) the applicant for such funds or other owner of such facility shall cease to be a public or nonprofit private entity, or

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(2) such facility shall cease to be used for the purposes for which such funds for its construction were provided, unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the applicant or other owner from the obligation to do so, the United States shall be entitled to recover from the applicant or other owner of the facility the amount bearing the same ratio to the then value (as determined by agreement of the parties or by action brought in the United States district court for the district in which such facility is situated) of the facility, as the amount of the Federal participation bore to the cost of construction of such facility.

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94TH CONGRESS
1ST SESSION

H. R. 2957

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 6, 1975

Mr. ROGERS (for himself, Mr. PREYER, Mr. SYMINGTON, Mr. CARNEY, Mr. SCHEUER, Mr. WAXMAN, Mr. HEFNER, Mr. FLORIO, Mr. CARTER, Mr. HASTINGS, and Mr. HEINZ) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend title VIII of the Publish Health Service Act to revise and extend the programs of assistance under that title for nurse training.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; REFERENCE TO ACT

SECTION 1. (a) This Act may be cited as the "Nurse Training Act of 1975".

(b) Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to

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be made to a section or other provision of the Public Health Service Act.

TITLE I—CONSTRUCTION ASSISTANCE

EXTENSION OF GRANTS AND LOAN GUARANTEES AND INTEREST SUBSIDIES

SEC. 101. (a) (1) Section 801 is amended by striking out "and" after "1973,"; and by inserting before the period a comma and the following: "$25,000,000 for fiscal year 1975, $25,000,000 for fiscal year 1976, and $25,000,000 for fiscal year 1977".

(2) Section 802 (a) (1) (A) is amended (A) by inserting "(i)" after "proposed facilities", and (B) by inserting before the semicolon ", or (ii) in expanding the capacity of the school to provide graduate training".

(b) (1) (A) Subsections (a) and (b) of section 809 are each amended by striking out "1974" and inserting in lieu thereof "1977".

(B) (i) The last sentence of subsection (a) of section 809 is amended (I) by striking out "(1)" and (II) by striking out all after "the project" and inserting in lieu thereof a period.

(ii) The amendment made by clause (i) shall apply with respect to loans guaranteed under subpart I of part A of title VIII of the Public Health Service Act after the date of the enactment of this Act.

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(2) Subsection (e) of such section is amended by striking out "and" after "1973," and by inserting after "1974" a comma and the following: "$2,000,000 for fiscal year 1975, $3,000,000 for fiscal year 1976, and $4,000,000 for fiscal year 1977", and by inserting a period after "Treasury" the second time it appears in the fourth sentence and by striking out the remainder of that sentence.

(c) (1) Subsection (a) of section 809 is amended by inserting "or the Federal Financing Bank" after "non-Federal lenders".

(2) Subsection (b) of section 809 is amended by inserting "or the Federal financing bank" after "non-Federal lender".

TECHNICAL AMENDMENTS

SEC. 102. (a) (1) Title VIII is amended by inserting after the heading for part A the following:

"Subpart I—Construction Assistance

(2) The heading for part A is amended by striking out "GRANTS" and inserting in lieu thereof "ASSISTANCE".

(b) Section 809 is inserted after section 804 and is redesignated as section 805.

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TITLE II—CAPITATION GRANTS

EXTENSION AND REVISION OF CAPITATION GRANTS

SEC. 201. (a) Section 806(a) is amended by striking out paragraphs (1) and (2) and inserting in lieu thereof the following:

"(1) Each collegiate school of nursing shall receive $400 for each student enrolled in each of the last two years of such school in such year.

"(2) Each associate degree school of nursing shall receive $275 for each student enrolled in the last year of such school in such year.

"(3) Each diploma school of nursing shall receive $250 for each full-time student enrolled in such school in such year."

(b) (1) Subsections (c), (d), and (f) of section 806 are repealed and subsections (e), (g), (h), and (i) are redesignated as subsections (c), (d), (e), and (f), respectively.

(2) Section 806(f)(1) (as so redesignated by paragraph (1) of this subsection) is amended by striking out "and" after "1973," and by inserting before "for grants" the following: "$45,000,000 for fiscal year 1975, $50,000,000 for fiscal year 1976, and $55,000,000 for fiscal year 1977,".

(c) For fiscal year 1975, and for each of the next two fiscal years, there are authorized to be appropriated such

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sums as may be necessary to continue to make annual grants to schools of nursing under section 806(a) of the Public Health Service Act (as in effect before the date of the enactment of this Act) based on the number of enrollment bonus students (determined in accordance with subsections (c) and (d) of section 806 of such Act (as so in effect)) enrolled in such schools who were first-year students in such schools for school years beginning before June 30, 1974.

TECHNICAL AMENDMENT

SEC. 202. Title VIII is amended by inserting after section 805 (as so redesignated by section 102(b) of this Act) the following:

"Subpart II—Capitation Grants".

TITLE III—FINANCIAL DISTRESS GRANTS

EXTENSION OF FINANCIAL DISTRESS GRANT PROGRAM

SEC. 301. Title VIII is amended by inserting after subpart II of part A (as provided by title II of this Act), the following:

"Subpart III—Financial Distress Grants

"FINANCIAL DISTRESS GRANTS

"SEC. 815. (a) The Secretary may make grants to assist public or nonprofit private schools of nursing which are in serious financial straits to meet operational costs required to maintain quality educational programs or which have special need for financial assistance to meet accreditation

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requirements. Any such grant may be made upon such terms and conditions as the Secretary determines to be reasonable and necessary, including requirements that the school agree (1) to disclose any financial information or data deemed by the Secretary to be necessary to determine the sources or causes of that school's financial distress, (2) to conduct a comprehensive cost analysis study in cooperation with the Secretary, and (3) to carry out appropriate operational and financial reforms on the basis of information obtained in the course of the comprehensive cost analysis study or on the basis of other relevant information.

"(b) (1) No grant may be made under subsection (a) unless an application thereof is submitted to and approved by the Secretary. The Secretary may not approve or disapprove such an application except after consultation with the National Advisory Council on Nurse Training.

"(2) An application for a grant under subsection (a) must contain or be supported by assurances satisfactory to the Secretary that the applicant will expend in carrying out its functions as a school of nursing, during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the average amount of funds exended by such applicant for such purpose (excluding expenditures of a nonrecurring na

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ture) in the three fiscal years immediately preceding the fiscal year for which such grant is sought. The Secretary may, after consultation with the National Advisory Council on Nurse Training, waive the requirement of the preceding sentence with respect to any school if he determines that the application of such requirement to such school would be inconsistent with the purposes of subsection (a).

"(c) For payments under grants under this section there are authorized to be appropriated $5,000,000 for fiscal year 1975, $5,000,000 for fiscal year 1976, and $5,000,000 for fiscal year 1977.".

TECHNICAL AMENDMENT

SEC. 302. Section 805 and 808 (as in effect on the date before the date of the enactment of this Act) are repealed.

TITLE IV—SPECIAL PROJECT ASSISTANCE

SPECIAL PROJECT GRANTS AND CONTRACTS

SEC. 401. (a) Title VIII is amended by inserting after subpart III of part A (as added by section 301(a) of this Act) the following:

"Subpart IV—Special Projects

"SPECIAL PROJECT GRANTS AND CONTRACTS

"SEC. 820. (a) The Secretary may make grants to public and other nonprofit private schools of nursing and other public or nonprofit private entities, and enter into contracts

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with any public or private entity, to meet the costs of special projects to—

"(1) assist in—

"(A) mergers between hospital training programs or between hospital training programs and academic institutions, or

"(B) other cooperative arrangements among hospitals and academic institutions,

leading to the establishment of nurse training programs;

"(2) plan, develop, or establish new nurse training programs or programs of research in nursing education, significantly improve curriculums of schools of nursing, or modify existing programs of nursing education;

"(3) increase nursing education opportunities for individuals from disadvantaged backgrounds, as determined in accordance with criteria prescribed by the Secretary, by—

"(A) identifying, recruiting, and selecting such individuals,

"(B) facilitating entry of such individuals into schools of nursing,

"(C) providing counseling or other services designated to assist such individuals to complete successfully their nursing education,

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"(D) providing, for a period prior to the entry of such individuals into the regular course of education at a school of nursing, prelininary education designed to assist them to compete successfully such regular course of education,

"(E) paying such stipends (including allowances for travel and dependents) as the Secretary may determine for such individuals for any period of nursing education, and

"(F) publicizing, especially to licensed vocational or practical nurses, existing sources of financial aid available to persons enrolled in schools of nursing or who are undertaking training necessary to qualify them to enroll in such schools;

"(4) provide continuing education for nurses;

"(5) provide appropriate retraining opportunities for nurses who (after periods of professional inactivity) desire again actively to engage in the nursing profession;

"(6) help to increase the supply or improve the distribution by geographic area or by specialty group of adequately trained nursing personnel (including nursing personnel who are bilingual) needed to meet the health needs of the Nation, including the need to in-

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crease the availability of personal health services and the need to promote preventive health care; or

"(7) provide training and education to upgrade the skills of licensed vocational or practical nurses, nursing assistants, and other paraprofessional nursing personnel.

Contracts may be entered into under this subsection without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(b) The Secretary may, with the advice of the National Advisory Council on Nurse Training, provide assistance to the heads of other departments and agencies of the Government to encourage and assist in the utilization of medical facilities under their jurisdiction for nurse training programs.

"(c) No grant or contract may be made under this section unless an application therefor has been submitted to and approved by the Secretary. The Secretary may not approve or disapprove such an application except after consultation with the National Advisory Council on Nurse Training. Such an application shall provide for such fiscal control and accounting procedures and reports, and access to the records of the applicant, as the Secretary may require to assure proper disbursement of and accounting for Federal funds paid to the applicant under this section.

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"(d) For payments under grants and contracts under this section there are authorized to be appropriated $20,000,000 for fiscal year 1975, $25,000,000 for fiscal year 1976 and $30,000,000 for fiscal year 1977. Not less than 10 per centum of the funds appropriated under this subsection for any fiscal year shall be used for payments under grants and contracts to meet the costs of the special projects described in subsection (a) (3).

"ADVANCED NURSE TRAINING PROGRAMS

"SEC. 821. (a) (1) The Secretary may make grants to and enter into contracts with public and nonprofit private collegiate schools of nursing to meet the costs of projects to—

"(A) plan, develop, and operate,

"(B) significantly expand, or

"(C) maintain existing,

programs for the advanced training of professional nurses to teach in the various fields of nurse training, to serve in administrative or supervisory capacities, or to serve in other professional nursing specialties (including service as nurse clinicians) determined by the Secretary to require advanced training.

"(b) For the purposes of making payments under grants and contracts under this section there are authorized to be appropriated $20,000,000 for fiscal year 1975, $25,000,-

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000 for fiscal year 1976, and $30,000,000 for fiscal year 1977.

"NURSE PRACTITIONER PROGRAMS

"SEC. 822. (a) (1) the Secretary may make grants to and enter into contracts with public or nonprofit private schools of nursing, medicine, and public health, public or nonprofit private hospitals, and other public or nonprofit private entities to meet the cost of projects to—

"(A) plan, develop, and operate,

"(B) significantly expand, or

"(C) maintain existing,

programs for the training of nurse practitioners.

"(2) (A) For purposes of this section, the term 'programs for the training of nurse practitioners' means educational programs which meet guidelines prescribed by the Secretary in accordance with subparagraph (B) and which have as their objective the education of nurses (including pediatric and geriatric nurses) who will, upon completion of their studies in such a program, be qualified to effectively provide primary health care.

"(B) On or before March 1, 1975, after consultation with appropriate educational organizations and professional nursing and medical organizations, the Secretary shall prescribe guidelines for programs for nurse practitioners. Such guidelines shall, as a minimum, require—

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"(i) a program of classroom instruction and supervised clinical practice directed toward preparing nurses to deliver primary health care;

"(ii) a minimum course of study of one academic year of which at least four months must be classroom instruction; and

"(iii) a minimum level of enrollment in each year of not less than eight students.

"(b) No grant may be made or contract entered into to plan, develop, and operate a program for the training of nurse practitioners unless the application for the grant or contract contains assurances satisfactory to the Secretary that the program will upon its development meet the guidelines which are in effect under subsection (a) (2) (B); and no grant may be made or contract entered into to expand or maintain such a program unless the application for the grant or contract contains assurances satisfactory to the Secretary that the program meets the guidelines which are in effect under such subsection.

"(c) The costs for which a grant or contract under this section may be made may include costs of preparation of faculty members in order to conform to the guidelines established under subsection (a) (2) (B).

"(d) For the purposes of making payments under grants and contracts under this section there are authorized

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to be appropriated $20,000,000 for fiscal year 1975, $25,000,000 for fiscal year 1976, and $30,000,000 for fiscal year 1977."

(b) Sections 810 and 868 are repealed.

TITLE V—ASSISTANCE TO NURSING STUDENTS

EXTENSION OF TRAINEESHIPS

SEC. 501. (a) Subsection (a) of section 821 (as in effect on the day before the date of the enactment of this Act) is amended to read as follows:

"(a) There are authorized to be appropriated $20,000,000 for fiscal year 1975, $25,000,000 for fiscal year 1976, and $30,000,000 for fiscal year 1977, to cover the costs of traineeships for the training of professional nurses—

"(1) to teach in the various fields of nurse training (including practical nurse training),

"(2) to serve in administrative or supervisory capacities,

"(3) to serve as nurse practitioners, or

"(4) to serve in other professional nursing specialties determined by the Secretary to require advanced training."

(b) Subsection (b) of section 821 (as so in effect) is amended by adding at the end thereof the following: "In making grants for traineeships under this section, the Secretary shall give special consideration to applications for

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traineeship programs which conform to guidelines established by the Secretary under section 822(a)(2)(B)."

EXTENSION OF STUDENT LOAN PROGRAM

SEC. 502. (a) Section 882(b)(4) (as in effect before the date of the enactment of this Act) is amended by striking out "1975" and inserting in lieu thereof "1977".

(b) Section 823(b)(2)(B) is amended by inserting "(or training to be a nurse anesthetist)" after "professional training in nursing".

(c) Effective July 1, 1974, section 824 is amended to read as follows:

"AUTHORIZATION OF APPROPRIATIONS FOR STUDENT LOAN FUNDS

"SEC. 824. There are authorized to be appropriated for allotments under section 825 to schools of nursing for Federal capital contributions to their student loan funds established under section 822, $30,000,000 for fiscal year 1975, $35,000,000 for fiscal year 1976, and $40,000,000 for fiscal year 1977. For fiscal year 1978, and for each of the next two succeeding fiscal years there are authorized to be appropriated such sums as may be necessary to enable students who have received a loan for any academic year ending before July 1, 1977, to continue or complete their education.".

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(d) Section 826 is amended by striking out "1977" each place it occurs and inserting in lieu thereof "1980".

(e) (1) Section 827 is repealed.

(2) The nurse training fund created within the Treasury by section 827 (d) (1) of the Public Health Service Act shall remain available to the Secretary of Health, Education, and Welfare for the purpose of meeting his responsibilities respecting participations in obligations acquired under section 827 of such Act. The Secretary shall continue to deposit in such fund all amounts received by him as interest payments or repayments of principal on loans under such section 827. If at any time the Secretary determines the moneys in the funds exceed the present and any reasonable prospective further requirements of such fund, such excess may be transferred to the general fund of the Treasury.

(3) There are authorized to be appropriated without fiscal year limitation such sums as may be necessary to enable the Secretary to make payments under agreements entered into under section 827 (b) of the Public Health Service Act before the date of the enactment of this Act.

EXTENSION OF SCHOLARSHIP PROGRAM

SEC. 503. Effective July 1, 1974, section 860 is amended—

(1) by striking out "1972" in subsection (b) and

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in subsection (c) (1) (A) and inserting in lieu thereof "1975";

(2) by striking out "1975" in the second sentence of subsection (b) and in subsection (c) (1) and inserting in lieu thereof "1978"; and

(3) by striking out "1974" in the second sentence of subsection (b) and in subsection (c) (1) (B) and inserting in lieu thereof "1977".

TITLE VI—TECHNICAL AND CONFORMING AMENDMENTS

TECHNICAL AND CONFORMING AMENDMENTS

SEC. 601. (a) (1) Section 802 is amended—

(A) by striking out "this part" each place it occurs and inserting in lieu thereof "this subpart";

(B) by striking out "subsection 806 (e) of this Act" in subsection (b) (2) and inserting in lieu thereof "section 810 (c)";

(C) by striking out paragraph (5) of subsection (b) and inserting in lieu thereof the following:

"(5) the application contains or is supported by adequate assurances that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a project will be paid wages at rates not less than those prevailing on similar con

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struction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).";

(D) by striking out "section 841 (hereinafter in this part referred to as the 'Council')" in the first sentence following paragraph (5) of subsection (b) and inserting in lieu thereof "section 851";

(E) by striking out "subsection (e) of section 806" in the second sentence following such paragraph and inserting in lieu thereof "section 810(c)";

(F) by striking out "section 806(e)" in the last sentence following such paragraph and inserting in lieu thereof "section 810(c)";

(G) by striking out in such last sentence "806(a)" and inserting in lieu thereof "810(a)"; and

(H) by striking out "paragraph (A)" in subsection (c)(1)(B) and inserting in lieu thereof "subparagraph (A)".

(b)(1) Subsection (a) of section 803 is amended to read as follows:

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"(a) The amount of any grant for a construction project under this subpart shall be such amount as the Secretary determines to be appropriate after obtaining the advice of the National Advisory Council on Nurse Training; except that—

"(1) in the case of a grant—

"(A) for a project for a new school,

"(B) for a project for new facilities for an existing school in cases where such facilities are of particular importance in providing a major expansion of training capacity, as determined in accordance with regulations, or

"(C) for a project for major remodeling or renovation of an existing facility where such project is required to meet an increase in student enrollment,

the amount of such grant may not exceed 75 per centum of the necessary cost of construction, as determined by the Secretary, of such project; and

"(2) in the case of a grant for any other project, the amount of such grant may not, except where the Secretary determines that unusual circumstances make a larger percentage (which may in no case exceed 75 per centum) necessary in order to effectuate the purposes of this subpart, exceed 67 per centum of the necessary cost

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of construction, as so determined, of the project with respect to which the grant is made."

(2) Subsections (b) and (c) of section 803 are each amended by striking out "this part" and inserting in lieu thereof "this subpart".

(c) Section 804 is amended (1) by striking out "this part" and inserting in lieu thereof "this subpart", and (2) by redesignating paragraphs (a), (b), and (c) as paragraphs (1), (2), and (3), respectively.

(d) Section 805 (as redesignated by section 102(b)) is amended by striking out "this part" each place it occurs and inserting in lieu thereof "this subpart".

(e) Section 806 is redesignated as section 810.

(f) Section 807 is redesignated as section 811 and is amended—

(1) by striking out "section 805, 806, or 810" in subsections (a) and (c) and inserting in lieu thereof "this subpart"; and

(2) by amending paragraph (1) of subsection (c) to read as follows:

"(1) is from a public or nonprofit private school of nursing;".

(g) (1) Title VIII is amended by inserting after the heading for part B the following:

"Subpart I—Traineeships".

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(2) Section 821 (as amended by section 501) is redesignated as section 830.

(3) Title VIII is amended by inserting after section 830 (as so redesignated) the following:

"Subpart II—Student Loans".

(h) Sections 822, 823, 825, 826, 828, and 830 (as in effect before the date of the enactment of this Act) are amended as follows:

(1) Sections 822 (a), 823, 825, 826, and 828 are each amended by striking out "this part" and inserting in lieu thereof "this subpart".

(2) Sections 822 (a), 823 (b), 823 (c), 825 (b) (2), and 826 (a) (1) are each amended by striking out "of Health, Education, and Welfare".

(3) Section 822 (b) (2) (A) is amended by striking out "under this part" and inserting in lieu thereof "from allotments under section 838".

(4) (A) Section 825 is amended—

(i) by striking out "(whether as Federal capital contributions or as loans to schools under section 827)" in subsection (a); and

(ii) by striking out ", and for loans pursuant to section 827," in subsection (b) (1).

(B) Section 826 (b) is amended by striking out "(other than so much of such fund as relates to pay-

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ments from the revolving fund established by section 827(d))".

(C) Section 828 is amended by striking out "or loans".

(5) Section 830 is—

(A) transferred to section 823 and inserted after subsection (i) of such section; and

(B) is amendedby striking out "SEC. 830. (a)" and inserting in lieu thereof "(j)".

(i) (1) Sections 822, 823, 824, 825, 826, 828, and 829 (as in effect on the day before the date of the enactment of this Act) are redesignated as sections 835, 836, 837, 838, 839, 840, and 841, respectively.

(2) Section 835 (as so redesignated) is amended (A) by striking out "829" each place it occurs and inserting in lieu thereof "841", and (B) by striking out "823" and inserting in lieu thereof "836".

(3) Section 837 (as so redesignated) is amended (A) by striking out "825" and inserting in lieu thereof "838", and (B) by striking out "822" and inserting in lieu thereof "835".

(4) Section 838 (as so redesignated) is amended by striking out "824" each place it occurs and inserting in lieu thereof "837".

(5) Section 839 (as so redesignated) is amended by

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striking out "822" each place it occurs and inserting in lieu thereof "835".

(6) Section 841 (as so redesignated) is amended (A) by striking out "822" and inserting in lieu thereof "835", and (B) by striking out "part D" and inserting in lieu thereof "subpart III of this part".

(j) (1) Part D of title VIII is inserted after subpart II of part B of such title and redesignated as subpart III; and sections 860 and 861 are redesignated as sections 845 and 846, respectively.

(2) Section 845 (a) (as so redesignated) is amended by striking out "this part" and inserting in lieu thereof "this section".

(3) Section 846 (as so redesignated) is amended (A) by striking out "this part" the first time it occurs and inserting in lieu thereof "section 845", and (B) by striking out "to the sums available to the school under this part for (and to be regarded as) Federal capital contributions, to be used for the same purpose as such sums" and inserting in lieu thereof "to the student loan fund of the school established under an agreement under section 835. Funds transferred under this section to such a student loan fund shall be considered as part of the Federal capital contributions to such fund".

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(4) Section 869 is repealed.

(k) (1) Sections 841, 842, 843, 844, and 845 (as in effect on the day before the date of enactment of this Act) are redesignated as sections 851, 852, 853, 854, and 855, respectively.

(2) Section 851 (as so redesignated) is amended (A) by striking out "part A of applications under section 805" in subsection (a) (2) and inserting in lieu thereof "subpart I of part A, of applications under section 805, and of applications under subpart III of part A"; (B) by striking out subsection (b); (C) by striking out "(a) (1)" and inserting in lieu thereof "(a)"; and (D) by striking out "(2)" and inserting in lieu thereof "(b)".

(3) Section 853 (as so redesignated) is amended—

(A) by striking out "part A" in paragraph (f) and inserting in lieu thereof "subpart I of part A";

(B) by striking out "806" in paragraph (f) and inserting in lieu thereof "810";

(C) by striking out "part B" each place it occurs in paragraph (f) and inserting in lieu thereof "section 835";

(D) by striking out "825" in paragraph (i) and inserting in lieu thereof "838";

(E) by redesignating paragraphs (a) through (j) as paragraphs (1) through (10) respectively;

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(F) by redesignating clauses (1), (2), and (3) of paragraph (6) (as so redesignated) as clauses (A), (B), and (C), respectively.

(G) by redesignating subclauses (A) and (B) of such paragraph (6) as subclauses (i) and (ii), respectively; and

(H) by redesignating clauses (1) and (2) of paragraph (9) (as so redesignated) as clauses (A) and (B), respectively.

(4) Part C is amended by adding at the end thereof the following:

"DELEGATION

"SEC. 856. The Secretary may delegate the authority to administer any program authorized by this title to the administrator of a central or regional office or offices in the Department of Health, Education, and Welfare, except that the authority—

"(1) to review, and prepare comments on the merit of, any application for a grant or contract under any program authorized by this title for purposes of presenting such application to the National Advisory Council on Nurse Training, or

"(2) to make such a grant or enter into such a contract,

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shall not be further delegated to any administrator of, or officer in, any regional office or offices.".

TITLE VII—MISCELLANEOUS

INFORMATION RESPECTING THE SUPPLY AND DISTRIBUTION OF AND REQUIREMENTS FOR NURSES

SEC. 701. (a) (1) Using procedures developed in accordance with paragraph (3), the Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the "Secretary") shall determine on a continuing basis—

(A) the supply (both current and projected and within the United States and within each State) of registered nurses, licensed practical and vocational nurses, nurse's aides, registered nurses with advanced training or graduate degrees, and nurse practitioners;

(B) the distribution, within the United States and within each State, of such nurses so as to determine those areas of the United States which are oversupplied, undersupplied, or which have an adequate supply of such nurses in relation to the population of the area and the demand for the services which such nurses provide; and

(C) the current and future requirements for such nurses, nationally and within each State.

(2) The Secretary shall survey and gather data, on a continuing basis, on—

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(A) the number and distribution of nurses, by type of employment and location of practice;

(B) the number of nurses who are practicing full time and those who are employed part time, within the United States and within each State;

(C) the average rates of compensation for nurses, by type of practice and location of practice;

(D) the activity status of the total number of registered nurses within the United States and within each State;

(E) the number of nurses with advanced training or graduate degrees in nursing, by specialty, including nurse practitioners, nurse clinicians, nurse researchers, nurse educators, and nurse supervisors and administrators; and

(F) the number of registered nurses entering the United States annually from other nations, by country of nurse training and by immigrant status.

(3) Within six months of the date of the enactment of this Act, the Secretary shall develop procedures for determining (on both a current and projected basis) the supply and distribution of and requirements for nurses within the United States and within each State.

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(b) Not later than February 1, 1976, and February 1 of each succeeding year, the Secretary shall report to the Congress—

(1) his determinations under subsection (a) (1) and the data gathered under subsection (a) (2) ;

(2) an analysis of such determination and data; and

(3) recommendations for such legislation as the Secretary determines, based on such determinations and data, will achieve (A) an equitable distribution of nurses within the United States and within each State, and (B) adequate supplies of nurses within the United States and within each State.

(c) The Office of Management and Budget may review the Secretary's report under this section before its submission to the Congress, but the Office may not revise the report or delay its submission, and it may submit to the Congress its comments (and those of other departments or agencies of the Government) respecting such report.

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94TH CONGRESS
1ST SESSION

H. R. 2958

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 6, 1975

Mr. ROGERS (for himself, Mr. PREYER, Mr. SYMINGTON, Mr. CARNEY, Mr. SCHEUER, Mr. WAXMAN, Mr. HEFNER, Mr. FLORIO, Mr. CARTER, Mr. BROYHILL, Mr. HASTINGS, and Mr. HEINZ) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Public Health Service Act to revise and extend the National Health Service Corps program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 329(h) of the Public Health Service Act is amended by striking out "and" after "1973;", and by inserting before the period a comma and the following: "and $16,000,000 for the fiscal year ending June 30, 1975".

(b) Effective with respect to appropriations made for fiscal years beginning after June 30, 1975, under section

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329 of the Public Health Service Act, such section is amended to read as follows:

"NATIONAL HEALTH SERVICE CORPS

"SEC. 329. (a) There is established, within the Service, the National Health Service Corps (hereinafter in this section referred to as the 'Corps') which shall consist of those officers of the Regular and Reserve Corps of the Service and such other personnel as the Secretary may designate and which shall be utilized by the Secretary under this section to improve the delivery of health services to medically underserved populations.

"(b) (1) The Secretary shall designate the medically underserved populations in the States. For purposes of this section, a medically underserved population is the population of an urban or rural area (which does not have to conform to the geographical boundaries of a political subdivision and which should be a rational area for the delivery of health services) which the Secretary determines has a critical health manpower shortage or a population group determined by the Secretary to have such a storage; and the term 'State' includes Guam, American Samoa, and the Trust Territory of the Pacific Islands. In designating medically underserved populations, the Secretary shall take into account (A) the recommendations of the entities responsible for the development of the plans referred to in section 314(b)

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which cover all or any part of the areas in which populations under consideration for designation reside, and (B) in the case of any such area for which no such entity is responsible for developing such a plan, the recommendations of the agency of the State (or States) in which such area is located which administers or supervises the administration of a State plan approved under section 314 (a).

"(2) Any person may apply to the Secretary (in such manner as he may prescribe) for the designation of a population as a medically underserved population. In considering an application under this paragraph, the Secretary shall, in addition to criteria utilized by him in making a designation under paragraph (1), take into account the following:

"(A) Ratios of available health manpower to the population for which the application is made.

"(B) Indicators of the population's access to health services.

"(C) Indicators of the health status of the population.

"(D) Indicators of such population's needs and demand for health services.

"(3) The Secretary shall (A) provide assistance to persons seeking assignment of Corps personnel to provide under this section health services for medically underserved populations, and (B) conduct such information programs

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in areas in which such populations reside as may be necessary to inform the public and private health entities serving those areas of the assistance available to such populations by virtue of their designation under this section as medically underserved.

"(c) (1) (A) The Secretary may assign personnel of the Corps to provide, under regulations prescribed by the Secretary, health services for a medically underserved population if—

"(i) the State health agency of each State in which such population is located or the local public health agency or any other public or nonprofit private health entity serving such population makes application to the Secretary for such assignment, and

"(ii) the

"(I) local government of the area in which such population resides, and

"(II) any State and district medical osteopathic, or dental society for such area, or any other appropriate health society (as the case may be) for such area,

certify to the Secretary that such assignment of Corps personnel is needed for such population.

"(B) The Secretary may not approve an application under paragraph (1) (A) (i) for an assignment unless the

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applicant agrees to enter into an arrangement with the Secretary in accordance with subsection (e) (1) and has afforded—

"(i) the entity responsible for the development of the plans referred to in section 314 (b) which covers all or any part of the area in which the population for which the application is submitted resides, and

"(ii) if there is a part of such area for which no such entity is responsible for developing such plans, the agency of the State in which such part is located which administers or supervises the administration of a State plan approved under section 314 (a),

an opportunity to review the application and submit its comments to the Secretary respecting the need for and proposed use of the manpower requested in the application. In considering such an application, the Secretary shall take into consideration the need of the population for which the application was submitted for the health services which may be provided under this section; the willingness of the population aand the appropriate governmental agencies or health entities serving it to assist and cooperate with the Corps in providing effective health services to the population; and recommendations from medical, dental, or other health societies or from medical personnel serving the population.

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"(C) If with respect to any proposed assignment of Corps personnel for a medically underserved population the requirements of clauses (i) and (ii) of subparagraph (A) are met except for the certification by a State and district medical, osteopathic, or dental society or by any other appropriate health society required by clause (ii) (II) and if the Secretary finds from all the facts presented that such certification has clearly been arbitrarily and capriciously withheld, the Secretary may, after consultation with appropriate medical, osteopathic, dental, or other health societies, waive the application of the certification requirement to such proposed assignment.

"(2) (A) In approving an application submitted under paragraph (1) for the assignment of Corps personnel to provide health services for a medically underserved population, the Secretary may approve the assignment of Corps personnel for such population during a period (referred to in this paragraph as the 'assistance period') which may not exceed four years from the date of the first assignment of Corps personnel for such population after the date of the approval of the application. No assignment of individual Corps personnel may be made for a period ending after the expiration of the applicable approved assistance period.

"(B) Upon expiration of an approved assistance period for a medically underserved population, no new assignment

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of Corps personnel may be made for such population unless an application is submitted in accordance with paragraph (1) for such assignment. The Secretary may not approve such an application unless—

"(i) the application and certification requirements of paragraph (1) are met;

"(ii) the Secretary has conducted an evaluation of the continued need for health manpower of the population for which the application is submitted, of the utilization of the manpower by such population, of the growth of the health care practice of the Corps personnel assigned for such population, and of community support for the assignment; and

"(iii) the Secretary has determined that such population has made continued efforts to secure its own health manpower, that there has been sound fiscal management of the health care practice of the Corps personnel assigned for such population, including efficient collection of fee-for-service, third-party, and other funds available to such population, and that there has been appropriate and efficient utilization of such Corps personnel.

"(3) Corps personnel shall be assigned to provide health services for a medically underserved population on the basis of the extent of the population's need for health services

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and without regard to the ability of the members of the population to pay for health services.

"(4) In making an assignment of Corps personnel the Secretary shall seek to match characteristics of the assignee (and his spouse (if any)) and of the population to which such assignee may be assigned in order to increase the likelihood of the assignee remaining to serve the population upon completion of his assignment period. The Secretary shall, before the expiration of the last nine months of the assignment period of a member of the Corps, review such member's assignment and the situation in the area to which he was assigned for the purpose of determining the advisability of extending the period of such member's assignment.

"(5) To assist in the recruitment of health manpower, the Secretary shall provide technical assistance to all medically underserved populations to which are not assigned Corps personnel. The Secretary shall also give such populations current information respecting public and private programs which may assist in securing health manpower for them.

"(d) (1) In providing health services for a medically underserved population under this section, Corps personnel shall utilize the techniques, facilities, and organizational forms most appropriate for the area in which the population resides and shall, to the maximum extent feasible, provide

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such services (A) to all members of the population regardless of their ability to pay for the services, and (B) in connection with (i) direct health services programs carried out by the Service; (ii) any direct health services program carried out in whole or in part with Federal financial assistance; or (iii) any other health services activity which is in furtherance of the purposes of this section.

"(2) (A) Notwithstanding any other provision of law, the Secretary (i) may, to the extent feasible, make such arrangements as he determines necessary to enable Corps personnel in providing health services for a medically underserved population to utilize the health facilities of the area in which the population resides and if there are no health facilities in or serving such area, the Secretary may arrange to have Corps personnel provide health services in the nearest health facilities of the Service or the Secretary may lease or otherwise provide facilities in such area for the provision of health services, (ii) may make such arrangements as he determines are necessary for the use of equipment and supplies of the Service and for the lease or acquisition of other equipment and supplies, and (iii) may secure the temporary services of nurses and allied health professionals.

"(B) If such area is being served (as determined under regulations of the Secretary) by a hospital or other health

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care delivery facility of the Service, the Secretary shall, in addition to such other arrangements as the Secretary may make under subparagraph (A), arrange for the utilization of such hospital or facility by Corps personnel in providing health services for the population, but only to the extent that such utilization will not impair the delivery of health services and treatment through such hospital or facility to persons who are entitled to health services and treatment through such hospital or facility.

"(3) The Secretary may make one grant to any applicant with an approved application under subsection (c) to assist it in meeting the costs of establishing medical practice management systems for Corps personnel, acquiring equipment for their use in providing health services, and establishing appropriate continuing education programs and opportunities for them. No grant may be made under this paragraph unless an application therefor is submitted to, and approved by, the Secretary. The amount of any grant shall be determined by the Secretary, except that no grant may be made for more than $25,000.

"(4) Upon the expiration of the assignment of Corps personnel to provide health services for a medically underserved population, the Secretary (notwithstanding any other provision of law) may sell to the entity which submitted the last application approved under subsection (c) for the

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assignment of Corps personnel for such population equipment of the United States utilized by such personnel in providing health services. Sales made under this paragraph shall be made for the fair market value of the equipment sold (as determined by the Secretary).

"(e) (1) The Secretary shall require as a condition to the approval of an application under subsection (c) that the entity which submitted the application enter into an appropriate arrangement with the Secretary under which—

"(A) the entity shall be responsible for charging in accordance with paragraph (2) for health services by the Corps personnel to be assigned;

"(B) the entity shall take such action as may be reasonable for the collection of payments for such health services, including if a Federal agency, an agency of a State or local government, or other third party would be responsible for all or part of the cost of such health services if it had not been provided by Corps personnel under this section, the collection, on a fee-for-service or other basis, from such agency or third party the portion of such cost for which it would be so responsible (and in determining the amount of such cost which such agency or third party would be responsible, the health services provided by Corps personnel shall be considered as being provided by private practitioners); and

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"(C) the entity shall pay to the United States as prescribed by the Secretary for each calendar quarter (or other period as may be specified in the arrangement) during which any Corps personnel are assigned to such entity the sum of—

"(i) the pay (including amounts paid in accordance with subsection (f)) and allowances of such Corps personnel for the portion of such quarter (or other period) during which assigned to the entity;

"(ii) if such entity received a grant under subsection (d)(3) for the assistance period, an amount which bears the same ratio to the amount of such grant as the number of days in such quarter (or other period) during which any Corps personnel were assigned to the entity bears to the number of days in the assistance period after such entity received such grant; and

"(iii) if during such quarter (or other period) any member of the Corps assigned to such entity is providing obligated service pursuant to an agreement under the Public Health and National Health Service Corps Scholarship Training Program, for each such member an amount which bears the same ratio to the amount paid under such Program to or

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on the behalf of such member as the number of days of obligated service provided by such member during such quarter (or other period) bears to the number of days in his period of obligated service under such Program.

The Secretary may waive in whole or in part the application of the requirement of subparagraph (C) to an entity if he determines that the entity is financially unable to meet such requirement or if he determines that compliance with such requirement would unduly limit the ability of the entity to maintain the quality of the services it provides. The excess (if any) of the amount collected by an entity in accordance with subparagraph (B) over the amount paid to the United States in accordance with subparagraph (C) shall be used by the entity to expand or improve the provision of health services to the population for which the entity submitted an application under subsection (c) or to recruit and retain health manpower to provide health services for such population. Funds received by the Secretary under such an arrangement shall be deposited in the Treasury as miscellaneous receipts and shall be disregarded in determining the amounts of appropriations to be requested under subsection (i) and the amounts to be made available from appropriations made under such subsection to carry out this section.

"(2) Any person who receives health services provided

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by Corps personnel under this section shall be charged for such services on a fee-for-service or other basis at a rate approved by the Secretary, pursuant to regulations, to recover the value of such services; except that if such person is determined under regulations of the Secretary to be unable to pay such charge, the Secretary shall provide for the furnishing of such services at a reduced rate or without charge.

"(f) (1) The Secretary shall conduct at medical and nursing schools and other schools of the health professions and at entities which train allied health personnel, recruiting programs for the Corps. Such programs shall include the wide dissemination of written information on the Corps and visits to such schools by personnel of the Corps.

"(2) The Secretary may reimburse applicants for positions in the Corps for actual expenses incurred in traveling to and from their place of residence to an area in which they would be assigned for the purpose of evaluating such area with regard to being assigned in such area. The Secretary shall not reimburse an applicant for more than one such trip.

"(3) Commissioned officers and other personnel of the Corps assigned to provide health services for medically underserved populations shall not be included in determining whether any limitation on the number of personnel

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which may be employed by the Department of Health, Education, and Welfare has been exceeded.

"(4) The Secretary shall, under regulations prescribed by him, adjust the monthly pay of each physician and dentist member of the Corps who is directly engaged in the delivery of health services to a medically underserved population as follows:

"(A) During the first thirty-six months in which such a member is so engaged in the delivery of health services, his monthly pay shall be increased by an amount (not to exceed $1,000) which when added to the member's monthly pay and allowances will provide a monthly income competitive with the average monthly income from an established practice of a member of such member's profession with equivalent training.

"(B) During the period beginning upon the expiration of the thirty-six months referred to in subparagraph (A) and ending with the month in which the member's monthly pay and allowances is equal to or exceeds the monthly income he received for the last of such thirty-six months, the member shall receive in addition to his monthly pay and allowances an amount which when added to such monthly pay and allowances equals the monthly income he received for such last month.

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For purposes of subparagraphs (A) and (B), the term 'monthly pay' includes special pay received under chapter 5 of title 37 of the United States Code. In the case of a member of the Corps who is directly engaged in the provision of health services to a medically underserved population in accordance with a service obligation incurred under the Public Health Service and National Health Service Corps Scholarship Training Program, the provisions of this paragraph shall apply to such member upon satisfactory completion of such service obligation and the first thirty-six months of his being so engaged in the delivery of health care shall, for purposes of this paragraph, be deemed to begin upon such satisfactory completion.

"(g) The Secretary shall report to Congress no later than May 15 of each year—

"(1) the number and identity of all medically underserved populations in each of the States in the calendar year preceding the year in which the report is made and the number of medically underserved populations which the Secretary estimates will be designated under subsection (b) in the calendar year in which the report is made;

"(2) the number of applications filed in such preceding calendar year for assignment of Corps personnel

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under this section and the action taken on each such application;

"(3) the number and types of Corps personnel assigned in such preceding year to provide health services for medically underserved populations, the number and types of additional Corps personnel which the Secretary estimates will be assigned to provide such services in the calendar year in which the report is submitted, and the need (if any) for additional personnel for the Corps;

"(4) the recruitment efforts engaged in for the Corps in such preceding year, including the programs carried out under subsection (f) (1) and the number of qualified persons who applied for service in the Corps in each professional category;

"(5) the total number of patients seen and patient visits recorded during such preceding year in each area where Corps personnel were assigned;

"(6) the number of health personnel electing to remain after termination of their service in the Corps to provide health services to medically underserved populations and the number of such personnel who do not make such election and the reasons for their departure;

"(7) the results of evaluations made under sub-

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section (c) (2) (B) (ii), and determinations made under subsection (c) (2) (B) (iii), during such preceding year; and

"(8) the amount (A) charged during such preceding year for health services by Corps personnel, (B) collected in such year by entities in accordance with arrangements under subsection (e) (1), and (C) paid to the Secretary in such year under such arrangements.

"(h) (1) There is established a council to be known as the National Advisory Council on the National Health Service Corps (hereinafter in this section referred to as the 'Council'). The Council shall be composed of fifteen members appointed by the Secretary as follows:

"(A) Four members shall be appointed from the general public to represent the consumers of health care, at least two of whom shall be members of a medically underserved population for which Corps personnel are providing health services under this section.

"(B) Three members shall be appointed from the medical, dental, and other health professions and health teaching professions.

"(C) Three members shall be appointed from State health or health planning agencies.

"(D) Three members shall be appointed from the Service, at least two of whom shall be members of the

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Corps directly engaged in the provision of health services for a medically underserved population.

"(E) One member shall be appointed from the National Advisory Council on Comprehensive Health Planning.

"(F) One member shall be appointed from the National Advisory Council on Regional Medical Programs.

The Council shall consult with, advise, and make recommendations to, the Secretary with respect to his responsibilities in carrying out this section, and shall review and comment upon regulations promulgated by the Secretary under this section and section 747.

"(2) Members of the Council shall be appointed for a term of three years and shall not be removed, except for cause. Members may be reappointed to the Council.

"(3) Appointed members of the Council, while attending meetings or conferences thereof or otherwise serving on the business of the Council, shall be entitled to receive for each day (including traveltime) in which they are so serving the daily equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 (b)

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of title 5 of the United States Code for persons in the Government service employed intermittently.

"(i) (1) To carry out the purposes of this section, there are authorized to be appropriated $30,000,000 for fiscal year 1976.

"(2) An appropriation under an authorization under paragraph (1) of this subsection for any fiscal year may be made at any time before that fiscal year and may be included in an Act making an appropriation under an authorization under paragraph (1) for another fiscal year; but no funds may be made available from any appropriation under such authorization for obligation under this section before the fiscal year for which such appropriation is authorized.".

(c) (1) The Secretary of Health, Education, and Welfare shall report to Congress (1) not later than three months after the date of the enactment of this Act, the criteria to be used by him in designating medically underserved populations for purposes of section 329 of the Public Health Service Act (as amended by subsection (b)) and (2) not later than six months after the date of the enactment of this Act, the identity and number of medically underserved populations in each State meeting such criteria.

(2) The Secretary of Health, Education, and Welfare shall conduct or contract for studies of methods of assigning

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under section 329 of the Public Health Service Act National Health Service Corps personnel to medically underserved populations and of providing health care to such populations. Such studies shall be for the purpose of identifying (A) the characteristics of health manpower who are more likely to remain in practice in areas in which medically underserved populations are located, (B) the characteristics of areas which have been able to retain health manpower, (C) the appropriate conditions for assignment of nurse practitioners, physician's assistants, and expanded function dental auxiliaries in areas in which medically underserved populations are located, and (D) the effect that primary care residency training in such areas has on the health care provided in such areas and on the decisions of physicians who received such training respecting the areas in which to locate their practice.

(d) (1) The amendment made by subsection (b) which changed the name of the advisory council established under section 329 of the Public Health Service Act shall not be construed as requiring the establishment of a new advisory council under that section; and the amendment made by such subsection with respect to the composition of such advisory council shall apply with respect to appointments made to the advisory council after June 30, 1975, and the Secretary of Health, Education, and Welfare shall make appointments to the Advisory Council after such date in

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a manner which will bring about, at the earliest feasible time, the Advisory Council composition prescribed by the amendment.

(2) (A) Effective July 1, 1975, section 741 (f) (1) (C) is amended by striking all that follows after "in a State" and inserting in lieu thereof "in which is located a medically underserved population designated under section 329 (b) ;".

(B) The amendment made by subparagraph (A) shall apply with respect to agreements entered into under section 741 (f) of the Public Health Service Act after June 30, 1975.

SEC. 2. (a) Section 747 is repealed and effective July 1, 1975, section 225 is transferred to subpart II of part C of title VII, is redesignated section 747, and is amended to read as follows:

"PUBLIC HEALTH AND NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP TRAINING PROGRAM

"SEC. 747. (a) The Secretary shall establish the Public Health and National Health Service Corps Scholarship Training Program (hereinafter in this section referred to as the 'Program') to obtain trained physicians, dentists, and nurses and, if needed by the Corps or other unit of the Service, podiatrists, optometrists, pharmacists, graduates of schools of public health, graduates of programs in health administration, and other health-related specialists.

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"(b) To be eligible for acceptance in the Program, an applicant for the Program must—

"(1) be accepted for enrollment, or be enrolled, as a full-time student (A) in an accredited (as determined by the Secretary) educational institution in a State and (B) in (i) a course of study offered by such institution and approved by the Secretary which leads to a degree in medicine, osteopathy, dentistry, nursing, or other health-related specialty as determined by the Secretary or (ii) a program offered by such institution for the training of physician assistants, expanded function dental auxiliaries, or nurse practitioners;

"(2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Service; and

"(3) agree in writing to serve, as prescribed by subsection (d) of this section, in the Commissioned Corps of the Service or as a civilian member of the Service.

To remain in the program an individual must pursue at such an institution such an approved course of study or such a program and maintain an acceptable level of academic standing in it.

"(c) (1) (A) Each participant in the Program shall

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receive a scholarship for each approved academic year of training, not to exceed four years. A participant's scholarship shall consist of (i) an amount equal to the basic pay and allowances of a commissioned officer on active duty in pay grade O–1 with less than two years of service, and (ii) payment of the tuition expenses of the participant and all other reasonable educational expenses incurred by the participant, including fees, books, and laboratory expenses.

"(B) The Secretary may contract with an institution in which participants in the Program are enrolled for the payment to the institution of the tuition and other educational expenses of such participants. Payment to such institution may be made without regard to section 3648 of the Revised Statutes (31 U.S.C. 529).

"(2) When the Secretary determines that an institution has increased its total enrollment for the sole purpose of accepting members of the Program, he may provide under a contract with such an institution for additional payments to the institution to cover the portion of the increased costs of the additional enrollment which are not covered by the institution's normal tuition and fees.

"(d) (1) Each participant in the Program shall provide service as prescribed by paragraph (2) for a period of time (hereinafter in this section referred to as a 'period of

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obligated service') prescribed by the Secretary which may be not less than—

"(A) one year of such service for each academic year of training received under the Program, or

"(B) two years.

For persons receiving a degree from a school of medicine, osteopathy, or dentistry, the commencement of a period of obligated service shall be deferred by the Secretary, at the request of the participant, for the period of time required to complete internship, residency, or other advanced clinical training. For persons receiving degrees in other health professions the obligated service period shall commence upon completion of their academic training. Periods of internship, residency, or other advanced clinical training shall not be creditable in satisfying a service obligation under this subsection.

"(2) (A) Except as provided in subparagraphs (B), (C), and (D), an individual obligated to provide service on account of his participation in the Program shall provide such service for the period of obligated service applicable to him as a member of the National Health Service Corps or the Indian Health Service in the clinical practice of his profession.

"(B) If at the time an individual is required by the

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Secretary to begin his period of obligated service neither the National Health Service Corps nor the Indian Health Service has a position available for a member of the profession for which such individual was trained, such individual shall serve as a member of the Service in the clinical practice of his profession in connection with the delivery of health services under the authority of section 321 (relating to hospitals), 322 (relating to care and treatment of seamen and others), 323 (relating to care and treatment of Federal prisoners), 324 (relating to examination and treatment of certain Federal employees), 325 (relating to examination of aliens), or 326 (relating to services to certain Federal employees) or part D of title III (relating to services for persons with Hansen's disease).

"(C) If at the time an individual is required by the Secretary to begin his period of obligated service—

"(i) the Corps and the Indian Health Service have no positions available for a member of the profession for which such individual was trained, and

"(ii) the Service has no need for such individual in connection with the delivery of health services under the authorities referred to in subparagraph (B),

such individual shall serve in the clinical practice of his profession for such period in a medical facility of a State correctional facility, State mental hospital, community

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mental health center, migrant health center, community health center, or other medical entity designated by the Secretary as having a priority need for health personnel.

"(D) If at the time an individual is required by the Secretary to begin his period of obligated service—

"(i) the Corps and the Indian Health Service have no positions available for a member of the profession for which such individual was trained,

"(ii) the Service has no need for such individual in connection with the delivery of health services under the authorities referred to in subparagraph (B), and

"(iii) no entity designated under subparagraph (C) has positions available for a member of the profession for which such individual was trained,

such individual shall serve for such period as a member of the Public Health Service in such unit of the Department as the Secretary may prescribe.

"(e) If, for any reason, a person fails to either begin his service obligation under this section in accordance with subsection (d) or to complete such service obligation, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula

$$A=2\phi\left(\frac{t-s}{t}\right)$$

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in which 'A' is the amount the United States is entitled to recover; 'φ' is the sum of the amount paid under this section to or on behalf of such person and the interest on such amount which would be payable if at the time it was paid it was a loan bearing interest at the maximum legal prevailing rate; 't' is the total number of months in such person's service obligation; and 's' is the number of months of such obligation served by him in accordance with subsection (d). Any amount which the United States is entitled to recover under this subsection shall, within the three-year period beginning on the date the United States becomes entitled to recover such amount, be paid to the United States.

"(f) (1) (A) The Secretary shall release any participant in the Program from his service obligation under subsection (d) if such participant enters into a written agreement with the Secretary to engage on a full-time basis in the private practice of his profession—

"(i) in an area in a State in which is located a medically underserved population designated under section 329 (b); and

"(ii) for a period of—

"(I) one year for each academic year of training received under the Program, or

"(II) two years,

whichever is greater.

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"(B) An agreement described in subparagraph (A) shall—

"(i) provide that during the period of private practice by a participant pursuant to the agreement—

"(I) any individual who receives health services provided by the participant in connection with such private practice will be charged for such services at the usual and customary rate prevailing in the area in which such services are provided, except that if such individual is unable to pay such charge (as determined in accordance with regulations prescribed by the Secretary) such individual shall be charged at a reduced rate or not charged any fee; and

"(II) the participant in providing health services in connection with such private practice shall not discriminate against any individual on the basis of such individual's ability to pay for such services or because payment for the health services provided to such individual will be made under the insurance program established under part A or B of title XVIII of the Social Security Act or under a State plan for medical assistance approved under title XIX of such Act; and

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"(ii) contain such additional provisions as the Secretary may require to carry out the purposes of this subsection.

"(2) (A) The Secretary may make one grant to any participant—

"(i) who has entered into an agreement under paragraph (1), and

"(ii) who has agreed to extend the period of practice under such agreement by a period of not less than one year,

to assist such participant in meeting the costs of beginning the practice of his profession in accordance with such agreement, including the costs of acquiring equipment and renovating facilities for use in providing health services, and of hiring nurses and other personnel to assist in providing health services. No such grant may be used for the purchase or construction of any health care facility.

"(B) the amount of the grant to any participant under subparagraph (A) shall be—

"(i) $12,500, if such participant agrees to extend the period of practice under the agreement under paragraph (1) for a period of at least one year but less than two years; or

"(ii) $25,000, if such participant agrees to extend

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the period of practice under the agreement under paragraph (1) for a period of at least two years.

"(3) The Secretary may not enter into any agreement under paragraph (1) or make any grant under paragraph (2) unless an application therefor has been submitted to, and approved by, the Secretary.

"(4) (A) The Secretary shall pay, as soon as practicable after the close of each calendar quarter, to each participant who entered into an agreement under paragraph (1) an amount which is equal to the excess (if any) of—

"(i) the amount of basic pay and allowances which such participant would have received for the period—

"(I) in which he practiced his profession in accordance with the agreement under paragraph (1), and

"(II) which is in the calendar year in which such calendar quarter occurs and ends at the close of such calendar quarter,

(which period is hereafter in this paragraph referred to as the 'service period') if during his service period he was a commissioned member of the National Health Service Corps providing service during a period of obligated service under subsection (d), over

"(ii) the sum of the net income (as determined

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under regulations prescribed by the Secretary) derived by such participant during his service period from the private practice of his profession and the amount (if any) paid before the close of such calendar quarter to such participant under this paragraph with respect to the portion of his service period which ended at the close of the preceding calendar quarter.

"(B) If after the close of any calendar year—

"(i) the amount described in subparagraph (A) (ii) which was received by the participant for the period in such year in which he practiced his profession in accordance with an agreement under paragraph (1), exceeds

"(ii) the amount of basic pay and allowances which the participant would have received for such period if during such period he was a commissioned member of the National Health Service Corps providing service during a period of obligated service under subsection (d),

the Secretary shall be entitled to recover from the participant an amount equal to the lesser of the amount of such excess or the amount paid to the participant under subparagraph (A) for the period in such year in which he practiced his profession in accordance with an agreement under paragraph (1).

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"(C) The Secretary may not make any payment to any participant under subparagraph (A) unless—

"(i) an application therefor has been submitted to the Secretary in such manner and containing such information as he shall by regulation prescribe; and

"(ii) such participant keeps such records as the Secretary may prescribe and makes such records available to the Secretary for any examination he may require.

"(g) (1) The Secretary may make one grant to any individual (other than an individual who entered into an agreement under subsection (f) (1))—

"(A) who has completed his period of obligated service under the Program, and

"(B) who has agreed in writing to engage on a full-time basis in the private practice of his profession in accordance with subsection (f) (1) for a period of not less than one year,

to assist such individual in meeting the costs of beginning the practice of his profession in accordance with such agreement, including the costs of acquiring equipment and renovating facilities for use in providing health services, and of hiring nurses and other personnel to assist in providing

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health services. Such grant may not be used for the purchase or construction of any health care facility.

"(2) The amount of the grant under paragraph (1) to any individual shall be—

"(A) $12,500, if such participant agrees to practice his profession in accordance with subsection (f) (1) for a period of at least one year but less than two years; or

"(B) $25,000, if such participant agrees to practice his profession in accordance with subsection (f) (1) for a period of at least two years.

"(3) The Secretary may not make a grant under paragraph (1) unless an application therefor has been submitted to, and approved by, the Secretary.

"(h) If the Secretary determines that an individual has violated an agreement under subsection (f) (1) or (g) (1) (B), he shall, as soon as practicable after making such determination notify the individual of such determination. If within one hundred and twenty days after the date of giving such notice, such individual is not practicing his profession in accordance with the agreement under subsection (f) (1) or (g) (1) (B), as the case may be, and has not provided assurances satisfactory to the Secretary that he will not knowingly violate such agreement again, the United States shall be entitled to recover from such individual an

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amount determined under subsection (e), except that in applying the formula contained in such subsection—

"(1) in the case of an agreement under subsection (f) (1), 'Φ' shall be the sum of the amount paid under this section (other than any amount paid under subsection (f) (4)) to or on behalf of such person and the interest on such amount which would be payable if at the time it was paid it was a loan bearing interest at the maximum legal prevailing rate, 't' shall be the number of months that such individual agreed to practice his profession under such agreement, including the number of months that the period of practice under such agreement was extended under subsection (f) (2) (A), and 's' shall be the number of months that such individual practiced his profession in accordance with such agreement; or

"(2) in the case of an agreement under subsection (g) (1) (B), 'Φ' shall be the sum of the amount of the grant made under subsection (g) to such person and the interest on such amount which would be payable if at the time it was paid it was a loan bearing interest at the maximum legal prevailing rate, 't' shall be the number of months that such individual agreed to practice his profession under such agreement, and 's' shall

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be the number of months that such individual practiced his profession in accordance with such agreement.

"(i) (1) When a person undergoing training in the Program is academically dismissed or voluntarily terminates academic training, he shall be liable for repayment to the Government for an amount equal to the scholarship which he received under the Program.

"(2) (A) Any obligation of any individual under paragraph (1) or under subsection (e) or (h) shall be canceled upon the death of such individual.

"(B) The Secretary shall by regulation provide for the waiver or suspension of any obligation under paragraph (1) or under subsection (e) or (h) applicable to any individual whenever compliance by such individual is impossible or would involve extreme hardship to such individual and if enforcement of such obligation with respect to any individual would be against equity and good conscience.

"(j) Notwithstanding any other provision of law, persons undergoing academic training under the Program shall not be counted against any employment ceiling affecting the Department of Health, Education, and Welfare.

"(k) The Secretary shall issue regulations for the implementation of this section.

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"(l) To carry out the Program, there are authorized to be appropriated $80,000,000 for fiscal year 1976."

(b) Effective July 1, 1975, the heading for subpart II of part C of title VII is amended to read as follows:

"Subpart II—Student Scholarships".

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94TH CONGRESS
1ST SESSION

H. R. 3279

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 19, 1975

Mr. ROGERS (by request) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Public Health Service Act to revise and extend the program of assistance under title VII for training in the health professions, to revise the national health service corps program and the national health service corps scholarship training program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; TABLE OF CONTENTS

SECTION 1. (a) This Act, with the following table of contents, may be cited as the "Health Manpower Act of 1975".

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TABLE OF CONTENTS

Sec. 1. Short Title; Table of Contents.
Sec. 2. References to Public Health Service Act.

TITLE I—GENERAL PROVISIONS

Sec. 101. Repeal of research facility construction provisions; transfer of general provisions.
Sec. 102. Definitions.
Sec. 103. Advisory council.
Sec. 104. Advance funding.
Sec. 105. Limit on delegation of authority.
Sec. 106. Active service under Soldiers' and Sailors' Civil Relief Act.

TITLE II—ASSISTANCE FOR CONSTRUCTION OF TEACHING FACILITIES

Sec. 201. Grants and appropriations authorized.
Sec. 202. Amount of grants.
Sec. 203. Special consideration for certain facilities.
Sec. 204. Loan guarantees and interest subsidies.
Sec. 205. Approval of applications for grants.
Sec. 206. Redesignations.

TITLE III—STUDENT ASSISTANCE; NATIONAL HEALTH SERVICE CORPS

Sec. 301. Student loan agreements.
Sec. 302. Loan provisions.
Sec. 303. Authorization of appropriations.
Sec. 304. Distribution of assets.
Sec. 305. Loans to schools.
Sec. 306. Redesignations.
Sec. 307. Two-year scholarships for needy students.
Sec. 308. Temporary continuation of shortage area scholarships.
Sec. 309. Public health traineeships.
Sec. 310. National Health Service Corps.
Sec. 311. National Health Service Corps scholarships.

TITLE IV—GRANTS FOR HEALTH PROFESSIONS SCHOOLS

Sec. 401. Support grants.
Sec. 402. Conditions of eligibility for start-up grants.
Sec. 403. Temporary continuation of start-up grants.
Sec. 404. Grants to schools in financial distress.
Sec. 405. Redesignations and temporary extensions.

TITLE V—SPECIAL PROJECT GRANTS AND CONTRACTS

Sec. 501. Redesignations and temporary extensions.
Sec. 502. Special projects for health professions schools.
Sec. 503. Assistance to disadvantaged students.
Sec. 504. Area health education centers.
Sec. 505. Project grants for underserved areas, primary care training, bilingual training centers, and health education.

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TITLE VI—MEDICAL RESIDENCY TRAINING PROGRAMS; ADMISSION OF ALIEN DOCTORS; REPORTS

Sec. 601. Medical residency training programs.
Sec. 602. Admission of alien doctors.
Sec. 603. Report on health manpower.

REFERENCES TO PUBLIC HEALTH SERVICE ACT

SEC. 2. Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a title, part, section, or other provision, the reference shall be considered to be made to that title, part, section, or other provision of the Public Health Service Act.

TITLE I—GENERAL PROVISIONS

REPEAL OF RESEARCH FACILITY CONSTRUCTION PROVISIONS; TRANSFER OF GENERAL PROVISIONS

SEC. 101. (a) Sections 701 through 711 are repealed.

(b) Sections 724, 725, 799, and 799A are transferred to part A of title VII and are redesignated as sections 701, 702, 703, and 704, respectively.

(c) The heading of part H of title VII is deleted.

(d) The heading of part A of title VII is amended to read:

"PART A—GENERAL PROVISIONS"

DEFINITIONS

SEC. 102. Section 701 (as so redesignated) is amended—

(1) by striking out "As used in this part and parts

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C, E, and F—" and inserting in lieu thereof "For purposes of this title:";

(2) by inserting "or an equivalent degree" after "degree in public health" in paragraph (4); and

(3) by adding at the end the following new paragraphs:

"(7) The term 'program for the training of physician assistant's means an education program which (A) has as its objective the education of individuals who will, upon completion of their studies in the program, be qualified to effectively provide primary health care under the supervision of a physician, and (B) meets guidelines prescribed by the Secretary; such guidelines shall be prescribed on or before October 1, 1975, after consultation with appropriate professional organizations and shall, as a minimum, require that such an educational program (C) and (i) a program of classroom instruction and supervised clinical practice directed toward preparing students to deliver primary health care and (ii) a minimum course of study of one academic year, and (D) have an enrollment in each year of not less than twenty-five students.

"(8) The term 'program for the training of nurse practitioners' means an educational program which (A) has as its objective the education of professional nurses

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who will, upon completion of their studies in the program, be qualified to effectively provide primary health care, and (B) meets guidelines prescribed by the Secretary; such guidelines shall be prescribed on or before October 1, 1975, after consultation with appropriate professional organizations and shall, as a minimum, require that such an educational program (C) have (i) a program of classroom instruction and supervised clinical practice directed toward preparing nurses to deliver primary health care and (ii) a minimum course of study of one academic year, and (D) have an enrollment in each year of not less than twenty-five students.

"(9) The term 'program for the training of expanded function dental auxiliaries' means an educational program which (A) has as its objective the education of individuals who will, upon completion of their studies in the program, be qualified to effectively provide primary dental care under the supervision of a dentist, and (B) meet guidelines prescribed by the Secretary; such guidelines shall be prescribed on or before October 1, 1975, after consultation with appropriate professional organizations and shall, as a minimum, require that such an educational program (C) have (i) a program of classroom instruction and supervised clinical practice directed toward preparing students to deliver primary

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dental care and (ii) a minimum course of study of one academic year, and (D) have an enrollment in each year of not less than twenty-five students.

"(10) The term 'primary health care' means (with further definition of the following terms by the Secretary with the advice of the appropriate professional organizations) family medicine, general internal medicine, general pediatrics, obstetrics, and gynecology."

ADVISORY COUNCIL

SEC. 103. (a) The second sentence of subsection (a) of section 702 (as so redesignated) is amended to read as follows: "Of the appointed members of the Council (1) twelve shall be representatives of the health professions schools assisted under programs authorized by this title (other than part G), including at least one representative for schools of medicine, one for schools of veterinary medicine, schools of dentistry, one for schools of veterinary medicine, one for schools of optometry, one for schools of pharmacy, one for schools of podiatry, and one for schools of public health, (2) two shall be fulltime students each of whom is enrolled in one of the types of health professions schools described in clause (1), and (3) six shall be members of the general public.".

(b) The amendment made by subsection (A) with respect to composition of the National Advisory Council

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on Health Professions Education shall apply with respect to appointments made to the Council after the date of the enactment of this Act, and the Secretary of Health, Education, and Welfare shall make appointments to the Council after such date in a manner which will bring about, at the earliest feasible time, the Council composition prescribed by the amendment.

ADVANCE FUNDING

SEC. 104. Section 703 (as so redesignated) is amended to read as follows:

"ADVANCE FUNDING

"SEC. 703. An appropriation under an authorization of appropriations for grants or contracts under this title for any fiscal year may be made at any time before that fiscal year and may be included in an Act making an appropriation under such authorization for another fiscal year; but no funds may be made available from any appropriation under such authorization for obligation for such grants or contracts before the fiscal year for which such appropriation is authorized."

LIMIT ON DELEGATION OF AUTHORITY

SEC. 105. Part A of title VII is amended by adding after section 704 (as so redesignated) the following new section:

"DELEGATION OF AUTHORITY

"SEC. 705. The Secretary may delegate the authority to administer any program authorized by this title to the admin-

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istrator of a central or regional office or offices in the Department of Health, Education, and Welfare, except that the authority—

"(1) to review, and prepare comments on the merit of, any application for a grant or contract under any such program for purposes of presenting such application to the National Advisory Council on Health Professions Education, and

"(2) to make such a grant or enter into such a contract,

shall not be delegated to any administrator of, or officer in, a regional office or offices."

ACTIVE SERVICE UNDER SOLDIERS' AND SAILORS' CIVIL RELIEF ACT

SEC. 106. Section 212 is amended by adding after subsection (d) the following new subsection:

"(e) Active service of commissioned officers of the Service shall be deemed to be active military service in the Armed Forces of the United States for the purposes of all rights, privileges, immunities, and benefits now or hereafter provided under the Solders' and Sailors' Civil Relief Act of 1940 (50 App. U.S.C. 501 et seq.).".

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TITLE II—ASSISTANCE FOR CONSTRUCTION OF TEACHING FACILITIES

GRANTS AND APPROPRIATIONS AUTHORIZED

SEC. 201. Section 720 is amended to read as follows:

"GRANTS FOR TEACHING FACILITIES; AUTHORIZATION OF APPROPRIATIONS

"SEC. 720. (a) The Secretary may make grants to assist in the construction of teaching facilities (including teaching hospitals) for the training of physicians, dentists, pharmacists, optometrists, podiatrists, veterinarians, and professional public health personnel.

"(b) There are authorized to be appropriated $100,000,000 each for the fiscal year beginning July 1, 1974, and the next three fiscal years.".

AMOUNT OF GRANTS

SEC. 202. (a) (1) Subsection (a) of section 722 is amended to read as follows:

"(a) The amount of any grant under this part for construction of a project shall be such amount as the Secretary determines to be appropriate after obtaining the advice of the Council, except that no grant for any project may exceed 80 per centum of the necessary costs of construction, as determined by the Secretary, of such project.".

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(2) The amendment made by paragraph (1) shall apply with respect to grants made under part B of title VII of the Public Health Service Act from appropriations under section 720 of such Act for fiscal years beginning after June 30, 1975.

(b) Subsection (d) of section 722 is amended by striking out "(within the meaning of part A of this title)".

SPECIAL CONSIDERATION FOR CERTAIN FACILITIES

SEC. 203. (a) Section 727(a) is amended by adding at the end thereof the following new sentence: "In such regulations covering the order of priority in approving applications for grants under this part, the Secretary shall give special consideration first to projects for the construction of facilities for the provision of ambulatory care as part of the provision of training in primary health care, second to projects for the replacement or modernization of existing facilities for the provision of training, and third to construction of facilities for new schools or expansion of capacity of existing schools.".

(c) The amendment made by subsection (a) shall apply with respect to applications for grants under section 720 of the Public Health Service Act for fiscal years beginning after June 30, 1975.

LOAN GUARANTEES AND INTEREST SUBSIDIES

SEC. 204. (a) Subsections (a) and (b) of section 729

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are each amended by striking out "June 30, 1974" and inserting in lieu thereof "June 30, 1978".

(b) The second sentence of section 729 (e) is amended by striking out "and" after "June 30, 1973," and by striking out the period at the end thereof and inserting in lieu thereof a comma and the following: "$24,000,000 for the fiscal year ending June 30, 1975, $1,000,000 for the fiscal year ending June 30, 1976, $2,000,000 for the first fiscal year thereafter, and $3,000,000 for the second fiscal year thereafter."; and the fourth sentence of such section is amended by inserting a period after "Treasury" the second time it appears in that sentence and by striking the remainder of that sentence.

(c) (1) Third sentence of section 729 (a) is amended to read as follows: "No such loan guarantee may, except under special circumstances and under such conditions as are prescribed by regulations, apply to any amount which, when added to any grant under this part or any other law of the United States, exceeds 90 per centum of the costs of the construction of the project.".

(2) The amendment made by paragraph (1) shall apply with respect to loans guaranteed under section 727 (a) of the Public Health Service Act (as redesignated by this Act) after the date of the enactment of this Act.

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(d) Subsections (a) and (b) of section 729 are each amended by inserting "or the Federal Financing Bank" after "non-Federal lender".

APPROVAL OF APPLICATIONS FOR GRANTS

SEC. 205. Section 721 (c) is amended—

(1) by, in paragraph (2), striking out clause (D), inserting "and" after the comma at the end of clause (B), and striking out the comma at the end of clause (C) and inserting in lieu thereof a period;

(2) by striking out paragraph (5) and redesignating paragraphs (6) and (7) as paragraphs (5) and (6), respectively;

(3) by striking out "and" at the end of paragraph (5) (as so redesignated), by striking out the period at the end of paragraph (6) (as so redesignated) and inserting in lieu thereof "; and", and by inserting after paragraph (6) the following:

"(7) the application contains or is supported by adequate assurance that any laborer or mechanic employed by a contractor or subcontractors in the performance of work on the construction of the facility will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of

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March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act).

The Secretary of Labor shall have with respect to the labor standards specified in paragraph (7) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c)."; and

(5) by striking out "725" in the last sentence and inserting in lieu thereof "702".

REDESIGNATIONS

SEC. 206. Sections 726, 727, 728, and 729 are redesignated as sections 724, 725, 726, and 727, respectively.

TITLE III—STUDENT ASSISTANCE; NATIONAL HEALTH SERVICE CORPS

STUDENT LOAN AGREEMENTS

SEC. 301. (a) Subsection (a) of section 740 is amended by striking out "or veterinary medicine" and inserting in lieu thereof "veterinary medicine, or public health".

(b) (1) Subsection (b) of section 740 is amended (A) by striking out "and" at the end of paragraph (4), (B) by redesignating paragraph (5) as paragraph (6), and (C) by inserting after paragraph (4) the following new paragraph:

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"(5) provide that the school shall advise, in writing, each applicant for a loan from the student loan fund of the provisions of section 741 under which outstanding loans from the student loan fund may be paid (in whole or in part) by the Secretary; and".

(2) Paragraph (4) of such subsection (b) is amended by striking out "veterinary medicine or an equivalent degree," and inserting in lieu thereof "veterinary medicine or an equivalent degree or to a graduate degree in public health or an equivalent degree,".

LOAN PROVISIONS

SEC. 302. (a) Subsection (a) of section 741 is amended to read as follows:

"(a) Loans from a student loan fund established under an agreement under section 740 may not exceed for any student for any academic year (or its equivalent) the sum of—

"(1) the cost of tuition for such year at the school for which such fund was established, and

"(2) $3,000.".

(b) Subsection (b) of section 741 is amended by striking "to a student in need of the amount thereof" and inserting in lieu thereof "to a student with exceptional financial need who needs the amount of such loan".

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(c) Subsection (b) of section 741 is further amended by striking out the period at the end and inserting in lieu thereof "or to a graduate degree in public health or an equivalent degree.".

(d) Subsection (c) of section 741 is amended by striking out "or veterinary medicine" and inserting in lieu thereof "veterinary medicine, or public health".

(e) Subsection (e) of section 741 is amended by striking out "3 per centum" and inserting in lieu thereof "5 per centum".

(f) (1) Subsection (f) (1) of section 741 is amended—

(A) by inserting before the semicolon at the end of subparagraph (A) the following: "or a graduate degree in public health or an equivalent degree"; and

(B) by striking out "or podiatry" in subparagraph (B) and inserting in lieu thereof "podiatry, or public health".

(2) Subsection (f) of section 741 is further amended by striking out "30 per centum" each time it occurs in subparagraphs (A) and (B) of paragraph (2) and inserting in lieu thereof "25 per centum"; by striking out the semi-colon in paragraph (3) and all that follows before the period at the end thereof; by inserting "or (D)" after "(2) (C)" in such paragraph (3); and by inserting after subparagraph (C) in paragraph (2) the following:

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"(D) Upon completion by that individual of a fourth year of such practice, the Secretary shall pay another 25 per centum of the principal of and the interest on each such loan.".

(g) The amendments made by this section (other than paragraph (2) of subsection (f)) shall apply with respect to loans made after the date of the enactment of this Act from student loan funds established under section 740 of the Public Health Service Act. The amendments made by paragraph (2) of subsection (f) in subparagraphs (A) and (B) of section 741 (f) (2) of the Public Health Service Act shall apply with respect to agreements entered into under such section 741 (f) after the date of the enactment of this Act. The other amendments made by such paragraph (2) shall also apply in the case of agreements entered into on or before such date of enactment but with the percentage in subparagraph (D) of such section 741 (f) (2) set at 15 per centum instead of 25 per centum.

(h) In the case of any individual who, on or after November 18, 1971, and before the date of the enactment of this Act, met the requirements of subparagraphs (A) and (B) of section 741 (f) (1) of the Public Health Service Act and who practiced his profession in an area described in subparagraph (C) of such section (as in effect before the date of the enactment of this Act) while a member of the Na-

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tional Health Service Corps or as an officer of the Regular or Reserve Corps of the Public Health Service or as a civilian employee of the Public Health Service, the individual shall, for purposes of section 741 (f) of such Act, be deemed to have entered into the agreement required by such subparagraph (C) with respect to that practice.

AUTHORIZATION OF APPROPRIATIONS

SEC. 303. Effective with respect to appropriations under section 742 of the Public Health Service Act for fiscal years beginning after June 30, 1974, subsection (a) of section 742 is amended to read as follows:

"(a) For the purpose of making Federal capital contributions into the student loan funds of schools which have established such funds under an agreement under section 740 and making transfers under section 745, there are authorized to be appropriated $60,000,000 for the fiscal year ending June 30, 1975, $30,000,000 for the fiscal year ending June 30, 1976, and $30,000,000 each for the next two fiscal years. For each of the three fiscal years after such two fiscal years there are authorized to be appropriated such sums as may be necessary to enable students who have received a loan under this part for any academic year ending before the end of such two fiscal years to continue or complete their education."

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DISTRIBUTION OF ASSETS

SEC. 304. Section 743 is amended by striking out "June 30, 1977" and "September 30, 1977" each place they occur and inserting in lieu thereof "September 30, 1981" and "December 31, 1981", respectively.

LOANS TO SCHOOLS

SEC. 305. (a) Section 744 is repealed.

(b) The health professions education fund created within the Treasury by section 744(d)(1) of the Public Health Service Act shall remain available to the Secretary of Health, Education, and Welfare for the purpose of meeting his responsibilities respecting participations in obligations acquired under section 744 of such Act. The Secretary shall continue to deposit in such fund all amounts received by him as interest payments or repayments of principal on loans under such section 744. If at any time the Secretary determines the moneys in the fund exceed the present and any reasonable prospective future requirements of such fund, such excess may be transferred to the general fund of the Treasury.

(c) There are authorized to be appropriated without fiscal year limitation such sums as may be necessary to enable the Secretary to make payments under agreements entered into under section 744(b) of the Health Service Act before the date of the enactment of this Act.

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(d) Section 742 (b) is amended (1) by striking out ", and for loans pursuant to section 744" in paragraph (1); and (2) by striking out "(whether as Federal capital contributions or as loans to schools under section 744)" in paragraph (3).

REDESIGNATIONS

SEC. 306. (a) Section 740 is amended (A) by striking out "of Health, Education, and Welfare" in subsection (a).

(b) Section 745 is redesignated as section 744 and section 746 is redesignated as section 745.

(c) The heading for part C of title VII is amended to read as follows:

"PART C—STUDENT ASSISTANCE"

(d) The heading for subpart I of part C of title VII is amended to read as follows:

"SUBPART I—STUDENT LOANS"

TWO-YEAR SCHOLARSHIPS FOR NEEDY STUDENTS

SEC. 307. (a) Subsection (a) of section 780 is amended by striking out "or veterinary medicine" and inserting in lieu thereof "veterinary medicine, or public health" and by striking out "subpart" and inserting in lieu thereof "section".

(b) (1) The second sentence of subsection (b) of section 780 is amended by striking out "and the next fiscal

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year" and inserting in lieu thereof "and each of the next two fiscal years".

(2) Such subsection (b) is further amended by striking out the last sentence and inserting in lieu thereof: "The amount of such grant for the fiscal year ending June 30, 1976, and each of the next two fiscal years shall be equal to the greater of

"(3) $3,000 multiplied by the number of full-time first-year students and second-year students of such school who are from low-income backgrounds, as determined under regulations of the Secretary, or

"(4) $3,000 multiplied by one-tenth of the number of full-time first-year students and second-year students of such school,

plus such amount as may be necessary to enable such school to continue making payments under scholarship awards to students who initially received such awards out of grants made to the schools hereunder for fiscal years ending before July 1, 1975. The amount of such grant for the third fiscal year after the fiscal year ending June 30, 1976, shall be such amount as may be necessary to continue making payments under scholarship awards to second-year students who initially received such awards out of grants made to the schools for the second fiscal year ending after June 30, 1976.".

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(c) (1) Paragraph (1) of subsection (c) of section 780 is amended by striking out "next two fiscal years" in subparagraph (A) and inserting in lieu thereof "next three fiscal years"; and by striking out subparagraph (B) and inserting in lieu thereof:

"(B) in the case of awards from such grants for the fiscal year ending June 30, 1976, or any of the next two fiscal years, only to individuals enrolled and in good standing as (i) full-time first-year students; or (ii) full-time second-year students who initially received scholarship awards out of such grants for an earlier fiscal year; or (iii) other full-time students who initially received scholarship awards out of such grants for a fiscal year ending before July 1, 1975; and

"(C) in the case of awards from such grants for the third fiscal year ending after June 30, 1976, only to individuals enrolled and in good standing as full-time second-year students who initially received scholarship awards out of such grants for a fiscal year ending before such third fiscal year.".

(d) (1) The first sentence of paragraph (2) of subsection (c) of section 780 is amended by inserting before the period at the end thereof "leading to a degree of doctor of medicine, doctor of dentistry or an equivalent degree, doctor of osteopathy, bachelor of science in pharmacy or an equiv-

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alent degree, doctor of podiatry or an equivalent degree, doctor of optometry or an equivalent degree, or doctor of veterinary medicine or an equivalent degree, or to a graduate degree in public health or an equivalent degree".

(2) The second sentence of such paragraph (2) is amended by striking out "$3,500" and inserting in lieu thereof "the amount of such tuition plus $3,000".

(c) Section 780 is further amended by adding at the end thereof the following new subsection:

"(f) There are authorized to be appropriated for grants under this section $30,000,000 for the fiscal year ending June 30, 1976, $22,500,000 for the first year thereafter, and $15,000,000 for the second fiscal year thereafter. If for any such year the amount appropriated pursuant to the preceding sentence is not sufficient to pay in full the amounts which schools would otherwise be paid under subsection (b), the amount to be paid to each such school for such year shall bear the same ratio to the amount payable to such school under subsection (b) as the appropriation for such year bears to the total required to pay in full the amounts provided for under such subsection for such year. There are also authorized to be appropriated for the third fiscal year ending after June 30, 1976, such sums as may be necessary to enable each school to continue making payments under scholarship awards to full-time second-year students who initially re-

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ceived such awards out of grants made to the school for the preceding fiscal year."

(f) Section 781 is amended by striking out "this subpart" and inserting in lieu thereof "this section" by striking out its heading, by striking out "SEC. 781," and inserting in lieu thereof "(g)" and by transferring it, as so amended, to section 780 to be inserted after subsection (f) thereof.

(g) Section 780, as so amended, is transferred to subpart II of part C, is inserted after section 747 (as redesignated by this Act) and is redesignated section 748.

(h) Subpart II of part F of title VII, including the heading, is repealed.

(i) The amendments made by subsection (d) (2) shall apply with respect to scholarships awarded for school years beginning after June 30, 1975.

TEMPORARY CONTINUATION OF SHORTAGE AREA SCHOLARSHIPS

SEC. 308. (a) Subpart III of part F of title VII is amended by striking out the heading thereof, by striking out "this subpart" wherever it occurs in section 784 and inserting in lieu thereof "this section", by inserting "as in effect prior to the enactment of the Health Manpower Act of 1975" after "741 (f) (1) (C)" and after "768 (c) (3) (B)" in subsection (a) of such section, by striking out "this subpart" wherever it occurs in the next two sections and inserting in

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lieu thereof "section 749" and by transferring section 784, the first section following it, and the second section following it, to subpart II of part C of title VII (after the section redesignated as section 748) and redesignating them as sections 749, 750, and 750A, respectively.

(b) The first sentence of section 750A (as so redesignated) is amended by inserting "each" after "$3,500,000" and inserting before the period at the end thereof "and the next fiscal year". The second sentence of such section 750A is amended by striking out "1975" and "1974" and inserting in lieu thereof "1976" and "1975", respectively.

PUBLIC HEALTH TRAINEESHIPS

SEC. 309. Part C of title VII is amended by adding after section 750A (as redesignated by this Act) the following new subpart:

"Subpart III—Traineeships for Students in Schools of Public Health

"TRAINEESHIPS

"SEC. 751. (a) The Secretary may make grants to schools of public health for traineeships to train students enrolled in such schools.

"(b) (1) No grant for traineeships may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner,

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and contain such information as the Secretary by regulation may prescribe. Traineeships under such a grant shall be awarded in accordance with such regulations as the Secretary shall prescribe. The amount of any such grant shall be determined by the Secretary and payments under such a grant may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

"(2) Traineeships awarded under grants made under subsection (a) shall provide for such stipends and allowances (including travel and subsistence expenses and dependency allowances) for the trainees as the Secretary may deem necessary.

"(c) For the purpose of making payments under grants under subsection (a), there are authorized to be appropriated $6,000,000 each for the fiscal year ending June 30, 1976, and the next two fiscal years.".

NATIONAL HEALTH SERVICE CORPS

SEC. 310. (a) Section 329 is amended to read as follows:

"NATIONAL HEALTH SERVICE CORPS

"SEC. 329. (a) There is established, within the Service, the National Health Service Corps (hereinafter in this section referred to as the 'Corps') which shall consist of those commissioned officers of the Service and such other personnel

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as the Secretary may designate and which shall be utilized by the Secretary under this section to improve the delivery of health services to medically underserved populations.

"(b) (1) For purposes of this section, (A) a medically underserved population is the population of an urban or rural area (which does not have to conform to the geographical boundaries of a political subdivision, but which should be an area the boundaries of which are determined in the light of the relative ease or difficulty in the delivery of health services needed by the population) which the Secretary determines has a critical health manpower shortage or a population group determined by the Secretary to have such a shortage; and (B) the term 'State' includes Guam, American Samoa, and the Trust Territory of the Pacific Islands.

(2) The Secretary shall designate underserved populations in the States. In determining whether to make any such designation, the Secretary shall take into account—

"(A) the recommendations of the entity or entities responsible for the development of the plans referred to in section 314(b) which cover all or any part of the area in which the population is located;

"(B) in the case of any such area for which there is no such entity, the recommendations of the agency of the State (or States) in which such area is located

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which administers or supervises the administration of a State plan approved under section 314(a);

"(C) ratios of available health manpower to the population;

"(D) the accessibility of health services to the population;

"(E) the health status of the population;

"(F) the population's need and demand for health services.

"(3) The Secretary shall (A) provide assistance to persons seeking assignment of Corps personnel to provide under this section health services for medically underserved populations, and (B) conduct such information programs in areas in which such populations reside as may be necessary to inform the public and public or private health agencies and other health entities serving those areas of the assistance available to such populations by virtue of their designation under this section as medically underserved.

"(c)(1)(A) The Secretary may assign personnel of the Corps to provide, under regulations prescribed by the Secretary, health services for a medically underserved population only if—

"(i) he approves an application therefor submitted by the State health agency of each State in which such population is located or the local public health agency

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or any other public or nonprofit private health entity serving such population, and

"(ii) the local government of the area in which such population resides certifies to the Secretary that such assignment of Corps personnel is needed for such population.

"(B) The Secretary may not approve an application under paragraph (1) (A) (i) for an assignment unless the applicant agrees to enter into an arrangement with the Secretary in accordance with subsection (e) (1) and has afforded—

"(i) the entity responsible for the development of plans referred to in section 314(b) which covers all or any part of the area in which the population for which the application is submitted resides,

"(ii) if there is a part of such area for which no such entity is responsible for developing such plans, the agency of the State in which such part is located which administers or supervises the administration of a State plan approved under section 314(a), and

"(iii) any State or district medical, osteopathic, or dental society for such area, or any other appropriate health society (as the case may be) of the area in which the population resides,

an opportunity to review the application and submit its

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comments to the Secretary respecting the need for and proposed use of the manpower requested in the application. In considering such an application, the Secretary shall take into consideration the need of the population for which the application was submitted for the health services which may be provided under this section; the willingness of the population and the appropriate governmental agencies or health entities serving it to assist and cooperate with the Corps in providing effective health services to the population; and recommendations from medical, dental, or other health societies or from medical personnel serving the population.

"(2) (A) The Secretary may assign Corps personnel to provide health services for a medically underserved population only during a period (referred to in this paragraph as the 'assistance period') not exceeding four years from the date of the first assignment of Corps personnel for such population after the date of the approval of the application therefor.

"(B) Upon expiration of an assistance period for a medically underserved population, no new assignment of Corps personnel may be made for such population unless an application is submitted in accordance with paragraph (1) for such assignment. The Secretary may not approve such an application unless—

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"(i) the application and certification requirements of paragraph (1) are met;

"(ii) the Secretary has conducted an evaluation of the continued need for health manpower of the population for which the application is submitted, of the utilization of the manpower by such population, of the growth of the health care practice of the Corps personnel assigned for such population, and of community support for the assignment; and

"(iii) the Secretary has determined that such population has made continued efforts to secure its own health manpower, that there has been sound fiscal management of the health care practice of the Corps personnel assigned for such population, including efficient collection of fee-for-service, third-party, and other funds available to such population, and that there has been appropriate and efficient utilization of such Corps personnel.

"(3) Corps personnel shall be assigned to provide health services for a medically underserved population on the basis of the extent of the population's need for health services and without regard to the ability of the members of the population to pay for health services.

"(4) In making an assignment of Corps personnel the Secretary shall seek to match characteristics of the assignee

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(and his spouse (if any)) and of the population to which such assignee may be assigned in order to increase the likelihood of the assignee remaining to serve the population upon completion of his assignment period. The Secretary shall, before the expiration of the last nine months of the assignment period of a member of the Corps, review such member's assignment and the situation in the area to which he was assigned for the purpose of determining the advisability of extending the period of such member's assignment.

"(5) To assist in the recruitment of health manpower, the Secretary shall provide technical assistance to all medically underserved populations to which Corps personnel are not assigned. The Secretary shall also give such populations current information respecting public and private programs which may assist in securing health manpower for them.

"(6) The Secretary may not assign personnel of the Corps to serve any medically underserved population unless such service will be provided as part of a unit consisting of such medical and other health personnel as the Secretary may determine to be reasonable for the efficient and effective delivery of health services to such population; except that in no case may the number of the doctors of medicine or osteopathy for any such unit be less than four. Where for fiscal or other sufficient reasons, such a unit is not appro-

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priate for a medically underserved population, there may be a joint application filed under paragraph (1) for more than one such population.

"(d) (1) In providing health services for a medically underserved population under this section, Corps personnel shall utilize the techniques, facilities, and organizational forms most appropriate for the area in which the population resides and shall, to the maximum extent feasible, provide such services (A) to all members of the population regardless of their ability to pay for the services, and (B) in connection with (i) direct health services programs carried out by the Service; (ii) any direct health services program carried out in whole or in part with Federal financial assistance; or (iii) any other health services activity which is in furtherance of the purposes of this section.

"(2) (A) Notwithstanding any other provision of law, the Secretary (i) may, to the extent feasible, make such arrangements as he determines to be necessary to enable Corps personnel in providing health services for a medically underserved population to utilize the health facilities of the area in which the population resides and, if there are no health facilities in or serving such area, the Secretary may arrange to have Corps personnel provide health services in the nearest health facilities of the Service or the Secretary may lease or otherwise provide facilities in such area for the

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provision of health services, (ii) may make such arrangements as he determines are necessary for the use of equipment and supplies of the Service and for the lease or acquisition of other equipment and supplies, (iii) may secure the temporary services of nurses and allied health professionals, (iv) may make such arrangements as he determines are necessary for such communications or transportation systems as may be appropriate in the case of a population in an area covering a distance which is unusually large in the light of the size of the population.

"(B) If the area in which an underserved population resides is being served (as determined under regulations of the Secretary) by a hospital or other health care delivery facility of the Service, the Secretary shall, in addition to such other arrangements as the Secretary may make under subparagraph (A), arrange for the utilization of such hospital or facility by Corps personnel in providing health services for the population, but only to the extent that such utilization will not impair the delivery of health services and treatment through such hospital or facility to persons who are entitled to health services and treatment through such hospital or facility.

"(3) The Secretary may make one grant to any applicant with an approved application under subsection (c) to assist it in meeting the costs of establishing medical practice

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management systems for Corps personnel, acquiring equipment for their use in providing health services, and establishing appropriate continuing education programs and opportunities for them. No grant may be made under this paragraph unless an application therefor is submitted to, and approved by, the Secretary. The amount of any grant shall be determined by the Secretary, except that no grant may be made for more than $25,000.

"(4) Upon the expiration of the assignment of Corps personnel to provide health services for a medically underserved population, the Secretary (notwithstanding any other provision of law) may sell, to the entity which submitted the last application approved under subsection (c) for the assignment of Corps personnel for such population, equipment of the United States utilized by such personnel in providing health services. Sales made under this paragraph shall be made for the fair market value of the equipment sold (as determined by the Secretary).

"(5) In the case of any medically underserved population in an area too small to warrant assignment of personnel of the Corps to provide health services in accordance with this section as part of a unit meeting the requirements of this section, an arrangement may be made for the provision of such services by such a unit serving another medically underserved population. Such an arrangement shall

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include provisions with respect to provision of services and facilities and payment therefor which are, as nearly as practicable (as determined under regulations of the Secretary in the light of the relevant conditions applicable to such population in such small area) in conformity with the requirements of this section.

"(e) (1) The Secretary shall require as a condition to the approval of an application under subsection (c) that the entity which submitted the application enter into an appropriate arrangement with the Secretary under which—

"(A) the entity shall be responsible for charging in accordance with paragraph (2) for health services by the Corps personnel to be assigned;

"(B) the entity shall take such action as may be reasonable for the collection of payments for such health services, including if a Federal agency, an agency of a State or local government, or other third party would be responsible for all or part of the cost of such health services if it had not been provided by Corps personnel under this section, the collection, on a fee-for-service or other basis, from such agency or third party of the portion of such cost for which it would be so responsible (and in determining the amount of such cost for which such agency or third party would be responsible, the

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health services provided by Corps personnel shall be considered as being provided by private practitioners);

"(C) the entity shall pay to the United States for each calendar quarter (or such other period as may be specified in the arrangement) during which any Corps personnel are assigned to such entity the sum of—

"(i) the pay (including amounts paid in accordance with subsection (f)) and allowances of such Corps personnel for the portion of such quarter (or other period) during which they are assigned to the entity;

"(ii) if such entity received a grant under subsection (d)(3) for the assistance period, an amount which bears the same ratio to the amount of such grant as the number of days in such quarter (or other period) during which any Corps personnel were assigned to the entity bears to the number of days in the assistance period after such entity received such grant;

"(iii) if during such quarter (or other period) any member of the Corps assigned to such entity is providing obligated service pursuant to an agreement under the Public Health and national health service corps scholarship training program, for

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each such member an amount which bears the same ratio to the amount paid under such program to or on the behalf of such member as the number of days of obligated service provided by such member during such quarter (or other period) bears to the number of days in his period of obligated service under such program; and

"(D) the entity shall pay to the United States such amount as the Secretary determines to be necessary to cover the cost of the provision or use under subsection (d) of facilities, equipment, supplies, services, and systems.

The Secretary may waive in whole or in part the application of the requirements of subparagraphs (C) and (D) to an entity if he determines that the entity is financially unable to meet such requirements or if he determines that compliances with such requirements would unduly limit the ability of the entity to maintain the quality of the services it provides. The excess (if any) of the amount collected by an entity in accordance with subparagraph (B) over the amount paid to the United States in accordance with subparagraphs (C) and (D) shall be used by the entity to expand or improve the provision of health services to the population for which the entity submitted an application under subsection (c) or to recruit and retain health man-

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power to provide health services for such population. Funds received by the Secretary under such an arrangement shall be deposited in the Treasury as miscellaneous receipts and shall be disregarded in determining the amount of appropriations to be requested under subsection (i) and the amounts to be made available from appropriations made under such subsection to carry out this section.

"(2) Any person who receives health services provided by Corps personnel under this section shall be charged for such services on a fee-for-service or other basis at a rate, approved by the Secretary pursuant to regulations, sufficient to recover the value of such services; except that if such person is determined under regulations of the Secretary to be unable to pay such charge, the Secretary shall provide for the furnishing of such services at a reduced rate (if any) based on such person's ability to pay.

"(f) (1) The Secretary shall conduct at medical and nursing schools and other schools of the health professions, and at entities which train allied health personnel, recruiting programs for the Corps. Such programs shall include the wide dissemination of written information on the Corps and visits to such schools by personnel of the Corps.

"(2) The Secretary may reimburse applicants for position in the Corps for actual expenses incurred in traveling to and from their place of residence to an area in which

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they would be assigned for the purpose of evaluating such area with regard to being assigned in such area. The Secretary shall not reimburse an applicant for more than one such trip.

"(3) Commissioned officers and other personnel of the Corps assigned to provide health services for medically underserved populations shall not be counted against any employment ceiling affecting the Department of Health, Education, and Welfare.

"(4) The Secretary shall, under regulations prescribed by him, adjust the monthly pay of each physician and dentist member of the Corps who is directly engaged in the delivery of health services to a medically underserved population as follows:

"(A) During the first thirty-six months in which such a member is so engaged in the delivery of health services, his monthly pay shall be increased by an amount (not to exceed $1,000) which when added to the member's monthly pay and allowances will provide a monthly income competitive with the average monthly income from an established practice of a member of such member's profession with equivalent training.

"(B) During the period beginning upon the expiration of the thirty-six months referred to in subparagraph (A) and ending with the month in which the member's

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monthly pay and allowances is equal to or exceeds the monthly income he received for the last of such thirty-six months, the member shall receive in addition to his monthly pay and allowances an amount which when added to such monthly pay and allowances equals the monthly income he received for such last month.

For purposes of subparagraphs (A) and (B), the term 'monthly pay' includes special pay received under chapter 5 of title 37 of the United States Code. In the case of a member of the Corps who is directly engaged in the provision of health services to a medically underserved population in accordance with a service obligation incurred under the Public Health Service and national health service corps scholarship training program, the provisions of this paragraph shall apply to such member upon satisfactory completion of such service obligation and the first thirty-six months of his being so engaged in the delivery of health services shall, for purposes of this paragraph, be deemed to begin upon such satisfactory completion.

"(g) The Secretary shall report to Congress no later than May 15 of each year—

"(1) the number and identity of all medically underserved populations in each of the States in the calendar year preceding the year in which the report is made and the number of medically underserved popu-

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lations which the Secretary estimates will be designated under subsection (b) in the calendar year in which the report is made;

"(2) the number of applications filed in such preceding calendar year for assignment of Corps personnel under this section and the action taken on each such application;

"(3) the number and types of Corps personnel assigned in such preceding year to provide health services for medically underserved populations, the number and types of additional Corps personnel which the Secretary estimates will be assigned to provide such services in the calendar year in which the report is submitted, and the need (if any) for additional personnel for the Corps;

"(4) the recruitment efforts engaged in for the Corps in such preceding year, including the programs carried out under subsection (f) (1) and the number of qualified persons who applied for service in the Corps in each professional category;

"(5) the total number of patients seen and patient visits recorded during such preceding year in each area where Corps personnel were assigned;

"(6) the number of health personnel electing to remain after termination of their service in the Corps

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to provide health services to medically underserved populations and the number of such personnel who do not make such election and the reasons for their departure;

"(7) the results of evaluations made under subsection (c) (2) (B) (ii), and determinations made under subsection (c) (2) (B) (iii), during such preceding year; and

"(8) the amount (A) charged during such preceding year for health services by Corps personnel, (B) collected in such year by entities in accordance with arrangements under subsection (e) (1), and (C) paid to the Secretary in such year under such arrangements.

"(h) (1) There is established a council to be known as the National Advisory Council on the National Health Service Corps (hereinafter in this section referred to as the 'Council'). The Council shall be composed of fourteen members appointed by the Secretary as follows:

"(A) Four members shall be appointed from the general public to represent the consumers of health care, at least two of whom shall be members of a medically underserved population for which Corps personnel are providing health services under this section.

"(B) Three members shall be appointed from the

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medical, dental, and other health professions and health teaching professions.

"(C) Three members shall be appointed from State health or health planning agencies.

"(D) Three members shall be appointed from the Service, at least two of whom shall be members of the Corps directly engaged in the provision of health services for a medically underserved population.

"(E) One member shall be appointed from the National Council on Health Planning and Development. The Council shall consult with, advise, and make recommendations to the Secretary with respect to his responsibilities in carrying out this section, and shall review and comment upon regulations promulgated by the Secretary under this section and section 747.

"(2) Members of the Council shall be appointed for a term of three years and shall not be removed, except for cause. Members may be reappointed to the Council.

"(3) Appointed members of the Council, while attending meetings or conferences thereof or otherwise serving on the business of the Council, shall be entitled to receive for each day (including traveltime) in which they are so serving the daily equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule, and while so serving away from their homes or regular places

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of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 (b) of title 5 of the United States Code for persons in the Government service employed intermittently.

"(i) (1) To carry out the purposes of this section, there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1976; $35,000,000 for the first fiscal year thereafter; and $50,000,000 for the second fiscal year thereafter.

"(2) An appropriation under an authorization under paragraph (1) of this subsection for any fiscal year may be made at any time before that fiscal year and may be included in an Act making an appropriation under an authorization under paragraph (1) for another fiscal year; but no funds may be made available from any appropriation under such authorization for obligation under this section before the fiscal year for which such appropriation is authorized.".

(b) (1) The Secretary of Health, Education, and Welfare shall report to Congress (1) not later than October 1, 1975, the criteria used by him in designating medically underserved populations for purposes of section 329 of the Public Health Service Act, and (2) not later than January 1, 1976, the identity and number of medically underserved populations in each State meeting such criteria.

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(2) The Secretary of Health, Education, and Welfare shall conduct or contract for studies of methods of assigning, under section 329 of the Public Health Service Act, National Health Service Corps personnel to medically underserved populations and of providing health care to such populations. Such studies shall be for the purpose of identifying (A) the characteristics of health manpower who are more likely to remain in practice in areas in which medically underserved populations are located, (B) the characteristics of areas which have been able to retain health manpower, (C) the appropriate conditions for assignment of nurse practitioners, physician's assistants, and expanded function dental auxiliaries in areas in which medically underserved populations are located, and (D) the effect that primary health care (as defined in section 701 of such Act) residency training in such areas has on the health care provided in such areas and on the decisions of physicians who received such training respecting the areas in which to locate their practice.

(c) (1) The amendment made by subsection (a) which changes the name of the Advisory Council established under section 329 of the Public Health Service Act shall not be construed as requiring the establishment of a new Advisory Council under that section; and the amendment made by such subsection with respect to the composition of such Advisory Council shall apply with respect to appointments

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made to the Advisory Council after the date of the enactment of this Act, and the Secretary of Health, Education, and Welfare shall make appointments to the Advisory Council after such date in a manner which will bring about, at the earliest feasible time, the Advisory Council composition prescribed by the amendment.

(2) (A) Section 741 (f) (1) (C) is amended by striking out all that follows after "in a State" and inserting in lieu thereof "in which is located a medically underserved population designated under section 329 (b) ;".

(B) The amendment made by subparagraph (A) shall apply with respect to agreements entered into under section 741 (f) of the Public Health Service Act after June 30, 1975.

(3) Section 329 (h), as in effect prior to the enactment of this Act, is amended by inserting before the period ", and $25,000,000 for the fiscal year ending June 30, 1975".

NATIONAL HEALTH SERVICE CORPS SCHOLARSHIPS

SEC. 311. (a) Effective July 1, 1975, section 747 is repealed and section 225 is transferred to subpart II of part C of title VII, is redesignated section 747, and is amended to read as follows:

"PUBLIC HEALTH AND NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP TRAINING PROGRAM

"SEC. 747. (a) The Secretary shall establish the public health and national health service corps scholarship train-

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ing program (hereinafter in this section referred to as the 'program') to obtain trained physicians, dentists, and nurses and, if needed by the Corps or other unit of the Service, podiatrists, optometrists, pharmacists, graduates of schools of public health, and other health-related specialists.

"(b) To be eligible to participate in the program, an individual must—

"(1) be accepted for enrollment, or be enrolled, as a full-time student (A) in an accredited (as determined by the Secretary) educational institution in a State and (B) in (i) a course of study offered by such institution and approved by the Secretary which leads to a degree in medicine, osteopathy, dentistry, nursing, or other health-related specialty as determined by the Secretary or (ii) a program offered by such institution for the training of physician assistants, expanded function dental auxiliaries, or nurse practitioners;

"(2) be eligible for, or hold, an appointment as a commissioned officer in the Service or be eligible for selection for noncommissioned service in the Service; and

"(3) agree in writing to serve, as prescribed by subsection (d) of this section, in the National Health Service Corps, the Indian Health Service or other parts of the Public Health Service or the Department of Health, Education, and Welfare, or other medical entities designated by the Secretary.

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To remain as a participant in the program an individual must pursue at such an institution such an approved course of study or such a program and maintain an acceptable (as determined by the institution under regulations of the Secretary) level of academic standing in it.

"(c) (1) (A) Each participant in the program while pursuing such a course of study or such a program shall receive a scholarship for each academic year of training, not to exceed four years. The scholarship for any such year shall be equal to (i) the basic pay and allowances of a commissioned officer of the Service on active duty in pay grade O–1 with less than two years of service, and (ii) tuition and an amount to cover other reasonable educational expenses of the participant, including fees, books, and laboratory expenses.

"(B) The Secretary may make a contract with an institution in which participants in the program are enrolled providing for payment to the institution of the tuition and other educational expenses of such participants, in lieu of payment to such participants. Payment to such institutions may be made without regard to section 3648 of the Revised Statutes (31 U.S.C. 529).

"(2) If the Secretary determines that an institution has increased its total enrollment for the sole purpose of accepting members of the program, he may pay additional amounts

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to the institution to cover the portion of the increased costs of the additional enrollment which are not covered by the institution's normal tuition and fees.

"(d) (1) Each participant in the program shall be obligated to provide service as prescribed by paragraph (2) for a period of time (hereinafter in this section referred to as a 'period of obligated service') equal to—

"(A) one year for each academic year of training for which a scholarship was received under the program, or

"(B) two years,

whichever is greater. For any person receiving a degree from a school of medicine or osteopathy, a period of obligated service shall begin at the end of the second year of postgraduate training in medicine or osteopathy, except that in the case of any such individual who prior to or immediately after the end of such second year of postgraduate training begins his residency in family medicine, general internal medicine, general pediatrics, or obstetrics and gynecology, or any other field of medicine which the Secretary determines has a shortage of practitioners, such period shall begin upon completion of such residency; and such period of obligated service shall continue without substantial interruption (as determined under regulations of the Secretary) until the period of service is completed.

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For persons receiving degrees in other health professions the period of obligated service shall commence upon completion of the course of study or program, referred to in subsection (b) (1), with respect to which they received scholarships under this section. The commencement of a period of obligated service or of the postgraduate training or the residency, referred to in this paragraph, may be postponed for any individual only for such temporary period or periods after completion of such course of study or program (but not in excess of a total of six months) as the Secretary may prescribe pursuant to regulations in order to take account of customary delays or unusual circumstances. Periods of internship, residency, or other advanced clinical training shall not be creditable in satisfying a service obligation under this subsection.

"(2) The service which such an individual is obligated to perform for his period of obligated service is—

"(A) service as a member of the National Health Service Corps or the Indian Health Service in the clinical practice of his profession for which he was trained with the help of a scholarship hereunder; or

"(B) if at the time an individual's period of obligated service is to begin neither the National Health Service Corps nor the Indian Health Service has a need for such service, then service as a member of the Service

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in the clinical practice of his profession in connection with the delivery of health services under section 321 (relating to hospitals), 322 (relating to care and treatment of seamen and others), 323 (relating to care and treatment of Federal prisoners), 324 (relating to examination and treatment of certain Federal employees), 325 (relating to examination of aliens), or 326 (relating to services to certain Federal employees) or part D of title III (relating to services for persons with Hansen's disease); or

"(C) if at the time an individual's period of obligated service is to begin there is no need for any of the foregoing service, then service in the clinical practice of his profession in a medical facility of a State correctional facility, State mental hospital, community mental health center, migrant health center, community health center, or other medical entity designated by the Secretary as having a priority need for health personnel; or

"(D) if at the time an individual's period of obligated service is to begin there is no need for any of the foregoing service, then service for such period as a member of the Public Health Service in such unit of the Department as the Secretary may prescribe.

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"(e) If, for any reason, a person fails either to begin his service obligation under this section in accordance with subsection (d) or to complete such service obligation, the United States shall be entitled to recover from such individual an amount determined in accordance with the formula

$$A=2P\left(\frac{t-s}{t}\right)$$

in which 'A' is the amount the United States is entitled to recover; 'P' is the amount paid under this section to or on behalf of such person, plus the interest on such amount which would be payable if at the time it was paid it was a loan bearing interest at the maximum legal prevailing rate; 't' is the total number of months in such person's period of obligated service; and 's' is the number of months of the period of obligated service served by him in accordance with subsection (d). Any amount which the United States is entitled to recover under this subsection shall, within the three-year period beginning on the date the United States becomes entitled to recover such amount, be paid to the United States.

"(f) (1) (A) The Secretary shall release any participant in the program from his service obligation under subsection (d) if such participant enters into a written agreement with the Secretary to engage on a full-time basis in the private practice of his profession—

"(i) in an area in a State in which is located a

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medically underserved population designated under section 329 (b) ; and

"(ii) for a period of—

"(I) one year for each academic year of training for which he received a scholarship under the program, or

"(II) two years,

whichever is greater.

"(B) An agreement described in subparagraph (A) shall—

"(i) provide that during the period of private practice by a participant pursuant to the agreement—

"(I) any individual who receives health services provided by the participant in connection with such private practice will be charged for such services at the usual and customary rate prevailing in the area in which such services are provided, except that if such individual is unable to pay such charge (as determined in accordance with regulations prescribed by the Secretary) such individual shall be charged at a reduced rate (if any) based on such individual's ability to pay; and

"(II) the participant in providing health services in connection with such private practice shall

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not discriminate against any individual on the basis of such individual's ability to pay for such services or because payment for the health services provided to such individual will be made under the insurance program established under part A or B of title XVIII of the Social Security Act or under a State plan for medical assistance approved under title XIX of such Act; and

"(ii) contain such additional provisions as the Secretary may require to carry out the purposes of this subsection.

"(2) (A) The Secretary may make one grant to any participant—

"(i) who has entered into an agreement under paragraph (1), and

"(ii) who has agreed to extend the period of practice under such agreement by a period of not less than one year,

to assist such participant in meeting the costs of beginning the practice of his profession in accordance with such agreement, including the costs of acquiring equipment and renovating facilities for use in proivding health services, and of hiring nurses and other personnel to assist in providing health services. No such grant may be used for the purchase or construction of any building.

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"(B) The amount of the grant to any participant under subparagraph (A) shall be—

"(i) $12,500, if such participant agrees to extend the period of practice under the agreement under paragraph (1) for a period of at least one year but less than two years; or

"(ii) $25,000, if such participant agrees to extend the period of practice under the agreement under paragraph (1) for a period of at least two years.

"(3) The Secretary may not enter into any agreement under paragraph (1) or make any grant under paragraph (2) unless an application therefor has been submitted to, and approved by, the Secretary.

"(4) (A) In the case of each participant who entered into an agreement under paragraph (1), the Secretary shall pay to him, as soon as practicable after the close of each calendar quarter in which he practiced his profession in accordance with such agreement, an amount which is equal to the excess (if any) of—

"(i) the basic pay and allowances such participant would have received for the period of such practice during such quarter and the preceding calendar quarters in the same calendar year if during that same period of practice he was a commissioned member of the Public Health Service serving in the National Health Service

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Corps during a period of obligated service under subsection (d), over

"(ii) the sum of the net income (as determined under regulations prescribed by the Secretary) derived by such participant during that period of practice (from the private practice of his profession in accordance with such agreement) and the amount (if any) paid to such participant under this paragraph with respect to the portion of that period of practice which occurred in such preceding calendar quarters.

"(B) If after the close of any calendar year—

"(i) the amount described in subparagraph (A) (ii) which was received by the participant for the period in such year in which he practiced his profession in accordance with an agreement under paragraph (1), exceeds

"(ii) the amount of basic pay and allowances which the participant would have received for such period if during such period he was a commissioned member of the Public Health Service serving in the National Health Service Corps during a period of obligated service under subsection (d),

the Secretary shall be entitled to recover from the participant an amount equal to the lesser of the amount of such excess or the amount paid to the participant under sub-

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paragraph (A) for the period in such year in which he practiced his profession in accordance with an agreement under paragraph (1).

"(C) The Secretary may not make any payment to any participant under subparagraph (A) unless—

"(i) an application therefor has been submitted to the Secretary in such manner and containing such information as he by regulation prescribes; and

"(ii) such participant keeps such records as the Secretary may prescribe and makes such records available to the Secretary for any examination he may require.

"(g) (1) The Secretary may make one grant to any individual (other than an individual who entered into an agreement under subsection (f) (1))—

"(A) who has completed his period of obligated service under the program, and

"(B) who has agreed in writing to engage on a full-time basis in the private practice of his profession in accordance with subsection (f) (1) for a period of not less than one year,

to assist such individual in meeting the costs of beginning the practice of his profession in accordance with such agreement, including the costs of acquiring equipment and renovating facilities for use in providing health services, and

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of hiring nurses and other personnel to assist in providing health services. Such grant may not be used for the purchase or construction of any building.

"(2) The amount of the grant under paragraph (1) to any individual shall be—

"(A) $12,500, if such participant agrees to practice his profession in accordance with subsection (f) (1) for a period of at least one year but less than two years; or

"(B) $25,000, if such participant agrees to practice his profession in accordance with subsection (f) (1) for a period of at least two year.

"(3) The Secretary may not make a grant under paragraph (1) unless an application therefor has been submitted to, and approved by, the Secretary.

"(h) (1) If any doctor of medicine or osteopathy who has not been a participant in the program, and who has completed his residency in family medicine, general internal medicine, general pediatrics, or obstetrics and gynecology, or any other field of medicine which the Secretary determines has a shortage of practitioners, enters into a written agreement with the Secretary to engage for not less than two years on a full-time basis (A) in the clinical practice of his profession as a member of the National Health Service Corps or (B) in the private practice of his profession

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in an area in a State in which is located a medically underserved population designated under section 329(a), then the Secretary may make (C) one grant to him of $15,000 as a bonus for entering into such agreement and (D) in the case of an agreement providing for such private practice, an additional grant equal to $25,000.

"(2) In the case of an agreement to which clause (B) of paragraphs (1) applies, the provisions of paragraph (1) (B) of subsection (f) shall apply to such agreement to the same extent as though the individual making the agreement were a 'participant' within the meaning of such subsection (f); the grant made pursuant to clause (D) of paragraph (1) of this subsection may be used only for the purposes for which a grant under paragraph (2) of subsection (f) may be used; and the provisions of paragraph (4) of subsection (f) shall apply with respect to the individual making the agreement under this subsection to the same extent as it applies to a 'participant' within the meaning of such subsection (f).

"(i) If the Secretary determines that an individual has violated an agreement under subsection (f) (1), (g) (1) (B), or (h), he shall, as soon as practicable after making such determination, notify the individual of such determination. If within one hundred and twenty days after the date of giving such notice, such individual is not practicing his

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profession in accordance with the agreement under subsection (f) (1), (g) (1) (B), or (h), as the case may be, and has not provided assurances satisfactory to the Secretary that he will not knowingly violate such agreement again, the United States shall be entitled to recover from such individual an amount determined under subsection (e), except that in applying the formula contained in such subsection—

"(1) in the case of an agreement under subsection (f) (1), 'P' shall be the amount paid under this section (other than any amount paid under subsection (f) (4)) to or on behalf of such person plus the interest on such amount which would be payable if at the time it was paid it was a loan bearing interest at the maximum legal prevailing rate, 't' shall be the number of months that such individual agreed to practice his profession under such agreement, including the number of months that the period of practice under such agreement was extended under subsection (f) (2) (A), and 's' shall be the number of months that such individual practiced his profession in accordance with such agreement;

"(2) in the case of an agreement under subsection (g) (1) (B), 'P' shall be the amount of the grant made under subsection (g) to such person plus the interest on such amount which would be payable if at the time

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it was paid it was a loan bearing interest at the maximum legal prevailing rate, 't' shall be the number of months (not in excess of twenty-four) that such individual agreed to practice his profession under such agreement, and 's' shall be the number of months that such individual practiced his profession in accordance with such agreement;

"(3) in the case of an agreement under subsection (h), 'p' shall be the amount of the grant or grants made under such subsection to such person plus the interest on such amount which would be payable if at the time it was paid it was a loan bearing interest at the maximum legal prevailing rate, 't' shall be the number of months (not in excess of 24) that such individual agreed to practice his profession under such agreement, and 's' shall be the number of months that such individual practiced his profession in accordance with such agreement.

"(j) (1) When a person undergoing training in the Program voluntarily terminates academic training, or is dismissed by the institution for failure to meet academic standing requirements or for disciplinary reasons, he shall be liable for repayment to the Government of an amount equal to the scholarship which he received under the program.

"(2) (A) Any remaining liability of any individual under paragraph (1) and any remaining entitlement of the

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United States to recover from an individual under subsection (e) or (h) shall be cancelled upon the death of such individual.

"(B) The Secretary shall by regulation provide for the waiver or suspension of any obligation under paragraph (1), and any entitlement to recover under subsection (e) or (h), applicable to any individual whenever compliance by such individual is impossible or would involve extreme hardship to such individual and if enforcement of such obligation or entitlement to recover with respect to any individual would be against equity and good conscience.

"(k) Notwithstanding any other provision of law, persons undergoing academic training under the program shall not be counted against any employment ceiling affecting the Department of Health, Education, and Welfare.

"(l) The Secretary shall issue regulations for the implementation of this section.

"(m) To carry out the program, there are authorized to be appropriated $50,000,000 for the fiscal year ending June 30, 1976, $100,000,000 for the first fiscal year thereafter, and $150,000,000 for the second fiscal year thereafter."

(b) Effective with respect to appropriations for fiscal years ending after July 1, 1975, the heading for subpart II of part C of title VII is amended to read

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"Subpart II—Student Scholarships"

and is inserted above the heading for section 747 (as redesignated by this Act).

TITLE IV—GRANTS FOR HEALTH PROFESSIONS SCHOOLS

SUPPORT GRANTS

SEC. 401. (a) Subsection (a) of section 770 is amended to read as follows:

"(a) GRANT COMPUTATION.—The Secretary shall make annual grants to schools of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, and podiatry for the support of the education programs of such schools. The amount of the annual grant to each such school with an approved application shall be computed for each fiscal year as follows:

"(1) each school of medicine or osteopathy shall receive—

"(A) for the fiscal year ending June 30, 1976,

"(i) $3,250 in the case of a school of medicine, or $2,300 in the case of a school of osteopathy, for each full-time student enrolled in such school in such year; and

"(ii) $1,000 for each student who is enrolled in such year on a full-time basis in such school in a program for the training of

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physician assistants or nurse practitioners; and

"(B) for each of the next two fiscal years,

"(i) one-third of the net education expenditures per student for each full-time student enrolled in such school in such year, and

"(ii) $1,000 for each student who is enrolled in such year on a full-time basis in such school in such a program for the training of physician assistants or nurse practitioners;

"(2) each school of dentistry shall receive—

"(A) for the fiscal year ending June 30, 1976,

"(i) $2,450 for each full-time student enrolled in such school in such year; and

"(ii) $650 for each student who is enrolled in such year on a full-time basis in such school in a program for the training of expanded function dental auxiliaries; and

"(B) for each of the next two fiscal years,

"(i) One-third of the net education expenditures per student for each full-time student enrolled in such school in such year, and

"(ii) $1,000 for each student who is enrolled in such year on a full-time basis in such school in such a program for the training of expanded function dental auxiliaries;

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"(3) each school of public health shall receive (A) for the fiscal year ending June 30, 1976, $2,000 for each full-time student enrolled in such school in such year, and (B) for each of the next two fiscal years, one-third of the net education expenditures per student for each full-time student enrolled in such school in such year;

"(4) each school of veterinary medicine shall receive (A) for the fiscal year ending June 30, 1976, $1,850 for each full-time student enrolled in such school in such year, and (B) for each of the next two fiscal years, one-third of the net education expenditures per student for each full-time student enrolled in such school in such year;

"(5) each school of optometry shall receive (A) for the fiscal year ending June 30, 1976, $1,050 for each full-time student enrolled in such school in such year, and (B) for each of the next two fiscal years, one-third of the net education expenditures per student for each full-time student enrolled in such school in such year;

"(6) each school of podiatry shall receive (A) for the fiscal year ending June 30, 1976, $1,650 for each full-time student enrolled in such school in such year, and (B) for each of the next two fiscal years, one-third

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of the net education expenditures per student for each full-time student enrolled in such school in such year;

"(7) each school of pharmacy (other than a school of pharmacy with a course of study of more than four years) shall receive (A) for the fiscal year ending June 30, 1976, $1,000 for each full-time student enrolled in such school in such year, and (B) for each of the next two fiscal years, one-third of the net education expenditures per student for each full-time student enrolled in such school in such year; except that in the case of a school of pharmacy with a course of study of more than four years amounts referred to in clauses (A) and (B) shall apply only with respect to full-time students enrolled in the last four years of such school, and for purposes of section 748, 771, and 782, a student enrolled in the first year of the last four years of such school shall be considered a first-year student."

(b) Subsection (d) of section 770 is amended to read as follows:

"(c) APPORTIONMENT OF APPROPRIATIONS.—If the total appropriated under subsection (g) for any fiscal year for any schools is less than the aggregate of the amounts to which they would otherwise be entitled for such fiscal year under subsection (a) or (b), the sum to be paid each such school for such year shall, instead of the amount de-

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termined under subsection (a) or (b), bear the same ratio to that amount as such total of appropriations bears to such aggregate of amounts.".

(c) (1) Subsections (d), (e), (f), and (g) of section 770 are repealed.

(2) Subsection (h) of section 770 is (A) redesignated as subsection (d), and (B) amended to read as follows:

"(d) ENROLLMENT DETERMINATIONS.—

"(1) For purposes of this section and sections 748, 771, and 782, regulations of the Secretary shall include provisions relating to the determination of the number of students enrolled in a school or in a particular year-class in a school on the basis of estimates, on the basis of the number of students who in an earlier year were enrolled in a school or in a particular year-class, or on such other basis as he deems appropriate for making such determination, and shall include methods of making such determination when a school or a year-class was not in existence in an earlier year at a school.

"(2) For purposes of this section and sections 748, 771, and 782, the term 'full-time students' (whether such term is used by itself or in connection with a particular year-class) means students pursuing a full-time course of study leading to a degree of doctor of medicine, doctor of osteopathy, bachelor of science in pharmacy or

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an equivalent degree, doctor of optometry or an equivalent degree, doctor of veterinary medicine or an equivalent degree, or doctor of podiatry or an equivalent degree or to a graduate degree in public health or equivalent degree. In the case of a training program of a school designed to permit the students enrolled in such program to complete, within six years after completing secondary school, the requirements for degree of doctor of medicine, doctor of dentistry or an equivalent degree, or doctor of osteopathy, and in the case of schools of pharmacy with a course of study of more than four years, the term 'full-time students' shall only include students enrolled on a full-time basis in the last four years of such program (or course) and for purposes of section 748, 771, and 782, students enrolled in the first of the last four years of such program (or course) shall be considered as first-year students.".

(3) Subsection (i) of section 770 is (A) amended by inserting ", public health" after "osteopathy", and (B) redesignated as subsection (e).

(4) Section 770 is further amended by inserting after subsection (e) (as so redesignated) the following new subsection:

"(f) NET EDUCATION EXPENDITURES.—For purposes of this section, the net education expenditures per student

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for any fiscal year for any school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy or public health means the total expenditures for the training of full-time students enrolled in the schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and public health, respectively, made by such schools for the second school year ending before such fiscal year, divided by the number of full-time students enrolled in such schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and public health, respectively, in such school year, including expenditures for research or patient care which was performed as part of such training, but minus any income of such schools received for such research or patient care. The determination of such expenditures shall be made by the Secretary on the basis of data furnished by such sampling of each of the various types of schools as the Secretary may find appropriate after consideration of the results of the study conducted pursuant to section 205 of the Comprehensive Health Manpower Act of 1971 (Public Law 92–157). To the extent practical, the Secretary shall vary the schools used in his sampling of each of the types of schools each year. The Secretary shall provide technical assistance and such financial assistance as he finds reasonably necessary for purposes of this subsection to the schools providing such data.".

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(5) Subsection (j) of section 770 is redesignated as subsection (g) and is amended to read as follows:

"(g) AUTHORIZATIONS OF APPROPRIATIONS.—

"(1) (A) There are authorized to be appropriated $244,300,000 for the fiscal year ending June 30, 1976, $254,700,000 for the first fiscal year thereafter, and $262,800,000 for the second fiscal year thereafter, for payments under grants under this section to schools of medicine, osteopathy, and dentistry based on the number of full-time students enrolled in such schools.

"(B) There are authorized to be appropriated $4,000,000 for the fiscal year ending June 30, 1976, $6,000,000 for the first fiscal year thereafter, and $8,000,000 for the second fiscal year thereafter, for payments under grants under this section to schools of medicine, osteopathy, and dentistry based on the number of students enrolled in such schools in programs for the training of physician assistants and programs for the training of expanded function dental auxiliaries.

"(2) There are authorized to be appropriated $11,000,000 for the fiscal year ending June 30, 1976, $12,000,000 for the first fiscal year thereafter, and $13,000,000 for the second fiscal year thereafter, for payment under grants under this section to schools of public health.

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"(3) There are authorized to be appropriated $11,600,000 for the fiscal year ending June 30, 1976, $11,900,000 for the first fiscal year thereafter, and $12,100,000 for the second fiscal year thereafter, for payments under grants under this section to schools of veterinary medicine.

"(4) There are authorized to be appropriated $29,100,000 for the fiscal year ending June 30, 1976, $30,000,000 for the first fiscal year thereafter, and $31,000,000 for the second fiscal year thereafter, for payments under grants under this section to schools of optometry and pharmacy.

"(5) There are authorized to be appropriated $3,300,000 for the fiscal year ending June 30, 1976, $3,500,000 for the first fiscal year thereafter, and $3,700,000 for the second fiscal year thereafter, for payments under grants under this section to schools of podiatry.

"(6) No funds appropriated under any provision of this Act (other than this subsection) may be used to make grants under this section.".

(d) (1) The amendments made by the preceding subsections of this section shall apply with respect to appropriations, and grants therefrom, for fiscal years ending after June 30, 1975. With respect to appropriations, and grants

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therefrom, for the fiscal year ending June 30, 1975, subsection (j) of section 770 as in effect before the date of the enactment of this Act is amended by inserting "and $238,000,000 for the fiscal year ending June 30, 1975," after "June 30, 1974," in paragraph (1), and "and $41,000,000 for the fiscal year ending June 30, 1975," after "June 30, 1974," in paragraph (2).

(2) For the fiscal year ending June 30, 1976, and for each of the next two fiscal years, there are authorized to be appropriated such sums as may be necessary to continue to make annual grants to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, and podiatry under section 770(a) of the Public Health Service Act (as in effect before the date of the enactment of this Act) based on the number of enrollment bonus students (determined in accordance with subsections (d) and (e) of section 770 of such Act (as so in effect)) enrolled in such schools who were first-year students in such schools for school years beginning before July 1, 1975, except that the amount of any grant made to such a school from sums appropriated under this subsection may not exceed the amount of the grant the school received in the fiscal year ending June 30, 1975, based on the number of such students enrolled in it.

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(e) The heading for part E of title VII is amended to read as follows:

"PART E—GRANTS TO IMPROVE THE QUALITY OF SCHOOLS OF MEDICINE, OSTEOPATHY, PUBLIC HEALTH DENTISTRY, VETERINARY MEDICINE, OPTOMETRY, PHARMACY, AND PODIATRY".

CONDITIONS OF ELIGIBILITY FOR SUPPORT GRANTS

SEC. 402. With respect to appropriations, and grants therefrom, for the fiscal year ending June 30, 1975, section 771 is amended by striking out "two" in subsection (a) (6) and inserting in lieu thereof "three" and by striking out "1974" and "1975" in subsection (b) (2) and inserting in lieu thereof "1975" and "1976", respectively. With respect to appropriations, and grants therefrom, for fiscal years after the fiscal year ending June 30, 1975, section 771 is amended to read as follows:

"ELIGIBILITY FOR CAPITATION GRANTS

"SEC. 771. (a) IN GENERAL.—The Secretary shall not make a grant under section 770 to any school in a fiscal year beginning after June 30, 1975, unless the application meets the following requirements:

"(1) The application shall contain or be supported by reasonable assurances satisfactory to the Secretary that the first-year enrollment of full-time students in the

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school in the school year beginning after the fiscal year for which the grant is sought will not be less than the first-year enrollment of such students in the school in the preceding school year.

"(2) The application shall contain or be supported by reasonable assurances satisfactory to the Secretary that the applicant will expend in carrying out its functions as a school of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, or podiatry, as the case may be, during the fiscal year for which such grant is sought, an amount of funds (other than funds for construction as determined by the Secretary) from non-Federal sources which is at least as great as the amount of funds expended by such applicant for such purpose (excluding expenditures of a nonrecurring nature) from such sources in the fiscal year preceding the fiscal year for which such grant is sought.

"(b) CONDITIONS OF ELIGIBILITY FOR SECOND HALF OF GRANT.—

(1) SCHOOLS OF MEDICINE.—The Secretary shall limit the grant under section 770 to any school of medicine in a fiscal year beginning after June 30, 1975, to one-half of the amount determined thereunder unless the application therefor contains or is accompanied by reasonable assurances satisfactory to the Secretary that

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such school will carry on at least one project in each of any two of the following three categories:

"(A) Projects under which for the second school year beginning after the fiscal year for which the grant sought and for each school year thereafter beginning in a fiscal year for which such a grant is made (i) the first-year enrollment of full-time students in such school, plus the number (if any) of full-time students enrolled in such school who have been enrolled with advanced standing after having previously been enrolled

(I) in such a school in a program not leading to a degree of doctor of medicine, or

(II) in a medical school in a foreign country,

will exceed the first-year enrollment of full-time students in such school in the school year beginning during the fiscal year ending June 30, 1975, by 5 per centum of such last-mentioned first-year enrollment or 10 students, whichever is greater, or (ii) the school will maintain (with the same or increased numbers of full-time students) a program approved by the Secretary for the training of physician assistants or nurse practitioners which was not in existence at such school in the school year which began

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during the fiscal year ending June 30, 1975, or maintain an increase of not less than 25 per centum of the full-time students who were enrolled at such school in such a program which was in existence in the school year which began in the fiscal year ending June 30, 1975.

"(B) Projects under which for the second school year beginning after the fiscal year for which the grant is sought and for each school year thereafter beginning in a fiscal year in which such a grant is made—

"(i) first-year enrollment of full-time students in such school who are from a medically underserved population group or an area with such a population, as designated pursuant to section 329, will exceed the number of such students in the school year beginning during the fiscal year ending June 30, 1975, by not less than ten students, or

"(ii) the school will establish and maintain, or expand (and maintain the expansion), a program approved by the Secretary to train, in facilities which are in areas with medically underserved populations (as designated pursuant to section 329) and which are geo-

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graphically remote from the main site of the teaching facilities of the school, full-time students and students enrolled on a full-time basis in programs of the school for the training of physician assistants or nurse practitioners.

"(C) Projects under which for the second fiscal year beginning after the fiscal year for which the grant is sought and for each fiscal year thereafter in which such a grant is made

"(i) if the number of primary health care residencies at general hospitals affiliated with the school is less than 50 per centum of all the residencies at such hospitals, there will, until they total not less than 50 per centum of all the residencies at such hospitals, be an annual increase in such primary health care residencies equal to not less than 5 per centum of all the residencies at such hospitals for the fiscal year ending June 30, 1975, or

"(ii) if the number of primary health care residencies at general hospitals affiliated with the applicant is not less than 50 per centum of all the residencies at such hospitals, the number of such primary health care residencies will

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not decrease to less than 50 per centum of all the residencies at such hospitals, or

"(iii) the school will establish and maintain, or expand (and maintain the expansion), programs for training full-time students enrolled at the school in the provision of the primary health care in facilities providing outpatient or ambulatory care.

"(2) SCHOOLS OF OSTEOPATHY, DENTISTRY, VETERINARY MEDICINE, OPTOMETRY, PODIATRY, AND PHARMACY.—The Secretary shall limit the grant under section 770 to any school of osteopathy, dentistry, veterinary medicine, optometry, podiatry, or pharmacy in a fiscal year beginning after June 30, 1975, to one-half of the amount determined thereunder unless the application therefor contains or is accompanied by reasonable assurances satisfactory to the Secretary that such school will carry on at least one project in any one of the following two categories:

"(A) Projects under which for the second school year beginning after the close of the fiscal year for which the grant is sought and for each school year thereafter beginning in a fiscal year in which such a grant is made, (i) the first-year enrollment of full-time students in such school will

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exceed the number of such students enrolled in the school year beginning in the fiscal year ending June 30, 1975, by 5 per centum of such number, or 10 students, whichever is greater, or (ii) in the case of a school of osteopathy or dentistry, the school will maintain (with the same or an increased number of students enrolled on a full-time basis) a program approved by the Secretary for the training of physician assistants or nurse practitioners (in the case of a school of osteopathy), or of expanded function dental auxiliaries (in the case of a school of dentistry), which program was not in existence at such school in the school year which began during the fiscal year ending June 30, 1975, or will maintain an increase of not less than 25 per centum of the students who were enrolled on a full-time basis at such school in such a program which was in existence in the school year which began during the fiscal year ending June 30, 1975, or

"(B) Projects under which for the second school year beginning after the fiscal year for which the grant is sought and for each school year thereafter beginning in a fiscal year in which such a grant is made

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"(i) first-year enrollment of full-time students in such school who are from a medically underserved population group or an area with such a population, as designated pursuant to section 329, will exceed the number of such students enrolled in the school year beginning during the fiscal year ending June 30, 1975, by not less than 10 students, or

"(ii) the school will establish and maintain, or expand (and maintain the expansion), a program approved by the Secretary to train, in facilities which are in areas with medically underserved populations (as designated pursuant to section 329) and which are geographically remote from the main site of the teaching facilities of the school, full-time students and, in the case of schools of osteopathy or dentistry, students enrolled on a full-time basis in programs of the school for the training of physician assistants or nurse practitioners, and expanded function dental auxiliaries, respectively.

"(3) SCHOOLS OF PUBLIC HEALTH.—The Secretary shall limit the grant under section 770 to any schools of public health in a fiscal year beginning after

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June 30, 1975, to one-half of the amount determined thereunder unless the application therefor contains or is accompanied by reasonable assurances satisfactory to the Secretary that such school will carry on a project under which, for the second school year beginning after the close of the fiscal year for which the grant is sought and for each school year thereafter beginning in a fiscal year in which such a grant is made, the first-year enrollment of full-time students in such school will exceed the number of such students enrolled in the school year beginning in the fiscal year ending June 30, 1975, by 5 per centum of such number or 10 students, whichever is greater.".

TEMPORARY CONTINUATION OF START-UP GRANTS

SEC. 403. For the fiscal year ending June 30, 1976, and each of the next two fiscal years, there are authorized to be appropriated such sums as may be necessary to continue to make grants under section 771 of the Public Health Service Act (as in effect before the date of the enactment of this Act) to schools which received a grant under such section from appropriations for a fiscal year ending before July 1, 1975.

GRANTS TO SCHOOLS IN FINANCIAL DISTRESS

SEC. 404. (a) Subsection (a) of section 773 is amended

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by inserting "each" after "$10,000,000" and by inserting "and the fiscal year ending June 30, 1975," after "1974,". Effective with respect to appropriations for fiscal years ending after June 30, 1975, such subsection (a) is amended to read as follows:

"(a) There are authorized to be appropriated $20,000,000 each for the fiscal year ending June 30, 1976, and the next two fiscal years, for payments under grants under this section."

(b) Section 773 is further amended by inserting "public health," after "dentistry," in subsections (b) and (d).

REDESIGNATIONS AND TEMPORARY EXTENSIONS

SEC. 405. (a) Section 775 is redesignated as section 774 and is amended—

(1) by striking out "770, 771, 772, or 773" each place it occurs and inserting in lieu thereof "770, 781, or 773";

(2) by inserting ", public health" after "dentistry" in subsection (b);

(3) by striking out "this part" and "section 725" in subsection (c) and inserting in lieu thereof "section 770, 781, or 773" and "section 702", respectively.

(4) by striking out "770, 771, or 773" in subsection (d) (1) and inserting in lieu thereof "770, 781, or 773".

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(b) The section heading of section 774 (as so redesignated) is amended by striking out "START-UP,".

(c) Sections 312 and 313 are repealed.

(d) The amendments (and repeals) made by this section shall apply with respect to appropriations, and grants therefrom, for fiscal years ending after June 30, 1975. Effective for appropriations for the fiscal year ending June 30, 1975, section 312 is amended by inserting "each" after "$10,000,000" and inserting "and the next fiscal year" after "1974", and subsections (a) and (c) of section 313 are each amended by inserting "each" after "$6,500,000" and inserting "and for the next fiscal year" after "1974".

TITLE V—SPECIAL PROJECT GRANTS AND CONTRACTS

REDESIGNATIONS AND TEMPORARY EXTENSIONS

SEC. 501. (a) Section 767 (entitled "GRANTS FOR TRAINING, TRAINEESHIPS, AND FELLOWSHIPS IN FAMILY MEDICINE") is repealed.

(b) Section 768 is amended by, in subsection (a), inserting "each" after "$15,000,000" and inserting "and the next fiscal year" after "1974," and, in subsection (b) (3) (B), inserting "or the next fiscal year," after "1974,".

(c) Section 769 (a) is amended by inserting "each"

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after "$20,000,000" and inserting "and the next fiscal year," after "1974,".

(d) Section 769A is amended by inserting "each" after "$15,000,000" and inserting "and the next fiscal year," after "1974,".

(e) Section 776(e) is amended by inserting "each" after "$10,000,000" and inserting ", and the next fiscal year" after "1974".

SPECIAL PROJECTS FOR HEALTH PROFESSIONS SCHOOLS

SEC. 502. (a) Section 772 is transferred to the beginning of part F of title VII and redesignated as section 781.

(b) Subsection (a) of section 781 (as so redesignated) is amended as follows:

(1) Strike out "or" at the end of subparagraph (13);

(2) Strike out the period at the end of subparagraph (14) and insert in lieu thereof a semicolon.

(3) Insert after subparagraph (14) the following new subparagraphs:

"(15) plan, develop, and operate programs to increase the awareness by health professions personnel of the cultural sensitivities related to the health of individuals with limited English-speaking ability, with special emphasis on training programs which include clinical training and utilize team training, and on con-

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tinuing education programs, in communities where a substantial proportion of the population is of limited English-speaking ability;

"(16) establish and operate programs to encourage greater knowledge of and sensitivity toward the special health problems of women;

"(17) establish and operate programs designed to provide increased emphasis on, and training in, rehabilitation medicine and encourage greater knowledge of and sensitivity toward the special health problems of handicapped individuals, especially women and who are handicapped;

"(18) provide increased emphasis on, and training in, the aging process, including the social, behavioral, and biomedical aspects of the aging process, and training in the diagnosis, treatment, and prevention of diseases and related problems of the aged; or

"(19) encourage experienced physicians and other health care personnel to relocate to areas with medically underserved populations, as designated pursuant to section 329.".

(c) Subsection (d) of section 781 (as so redesignated) is amended by striking out "and $156,000,000" and inserting in lieu thereof "$156,000,000 each" and by inserting after "1974," the following: "and the next fiscal year, and

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$75,000,000 each for the fiscal year ending June 30, 1976, and the next two fiscal years,".

(d) The amendments made by this section shall apply with respect to appropriations, and grants therefrom, for fiscal years ending after June 30, 1975; and effective with respect to grants under section 781 (as so redesignated) from appropriations thereunder for fiscal years beginning after June 30, 1975, subparagraphs (9) and (11) of subsection (a) thereof are repealed.

ASSISTANCE TO DISADVANTAGED STUDENTS

SEC. 503. Part F of title VII is amended by inserting after section 781 (as redesignated by this Act) the following new section:

"ASSISTANCE TO INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS

"SEC. 782. (a) (1) For the purpose of assisting individuals from disadvantaged backgrounds, as determined in accordance with criteria prescribed by the Secretary, to undertake education to enter a health profession, the Secretary may make grants to and enter into contracts with schools of medicine, osteopathy, public health, dentistry, veterinary medicine, optometry, pharmacy, and podiatry and other public or nonprofit private health or educational entities to assist in meeting the costs described in paragraph (2).

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"(2) A grant or contract under paragraph (1) may be used by the health or educational entity to meet the costs of—

"(A) identifying, recruiting, and selecting individuals from disadvantaged backgrounds, as so determined, for the education provided by a health professional school,

"(B) facilitating the entry of those individuals into such a school,

"(C) providing counseling or other services designed to assist those individuals to complete successfully their education at such a school,

"(D) providing, for a period prior to the entry of those individuals into the regular course of education at such a school, preliminary education designed to assist them to complete successfully such regular course of education at such a school or referring such individuals to institutions providing such preliminary education, and

"(E) publicizing existing sources of financial aid available to persons enrolled in the education program of such a school or who are undertaking training necessary to qualify them to enroll in such a program.

"(3) No grant may be made or contract entered into under paragraph (1) with a school of medicine, osteopathy, dentistry, public health, veterinary medicine, optometry, pharmacy, or podiatry unless its application for such grant

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or contract contains or is supported by assurances satisfactory to the Secretary that in the second school year beginning after the close of the fiscal year for which such grant is made or contract entered into such school will enroll in its first-year class a number of full-time students from disadvantaged backgrounds, as determined in accordance with criteria prescribed by the Secretary, which is at least equal to the lesser of—

"(A) 5 per centum of the number of first-year full-time students enrolled in the school in the preceding school year, or

"(B) ten.

"(b) There are authorized to be appropriated $20,000,000 each for the fiscal year ending June 30, 1976 and the next two fiscal years, for payments under grants and contracts under subsection (a).".

AREA HEALTH EDUCATION CENTERS

SEC. 504. (a) Section 774 (as in effect before the date of the enactment of this section) is transferred to part F of title VII, is inserted after section 782 (added by this Act) and redesignated section 783, and is amended to read as follows:

"AREA HEALTH EDUCATION CENTERS

"SEC. 783. (a) For the purpose of improving the distribution, supply, quality, utilization, and efficiency of health

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personnel in the health services delivery system and for the purpose of encouraging the regionalization of educational responsibilities of the health professions schools, the Secretary may make grants and enter into contracts for projects for area health education centers—

"(1) to conduct programs to alleviate shortages of health personnel in rural areas with sparse populations or urban areas with unusually dense populations through training or retraining of health personnel in community hospitals and other facilities located in such areas (including training of students enrolled in residency programs in family medicine, general internal medicine, general pediatrics, and obstetrics and gynecology) or to otherwise improve the distribution in such areas of health personnel by area or by specialty group;

"(2) to provide training programs in such areas leading to more efficient utilization in such areas of health personnel, emphasizing multidisciplinary and interdisciplinary patterns of undergraduate, graduate, and continuing education of health personnel; and

"(3) to provide education programs for the general population of such areas regarding the appropriate use of health services, the availability of health services in such areas (including services provided under federally funded programs), and the contribution each

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individual can make to the maintenance of his own health.

"(b) (1) A grant or contract under this section may be made only for such stipends and allowances (including travel and subsistence expenses and dependency allowances), for the students in the programs referred to in subsection (a), as the Secretary may deem necessary and costs of construction of new primary health care facilities and of medical school facilities necessary for the administration of the training program for which the grant or contract is made.

"(2) No application for a grant or contract under this section may be approved unless the application—

"(A) is made by a public or nonprofit private educational entity which has, or which is affiliated with, at least one school of medicine or osteopathy;

"(B) contains assurances satisfactory to the Secretary that, to the maximum extent feasible, the project of the applicant will be conducted in conjunction with (including the sharing of faculty and facilities) the projects (if any) under paragraph (1) (B) (ii) or (2) (B) (ii) of section 771 (b), of any schools of medicine or osteopathy participating in the project of the applicant for the remote site training of undergraduate students of medicine or osteopathy;

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"(B) contains a designation of the geographic boundaries of the areas to be served by area health education centers established under the project;

"(C) contains a list of the manpower needs of the areas to be served by area health education centers established under the project, the relative order in which those needs should be addressed, a detailed description of the types of programs to be carried out by the area health education centers and provision for periodic review and evaluation of such programs by experts in medical or osteopathic or other health professions education (as may be appropriate);

"(D) contains assurances that each medical or osteopathic school participating in the project will provide not less than six weeks of training per year in area health education centers for at least 50 per centum of the students enrolled in such school in a residency program in family medicine, general internal medicine, general pediatrics, or obstetrics and gynecology;

"(E) contains assurances satisfactory to the Secretary that a significant portion of the faculty of each participant in the project will serve as instructors in graduate training and continuing education programs in areas served by the area health education centers;

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"(F) contains a specific program for multidisciplinary and interdisciplinary training both at the main site of the training or clinical facilities of the applicant and in area health education centers established under the project;

"(G) contains a plan for frequent counseling and consultation between the faculty of the applicant at the main site of its training or clinical facilities and instructors and other appropriate participants in the applicant's programs in the areas served by the area health education centers; and

"(H) contains a detailed plan for frequent consultation and coordination of the applicant's project with appropriate local, regional, State, or Federal agencies in order to exchange information and avoid unnecessary duplication of programs.

"(c) There are authorized to be appropriated $40,000,000 for the fiscal year ending June 30, 1976, $70,000,000 for the first fiscal year thereafter, and $75,000,000 for the second fiscal year thereafter for payments under grants and contracts under this section.".

(b) For the fiscal year ending June 30, 1975, there are authorized to be appropriated such sums as may be necessary to continue payments to entities under grants or contracts entered into under section 774 of the Public Health

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Service Act (as in effect before the date of the enactment of this Act).

PROJECT GRANTS FOR UNDERSERVED AREAS, PRIMARY HEALTH CARE TRAINING, BILINGUAL TRAINING CENTERS, AND HEALTH EDUCATION

SEC. 505. Part F of title VII is amended by inserting after section 783 (as redesignated by this Act) the following new sections:

"PROJECTS TO SUPPORT UNDERSERVED AREA SERVICES

"SEC. 784. There are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1976, $20,000,000 for the first fiscal year thereafter, and $30,000,000 for the second fiscal year thereafter for grants by the Secretary to any school of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, or public health for special projects to assist in the provision of health services for medically underserved populations designated pursuant to section 329.

"PRIMARY HEALTH CARE RESIDENCIES AND UNDERGRADUATE TRAINING

"SEC. 785. (a) There are authorized to be appropriated $40,000,000 for the fiscal year ending June 30, 1976 and $50,000,000 each for the next two fiscal years for grants by the Secretary to any school of medicine or osteopathy, or any public or nonprofit private hospital, for special projects

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to plan, develop, operate, or participate in residency programs for primary health care which are accredited pursuant to section 1702 or, in the case of grants for any fiscal year beginning before January 1, 1978, accredited by an entity generally recognized by the medical profession for purposes of accrediting such a program.

"(b) There are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1976, $15,000,000 for the first fiscal year thereafter, and $20,000,000 for the second fiscal year thereafter for grants by the Secretary to any school of medicine or osteopathy for special projects to plan, develop, and operate programs for the training of physicians in primary health care provided in outpatient or ambulatory care facilities.

"PROJECTS FOR BILINGUAL HEALTH TRAINING CENTERS

"SEC. 786. There are authorized to be appropriated $2,500,000 each for the fiscal year ending June 30, 1976, and of the next two fiscal years for grants by the Secretary to any public or nonprofit private health or educational entity for projects for establishment and initial operation of not more than four bilingual health training clinical centers in communities, in widely separated areas of the United States, in which a substantial proportion of the residents is of limited English-speaking ability, such centers to place special em-

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phasis on (1) the training of interns, residents, and other health personnel who are bilingual and (2) the provision of health services to the surrounding community.

"HEALTH EDUCATION

"SEC. 787. (a) There are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1976, $10,000,000 for the first fiscal year thereafter, and $15,000,000 for the second fiscal year thereafter for grants by the Secretary to any school of medicine, osteopathy, or dentistry for the establishment and operation of programs to provide, in areas surrounding such school or any institutions or facilities affiliated with such school, education programs for the general population thereof regarding the importance of adequate preventive and remedial health care, the appropriate use of health services and facilities and the availability thereof, and the ways in which the population can contribute to their own health.".

TITLE VI—MEDICAL RESIDENCY TRAINING PROGRAMS; ADMISSION OF ALIEN DOCTORS; REPORTS

MEDICAL RESIDENCY TRAINING PROGRAMS

SEC. 601. The Public Health Service Act is amended by adding at the end the following new title:

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"TITLE XVII—MEDICAL RESIDENCY TRAINING PROGRAMS

"EFFECT OF NONACCREDITATION OR EXCESS POSITIONS IN MEDICAL RESIDENCY TRAINING PROGRAMS

"SEC. 1701. (a) For purposes of this title, the term 'medical residency training program' means a program which trains graduates of schools of medicine and schools of osteopathy in a medical specialty recognized by the liaison committee for specialty boards established jointly by the American Board of Medical Specialties and the Council on Medical Education of the American Medical Association (or any successor of such committee) and which provides the graduate education required by the specialty board (recognized by such liaison committee) for certification in such specialty. Such term does not include a residency training program in an osteopathic hospital.

"(b) (1) In the case of any entity which is engaged in business as a health care facility, the compensation of a doctor of medicine or a doctor of osteopathy in a medical residency training program which has not been accredited under section 1702 for a fiscal year beginning after December 31, 1977, or which has for such year a total number of positions in excess of the number prescribed for such program under section 1703 or a number of first-year positions in excess of the number prescribed therefor under such sec-

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tion (which compensation is paid for a health service provided by such a doctor of medicine or a doctor of osteopathy in connection with such program), may not be included in determining Federal payments under title V, XVIII, or XIX of the Social Security Act. With respect to any entity which is reimbursed on a per capita basis, in determining Federal payments under any such title for a year the Secretary shall exclude an amount which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this paragraph for such year if payment were made on other than a per capita basis.

"(2) If the Secretary determines that an entity is—

"(A) operating a medical residency training program during a fiscal year beginning after December 31, 1977, which has not been accredited under section 1702, or

"(B) operating a medical residency training program with a number of all positions or of first-year positions which for such year exceeds the numbers prescribed for that program under section 1703,

the Secretary shall notify the entity of his determination, shall publish the determination in the Federal Register, and shall not make any grant to or enter into any contract with such entity under this Act for the fiscal year beginning after

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the date the Secretary publishes such determination in the Federal Register.

"MEDICAL RESIDENCY TRAINING PROGRAM ACCREDITING AGENCY

"SEC. 1702. (a) (1) For the purpose of accrediting the medical residency training programs for which positions may be occupied or made available under section 1703, the Secretary shall in accordance with subsection (b) designate or establish a medical residency training program accrediting agency (hereinafter in this section referred to as the 'accrediting agency').

"(2) The accrediting agency shall review, in accordance with procedures established and published by the agency and made available to the public, each medical residency training program in the United States and shall either accredit or disapprove such programs. Each such program shall be reviewed at least every three years and an accreditation of a program shall be in effect for three years unless the accrediting agency terminates the accreditation before the expiration of three years. As soon after an accrediting agency is designated or established pursuant to this section as practicable, it shall review training programs for purposes of accrediting them or denying accreditation for purposes of this title. For the period prior to July 1, 1979, the accrediting agency may accredit a pro-

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gram on the basis of an accreditation granted such program by an entity generally recognized by the medical profession for purposes of accrediting such a program.

"(3) The accrediting agency shall submit to the agency designated or established under section 1703 and keep current for it a list of the medical residency training programs the accreditations of which are in effect. The first such list shall be so submitted not later than January 1, 1977.

"(b)(1) Not later than September 30, 1975, the Secretary shall prescribe and publish in the Federal Register requirements which must be met by an entity before it may be designated as the accrediting agency for purposes of this title. Such requirements shall provide that an entity—

"(A) have a governing body which is comprised of representatives of the medical profession, medical specialty boards, medical specialty societies, hospitals, schools of medicine, and the general public; and

"(B) meet the criteria established by the Secretary for recognition of nationally recognized accrediting agencies and associations.

"(2)(A) An entity which seeks designation as the accrediting agency shall submit an application to the Secretary not later than January 1, 1976. If such an application has been submitted to the Secretary by the liaison committee for

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graduate medical education of the coordinating council for medical education before such date, and—

"(i) if the Secretary determines that the liaison committee meets the requirements prescribed under paragraph (1), he shall approve such application and designate it as the accrediting agency; or

"(ii) if the Secretary finds that the liaison committee does not meet such requirements, he shall provide it with such technical and other nonfinancial assistance as may be appropriate to enable it to meet such requirements and, if the Secretary determines that it meets such requirements, he shall designate it as the accrediting agency.

"(B) If, by July 1, 1976, the Secretary (after providing such assistance) finds that the liaison committee still does not meet such requirements, he shall consider other applications for such designation and shall, if he determines that an entity filing such an application meets the requirements prescribed under paragraph (1) and that such entity is otherwise qualified to accredit medical residency training programs, designate, not later than September 30, 1976, such entity as the accrediting agency.

"(3) (A) A designation of the accrediting agency shall be in effect for three years unless the Secretary terminates such designation before the expiration of three years upon a

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determination by the Secretary (after notice and reasonable opportunity for a public hearing) that the agency no longer meets the requirements of paragraph (1) or is not qualified to accredit medical residency training programs. A designation may, upon application, be renewed for a period of three years.

"(B) If the Secretary terminates a designation or determines a designated accrediting agency is not qualified to have its designation renewed, the Secretary shall publish notice of such termination or determination and solicit applications from other entities for designation as the accrediting agency.

"(4) (A) If—

"(i) by September 30, 1976, the Secretary determines that no entity which has applied for designation meets the requirements prescribed under paragraph (1) and is otherwise qualified to accredit medical residency training programs or if by such date no entity has applied for designation, or

"(ii) upon the expiration of a designation under this section, the Secretary determines that the designated agency is not qualified to have its designation renewed and that there are no other qualified applicants for designation, or upon the termination of such a designation,

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the Secretary determines that there are no qualified applicants for designation,

the Secretary shall, within two months of the determination, establish an accrediting agency for purposes of this title.

"(B) An accrediting agency established by the Secretary under subparagraph (A) shall meet the criteria established by the Secretary for recognition of nationally recognized accrediting agencies and associations and be composed of members who are fairly representative of the medical profession, medical specialty boards, medical specialty societies, hosptials, schools of medicine, and the general public. While away from their homes or regular places of business in the performance of services for the agency, members of the agency shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703(b) of title 5 of the United States Code. The agency may appoint, without regard to the provisions of title 5, United States Code, respecting appointments in the competitive service, and pay, without regard to the provisions of such title respecting rates of pay, such personnel as it deems necessary for the agency to carry out its functions.

"(C) The establishment of an accrediting agency under subparagraph (A) shall be for such period (but not more

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than three years) as the Secretary prescribes. If an accrediting agency has been established by the Secretary an entity may apply for designation as such agency upon the termination of the period for which the accrediting agency was established. If no entity submits an approvable application for designation before the date of such termination, the Secretary shall renew the authority of the established accrediting agency for a period not to exceed three years.

"ESTABLISHMENT OF POSITIONS FOR MEDICAL RESIDENCY TRAINING PROGRAMS

"SEC. 1703. (a) (1) For purposes of this title, the Secretary shall, by April 1, 1977, with the approval of the agency designated or established by him under this section, (A) establish (and publish in the Federal Register) the aggregate number of all positions which may be occupied in the first fiscal year beginning not less than twelve months after such date in accredited medical residency training programs and the total number of first-year positions in such programs which may be made available in such fiscal year; and (B) establish, and give to each entity which maintains such a program, written notice of the number of all positions in its medical residency training program which may be occupied in such fiscal year and the number of first-year positions which it may make available in such program in such fiscal year. The numbers of positions so established

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for any fiscal year thereafter shall be published in the Federal Register not later than April 1 of the preceding calendar year and each entity which maintains an accredited medical residency training program shall be given written notice by such date of the numbers of such positions for its program for such fiscal year.

"(2) The Secretary's and the designated or established agency's determinations under clause (A) of paragraph (1) in any year shall be based on his estimate of the number of graduates from schools of medicine in the fiscal year which began in the preceding calendar year, and the number of positions in medical residency training programs occupied in such fiscal year. In making their determinations under paragraph (1) in any year, the Secretary and the designated or established agency shall—

"(A) take into consideration the report made with respect to the study conducted under section 15(c) of the Act of December 30, 1973 (Public Law 93-233), and the annual reports of the Secretary under section 703 of the Health Manpower Act of 1975;

"(B) seek to insure that positions in medical residency training programs are distributed equitably throughout various geographical areas of the United States;

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"(C) afford special consideration to positions in medical residency training programs maintained in conjunction with area health education centers under section 783 of this Act; and

"(D) afford particular attention to the need for medical residency training programs in the primary health care specialties of general internal medicine, general pediatrics, family medicine, and obstetrics and gynecology.

"(b) (1) Not later than September 30, 1975, the Secretary shall prescribe and publish in the Federal Register requirements which must be met by an entity before it may be designated as the agency to establish hereunder the number of positions which may be occupied or made available in medical residency training programs accredited pursuant to section 1702. Such requirements shall provide that an entity have a governing body which is comprised of the Secretary (or his delegate) and representatives of the medical profession, medical specialty boards, medical specialty societies, hospitals, schools of medicine, and the general public.

"(2) (A) If the coordinating council for medical education has submitted an application for designation under this section to the Secretary before December 31, 1975, and—

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"(i) if the Secretary determines that the coordinating council meets the requirements prescribed under paragraph (1), he shall approve such application and designate it; or

"(ii) if the Secretary finds that the coordinating council does not meet such requirements, he shall provide it with such technical and other nonfinancial assistance as may be appropriate to enable it to meet such requirements, and if the Secretary determines not later than February 20, 1976, that it meets such requirements, he shall designate it.

"(B) If, by February 29, 1976, the Secretary has not designated the coordinating council for medical education pursuant to subparagraph (A), he shall as soon as practicable establish an agency consisting of the Assistant Secretary of Health and the Administrator of the Health Resources Administration from the Department of Health, Education, and Welfare, the Chief Medical Director of the Veterans' Administration, and the President of the Uniformed Services University of the Health Sciences, all ex officio, nonvoting members, and nineteen members appointed by the Secretary. Of the nineteen appointed members,

"(A) ten shall be appointed from lists of nominees submitted by the American Medical Association, the American Hospital Association, the Association of Amer-

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ican Medical Colleges, the American Board of Medical Specialties, and the Council on Medical Specialty Societies, each such list to contain four or more nominees and two appointees to be appointed from each such list;

"(B) one each shall be appointed from lists of two or more nominees submitted by the American Osteopathic Association and the American Association of Colleges of Osteopathic Medicine;

"(C) six, none of whom may be providers of health care, shall be representatives of consumers of health care; and

"(D) one shall be in a full-time medical residency position.

"(3)(A) A designation of the coordinating council for medical education under paragraph (2) shall be in effect for three years unless the Secretary terminates such designation before the expiration of three years upon a determination by the Secretary (after notice and reasonable opportunity for a public hearing) that the agency no longer meets the requirements of paragraph (1) or is not qualified to pass upon the number of positions in medical residency training programs accredited pursuant to section 1702. Such a designation may, upon application, be renewed for a period of three years.

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"(B) If the Secretary terminates such a designation or determines the designated agency is not qualified to have its designation renewed, the Secretary shall publish notice of such termination or determination.

"(4) (A) If upon the expiration of a designation under this section, the Secretary determines that the designated agency is not qualified to have its designation renewed, or upon the termination of such a designation, the Secretary shall, within three months of such determination, establish an agency as provided in paragraph (2) (B) to pass upon the numbers of positions in medical residency training programs accredited pursuant to section 1702.

"(B) While away from their homes or regular places of business in the performance of services for the agency, members of an agency established pursuant to paragraph (2) (B) shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 (b) of title 5 of the United States Code. The agency may appoint, without regard to the provisions of title 5, United States Code, respecting appointments in the competitive service, and pay, without regard to the provisions of such title respecting rates of pay, such personnel as it deems necessary for the agency to carry out its functions.

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"(C) The establishment of an agency under paragraph (2) (B) shall be for such period (but not more than three years) as the Secretary prescribes. If such an agency has been established by the Secretary the coordinating council for medical education may apply for designation as such agency upon the termination of the period for which the agency was established. If the council does not submit such an approvable application for designation before the date of such termination, the Secretary shall renew the authority of the established agency for a period not to exceed three years.

"(5) The Secretary may make grants to the coordinating council for medical education if designated under this section for its costs in carrying out its functions under this section. Any such grant shall cover the council's costs incurred in carrying out such functions for a period of not to exceed one year; and no such grant for any year may exceed $300,000.".

ADMISSION OF ALIEN DOCTORS

SEC. 602. (a) Section 212 (a) of the Immigration and Nationality Act (8 U.S.C. 1182) is amended by renumbering paragraphs (15) through (31) as (16) through (32), respectively, and by inserting after paragraph (14) the following:

"(15) (A) Aliens who are members of the medical profession, unless the Attorney General finds, after con-

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sultation with the Secretary of Health, Education, and Welfare, that—

"(i) the alien has passed parts I and II of the National Board of Medical Examiners Examination; and

"(ii) the alien has demonstrated competency in oral and written English; and

"(iii) the admission of the alien will not lead to a surplus of practitioners in a specialty area or geographical area in which there is no present or projected need.

"(B) The exclusion of aliens under this paragraph shall apply only to (i) special immigrants defined in section 101(a)(27)(A) (other than the parents, spouses, or children of United States citizens or of aliens lawfully admitted to the United States for permanent residence), (ii) to preference immigrant aliens described in section 203(a)(3) and (6), and (iii) to nonpreference immigrant aliens described in section 203(a)(8);".

(b) Section 212(a)(14) of the Immigration and Nationality Act is amended by inserting "(except aliens described in paragraph (15))" after "Aliens".

(c) The amendments made by this section shall take effect July 1, 1975.

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REPORT ON HEALTH MANPOWER

SEC. 603. (a) The Secretary shall not later than June 30 of 1976, and of each year thereafter, report to the Congress on the supply of personnel of the various health professions, and of the various specialty groups within each profession, as of the end of the preceding calendar year, the distribution of such personnel and members of such groups within various geographical areas of the United States, the need for such personnel and members in the United States and in such area, the extent to which the anticipated additions of such personnel and members from the various training programs is likely to meet such needs, and other data relevant to the need for training of additional such personnel and members of such groups or redistribution thereof.

(b) Such report shall be made only after approval by a commission of ten persons not otherwise in the regular full-time employ of the United States, appointed by the Secretary, who by their training and experience are eminently qualified to assess health personnel supply and needs. Members of such commission while serving on business of the commission away from their homes or regular places of business shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 (b) of title 5 of the United States Code.

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IDENTICAL AND SIMILAR BILLS BEING CONSIDERED BY THE SUBCOMMITTEE

H.R. 242, introduced by Mr. Downing on January 14, 1975;
H.R. 872, introduced by Mr. Price on January 14, 1975;
H.R. 1443, introduced by Mr. Carter on January 15, 1975;
H.R. 2304, introduced by Mrs. Burke of California on January 29, 1975;
H.R. 2306, introduced by Mr. Carter on January 29, 1975;
H.R. 2432, introduced by Mr. Dodd on January 30, 1975;
H.R. 2657, introduced by Mr. Dodd on February 4, 1975;
H.R. 2691, introduced by Mr. Lehman on February 4, 1975;
H.R. 2710, introduced by Mr. Pepper on February 4, 1975; and
H.R. 3268, introduced by Mr. Patten on February 19, 1975.

Mr. ROGERS. As our first witness today, I am pleased to welcome back—and wish to thank him for his continuing patience for the long hours involved—the distinguished Secretary of Health, Education, and Welfare, the Honorable Caspar Weinberger.

The Secretary is accompanied by Dr. Theodore Cooper, Acting Assistant Secretary for Health; Mr. Stephen Kurzman, Assistant Secretary for Legislation; and Dr. Stuart Altman, Deputy Assistant Secretary for Health Planning and Analysis.

We welcome all of you, and the committee will be pleased to receive your testimony.

STATEMENT OF HON. CASPAR W. WEINBERGER, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY THEODORE COOPER, M.D., ACTING ASSISTANT SECRETARY FOR HEALTH; STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION; STUART ALTMAN, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH PLANNING AND ANALYSIS; AND KENNETH M. ENDICOTT, M.D., ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION

Secretary WEINBERGER. Thank you, Mr. Chairman. We are pleased to discuss these matters with you.

I do have a long statement which you have before you. I will try to shorten it in the presentation. However, there are a large number of separate topics, so we will spend some time going through those. And the same as yesterday, if there are questions you would like to ask, I hope you won't hesitate to break in.

Three bills that are before you, the ones you have identified, and the administration's bills, entitled "The Comprehensive Health Professions Act of 1975" and the "National Health Service Corps Amendments of 1975," will be submitted to Congress within a week. [See p. 342.]

As we pointed out during our appearance last May when similar legislation was considered, although we did not fully agree with some of the provisions in bills similar to H.R. 2956 and H.R. 2957, the approach taken by these bills conforms in a number of areas to the administration's approach. Mr. Chairman, it remains our hope that we can work together to address constructively the complex health manpower issues confronting the Nation.

Before presenting our specific comments on the bills before you today, I think it would be useful to summarize briefly what we continue to feel are the major issues which surround new health manpower legislation.

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Over the past decade, the nature and extent of Federal intervention in the health care system and its associated education and training programs have grown substantially. Only 10 years ago, the Health Professions Educational Assistance Act marked the beginning of the Federal role in providing direct support for the education of health professionals. Numerous studies had concluded that a health crisis would result unless the production of physicians was substantially increased. Initially, therefore, the primary objective of the Federal health manpower effort was to increase the aggregate supply of health manpower.

The Health Professions Educational Assistance Act was amended at various times to provide for the support of activities to demonstrate selected improvements in health manpower education, such as curriculum reform, maintenance of accreditation, relief of financial distress, and the recruitment of minorities. In 1971, the Federal role for the first time was expanded to provide basic operational support to the schools.

In 1969, concern over the issue of supply adequacy was intensified. Reports from both Government and nongovernmental groups suggested that there was a shortage of approximately 50,000 physicians, 200,000 nurses, and almost 150,000 technicians. In 1970, the Carnegie Commission issued a report which concluded that medical and dental education were inadequately funded and recommended that the Federal Government increase its role in the financing of health manpower education.

I would like to point out that while many of the studies have been helpful in highlighting certain manpower problems, for the most part, they only concentrated on aggregate numbers and provider-population ratios. Such undertakings fail to deal with the very complex questions of appropriate manpower utilization, for example, increased productivity, that can be obtained through various methods, and the proper use of allied health professionals, improved health delivery systems, and distribution. In 1971 the Comprehensive Health Manpower Training Act provided for the first time Federal operational support of schools of the health professions.

CHANGES IN THE TRAINING OF HEALTH MANPOWER

As we pointed out in earlier testimony before the subcommittee, health manpower training programs have experienced significant changes over the past 10 years. First, there has been a substantial increase in the national capacity to train health professionals.

Since 1963, Federal programs have assisted in the building of 21 medical schools, 9 dental schools, 1 school of osteopathy, and 1 school of veterinary medicine. Federal financial assistance has been provided to help create about 1,600 annual medical and 650 dental school slots.

Second, enrollment has increased significantly for schools of medicine, dentistry, and nursing. First-year medical school places have grown from 8,759 in 1965 to 14,153 in 1973–74. It is impossible to measure the exact impact of Federal programs in this increase. Nevertheless, we believe that our efforts have had a significant impact. Where first-year enrollment rose at an annual rate of 1.3 percent between 1950 and 1965, the annual growth since 1965 has been about 6.6 percent.

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Third, minority group enrollment has risen substantially in medical and dental schools although it cannot be directly traced to Federal programs. First-year enrollment of black students in U.S. medical schools has increased from 4.2 percent in academic year 1969–70 to 7.2 percent in academic year 1973–74. There has also been a significant increase in the enrollment of women in medical schools from 9.1 percent in 1969–70 to 19.7 percent in 1973–74.

The ready availability of Federal funds, including medicare and medicaid reimbursement, has produced only limited cost consciousness in the health professional schools and, accordingly, we have seen the cost of such education rise substantially. Over the past 10 years, annual Federal obligations for health manpower programs, not including research training, mental health manpower or nursing, have grown from $65 million in 1963 to $525 million in 1974.

Between 1963 and 1973, a total of approximately $3.4 billion was obligated for the training of health professionals. Federal funds from all sources now account for nearly 50 percent of the revenue to U.S. medical schools, making the Federal Government the largest single supporter of medical schools. The programs providing support through the legislation being considered today amount to only between 5 and 10 percent of the schools' total revenue.

But even with this large investment in terms of Federal dollars, health professions education programs have had only very limited success in addressing issues beyond that of increasing numbers of health professionals. With the exception of expenditures for biomedical research, most Federal spending for health professional schools has gone for general institutional support rather than being directed toward solving specific problems. With the exception of recent programs in family medicine residency training, Federal programs have simply not been geared toward solving the problems of specialty allocation. Nor have Federal funds been focused on the need to provide additional health professionals to meet Federal direct health care responsibilities, for example, the Indian Health Service and the Veterans' Administration.

Furthermore, geographic distribution of health care providers has not been affected significantly by Federal policies which have relied upon loan forgiveness as the principal mechanism for change. Since 1965, 170,000 students were provided loans under the Health Professions Educational Assistance Act loan program which contained a forgiveness provision to encourage graduates to locate in medically underserved areas. While we cannot, of course, draw definitive conclusions about this program, since many of those who have taken out loans are still in training, it is important to note that since 1965 very few graduates have taken advantage of the loan-forgiveness provision.

This situation could be caused by the fact that the amount of student indebtedness has been quite small and the length of service requirement has been disproportionately burdensome when viewed in terms of the amount to be repaid. However, the expanded repayment provisions of the 1971 act, which allow Federal repayment of up to 85 percent of any educational loan, would seem to be more attractive.

Since the regulations were announced, almost 1,000 applications have been received. The requests far outstripped our expectations.

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Whereas, we had budgeted about $500,000 for loan repayments in fiscal year 1975, using the experience of the past forgiveness program, we now believe that we will have to allocate about $3.5 million for this program this year. So, a great many more people are applying for this program and we hope it will have a more substantial effect than the other program. For fiscal year 1976, $6 million is being requested for this activity for health professions students, and an addditional $2.5 million for nursing students.

Mr. Chairman, last May we presented our views on the issues involving setting the appropriate future Federal role in the development of health manpower. We believed then and believe now that the critical issues which must be addressed involve (1) adequacy of supply; (2) foreign medical graduate—(FMG)—quality; (3) geographic and specialty distribution; (4) productivity; and (5) equity.

ADEQUACY OF SUPPLY

With respect to the supply of health professionals, we find that, in general, the allied health and nursing professions adjust reasonably well to market demands without substantial Federal assistance. The shortness and relatively low cost of these training programs, together with localized demand, contribute to this response. Both public and private training institutions have responded quickly as the demand for nurses annd allied health personnel grew.

Based on current projections which assume maintenance of our current and planned output capacity, we anticipate nearly a 60 percent increase in registered nurses from 1970 to 1985. For these reasons, continuing Federal subsidies are not necessary for these fields, in our opinion.

With respect to the medical and dental professions, we have developed a series of manpower supply and requirement projections. These projections indicate that if we maintain our present and planned output capacity, we can expect by 1985 to have increased the number of physicians by more than 50 percent and dentists by 40 percent. While about 9,000 graduated from medical school in 1971, the expected number of graduates in 1977 will be in excess of 13,000. The pipeline to train physicians is now in place and we are just beginning to feel its impact. Thus, in terms of absolute numbers, the U.S. physician pool is expected to be between 495,000 and 520,000 and the U.S. dental pool 140,000 by 1985, up from 323,000 and 102,220 respectively, in 1970. With respect to nursing, we estimate this pool to range between 1,000,000 to 1,100,000 individuals in 1980, up from the 720,000 in 1970.

Projected increases in physician supply are even more significant when viewed in connection with the expected population growth. Assuming a population growth rate of slightly greater than 1 percent, the physician population ratio will increase substantially from 158 per 100,000 in 1970 to between 207 and 217 in 1985. These rates would place the United States near the top of all the industrialized nations in terms of overall physician supply.

We have also considered how changes in insurance coverage and provider productivity may affect manpower requirements. Using what we consider to be a reasonable range of estimates for demand and productivity increases, we estimate that by 1980, physician requirements

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will be between 400,000 and 450,000. This compares to a supply projection of between 435,000 and 450,000 for 1980. This supply projection assumed that the 1975 medical school capacity would be maintained. If the annual rate of enrollment increases of the past 5 years of over 6 percent were to continue, however, we would increase the already present likelihood of an excess above the number of health professionals needed, especially physicians and nurses.

A surplus of health professionals may at first seem attractive but upon more careful examination several undesirable consequences emerge. Because physicians tend to have considerable control over the volume and mix of services they deliver, and the pricing of these services, a surplus of physicians is likely to yield:

(1) an increase rather than decrease in the total and perhaps even per unit cost of health services—each graduate is expected to generate $100,000–$200,000 per year in fees and services;

(2) a reduction in productivity, which may affect the quality of care rendered; and

(3) a displacement of other types of health manpower from their roles in the health delivery system—for example, the physician extender.

These supply and requirement projections obviously raise the critical question of whether the Federal Government should continue to follow policies which would encourage continued expansion in the output capacity of U.S. health professional schools.

As you will see, we believe it should not. I have in mind particularly the problems that resulted from continuing too long funding of space scientists and others. We have substantial surpluses and different problems for people in those professions and certainly no lessening of inflation as a result. We would think the same thing would happen if we funded increased capacity for health professions schools too long. The problem is complex because of the length of time involved and the productivity rates.

But we think we are on a path that would bring us out where we should be and should have that in mind when viewing proposals to increase substantially supply capacities in the schools.

FOREIGN MEDICAL GRADUATE QUALITY

On foreign medical graduate quality—these supply projections for physicians, which I have just discussed, take into account the future inflow of foreign trained physicians, a subject of significant concern to this subcommittee. Increases in the numbers of U.S. graduates and the likely actions of both the private and public sectors in addressing the training of graduate physicians, both foreign and domestic educated, may well produce a downward trend in the influx of foreign medical graduates. Our estimates take into account a possible reduction by as much as 40 percent of the fiscal year 1972 level.

Since the mid-1960's FMG's have been entering this country at approximately the same level as U.S. medical school graduates. The increase in the inflow of FMG's resulted from the change in the immigration laws which permitted much higher levels of immigration from the Eastern hemisphere, particularly Asia. The increased numbers of foreign-trained physicians has resulted in concern expressed in a number of quarters that feel the high utilization of FMG's in this country is undesirable. Some are morally concerned with the "brain drain"

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from underdeveloped countries, some with the fact that U.S. citizens are being denied a medical education and that others with a belief that patient care provided by FMG's is of poorer quality.

I think that is absurd. I think we have not the right to discourage anyone from coming to the United States if they wish to do so. I think that is not a contention that is constrainable.

I feel strongly that we should not restrict qualified foreign physicians from immigrating to this country. A fundamental strength of this country has been that it has permitted individuals to enter freely. Through such policy both the individual and this country have benefited greatly. I am equally strong in my belief that those foreign physicians who are allowed to practice here meet the same rigorous standards that we have for U.S. graduates.

Although there is no definitive work indicating that FMG's are of an inferior quality, the quality issue is of major concern to the Department as FMG's do not pass the same examination before entry into a residency program and many FMG's are providing care over a long period of time in governmental institutions on a restricted license. Under existing authorities, the Department is undertaking a number of actions to assure the quality of care provided by FMG's. They include the following:

(1) Working with appropriate organizations to establish a new qualifying examination for all U.S. medical graduates and foreign medical graduates for entrance into graduate medical education—such an examination will assure that all interns and residents are capable of providing patient care. The Department is actively engaged with the Board of Medical Examiners in developing this examination.

(2) Strengthening the residency training of foreign medical graduates who pass the qualifying examinations.

(3) Exploring the use of reimbursement mechanisms to achieve compliance with quality measures. Of course, our PSRO program will help to improve the quality of all medical care.

In addition, the Department is also considering whether changes in current immigration policies are warranted. We plan to discuss options with the Departments of State, Labor, and Justice before proposing anything to the Congress.

Examples of the kinds of things we would be considering but to which we are now not committed are:

(1) Removing physicians from the national shortage list developed by the Labor Department; and

(2) Modifying the educational exchange program to make conversion to immigration status more difficult by requiring individuals to return home after completing their residency training and to train such physicians only in specialties needed in their home country, and so on. I think removal of physicians from the national shortage list may be beneficial at this time.

Through these quality enhancements and other possible actions, the flow of FMG's into the United States may fall substantially. We are concerned that an abrupt cutoff in the flow of FMG's will adversely affect the quantity and quality of health care provided to those populations, often the poor and the elderly, now being served by FMG's. To soften this impact, we will utilize special projects to fund special training programs to upgrade the skills of FMG's currently employed,

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but not fully licensed, in State and municipal institutions. This can be done within the President's 1976 requested funding level.

Before leaving this topic, I think any blanket method to keep out the foreign medical graduate, I would oppose. But I see no reason why those students should not pass exactly the same examination that U.S. students do before they are allowed to practice medicine.

Mr. ROGERS. May I ask one question there?

Secretary WEINBERGER. Yes, sir.

Mr. ROGERS. Does your projection for the number of physicians include FMG's?

Secretary WEINBERGER. Yes, at a reduced rate of inflow. Roughly 40 percent less than the present stream.

Mr. ROGERS. Your projections do include 60 percent of the present levels of FMG's?

Secretary WEINBERGER. Yes.

Mr. ROGERS. Now, if the immigration policy were to be changed, in other words, if we allowed FMG's to come for training but not to remain except under special circumstances, that would have a rather significant impact on the projection, would it not?

Secretary WEINBERGER. Yes, and I would not favor that kind of projection. It is an unjustified departure from the kind of policy that had a great deal to do with building America.

Mr. ROGERS. I think we have already taken this stand with respect to other labor markets. Right now it is very difficult to get a work permit for any immigrant coming into the country because of unemployment.

I think it would be well if you could project for us—I assume it wouldn't be difficult—what would happen if we passed this legislation with the change in the immigration policy which was projected by the Senate last year in their bill. This committee, I think, is not opposed to considering it as well.

Secretary WEINBERGER. We will get those projections.

[The following information was received for the record:]

IMPACT OF SENATE RESTRICTIONS ON IMMIGRATION FOR PHYSICIAN SUPPLY IN THE UNITED STATES

Senate bill would require all FMGs entering this country as immigrants to pass Parts I and II of the National Boards. Currently, FMGs take a special, relatively easy examination, the ECFMG, as a requirement for entry into graduate medical training.

Based upon the performance on the ECFMG and the Federal Licensure Examination (Flex), estimates have been made by the National Board of Medical Examiners and DHEW on the number of FMGs who would pass Parts I and II. These studies suggest that only 20 to 25 percent of all FMGs that have passed the ECFMG would be successful on Parts I and II of the National Boards. Accordingly, this would lead us to predict, at least initially, that 75 to 80 percent of the physician immigrants entering the U.S. for the first time would not be eligible for graduate training. However, over time, we expect the foreign medical schools to modify their curriculum in order to increase the passing rate. This could produce a significant increase in the number passing after a few years.

If an 80 percent decrease in newly entering immigrants occurred, this would reduce the net annual increase of FMGs in the U.S. from 5500 to about 2500, or by 3000 annually. As the Department's physician supply projection assumed an annual reduction of 2000 the net impact on the supply projections would be a 1000 physician reduction annually. This would result in an expected physician supply of 427,000 in 1980 and 485,000 in 1985. Finally, if the examination results were to pertain to all entering physicians, that is those that enter on J and H visas as well as immigrants, the impact on our physician supply projections would be substantially greater.

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Secretary WEINBERGER. I would suggest to you that there are very substantial differences between immigration policies affecting construction workers and immigration policies affecting physicians. We would be concerned that all doctors be equal. We have to bear in mind a lot of foreign medical graduates are American citizens.

Mr. ROGERS. I understand that. That would perhaps be of some consideration. What do we have, about a thousand American FMG's returning each year?

Dr. COOPER. Our preliminary projection is that that would be down to 25 percent of the current flow.

Secretary WEINBERGER. The kind you describe.

Mr. ROGERS. If you could project those in actual figures I think that would be helpful.

Secretary WEINBERGER. One, you could remove them from the shortage list and the other, put in the provision about requiring them to go home after their training period. We have quite a range of assumptions.

[The following information was received for the record:]

U.S. CITIZENS STUDYING MEDICINE ABROAD AND RETURNING TO THE UNITED STATES

Although precise figures are not available, about 900 U.S. citizens might have returned to the U.S. in 1974 either to continue their undergraduate medical education or to begin graduate training. Over 250 U.S. citizens studying medicine abroad transferred to U.S. medical schools through the COTRANS program. Also, over 600 U.S. citizens passed the ECFMG examination, which allows them to enter into approved graduate training positions.

Mr. ROGERS. One of the concerns that has been expressed is the fact that many experts don't feel that the education in many instances has been comparable to American medical education that is given; and that many FMG's may not be able to speak the language well.

Secretary WEINBERGER. Of course the point I made in the testimony is to the extent there is any difference—as there is now—that we do have a uniform, high standard of test for all points of the career, at particularly the beginning of the career when the actual practice of medicine starts. This appears during residency and in some cases during internship.

As far as the language is concerned, the test would be administered in English and, therefore, there would have to be a proficiency in the English language. Instruction is given in English so there is an assumption there is that proficiency. And, as mentioned, a lot of them are American citizens going abroad for training.

Mr. ROGERS. I don't think it is too large a percentage of the total. Isn't it about 10 percent?

Secretary WEINBERGER. That is a significant number.

Mr. ROGERS. I understand the test scores indicate that only about 50 percent of foreign trained physicians pass the examination, whereas 90 percent of U.S. students pass an equivalent examination.

Secretary WEINBERGER. No one who is unable to pass the test should practice medicine. I think we have to get the test in at an early stage before anyone practices medicine.

Mr. CARTER. On that very thing, I know you said the flow of foreign graduates—although you didn't want to limit the number—would diminish in the next few years. What is your basis for that?

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Secretary WEINBERGER. I think some of the points the chairman has made are——

Mr. CARTER. Why will they diminish?

Secretary WEINBERGER. I think because at this point there is not a testing early enough in the educational process to require them to pass a test before they enter upon practice. That would be one thing. They are now able to practice in the internships and residency and in some institutions of State Government without passing the qualifying examinations that domestic trained physicians have to pass.

The other would be a change in the immigration policies. If you remove the physicians shortage provision, few would be able to qualify under the existing immigration laws to enter.

Mr. CARTER. That is true, but I don't know you would recommend that.

You were commenting upon the quality of those particular physicians. I would tell you many go into the field of psychiatry and we find them in State institutions throughout the country. One of the basic requirements of the psychiatrist is to be able to communicate with the patient. The patients are at a total loss in many cases.

Secretary WEINBERGER. That is right, but we talked about English as part of the test. In many State institutions the foreign-speaking population is large and some of those doctors are assigned——

Mr. CARTER. I assure you in Kentucky we don't have a large foreign population, but we do have a large number of FMG's in institutions.

Secretary WEINBERGER. There are State licensing boards to test their proficiency.

Mr. CARTER. It is quite a problem, a severe problem.

I would like to ask you another question. What foreign medical college supplies most of our FMG's?

Secretary WEINBERGER. Mexico City, I believe.

Dr. COOPER. No; it is Guadalajara.

Mr. CARTER. How many does it furnish each year?

Secretary WEINBERGER. Somewhere in the neighborhood of 3,000 or 4,000.

Dr. COOPER. About 30 percent of all——

Mr. CARTER. I mean Guadalajara. How many come from Guadalajara?

Dr. COOPER. Approximately 400 per year.

Mr. CARTER. It is a pretty good school?

Secretary WEINBERGER. The largest in the world, I believe.

Mr. CARTER. What about its rating?

Secretary WEINBERGER. Again, under the provisions we are proposing, the graduate would be subjected to the same test as the American graduates and could not practice in a residency or otherwise until they had passed the test of proficiency.

Mr. ROGERS. Would you confirm for us—we understand 30,000 foreign trained physicians have applied to take the examination as of this last month. Is that a correct figure?

Dr. COOPER. That is correct.

Mr. ROGERS. Thank you.

Secretary WEINBERGER. That is from all over the world.

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GEOGRAPHIC AND SPECIALTY DISTRIBUTION

On geographic distribution, in the past, Federal policies toward specialty and geographic distribution of health professionals have relied too heavily on a notion that an increase in total supply would solve the distributional problems. If large enough numbers of health professionals are produced, it was reasoned, competitive pressure would force them to practice in nonmetropolitan areas and in the medical specialties that offer lower income potentials, longer working hours, and/or relatively lower levels of prestige. Experience has shown this reasoning to be incorrect.

During the 1960's and 1970's, while there was a significant increase in the supply of physicans, the absolute number of primary care physicians decreased sharply. There are, for example, strong indications to suggest that we are training too many of certain specialists. A number of professional specialty associations are increasingly concerned about the likelihood of oversupply in their specialties. As a result of this oversupply of certain specialists, primary care is often delivered by high-priced specialists in expensive settings and, in addition, it may be of lower quality.

On the geographic side, while we have experienced a significant increase in our physician-population ratio during the 1960's and early 1970's, disparities in the distribution of physicians by States has actually worsened. Population groups in rural areas and in the inner city have had difficulty gaining access to health care.

Policies aimed at solving the problem of geographic and specialty maldistribution which concentrate on increasing the aggregate supply of health manpower probably will continue to be extremely expensive and largely ineffective.

PRODUCTIVITY

Sheer numbers do not seem to be the answer. Increased physician and dentist productivity, on the other hand, may have the potential to contain the cost of medical services. Even more important, increased productivity may lower the levels of health professionals required. If, for example, annual physician productivity, as measured by physician visits, were to increase by 1 percent annually for 10 years, over 30,000 fewer physicians would be needed to provide the same total number of visits. This is a goal clearly within our grasp.

It is now well documented that many tasks performed by physicians and dentists can be performed by health personnel who require a shorter period of training. Yet, there is evidence that physicians and dentists are employing and utilizing effectively too few assistants and that by increasing the number of assistants they use, they could greatly increase their output.

In addition, physician assistants, nurse practitioners, and expanded dental auxiliaries offer even greater potential for productivity increases than traditional aides. Dentists practicing with teams of four specialty trained auxiliaries have been known to increase their productivity by 130 percent over that of the dentists working alone or with only one chairside assistant.

Other studies have shown that a physician assistant can increase a physician's productivity by between 30 and 70 percent.

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Therefore, it is in the interest of the Federal Government to continue to address the issue of appropriate task delegation and non-physician training programs, and that we are doing.

EQUITY

As a generalization, schools of the health professions are tending to look increasingly for Federal support as a primary source of income for many programs and have sought non-Federal support to meet financing requirements unmet by the Federal Government.

From 1959 to 1970, Federal support increased from 29.5 percent of the total income for medical schools to almost 50 percent. At the same time, State appropriations remained constant at 15 percent and tuition income decreased from 7.6 percent to 3.7 percent. It should be noted, however, that these figures relate to income from all sources.

Students of health professional schools have not been asked to assume a proportionate share of their increased educational costs. A review of the distribution of tuition charges by schools shows that 80 percent of the publicly supported institutions plan next year to charge resident students $1,200 or less, with 70 percent of the private schools expected to charge $3,000 or less. In view of the high earnings of health professionals, particularly physicians and dentists, and the relatively low educational costs they bear, the rate of return on a basic medical and dental education has been estimated to be two to three times that of graduate education generally.

Stated another way, the full personal investment in a medical education can be recouped on the average with 5 years of practice. Moreover, interest in these career fields is increasing. An example of the attraction of these professions is the ratio of the applicants to places—currently approximately 3 to 1—and increasing steadily. Also, an examination of the stated career plans of today's undergraduate student population reveals that enthusiasm for a health profession education and career is rising dramatically. Moreover, the health professions have experienced Federal financial support in major ways not generally available to other fields of education and training.

HEALTH MANPOWER OBJECTIVES

On health manpower objectives, after a thorough analysis of these issues, we have concluded that Federal support to health professions education should meet the following objectives:

(1) Encourage the maintenance of existing enrollment levels of critical health professional schools.

(2) Target Federal support on distribution, both specialty and geographic, through special project funding and service scholarships.

(3) Increase provider productivity through more efficient use of paramedical personnel through support of demonstration efforts; and

(4) Reduce unnecessary and inequitable Federal subsidies for health professional schools and students, because we believe students will enter without a subsidy under current conditions.

When we evaluated the alternative ways to meet these objectives, it became increasingly clear that the solutions to many of today's major issues would not be simple. Health manpower problems cannot be

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attributed to any single cause but, in our view, are structural conditions of our complex, pluralistic, largely private national health care system. It is unlikely that any single solution will resolve these complex problems.

Our approach is to reinforce and facilitate those changes that will most effectively contribute to a resolution of the more persistent service delivery problems.

Two basic ways to provide support to solve persistent health professional training problems are direct grants to institutions or direct assistance to students. We weighted the efficacy of these two particular types of support apart from any budgetary implications. The question simply is, "What are the most effective funding mechanisms to accomplish the national objectives?" In the past year this question has become even more critical because of the Nation's serious economic difficulties.

Capitation grants to health professional schools can be viewed, at least in part, as a subsidization of enrolled students. Capitation grants also provide Federal funds to institutions without regard to their relative degrees of need. To the extent that health professional students are willing and able to pay, subsidization must be called into question. Of course, if training institutions are requested to take new actions, such as increasing enrollment which they would not otherwise undertake, one cannot view capitation as just a student subsidy.

In our view, capitation grants are less efficient than specially targeted projects in achieving changes that are necessary to address the major manpower problems of our country. Greater flexibility is necessary in negotiating with individual training institutions to mount innovative or special types of training projects. Special projects give us this flexibility. In such light, the current levels of capitation support are unnecessarily high. Given the relative levels of non-Federal sources of support (for example, State appropriations and tuition), the number of qualified applicants, and the public desire to maintain physician production, current levels of capitation are probably not needed to encourage health professional schools to maintain current enrollment levels.

Further, health professional students can and should be called upon to assume an increasing share of their educational costs. We are not asking students to pay for their entire educational costs. Capitation grants, which it should be noted amounted to about $2,000 in 1974 for schools of medicine, did not cover the entire costs either. Current tuitions covering only 10 or 20 percent of such costs are, in our view, much too low. Furthermore, the need and purpose of student assistance also have changed over the past decade; 10 years ago some health educators believed that scholarships and subsidized loans were necessary to assure enough qualified applicants. But today the high personal satisfaction and the anticipated financial rewards in all health professions are more than sufficient to attract adequate numbers of qualified applicants.

Instead, future Federal policy for health manpower student assistance should be directed toward achieving two goals:

(1) Equality of access to medical education, independent of students' financial resources. Access in this context does not mean a subsidy but the opportunity to obtain funds. As part of access, we should

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have appropriate types and levels of support for economically disadvantaged students.

(2) Adequate numbers of health professionals to staff Federal program needs.

I have set forth these health manpower objectives and our approach in order to provide a framework for discussing the similarities and contrasts between our proposal and the corresponding bills pending before this subcommittee.

THE ADMINISTRATION PROPOSAL

Before proceeding to that discussion, Mr. Chairman, I would like to describe some of the major themes of the administration's proposal. Mr. Chairman, I would like to point out that—for the benefit of the new members of this committee—the proposal I will be discussing is identical to H.R. 14930, introduced at the request of the administration last May.

We feel that the changing nature of our health manpower problems necessitates a significant change in Federal policy direction and spending patterns. Federal dollars should be directed into new programs which promise to be effective in resolving the persistent manpower problems facing us and withdrawn from those that do not. Being cognizant that institutions, particularly complex ones like health science centers, need time to adjust, we will be phasing down or out of most old programs as we move into new areas.

Mr. ROGERS. May I ask one question at this point?

Secretary WEINBERGER. Yes, sir.

Mr. ROGERS. Didn't you say that 10 years ago health educators believed scholarships and loans were necessary?

Secretary WEINBERGER. That appeared to be the case.

Mr. ROGERS. Ten years ago we probably had more applicants than spaces, did we not?

Secretary WEINBERGER. I think that is so.

Mr. ROGERS. Hasn't that been the consistent pattern of schools, so that was not necessarily the basis for our action?

Secretary WEINBERGER. From the persistence with which the proposals were put forth for capitation and student subsidies, I think there was a feeling we had to do that to get students.

Mr. ROGERS. It was not the feeling that the capitation would attract more students, because we had and still have more requests than spots. It was the fact that 60 percent of the schools were in financial distress.

We said, "We will support medical schools because they are national resources. We are going to support medical education to improve that education so we can have good instructors who are not forced to divert their efforts into research in order to support medical education."

That was the basis and not because we were trying to get more students. We wanted to give them the capacity to increase enrollments.

Secretary WEINBERGER. Qualified applicants from medical schools did diminish during the sixties, and nurse applicants diminished substantially during that period. I don't think there was efficient use of funds in taking care of their problems.

We do have a table that shows in 1950 there were 3.6 applicants for one spot. From those 3.6 applicants to those accepted, the figure diminished to 1.9.

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Mr. ROGERS. We also had more applicants than we had slots available.

Secretary WEINBERGER. But with the increased enrollment, I guess our feeling was some of the idea behind capitation was to get more students.

Mr. ROGERS. It was to open the schools to those being turned away. What is the ratio now?

Secretary WEINBERGER. Three to one now, I think, and probably climbing in view of the financial rewards.

Mr. ROGERS. I think tuition is rising now, is it not?

Secretary WEINBERGER. Yes.

Mr. ROGERS. Is not tuition increasing in all of the schools?

Mr. ENDICOTT. Yes, sir.

Secretary WEINBERGER. I think we have a problem of semantics. We are talking of accepted applicants.

Mr. CARTER. I believe we have six or seven applicants for every vacancy.

Mr. ROGERS. Mr. Florio?

Mr. FLORIO. Mr. Secretary, you mentioned the financial rewards that you say are coming to the medical profession and that you are concerned about the oversupply in the medical profession as a result of the enthusiasm for financial rewards.

Secretary WEINBERGER. Not yet.

Mr. FLORIO. Isn't it partly the financial rewards, aren't they attributing to the undersupply of the medical people at this point? Isn't that why the practice is so lucrative?

Secretary WEINBERGER. I wouldn't say so. I think there are Federal designs built into a lot of the medical programs, you have cost increases until recently that were out-racing the cost of living and setting all kinds of unpleasant records. You have a steadily increasing kind of built-in guaranteed demand. You have a lot of factors that make it a very attractive profession aside from the intrinsic attractiveness of it which is, of course, also there.

I think we would have to say that one of the major factors in increasing the number of applicants to such a wide degree over what it was just a few years ago is the fact it is one of the most lucrative professions there is.

I don't say that critically. It is just a fact. When you can get up to $40,000 or $45,000 income within the first year or so of your profession, it is attractive.

Mr. FLORIO. Just the divergence of the administration's general philosophy of supply and demand as being good things.

Secretary WEINBERGER. You don't have a free market in the health field when you have the Federal Government pumping $40 billion in in a year and other State governments adding to that, too, and then you have a series of Federal programs that encourage the most expensive modes of delivery of health care.

The problems of medicare are a whole separate set of subjects which I could go into if the chairman would allow me 4 hours.

There are a tremendous number of factors which are artificially distorting the market, so-called, but certainly they are there to an extent that doesn't require the Federal Government to encourage by

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subsidies with scarce dollars anybody else to go into it. That is the point we were making.

Mr. FLORIO. Is not one of the factors in not having the free market situation as you described, the absence of competition which comes in part from the lack of supply in certain areas of specialty?

Secretary WEINBERGER. I don't think there is undersupply. We have to keep going under the projection we have and the pipeline is and should, properly, be long. We are concerned with the very recent experience of what happened with the Federal subsidies of secondary and elementary teachers and space scientists where the subsidies continue too long.

We ended up with major problems and those are things we can see ahead if we get into more efficient use of paramedicals, physician extenders, and personnel of that kind who can greatly increase the productivity of the physician.

Given all those things and the assumptions we ground into it, we think we will come out about even in the 1980's and, if we increase what we are doing now, by that time we will have substantial surpluses, even with national health insurance, which will not increase the demand enough to require more.

All these assumptions have been ground in and even though occassionally Government prophecy is not quite right, we think we are pretty accurate in our ability to project the future in this much smaller area than in the total economy.

Mr. HEFNER. Mr. Secretary, as Mr. Florio mentioned, in fact what you are saying to us is that we do have a danger that we could have too many doctors?

Secretary WEINBERGER. Very easily.

Mr. HEFNER. It could be that in the future doctors may not be able to charge exhorbitant fees. Competition would cause this and maybe people could get some health care that was more reasonable to them.

Secretary WEINBERGER. I have substantial qualms as to whether the normal free market apparatus would work if you had too many doctors. You don't have a great many things that characterize other parts of the industrial economy. You don't have advertising, you don't just wander in to a hospital when you want to go, you have to have a doctor who is on the staff and all the rest. You have a different set of factors involved plus very heavy governmental involvement in delivering and paying more and more for health care.

I don't think the way to lower health care cost is to get 10,000 too many physicians. I don't think it is going to work that way.

I think it will have an adverse effect on the quality of care if you do that.

You can argue all you want. Ten years ago I would have joined fully in any argument that decried the degree of Federal participation in all of this. But you are so far in now that you have to, I think, look ahead and base your assumptions on what is realistically to be anticipated for future legislation on a future path and try to predict where we will come out.

We have done that and I feel considerably more confident with the physician and manpower projections than I do with some of the economic and other projections where you have such a wide range of variables. You don't have that here.

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I think these projections are accurate and I think, if we feel it necessary to subsidize and open 10 more medical schools, by 1990 we would have a great surplus of physicians. We would have a lot of doctors running around looking for things to do and not have better quality.

Dr. ALTMAN. In those areas which have the highest number of physicians relative to population, the cost of medicine is also highest. But the correlation seems to work opposite to other parts of the economy. One of the reasons is with reduced demand and the physician trying to keep his income at a level which he feels he deserves, there is a tendency to increase rates.

The Canadians also found this to be the case. They found with an increase in supply, there was an increase in the cost of medical care.

Mr. CARTER. On that very thing, isn't it true actually in those areas, your rates, your payments through medicare and medicaid are higher than they are in rural areas and other areas?

Secretary WEINBERGER. I am obviously not able to say what each rural area charges. We certainly have had a number of problems with medicare because of the initial design that virtually guaranteed payments. We are trying to overcome that now and, after 10 years, it is a long slow process.

Mr. FLORIO. There is one point the Secretary made about the fact of the Government's involvement in the medical field is in some way operating so to preclude a direct correlation between supply and demand, but isn't it the case that if there is a larger supply of physicians, Government involvement can be lessened with regard to setting fees for medicaid to a fair market value?

Secretary WEINBERGER. I have never seen any Government program adjusted except upward.

Mr. FLORIO. Hopefully that is what we are here for, to make the appropriate upward and downard adjustments.

Secretary WEINBERGER. I hope you are right.

Mr. HASTINGS. What is the average income of a physician in this country?

Secretary WEINBERGER. I guess it is $45,000.

Mr. HASTINGS. $45,000 in private, $65,000 in group practice. Is that substantial?

Secretary WEINBERGER. That plateau is reached much sooner in the health professions than in most of the others. That is an average, which means there are a few people above it.

Mr. HASTINGS. I understand.

And do we have a percentage figure that the Federal Government contributes to the total educational costs of a doctor as a percentage of the total cost of education?

Secretary WEINBERGER. For the years since medical assistance has been forthcoming from the Government on the scale it is now 50 percent.

Mr. HASTINGS. Does that include research, everything, grants to the schools, capitation, student assistance, loans, about 50 percent?

Secretary WEINBERGER. Yes.

Mr. HASTINGS. The Federal Government provided 50 percent of the educational costs to probably the highest paid profession in the country?

Secretary WEINBERGER. Yes.

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Mr. HASTINGS. And it is not solving the problem of maldistribution and so on?

Secretary WEINBERGER. That is the point I was going to make. That is the point to which our bill is addressed and the things we hope we would accomplish.

Mr. CARTER. This is quite true, Mr. Secretary, that the Federal Government does pay 50 percent and has for the past 10 years.

Secretary WEINBERGER. Roughly, yes, sir. It started out at 30 percent in 1959, it is now 50 percent.

Mr. CARTER. And it has been at that level for the past 10 years or so. Still there are certain schools—the Federal Government, strangely enough, contributes more to than other medical schools; is that correct?

Secretary WEINBERGER. I think through the placement of projects, that is correct.

Mr. CARTER. What is the Federal contribution to Harvard, if I might ask?

Secretary WEINBERGER. I don't know, I could find out.

[The following information was received for the record:]

PERCENTAGE OF HARVARD MEDICAL SCHOOL'S OPERATING COSTS PROVIDED BY THE FEDERAL GOVERNMENT

Because the Federal Government does not compile information on the total budgets of individual schools of medicine and the portion of these budgets met from Federal funds, it is not possible for this Department to provide the percentage of Harvard Medical School's operating costs provided by the Federal Government. The Department does have information on *total DHEW obligations* to schools of medicine. In FY 1972, the latest year for which information is available, total DHEW obligations to Harvard Medical School were $25,364,000, broken down as follows:

	Amount (in thousands)
DHEW total	$25,364
NIH	21,505
BHRD	(1,910)
HSMHA	3,676
SRS	183

(Harvard Medical School ranked third among all medical schools in the U.S. in amount of DHEW obligations.)

Mr. CARTER. The last statistic on that was 70 percent. I don't know whether it has varied or not.

Secretary WEINBERGER. There certainly is probably a great many more Federal research projects and other things placed at Harvard, obviously because of their superiority.

But I think they also have, as far as I could gather from the letters I get every week, a substantial supply of outside income. I don't think they get 70 percent of their medical school income from the Government.

Mr. CARTER. Look it up and I think you will find I am correct. It has been correct, at least.

Secretary WEINBERGER. I will.

Dr. COOPER. I would like to make it clear when we talk of 50 percent of the costs, we are talking of total operating cost and not just educational costs.

Dr. ENDICOTT. I am uneasy with those figures. It isn't just a balance or mix of research, it is also influenced by a portion of Medicaid and

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Medicare beneficiaries that the teaching hospital may provide services to. We are putting money into an institution that does three different things—research, education, and payment services—and there is Federal money flowing into all of these channels. The ranges are very substantial.

I wouldn't want us to go away leaving the impression that 50 percent Federal money going into the intitution means necessarily 50 percent of the educational costs. It is a very complex problem.

Secretary WEINBERGER. It is also an average and some schools are above and some below.

Mr. CARTER. This has been bandied about for ten years.

Mr. ROGERS. I think it might be well to let us know what services are being provided?

Dr. ENDICOTT. That is the most difficult figure to arrive at, the amount of funds going into the service dollar.

Mr. ROGERS. They have clinical centers and teaching hospitals and are delivering health care to people.

Dr. ALTMAN. We could estimate how much medicare gives to Harvard for medicare. We can't provide how much medicare and medicaid provide back into education. That is where we run into a problem.

Dr. ENDICOTT. As an example, some schools may have some responsibility for supervising the health services for as many as 8,000 beds of which perhaps not more than 2,000 are used for undergraduate medical education and, without a very extensive in-depth analysis, it is almost impossible to come up with anything other than crude approximations.

Mr. CARTER. With this you have your capitation, special project grants and so on. I maintain that my figures are correct.

Secretary WEINBERGER. I think perhaps the most illuminating study of those costs and sources of funds may well be the Institute of Medicine analysis which the Congress commissioned several years ago.

Mr. ROGERS. May I ask one other question and then we will proceed.

As I recall, there was an NIH study that projected a need for doctors presently at 30,000. Is that figure correct?

Secretary WEINBERGER. One of the earlier studies that I referred to, yes.

Mr. ROGERS. Wasn't it 50,000 a few years ago?

Mr. LYBRAND. That study included a range ranging from 4,000 to 30,000, depending on the kind of assumptions you would like to make.

Secretary WEINBERGER. The ratio is heavily involved. Whether you use 1 to 1,000, 1 to 2,000, rural areas, and so on.

Mr. ROGERS. I presume you are giving us figures that would not be at an undesirable ratio.

Secretary WEINBERGER. One study was done by NIH but what I think we have to understand is the ratio they used to get that 30,000 shortage was based on 1 physician per 1,000. I think there is a lot of discussion possible and a lot of argument back and forth as to whether that is necessarily a required ratio or a ratio that is effective.

We have the Health Service Corps that uses a ratio of about 1 to 2,000.

Mr. ROGERS. The Corps is not heavily funded yet.

Secretary WEINBERGER. That is just the figure, it has nothing to do with the experience. Your ratio can vary. If you used 1 to 2,500, your

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shortage would be 1,800 doctors. So you have to build into these, I think, sir, the productivity increases that can come with a wider use of paramedical personnel and that is what we are trying to do.

Mr. ROGERS. You have included the productivity increases?

Secretary WEINBERGER. We have tried to indicate that as one of the factors that we think will be important in considering that by 1985 we will have enough. If you use that to a greater extent—which we think would be desirable—you would get to your surplus figure a little sooner and, allowing for all of the variations, this indicates clearly that we should not be on a path that would increase anything in excess of the roughly 495,000 physicians available at that time, given the same state of progress we have projected.

Mr. ROGERS. I thought Dr. Altman said this is not the trend, that as you have more doctors and they come together, there would be less productivity, not more.

I thought you told the committee earlier that productivity of the physicians in Boston is about one-third or one-half what it was in the past.

Dr. ALTMAN. I said there were more surgeons so they cut the amount of operations they do.

Mr. ROGERS. So productivity is less?

Secretary WEINBERGER. That is not a requirement——

Mr. ROGERS. You say we are going to increase medical personnel, so I am not sure that your increased productivity necessarily follows either.

Dr. ALTMAN. We did our projections under two assumptions, one with no increase in productivity and the other with a 1 percent increase.

Mr. ROGERS. I think it would be well for the committee to have laid out how you compiled your final results particularly with respect to the FMG input. I think we would like to know particularly those factors, increased productivity, how many increased paramedical people you are counting on, and their acceptance in use.

Secretary WEINBERGER. This points up the increase of paramedical people.

Let me, if I might, run through briefly and I will summarize now.

Mr. CARTER. I believe that you are right, there will be 1 physician to about 500 people according to your figure of 495,000 physicians.

Secretary WEINBERGER. I don't think we can bring out that kind of ratio. That includes a lot of people that would be actually in practice.

Mr. CARTER. Your number would be how many? Considering our population, if it is 500,000 it would be 1 to 500 by that time according to your projections.

Secretary WEINBERGER. That would clearly indicate we would not be in any kind of deficit position and might very well want to be sure we don't adopt solutions that would be designed to increase drastically the number of physicians now.

Mr. CARTER. We might be actually overproducing.

Secretary WEINBERGER. I think there is a real worry about it.

Mr. ROGERS. May I say I don't share that.

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PROBLEMS OF DISTRIBUTION

Secretary WEINBERGER. In addressing the problems, we see many different provisions of our legislative proposal are directed at the twin distribution problems—specialty and geographic. These are complex problems which have no easy solution. We plan to address these problems through special projects in the health training legislation at both the professional and post professional training levels with incentives for both students and institutions.

In addressing the primary care problems, we proposed a new authority, National Priority Incentive Awards. Under part A of this authority, medical and osteopathy schools will receive $2,000 for each of their graduating students who enter a residency in family medicine. Obviously, those schools that have taken the lead in the production of primary care physicians would receive the largest bonus. I believe this is appropriate. However, given the magnitude of the problem, we would hope that all schools would increase their efforts to produce more primary care practitioners and therefore benefit from this program.

Part B of this authority would provide grants, including stipends, for post professional training, in shortage occupations. We will focus this authority on primary care training. In particular, we will support the development of ambulatory-based residency programs in family medicine and other primary care specialties. These grants will provide start-up and early operating assistance. When necessary, the grant will cover a portion of residency salaries.

In addition to the National Priority Incentive Awards, we propose to increase grant support for physician extender programs that train primary care specialists. Those training programs that emphasize the term training of physicians with physician extenders will be looked upon most favorably.

Finally, we plan on expending a larger portion of the special projects money on curriculum changes in medical and nursing schools. In particular, we will support efforts to develop family medicine departments and to reorient the pediatrics and internal medicine programs toward primary, rather than specialized, care.

I believe the geographic problem will be the harder of the distribution problems to solve. The days of the solo general practitioner (GP) establishing a practice in rural America are gone. Like the specialty distribution problem, I believe no one knows the exact size of the geographic problem. Many estimates have been bandied about. One study done by NIH and quoted widely reported a shortage of 30,000. This study was done on a country basis using a ratio of 1 physician per 1,000 population. The National Institutes of Health have also shown that the use of a geographic area more approximating medical service areas and a more reasonable physician to population ratio, would greatly reduce the number. For example, using a physician to population ratio of 1 to 2,000, which seems to be a more appropriate ratio for primary care providers in rural areas, drops the shortage number to about 4,000.

The long-run solution, I believe, hinges upon developing a medical-care delivery system which links physician practices with paramedical

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personnel in those rural areas not capable of supporting physicians. Schools can encourage this development by admitting students who find rural life preferable, by developing educational centers in nonmetropolitan communities, and by moving more residency training out of major teaching hospitals. Through our legislation, we will encourage and support such efforts—particularly through area health education centers and special project grants.

We believe that physician extenders can contribute greatly in bringing about a better geographic redistribution of health services. Physician extenders programs, particularly MEDEX, have been directed at rural America. We plan to give high priority to those nurse practitioner and physician assistant programs that are concentrating on providing rural practitioners.

Finally, we will provide direct economic incentives for students to enter practice in underserved areas through scholarships for service. Loan forgiveness has not been successful in getting physicians to practice in underserved areas. However, we believe that a conditional scholarship program, that is, the national health service scholarship program, by providing larger awards, will be more effective because students will make an affirmative commitment early in their training.

In addition, the National Health Service Corps is available as a mechanism to assist selected communities in meeting health manpower problems.

As you can see, we plan a multifaceted approach to solving the distribution problems. This is because no one knows the single best way. If, with further study, we learn of better approaches, we will be able to implement them through our flexible grant program.

On capitation, over the next 3 years, as we increase our efforts to address the distributional problems, we plan on phasing down some Federal capitation support. The capitation grants set forth in the Comprehensive Health Manpower Training Act were unrealistically high. As you know, they have been funded at only 60 percent. Yet, at this reduced level, most schools have not been financially pressed. Since we asked schools to expand enrollment for the capitation support, they had to incur some additional costs. In our new proposal, no expansion in enrollment is required. Thus, we feel capitation can be reduced without causing financial hardship.

Mr. ROGERS. These projections—do they include the increased cost of malpractice insurance? Has that been cranked in?

Secretary WEINBERGER. We are not talking about physician expenses, we are talking about average income which is $45,000, and we think malpractice insurance is a major item. We are hopeful first that we have a short-range solution, which I generally agreed to, that will insure coverage at current rates of most professions and a longer range solution we hope will be worked out by the private sector.

We don't want the Federal Government getting into it, but we don't want physicians denied the opportunity of practice because of the doubling, tripling, and quadrupling of malpractice insurance premiums.

Mr. ROGERS. You say you have found a short-range solution?

Secretary WEINBERGER. We are hopeful that the insurees, who we gathered here in Washington, and State insurance commissioners and

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others have what appears to them to be a model bill that the New York State Senate has passed and they believe can provide a short-term solution of holding the status quo while we work out the long range.

We had an insurance company that, after our first meeting, canceled everybody out as of March or May. We have had an increase in malpractice insurance rates in the case of neurosurgeons from something like $20,000 to $60,000 a year. All of that is a very major problem.

We have a lot of people who I know are very interested in this field and it is something that the Congress is addressing. Congressman Hastings has had meetings as have others. It is a major problem. It doesn't change the basic fact of whether we need to continue subsidy and capitation support for a profession where the rewards are great.

The risks are there, the expenses are there, as with everything.

Mr. ROGERS. Is this interim solution intended to be addressed by State legislatures?

Secretary WEINBERGER. Yes, a model act.

Mr. ROGERS. Not through the Congress?

Secretary WEINBERGER. That is right. I feel strongly that there is not at this point a role for the Federal Government and I hope there would not be given any predeliction for Federal powers and such. I think we just can't sit on the sidelines and see an increasing number of doctors afraid to interview a patient over the telephone because of no coverage. That is a very major crisis.

Mr. ROGERS. I know the committee is delighted to hear that you believe a short range solution has been agreed upon. It would be helpful to let the committee have a copy of this proposal.

Secretary WEINBERGER. We had a meeting yesterday, it is called the joint underwriting proposal and it is a State legislative act and New York, the State senate, has passed it.

Mr. HASTINGS. Isn't it essentially a pooling?

Secretary WEINBERGER. Yes.

Mr. HASTINGS. They point out it is just temporary. They in no way predict this is going to be necessary.

Secretary WEINBERGER. With the rate of cancellations and the rate of rate increases, we thought we should at least freeze the situation so the protection would be there.

Mr. ROGERS. I think this is important. Then I presume you would let us have your recommendations for any long-term solution that you might propose?

Secretary WEINBERGER. We are trying to move into this area and will keep the committee informed. We called the meeting initially because of the rapidly spreading nature of this problem.

Mr. CARTER. What is the average cost of malpractice insurance for a general surgeon, a certified general surgeon?

Dr. COOPER. It varies from State to State. In many States is is not a problem and even general surgeons in some jurisdictions pay $1,000 This is not the $15,000, $20,000 type of problem that currently some high risk specialists are incurring in some jurisdictions. An internist also often pays a fee less than that. The average fee might be between $1,000 and $2,000, in that category.

But I think in certain areas and in certain high risk specialties the current rates range up to $20,000 per year. Now this $35,000 figure

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that the Secretary mentioned does include his total cost, but in this case since these are mostly people in general practice or internal medicine, the number would be on the order of several hundred dollars.

Mr. CARTER. I would like very much to see that average figure if you could get it. Most of my letters concerning this have been from surgeons being required to pay as much as $17,000 or $18,000, or even up to $30,000.

Dr. COOPER. The surgeons in the recent publication by the AMA in their most recent year's report, which was 1972, on the average were paying $2,370.

Secretary WEINBERGER. One of our staff members in our office said he had to pay $29.50 a year for malpractice insurance when he first started his practice.

I think we may need some fundamental restructuring of the tort laws. At the same time, we have to keep in mind there has to be redress for patients injured by negligent practice.

Mr. ROGERS. Thank you, Mr. Secretary.

Dr. ENDICOTT. Some of the rate changes are spectacular. There was a hospital in Chicago which just this week had their malpractice premium proposed to be increased from $500,000 last year to $3,500,000, a sevenfold increase. It is the rate of change which is disturbing.

Secretary WEINBERGER. We continue in my statement—

Continued capitation under our proposal amounts to a subsidy for currently enrolled students. Capitation is merely one source of revenue for meeting the costs of education; student tuition is another source. Given the high earnings one derives from a health professional education, for example, the average annual physician adjusted income is approximately $45,000, the rate of return to the student is in excess of almost all other professions. This relationship would not change if students were asked to assume a larger direct share of the costs of their own education. Given these facts, Mr. Chairman, we find little rationale for the current subsidy provided by capitation.

Let me emphasize one point. If students were paying tuitions that bear a reasonable relationship to the cost of their education, as in the case for most private undergraduate schools and most professional schools, our concern over the unnecessary subsidization provided by capitation would be greatly diminished.

However, immediate withdrawal of capitation support for graduate education would be very disruptive to some institutions, particularly those receiving the highest rates of capitation. Accordingly, we propose to extend capitation for most health professional schools for an additional 3 years.

For postbaccalaureate schools training providers of personal health services, we plan on gradually phasing down capitation. The statutory capitation amounts for schools of medicine, osteopathy, and denistry would be reduced to $1,500 per enrolled student—without regard to class year—for fiscal year 1975, $1,250 per student for fiscal year 1976, and $1,000 for fiscal year 1977 per student. For schools of optometry and podiatry, capitation will be reduced to $400, $300, and $200 for fiscal years 1975, 1976, and 1977, respectively. Schools of veterinary medicine will also receive capitation support for the next 3 years.

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The effects of these phase-downs will be monitored closely and at the end of 3 years, we will reevaluate the need for continued capitation support.

We do not propose the continuation of capitation support for undergraduate education provided at schools of nursing and pharmacy. In general, these undergraduate professional schools are responsive to local needs and should, if necessary, be funded with local resources. We will continue to support particular program development such as clinical pharmacy through the special project mechanism.

STUDENT ASSISTANCE

1. Scholarship Program

While the several existing conditional scholarship programs—Public Health and National Health Service Corps, and physician shortage area scholarships—conceivably could continue to help to address the maldistribution problem, these separate programs were established at different times and for discrete purposes. In our view, much more could be accomplished through a single broad and conditional health manpower scholarship program.

A conditional scholarship program would also be consistent with the principle that the public is ordinarily entitled to public service, or service meeting a public need, from those individuals who receive special scholarship assistance while preparing for a health professions degree.

We propose the authority to consolidate the existing Public Health and NHSC, and physician shortage area scholarships into one broadened conditional scholarship program. Under the program, participants could be assigned to a Federal health service or other areas of critical need. Certain participants could serve in the National Health Service Corps, while others could serve in other parts of DHEW. Still others could serve elsewhere in other Federal agencies, or State or local governments.

A payback provision in lieu of service would be available. Payback would be equal to twice the cost of support—minus any time equivalent already fulfilled—plus compound interest at prevailing market rates dating back to the first year recipients would receive scholarship support.

Payback or service would begin immediately after the completion of training—in the case of medicine, deferments would be granted for the period of residency training; unlike some preceding scholarship programs, a direct Federal relationship would be established between DHEW and the student.

2. Loans

As a larger portion of the cost of education is shifted to the student, it is essential that we have adequate loan and scholarship assistance to assure that students, regardless of their family-income background not be denied access to a health professional career due solely to financial barriers.

Last year the administration proposed H.R. 13059, an expanded guaranteed student loan program for graduate-level training. We again recommend that the total existing loan ceiling be increased from

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$10,000 to $25,000 and the annual ceiling also be increased from $2,500 to $7,000.

Most students should have little difficulty in paying back these higher loans. Students not wishing to incur loans, however, would be eligible for our proposed expanded scholarship/service program.

The current direct loan program would continue to be operated by the educational institutions. We will, however, phase out our capital contribution over the next 3 years. The capital contribution funds and the repaid loans would remain available to the schools for the making of new loans and the continuation of existing student loans.

The interest rate for these direct loans will be raised from 3 to 7 percent—the same rate paid by those assuming guaranteed loans.

3. *Preadmission and scholarship assistance for the disadvantaged.*

There has been significant underrepresentation of students in health professions schools from among individuals who, due to socio-economic factors, are financially or otherwise disadvantaged. This has been a major factor in the resulting underrepresentation of racial minorities among practitioners of the health professions.

In recent years significant progress has been made. For example, the percentage of minority representation in the first-year classes of medical schools has risen steadily from 6.2 percent in 1969–70 to 11.5 percent in 1973–74. These students are largely from families of low income, 20 percent are from families with less than $5,000 per year income and 67 percent from families of less than $10,000 per year. Regardless of the gains made through improved educational opportunities in the preparation of such students for entry into health profession schools, these students remain the most vulnerable in terms of educational and economic risks.

We propose that a special preadmissions and scholarship program be established for the disadvantaged enrolled in postbaccalaureate programs. It would provide: Stipends for students in preadmission programs, and scholarships for students from disadvantaged backgrounds for their entry year in a health professional school. The scholarship is limited to the entry year because upon successful completion of the first year in school, students gain confidence and therefore become more willing to take out loans, or agree to accept service scholarships.

Nursing students in both college and hospital training programs, as well as other health professional students in undergraduate training in need of financial assistance, will have access to the basic opportunity grant (BOGS) program, administered by the Office of Education.

COMPARISON OF PENDING BILLS

Mr. Chairman, I would now like to comment on the administration's Comprehensive Health Manpower Act of 1975 as compared to the three separate bills before your committee today: H.R. 2956, The Health Manpower Act of 1975; H.R. 2957, The Nurse Training Act of 1975; and H.R. 2958, to revise and extend the National Health Service Corps program.

With regard to H.R. 2956, I would repeat our concern over authorization levels. We recognize that H.R. 2956 authorize-amounts lower than the ones originally considered by this subcommittee last spring,

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but the levels are still significantly above the amounts recommended by the President. Given the vigorous efforts which must be made to scale down Federal spending, the levels in this bill are simply too high and should be reduced to the levels in the President's 1976 budget.

In terms of program implication, we feel that H.R. 2956 reflects the continued reliance upon capitation grant subsidies as a major means of financing health manpower education. While it is true that the bill would decrease capitation in the third year and does make an effort through a repayment mechanism to shift a portion of the burden of educational costs to the students after their training is completed, we feel that these efforts do not go far enough.

Moreover, the bill would extend capitation grants to a new category of institutions—schools of public health—and continue capitation for pharmacy schools which we believe to be inappropriate as it involves prebaccalaureate training. Additionally, a new program of categorical grants to subsidize graduate programs in the field of health care administration would be authorized.

At a time when it is of critical importance to restrain Federal spending, and the President has stated that he would veto new programs, we oppose expanding Federal commitments to activities which could be considered marginal. A school that trains individuals who will work in the health area is not a sufficient reason for Federal subsidy. The question is whether a subsidy is needed.

As a health career is one of the most attractive today in terms of employment prospects, it is inequitable to subsidize such training while not subsidizing training in all of the other more risky and less lucrative areas. In this same vein, we are opposed to continuing the authority for teaching-facility construction.

Further, while we all agree that serious problems exist with regard to the distribution of medical specialties, we are strongly opposed to H.R. 2956's proposed system for control over the number of residency training positions. We feel that there is little basis for initiating this far-reaching regulatory mechanism at this time. The distributional and other problems to which these provisions are addressed are not sufficiently understood. It would be difficult to defend the distribution of residencies selected if the quotas established by the regulatory body lack sufficient basis. In our view, it is unwise to impose such limitations until their potential impact could be assessed and considered. We do not accept the proposition that regulation of residencies is the answer. We do believe that positive incentives should be tried before we turn to regulations which are difficult to revise or eliminate after being implemented.

The major residency problem is the imbalance between primary and nonprimary care. In large part, this imbalance has evolved from the inadequate insurance coverage of out-patient care and the associated lack of primary-care training. To overcome this problem, we plan on significantly increasing our support for primary-care training, particularly at the graduate level, with residency support, including stipends.

The ability of positive incentives to have an impact is clearly illustrated in the remarkable growth over the last few years in the demand for and support of family-medicine residency positions. This encour-

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aging event leads me to conclude that we can achieve a better balance in the distribution of residencies without the total regulatory control proposed by H.R. 2956.

As an alternative to the regulating body proposed in H.R. 2956 and in recognition of the need for much further analysis, we will conduct a study to consider and evaluate various approaches for determining and financing the total number and geographic/specialty distribution of residencies. We envision a 2-year study so that the alternatives can be considered by the Department and Congress before the next renewal of the manpower legislation.

Mr. ROGERS. How do you think—if I may interrupt—the problem will be handled if you have a first-year-residency limit of 200 percent of U.S. graduating classes? Do you think you can see a significant change?

Secretary WEINBERGER. Maybe I didn't understand your question.

Mr. ROGERS. I thought you said you did not think anything should be done in regard to residency programs.

Secretary WEINBERGER. We are opposed to an arbitrary number of residency positions which I think has some of the undesirable features of a lottery, and we think it would be unwise to impose various limitations and quotas until we can assess the impact of such proposals.

Mr. ROGERS. We have been assessing this for some time and all of the groups involved have advised us that nothing will ever be done as long as we have a residency outlet of 200 percent of each graduating class. There is no way to get a handle on it.

Secretary WEINBERGER. We had an increase in demand for family residencies in the last few years. Our feeling is the greatest problem we have to address is to get more people out of specialties and into family care.

Mr. ROGERS. How can we as long as there are residency positions available and you have a surgeon out there who says, "I want a young man to help me"? The hospital says, "OK, we will give it to you," and they do.

Secretary WEINBERGER. One way not to do it is to put an arbitrary 120-percent limit on the residences as one of the bills before the committee does.

Mr. ROGERS. What is wrong with that? You think we need 200 percent?

Secretary WEINBERGER. No, I don't think that. We need to get the types of residencies we are most in need of filled.

Mr. ROGERS. How would you do that?

Secretary WEINBERGER. By the proposal we have made here. We have had some experience with this proposal and we believe distribution of residencies will be achieved without trying to control the total number.

Dr. COOPER. It is my understanding from talking to several of the specialty groups that they are willingly and actively pursuing on their own the inductive influence of the specialist and subspecialist aspects of their program. The chairmen of the departments of medicine, the cardiologists, orthopedics and others have been in to talk about this and about pursuing a way to address this problem. We are also concerned that the impact, without additional data might com-

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plicate the problem of the utilization of the foreign medical graduate at the present time.

Mr. ROGERS. This bill gives 3 years to address the problem.

Secretary WEINBERGER. But it puts a limitation on the number of residencies and a mandatory reduction in the number of residencies. We think that, to be perfectly frank, is an arbitrary and capricious way to address the problem.

Mr. ROGERS. Let's look at the encouragements you are presently giving. As I understand it, of the $9.5 million for family-medicine training programs in the continuing resolution. Right now you are requesting a deferral of $1.3 million.

Secretary WEINBERGER. No, we have requested $27 million.

Mr. ROGERS. I am talking of the continuing resolution. Right now you are requesting a deferral of $1.3 million.

Secretary WEINBERGER. There is a little less than 4 months of the fiscal year left, and that is for the current fiscal year. 1976 is what we are trying to do and that is a $27 million request for family residents.

Mr. ROGERS. What has been the history on our support of such residencies? What have we been allocating in 1973 and 1974?

Dr. COOPER. Out of the 1973 appropriations, we spent the entire amount budgeted. We spent $5.9 million with the additional amount programed for 1974 for a total expenditure of over $13 million.

Secretary WEINBERGER. We are asking to go up to $27 million for family programs in 1976.

Mr. ROGERS. How many residencies would that support?

Secretary WEINBERGER. It would increase the enrollment by 500 or more in family medicine residencies. The family specialists would be supported by this amount.

Dr. COOPER. We expect to have new in 1976 up to 2,500 residencies, in family medicine, 174 programs in family medicine with 2,500——

Mr. ROGERS. Do you mean residency programs?

Dr. COOPER. 174 programs and we would project 2,500 residencies. In primary care residencies, aside from family medicine, we expect 68 programs with 120 residencies.

Mr. ROGERS. Now, how does that compare to the total number of the family medicine residencies? What percentage of such residencies are you supporting? How much funding is going for family or primary care compared to residencies as a whole?

Dr. COOPER. All residencies or vacant slots? There are 40,000 residency slots in the country.

Mr. ROGERS. There are really 50,000. We have more than we know what to do with.

What I want to know is what percentage are we supporting out of the total residency positions of 50,000?

Dr. COOPER. If there are 50,000 total residency slots, we would be supporting 2,500 out of the 50,000.

Mr. ROGERS. How many primary care physicians do you estimate we need?

Dr. COOPER. The general figure is about 50 percent.

Mr. ROGERS. What percentage are we assisting? Twenty-five hundred out of 50,000; that is not quite 50 percent.

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Dr. COOPER. Those are just the family medicine residencies. Primary care is the objective given by a spectrum of physicians in specialties other than family medicine. The calculation that I recall recently reviewing was that at the present time there are about 30 percent of the physicians that could be included in primary care and our objetcive would be to move that to the 50 percent figure.

In order to accomplish that, we would have to progressively increase our effort toward family practice residencies and restructure primary care emphasis in the other residency programs.

Mr. ROGERS. Many experts tell us that limitation is the proper approach. What is your objection to the limitation?

Secretary WEINBERGER. Well, we have a number—if you would permit me at this time—first of all, you would have to have some sort of regulatory body.

Mr. ROGERS. The professor already has a rudimentary body. They have the council on medical education and their accrediting body. The college of surgeons has done their study; the institute of medicine is doing a study.

Secretary WEINBERGER. We think we first should try the positive incentive of the kind we have talked about rather than that kind of regulation. The powers that would be delegated to that regulatory body would establish the number of primary residencies. They would establish the number of primary care specialists.

The Congress has had these studies requested, the institute of medicine has already done the first steps and I think to rush into a regulatory policy with respect to total residencies as to who can go where and who can study what, before you could get that study, that would be a rash policy.

Mr. ROGERS. We are simply setting up a mechanism. It doesn't happen for 3 years.

Secretary WEINBERGER. You could postpone it for 3 years Armageddon. But if you are going to get it, I don't think you should start with 3 years. You are saying so many people can be surgeons, so many people this, and so many people that, and it is a degree of control, and an attempt to predict the future that is unwarranted and I think it will fail.

Mr. ROGERS. You say I want to restrict the total number of overall doctors?

Secretary WEINBERGER. No, we say we don't think the Government should subsidize any more. We are saying if we continue an unnecessary subsidy at an expanded rate, we will have more than we need. We are saying nobody knows enough to register the number and types of specialties. What you should do is offer incentives.

Mr. ROGERS. How will incentives get them to do it if they don't know how? How will you bring the knowledge with incentives? You said no one knows how to do it.

Secretary WEINBERGER. I said no one knows how to force the allocation into each of these residencies. What we are saying is we would offer a substantial incentive to people who take family and primary care residencies. We would expect that to continue.

That is the way we would like to start and that is what we propose rather than a commission that will tell you in 3 years whether you can be a surgeon.

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Mr. ROGERS. Some of the professions have already done it. The neurologists have already started.

Secretary WEINBERGER. They have a lot of totals and numbers but we don't have a guild system.

Mr. ROGERS. It is pretty much a guild system. All the specialty groups have organizations.

Secretary WEINBERGER. We should move away from that. Rather than setting up a commission and saying you will reduce the total number of slots and so many can go here and so many there and we will tell you to do it by a Government commission, we think you should offer more incentive for family care and see if that won't solve the problem.

We have very encouraging experience that it will.

Mr. ROGERS. When will it be solved?

Secretary WEINBERGER. As Dr. Cooper mentioned, as you move along these paths, with other people already providing this care, I would think you would come out in 4 or 5 years with the kind of help needed.

Dr. COOPER. I think it would take closer to 10 to 15 years.

Mr. ROGERS. Ten to 15 years and that's assuming we got all of them to follow your incentive.

Dr. COOPER. There has been experience in the past when a carrot was offered to areas like psychiatry and neurology and it did have a significant impact on the number of physicians that have gone into the areas. We have had some significant evidence that the incentive approach can affect the mix.

Secretary WEINBERGER. Forty-six schools of medicine have departments of family medicine. These are quite recent developments and we think they are essential.

Mr. CARTER. On that, would you decribe a department of family medicine in a medical school, please, sir?

Dr. COOPER. I think they vary in different places because of the philosophy of family medicine might vary. But one I recently visited, the program emphasizes first ambulatory care and total family involvement, a total family relationship with a physician in continuity that will see all the family members. The trainee has an initial exposure to the training in internal medicine, pediatrics, obstetrics and gynecology, and emergency care.

There is additionally an option for some special interests with particular suggestions that they go into an experience in behavioral science or techniques of interview and that sort of thing. They have that rotation and then they begin their relationship with a prescribed family population which has subscribed to this particular program. The residency or training begins after his preliminary residency, when he begins to take care of these families subscribed to him under the school's supervision.

They are assigned to members of the full-time staff. When their patients require inpatient treatment, they have hospital privileges in the university hospitals with a hospital consultant and they have the opportunity for total followthrough care in an ambulatory setting in an inpatient setting and posthospital setting.

Mr. CARTER. I still maintain a family physician should be trained in different specialties that you mentioned. Every family physician

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should have pediatrics, obstetrics, and disciplines of that nature. He has to have a basic rounding in all these fields. If he has any common sense, he will obtain some knowledge of behavioral science.

Thank you, Mr. Chairman.

Secretary WEINBERGER. I would like to make the point that, finally, we strongly oppose the internal interference in the management of the Department through proposed restrictions on our ability to administer the health manpower program on a decentralized basis. The reasons for our opposition are, first, that it would conflict with the Department's and the administration's general objective of moving the operating program management activities from Washington to the regions where people are most affected by Federal policies; and second, the provision would seriously restrict the Secretary's general authority for administering HEW programs. We feel, therefore, that such a limitation is unnecessary and inappropriate, and strongly recommend its removal.

With regard to H.R. 2957, the nurse training bill, we have continually objected to separate legislation for nurse training and a categorical program of subsidies to this undergraduate field.

By treating nurse training apart from other health professions categories, this bill would perpetuate the fragmentation that results in gaps in some instances and overlap in others. The bill would set policy precedents that may limit what we can subsequently do in other health professions areas. And, as is the case with H.R. 2956, the authorization levels proposed vastly exceed the amounts that the administration believes should be allocated to nurse training within a flexible set of integrated health professions authorities.

Also, present evidence leads us to believe that a number of the provisions of H.R. 2957 are unnecessary. We very strongly oppose continued stimulation of output through capitation as we believe that such a continuation may set the stage for real employment problems during the next 5 years.

Since 1970, enrollments have increased by over 35 percent and the number of active nurses has risen from 722,000 in 1970 to 815,000 in 1973. Yet this increase in supply does not even take into consideration the 74-percent increase in baccalaureate enrollments which only began to graduate and practice last summer. Our projections indicate that even if the nurse-training system expands no further, the active nurse supply will reach about 1.1 million in 1980 which was the objective identified in nursing needs analyses.

Yet even the present rate of growth is not without its problems. Some programs, particularly those offering baccalaureate degrees are finding that service delivery sites in which clinical training is conducted are becoming glutted with students, and that the universities in which their programs are located are beginning to resist further expansion because the nursing programs are unbalancing the institution's general educational objectives and are putting a strain on shared resources.

In addition, although only anecdotal evidence is available, it is clear that there is already some tightening in employment opportunities for nurses in some local markets. At the same time, however, there is severe geographic maldistribution which the proposed legislation virtually

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neglects. For example, Georgia, South Carolina, and Kentucky fall in the lowest quarter of States in terms of nurse-to-population ratios for both RN's and licensed practical nurses. Arkansas and Alabama have ratios only 45 percent of the New England States' average. Yet only 7 percent of the fiscal year 1973 nursing capitation support went to these most needy States.

With nearly 25 percent of the proposed budget committed to general nationwide capitation, we believe that we are likely to face growing pockets of nurse oversupply which will not be pushed out into these underserved areas. Only vigorous, targeted initiatives can address these gross deficiencies and imbalances.

THE NATIONAL HEALTH SERVICE CORPS PROGRAM AND THE NHSC/PHS SCHOLARSHIP PROGRAM

Mr. Chairman, I would now like to turn our attention to proposals on the National Health Service Corps. There are two portions of the bill, H.R. 2958; one would extend the National Health Service Corps program; the other would extend the NHSC/PHS scholarship program. If you will recall, the administration offered testimony in hearings on the extension of the program on May 20, 1974, before this subcommittee.

Let me now address briefly the bill's provisions to extend the National Health Service Corps and Public Health Service scholarship program. We strongly believe this is an issue which should be considered in the context of health professions legislation.

As I noted earlier in my statement, we believe that overcoming geographic maldistribution is one of our major problems. The NHSC/PHS scholarship program is our major means of encouraging more medical students to work in underserved areas. The program provides up to 4 years of financial support in return for a commitment to serve in the NHSC or in PHS programs. Medical students agree to serve 1 year for each year of support, with a minimum of 2 years of service.

The 1976 budget request included $22.5 million for the scholarship program in fiscal year 1976. This compares with the $3 million appropriated in fiscal year 1974, and $12.5 million requested for fiscal year 1975.

Because we believe that the scholarship program is an integral part of our assistance to medical education, we oppose including it in a separate bill along with the National Health Service Corps management provisions.

I would now like to turn to those provisions of H.R. 2958 dealing with the operation of the National Health Service Corps. We continue to feel that the National Health Service Corps should be strengthened and extended.

The corps represents an exciting and challenging mechanism for placing health professionals in areas with critical health manpower shortages. The National Health Service Corps is in every sense a people program—linking health professionals in a very important personal and professional way to communities and to patients with needs and problems, who in many cases have not had other than distant emergency care available for long periods of time. The primary mis-

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sion of the National Health Service Corps addresses the documented problems of geographic maldistribution of providers, especially in rural communities. In addition, this program assists communities in developing the capability to independently attract and retain health professionals.

Considering such factors as the loss of the physician draft and the difficulties associated with establishing new programs, we believe the National Health Service Corps has made reasonable progress in its first years of operation. We have, in the last year, focused significant attention on the Corps and brought about a beneficial redirection and strengthening of the program.

The Corps has emphasized the development of an effective long-term recruitment program for provider personnel, especially physicians. Through an organized campaign of visits to over 100 medical schools and 250 house officer training programs, and other communication efforts including two special mailings to 52,000 house officers, the Corps has increased its recruitment of physicians and dentists from 14 in 1971 to over 300 in 1975. This major recruitment effort was conducted as an integrated effort with the Indian Health Service and Bureau of Medical Services.

Fiscal year 1975 saw considerable refinement in the process of matching NHSC assignees to communities. Data on every approved community are available through the NHSC data bank. Each candidate is matched with at least four sites in two regions which most closely resemble preferences expressed by the applicant; this process will be repeated, if necessary, until satisfaction with the choices is expressed. Based on both applicant and community needs and preferences, the most acceptable match is made. This interchange of information minimizes the possibility of future dissatisfaction of either party.

In 1975, 500 of these matching site visits have occurred. As a result, we are pleased that we can now report that over 300 physicians will be in practice in critical shortage areas by this summer. In 1975, the Corps has approved 428 sites for Corps assistance and has placed 405 doctors, dentists, nurses and other health professionals in 180 communities in 40 States. It has experimented successfully with utilizing physician extenders (nurse practitioners and physicians' assistants) to provide health services and will have over 70 in shortage areas by this July. The presence of Corps personnel is also drawing other health professionals to areas which have a critical shortage of health manpower.

A major activity has been assisting community groups in setting up programs that link assignees to other provider units. These programs, which foster improved systems of care and develop professional and personal relationships, will greatly improve the possibility of the health provider's remaining in the community. The Corps' retention rate for 1975, to date, was 30 percent compared to 25 percent in 1974 and 3 percent for 1973. Because of improved matching techniques and community assistance activities, this rate should increase in 1976.

The accomplishments I have cited as examples provide us with sufficient encouragement to wholeheartedly endorse the continuation of this program for 3 years. The Corps has now proven that it is an effective mechanism for assisting communities critically short of

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health manpower to establish and sustain appropriate health practices.

Because of the objective to ultimately have as many National Health Service Corps communities as possible establish independent practices. we have analyzed the current legislation in order to identify any existing impediments to achieving such status. We have identified three areas where legislative changes would facilitate development of strong local capabilities leading to independence.

First, we propose that communities beginning practices be given considerable latitude with regard to cost recovery in the initial stages of operation. Sites are now required to pay for the services received through National Health Service Corps on the basis of a cost recovery formula. The present formula does not allow flexibility during the start-up period of the practice when utilization and billings may be low and at a time when the community is assuming the largest share of the start-up costs. Many practices thus incur large debts during the initial 6 to 12 months of operation. These debts serve as a disincentive with respect to moving away from Federal support.

The administration's bill would provide the Department flexibility to deal with cost recovery as most appropriate during initial periods and would aid communities in avoiding large initial operating debts and would also serve to develop local resources. Presently, the Department conducts initial surveys of communities and helps to prepare the site for the arrival of a provider. Most of these functions, such as locating and setting up proper facilities and establishing billing and practice systems, could be done through local resources. We are not, however, authorized to provide funds to the communities for this purpose.

We note that H.R. 2958 does authorize grants for the purpose of assisting communities prepare for a practice. This provision is similar to the administration's bill but raises the ceiling to $25,000 rather than the $10,000 proposed in our bill. In view of the fact that most of these grants will be considerably less than $10,000, we believe it is inappropriate to place the ceiling so high.

Another impediment identified is the absence of an effective mechanism for transferring equipment to the communities.

Purchase of equipment being used at the site should not be permitted to stand in the way of the site becoming independent. It should be borne in mind, of course, that title would not go to the health practitioner but to the nonprofit entity established by the community. Also, no buildings or facilities would be involved since the Corps does not now fund construction or renovation of facilities.

We also note that H.R. 2958 provides for the transfer of equipment to the community at the fair market value cost. The administration bill would simply permit the Department to release such equipment under such condition as may be prescribed in regulations. Under such a provision the community will, of course, benefit from the receipt of such equipment, but also the Government may realize some economy by having a simple method of transferring the equipment. Requiring that the equipment be sold at fair market value may not be as convenient and would create another disincentive to moving toward full independence. We would, therefore, prefer the approach of the administration's bill.

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It is important to make a distinction between critical health manpower shortage areas and medically underserved areas. The National Health Service Corps is directed to the problem of availability of health manpower resources. Although we do not wish to enter into a difference of semantics, we do believe that the confusion of using medically underserved population indicators for the purpose of the National Health Service Corps program results in confusion with other programs in the Department such as HMO's or community health centers.

Many communities seen as medically underserved do not call for the manpower assistance available under the National Health Service Corps program. For example, their needs might be limited to transportation, organization, or delivery of services or financial barriers.

We believe the National Health Service Corps resources should appropriately be used where a fundamental health problem is a critical shortage of manpower and not as a mechanism to solve other health service problems where manpower resources are available.

We do not object to a separate bill on management aspects of the National Health Service Corps so that the program can plan for recruitment and operation in the current and future fiscal years.

We also feel that the additional pay incentive provisions in H.R. 2958 overlap legislative provisions in Public Law 93-274 and would create unfair salary differentials for NHSC assignees in comparison with other PHS personnel stationed in critical shortage areas (i.e., in the Indian Health Service). As such, they are unnecessary and we oppose them.

CONCLUSION

In summary, Mr. Chairman, I strongly recommend enactment of the administration's health manpower proposals. These proposals on the level of Federal support and funding mechanisms reflect a careful assessment of priorities and projections of health manpower. I know we can move forward together in developing new health manpower strategy that is financially prudent and appropriately targeted.

We look forward to working with you and your colleagues on this important legislation.

[Testimony resumes on p. 353.]

[The following letter from Secretary Weinberger to Speaker Albert, with draft bill attached, was subsequently received for the record:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., March 3, 1975.

HON. CARL ALBERT,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: There is enclosed for the consideration of the Congress a draft bill "To amend titles VII and VIII of the Public Health Service Act, and for other purposes." The bill, when enacted, would be cited as the "Comprehensive Health Professions Education Act of 1975".

The draft bill is intended to translate into legislation the health professions education themes of the President's budget for fiscal year 1976.

"In 1976, total HEW outlays for training health professionals are estimated at $620 million. Measures undertaken since 1969 have assured major increases in the number of graduates of U.S. health professions schools. From 1965 to 1974, medical school enrollments and the number of graduates each grew by 56%. Medical school enrollments have grown from 32,428 to 50,477 and the annual number of graduates has increased from 7,409 to 11,580.

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"As in other fields of higher education, Federal assistance in 1976 will emphasize aid to students rather than to institutions. Unnecessary Federal institutional subsidies will be gradually phased out. Since students in the health professions can anticipate high earnings, they can be expected to finance a greater share of their own educational costs. Federally guaranteed private loans are available, and recently increased ceilings on such loans will heighten their usefulness to students in the health professions. Proposed legislation will reflect this appropriate Federal role in the support of health professions training.

"An expanded National Health Service Corps program of scholarships in return for service will both assist students financially and help meet Federal needs for health professionals." (At p. 133.)

Of the 1976 outlay estimate of $620 million for all of the Department's health, education, and training activities, approximately $380 million is attributable to programs to be authorized in this bill.

Construction of health teaching facilities

Projections of the current volume of health professions graduates against expected population increases persuade us that existing facilities, if maintained, are sufficient to meet foreseeable future need. For example, in 1970 there were some 323,200 practicing physicians in the United States, or 159 physicians per 100,000 population. If the number of first-year training places existing at the end of 1972 are maintained without change through 1990, and we may assume a constant net addition of foreign medical graduates approximating the net increment during the mid-1960's, about 3,800 a year, the number of practicing physicians in the United States will grow to at least 435,000 in 1980—about 192 per 100,000 population, and 554,000 in 1990, or about 221 per 100,000. If there is sufficient public and private support to allow for a post-1978 growth in output capacity of 1.3 percent for medical schools and 0.6 percent for osteopathic schools, and a net addition of 5,200 foreign medical graduates per year (a level approximating recent levels) we would estimate the number of physicians in 1990 per 100,000 population to arrive at 237. We are aware of no studies that suggest that a projected increase of this size—almost 40 percent, and probably nearly 50 percent, more physicians per 100,000 population within sixteen years—would be insufficient, if appropriately distributed geographically and by specialty (concerns addressed by aspects of our proposal discussed below) to meet prospective national requirements for medical care.

Accordingly, the draft bill would change the focus of the current health professions teaching facilities, and nurse training facilities, construction programs. Rather than continuing to encourage, through the making of Federal grants, the multiplication of teaching facilities, we would instead concentrate resources on encouraging existing facilities to mantain and improve their adequacy. The bill would accomplish this (1) by allowing the expiration of the construction grant programs of part B of title VII of the Public Health Service Act and of title VIII; and (2) by amending the provisions that now make Federal guarantees available for loans for the construction of health professions and nursing teaching facilities, to instead provide assistance limited to the replacement or remodeling of facilities. Loan guarantees for the construction of new buildings (except as replacements for old buildings) or the expansion of existing buildings, would no longer be available. In addition, consistent with the philosophy expressed in the President's budget of aiding students rather than institutions, we would no longer offer to subsidize interest payments on new guaranteed loans under the program.

Loan guarantees would no longer be available under the program for schools of pharmacy and public health, because the replacement or remodeling of these facilities does not serve a significant national need. The draft bill also omits the long unfunded authorization for appropriations for the construction of health research facilities.

Capitation awards

In the Comprehensive Health Manpower Training Act of 1971, the establishment of a capitation grant program reflected a judgment by both the Congress and the Administration that "first dollar" funding of health professions education was an appropriate and needed mechanism of Federal support. Experience to date suggests that the capitation grant program has achieved certain of its original objectives, in that the financial viability of many of these educational

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institutions has improved, and in that some portion of the enrollment increases experienced would probably not have come about in the absence of the expansion requirements in the capitation grant law.

Despite these positive aspects, which the Administration recognizes, an analysis of the capitation program and consideration of future trends reveal serious flaws in the capitation grant concept. These defects call into question the appropriateness and desirability of the capitation mechanism as the Federal Government's primary tool for the support of health professions education. Chief among the deficiencies are that the capitation program:

due to its inherently rigid allocation formula, resulted in comparative windfalls for certain schools and shortfalls for other schools—that is to say, the funds were not targeted based on an assessment of need for such support;

the incremental enrollment increases that may have resulted from the program proved to be very costly;

the amounts authorized and appropriated for the program were arbitrary and unrelated to any concept of actual educational costs;

the costs of this program would only be expected to continue to increase, with the schools and the students becoming increasingly and undesirably dependent upon the continued flow of Federal subsidies for the health professions educational process; and

reasonable alternative sources of funding support for the health education process are available in lieu of Federal across-the-board, formula-type institutional subsidies.

In this regard, we would emphasize that capitation support must be viewed, at least in part, as a means of subsidizing health professions students indirectly through institutions. In conjunction with other assistance to health professions schools, Federal capitation grants enable a student to pay a tuition that commonly defrays from 10 to 20 percent of a school's costs of training that student. Nevertheless, health professionals, particularly physicians and dentists, have high earnings. The annual rate of return on the total costs of a basic medical and dental education has been estimated to be over 20 percent, a rate that is two to three times the rate of return for graduate education generally.

In view of these earnings, health professions students can and should be called upon to pick up a larger share of their educational costs. The Federal Government should not call upon the general public, through tax revenues, to subsidize the training of individuals who are themselves able to bear the real costs of their training and who, because of that training, will quickly recoup those costs from members of the public in the form of compensation for their professional services.

We recognize that immediate withdrawal of capitation support for health professions education would be very disruptive to some institutions, particularly those receiving the highest rates of capitation.

Accordingly, we propose to extend capitation for most health professions schools for an additional three years, but modified as follows:

1. The statutory capitation amounts for schools of medicine, osteopathy, and dentistry, now $2,500 for each student in each of the first three years of training and $4,000 for each student in a graduating class, would be set at $1,500 per enrolled student (without regard to year-class) for fiscal year 1975, $1,250 per student for fiscal year 1976, and $1,000 per student for fiscal year 1977. This compares to an average actual capitation level, under the 1974 appropriation for this activity, of about $2,000 per student.

2. Schools of veterinary medicine, for which capitation is now set at $1,750, would be set at $900, $600, and $300, for the fiscal years 1975, 1976, and 1977, respectively. Again, this compares with the actual 1974 appropriations level of about $1,325 per student.

3. Schools of optometry and podiatry, for which capitation is now set at $800 per student, would be set at $400, $300, and $200, for fiscal years 1975, 1976, and 1977, respectively. The actual 1974 appropriation for these disciplines averaged about $625 per student.

4. Because the draft bill would not impose any enrollment increase requirements on the school (merely requiring that the schools maintain their 1974 level of first-year enrollment), the capitation for "enrollment bonus students" (i.e., students in year-classes meeting certain enrollment increase requirements) would be dropped.

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5. Capitation of undergraduate training—*i.e.*, the training provided by schools of pharmacy and nursing—as well as general assistance, under section 309(c) of the Public Health Service Act, to schools of public health, would be allowed to expire.

6. The current program of grants for small medical, osteopathic, and dental schools—essentially a one-time bonus of $50,000—and the capitation for three-year schools of medicine ($2,500 for each student enrolled in a fiscal year, plus $6,000 for each student graduating in that year) would be repealed.

Start-up assistance

The current program of start-up assistance would be phased out by limiting it to schools that have received a start-up grant for fiscal year 1974.

National Priority Incentive Awards

The draft bill would establish a new program of National Priority Incentive Awards to increase the number of health professionals who enter critical health shortage specialties. The program would have two principal features:

1. It would award to each school of medicine and osteopathy an amount equal to $2,000 for each of its graduates who enters a residency in the practice of family medicine. As a condition of receiving this award, a school would be required to use its best efforts to increase the number of its graduates who enter such practice.

2. It would award grants to pay part of the cost of planning, developing, and operating for an initial period (not to exceed three years), programs of graduate or specialized education or training in family medicine, pediatrics, internal medicine, and other health care shortage fields. The grants could include amounts intended to augment the compensation otherwise payable to an individual in consideration of his participation in a program.

Consolidation of special project authorities

The existing health manpower special projects authority would be amended in order to embrace assistance now authorized under comparable special project authority contained in the nursing, allied health, and public health professions portions of the Public Health Service Act. Those latter authorities would be allowed to expire.

Consolidation of special project and HMEIA appropriations authorizations

The authorizations of appropriations for the special project grants for the health professions and the health professions Health Mnapower Education Initiative Awards would be consolidated in a single provision. That provision would extend both programs for three years.

Financial distress

The health professions financial distress grant program would be extended for three years, but would be amended to terminate the eligibility for financial distress grants of schools of pharmacy. The bill would also limit the financial distress grant to any school for a fiscal year to 75 percent of the financial distress grant awarded for the preceding fiscal year. This limitation is intended to make clear that amounts awarded under the financial distress provisions of the law are not intended as an increase of the general educational support that a school receives under the previously-described capitation provisions, but are truly amounts awarded on a short-term basis to meet an extreme and unusual exigency.

Pre-admission and follow-up assistance to the disadvantaged

The draft bill would amend the existing program of special assistance to the disadvantaged, for training in the health care field, by authorizing the payment to eligible individuals of stipends, with allowances for travel and for dependents, for post-secondary education or training required to qualify the individual for admission to a school providing health training, or to assist a person in undergoing that training.

The Department proposes to administer this authority as follows:

1. It would restrict the assistance to study in preparation for, or leading to, a first professional degree in the health care field. That is, stipends would not be provided in connection with training, such as in nursing or pharmacy, at the undergraduate level.

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2. It would limit assistance to fields that prepare the individual to provide health care. Stipends would not be provided, for example, for the study of public health administration.

3. As previously discussed, persons who enter most health care fields enjoy a high income potential. As their professional education progresses they are increasingly able to command loans for the completion of their education.

Accordingly, stipends awarded for professional study (as distinct from pre-admission assistance) under the amended health professions program of special assistance to the disadvantaged will be limited to the first year of training.

Scholarships for service

We believe that the Public Health and National Health Service Corps Scholarship Training Program offers the potential not only of assuring an adequate future supply of health professionals to meet essential Federal health care delivery responsibilities, but also of truly opening the door to a health professions education to sizeable numbers of deserving students. For these reasons, the President's 1976 Budget contemplates funding for this program, at a level of $22.5 million. Funding of the program at that level would provide full support for in excess of 2,000 health professions students, and would accompany the phasing out of the traditional scholarship programs operated by the Bureau of Health Resources Development in the Health Resources Administration. The basic philosophy reflected in this disposition of resources is that the public is ordinarily entitled to public service, or service meeting a public need, from those individuals who are beneficiaries of special scholarship assistance while receiving their health professions degrees. The traditional scholarship programs—which do not require such service—are inconsistent with that principle.

We propose to broaden and strengthen the program, consistent with these views, as follows:

1. We would extend the Program indefinitely, and authorize appropriations for it of such sums as may be necessary.

2. We would provide the Secretary with clear and unambiguous authority to assign participants in the Program to any civilian or uniformed Federal health service. The National Health Service Corps and other health service delivery programs of this Department would doubtless be the primary users of the program participants, and perhaps in the short run would be the sole users. At some future time, however, the Secretary might determine that certain of the participants could more appropriately serve elsewhere in the Department, or even in other Federal agencies (e.g., the Veterans Administration) or State or local governmental units. It would be preferable to not have to appoint individuals to the Commissioned Corps of the Public Health Service in order to do this, but rather to be able to assign them directly to other health service duties.

3. Finally, we believe there should be room within the Program to assist individuals who wish to remain in the private sector, but who are prepared to practice a health profession in a geographic area of critical health manpower shortage. These individuals would not be employed by the Federal Government but would undertake to serve in shortage areas, as determined by the Secretary, for the same period of service to which other individuals assisted under the program are obligated to serve the Federal Government: that is, one year of service for each year of scholarship assistance.

Health professions and nursing student loan programs

The draft bill would also limit further Federal capital contributions to health professions and nursing student loan funds to the amounts required to continue loans to students previously assisted from the funds. However, the funds would remain available, for the next three years, for the schools to make new student loans from amounts revolving back into the student loan funds; and for continuation loans.

The bill would also raise the interest rate on these loans from 3 to 7 percent (the same maximum rate of interest now prescribed under the student loan insurance program contained in the Higher Education Act of 1965).

We believe that enactment of this legislation would be an important step toward assuring an adequate future supply of health professionals, both for meeting the general needs of the public and meeting essential Federal health care responsibilities. It would remedy the problem of unnecessary public subsidization of the education of individuals preparing to enter highly paid health care occupations. Nevertheless, it would significantly improve the possibility of a

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health professions education for large numbers of students. We urge the Congress to give the measure its prompt and favorable consideration.

We are advised by the Office of Management and Budget that enactment of this draft bill would be in accord with the program of the President.

Sincerely,

CASPAR W. WEINBERGER, *Secretary.*

Enclosure.

A BILL To amend titles VII and VIII of the Public Health Service Act, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE; REFERENCES TO ACT

SECTION 1. (a) This Act may be cited as the "Comprehensive Health Professions Education Act of 1975".

(b) Whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a title, part, section or other provision, the reference shall be considered to be made to a title, part, section or other provision of the Public Health Service Act.

TITLE I—LOAN GUARANTEES FOR CONSTRUCTION FOR REPLACEMENT OR REMODELING OF TEACHING FACILITIES

SEC. 101. (a)(1) Section 729 (including the caption thereof) is amended to read as follows:

"LOAN GUARANTEES

"SEC. 729. (a) To assist eligible nonprofit private entities to carry out approved projects for the construction of teaching facilities of private nonprofit schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, or podiatry, other than the construction of new buildings or the expansion of existing buildings, the Secretary may, during the period beginning July 1, 1974, and ending with the close of September 30, 1977, guarantee (in accordance with this section and subject to subsection (f)) to any non-Federal lender that makes a loan to an eligible entity, for that project, payment when due of the principal of and interest on that loan. The Secretary may make commitments, on behalf of the United States, to make those loan guarantees prior to the making of the loans."

(2) Section 729(b) is repealed. This repealer shall not be construed to impair the obligation of the Secretary to pay any amount that the Secretary has agreed to pay, under that section, with respect to any loan made under section 729 prior to the enactment of this Act.

(3) There is added after section 729(a) a new section 729(b) to read as follows:

"(b) A nonprofit private entity shall be eligible to receive a loan guaranteed under subsection (a) if the entity meets the requirements (as determined under regulations of the Secretary) of sections 721, 722, and 723, insofar as they are applicable to nonprofit private entities, except that in lieu of any requirement of section 721(c) respecting the maintenance or increase of student enrollment, an application for a loan guarantee under this section shall contain or be supported by reasonable assurances that the teaching facility with regard to which the loan guarantee is obtained will maintain a first-year enrollment of full-time students after the completion of the construction, and for each of the next nine school years, that is not less than that enrollment during the fiscal year ending June 30, 1974. For purposes of the application of sections 721, 722, and 723 to this section, the term 'grant', as used in sections 721, 722, and 723 is deemed to mean 'grant by the Secretary of a loan guarantee under section 729'."

(4) Section 729(c) is amended by striking out "or interest subsidy payment" in the first and second sentence.

(5) Section 729(e) is amended (A) by striking out "interest subsidy payments authorized by this section" each time it appears and inserting in lieu thereof "interest subsidy payments for which an agreement was entered into under this section prior to its amendment by the Comprehensive Health Manpower Act of 1975"; and (B) by inserting before the period after "1974" the following: ", and for each succeeding fiscal year such sums as may be necessary to make interest subsidy payments for which an agreement was entered into under this

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section prior to its amendment by the Comprehensive Health Manpower Act of 1975".

(6) Section 729(f) is amended (A) by striking out "(1)" after "(f)", and (B) by striking out paragraph (2).

(b)(1) Section 809(a) (including the caption thereof) is amended to read as follows:

"LOAN GUARANTEES

"SEC. 809. (a) In order to assist nonprofit private schools of nursing to carry out construction projects for training facilities, other than the construction of new buildings or the expansion of existing buildings, the Secretary may, during the period beginning July 1, 1974, and ending with the close of September 30, 1977, guarantee (in accordance with this section and subject to subsection (f)) to non-Federal lenders making loans to such schools, for such construction projects, payment when due of the principal of and interest on any loan for that construction. The Secretary may make commitments, on behalf of the United States, to make those loan guarantees prior to the making of the loans."

(2) Section 809(b) is repealed. This repealer shall not be construed to impair the obligation of the Secretary to pay any amount that the Secretary has agreed to pay, under that section, with respect to any loan made under section 729 prior to the enactment of this Act.

(3) There is added after section 809(a) a new section 809(b) to read as follows:

"(b) A nonprofit private school of nursing shall be eligible to receive a loan guaranteed under subsection (a) if it meets the requirements (as determined under regulations of the Secretary) of sections 802, 803, and 804, insofar as they are applicable to nonprofit private schools of nursing, except that in lieu of any requirement of section 802(b) respecting the maintenance or increase of student enrollment, an application for a loan guarantee under this section shall contain or be supported by reasonable assurances that the applicant with respect to which loan is guaranteed under this section will maintain a first-year enrollment of full-time students after the completion of the construction, and for each of the next nine school years, that is not less than tha enrollment during the fiscal year ending June 30, 1974. For purposes of the application of sections 802. 803, and 804 to this section, the term 'grant', as used in sections 802, 803, and 804 is deemed to mean 'grant by the Secretary of a loan guarantee under section 809'."

(4) Section 809(c) is amended by striking out "or interest subsidy payment" in the first and second sentence.

(5) Section 809(e) is amended (A) by striking out "interest subsidy payments authorized by this section" each time it appears and inserting in lieu thereof "interest subsidy payments for which an agreement was entered into under this section prior to its amendment by the Comprehensive Health Manpower Act of 1975"; and (B) by inserting before the period after "1974" the following: ", and for each succeeding fiscal year such sums as may be necessary to make interest subsidy payments for which an agreement was entered into under this section prior to its amendment by the Comprehensive Health Manpower Act of 1975".

(6) Section 809(f) is amended (A) by striking out "(1)" after "(f)", and (B) by striking out paragraph (2).

TITLE II—CAPITATION GRANTS, START-UP ASSISTANCE, AND NATIONAL PRIORITY INCENTIVE AWARDS

CAPITATION AMENDMENTS

SEC. 201. (a) Section 770 is amended to read as follows:

"SEC. 770. (a) GRANT COMPUTATION.—The Secretary shall make annual grants to schools of medicine, osteopathy, dentistry, optometry, podiatry, and veterinary medicine for the support of the education programs of those schools. The amount of the annual grant to each school with an approved application shall be computed as follows:

"(1)(A) Each school of medicine, osteopathy, and dentistry shall receive for the fiscal year ending June 30, 1975, 1976, and 1977, $1,500, $1,250, and $1,000, respectively for such years, for each full-time student enrolled, in each of those years, in the medical or dental training program of the school.

"(B) In the case of a school that conducts a training program designed to permit the student to complete, within six years after completing secondary

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school, the requirements for the degree of doctor of medicine, osteopathy, or dentistry the medical or dental training program of the school, within the meaning of subparagraph (A), shall be deemed to be the last three years of the school's training program.

"(2) Each school of optometry and podiatry shall receive for the fiscal year ending June 30, 1975, 1976, and 1977, $400, $300, and $200, respectively for those years, for each full-time student enrolled in the school in each of those years.

"(3) Each school of veterinary medicine shall receive for the fiscal year ending June 30, 1975, 1976, and 1977, $900, $600, and $300, respectively for those years, for each full-time student enrolled in the school in each of those years.

"(b) APPORTIONMENT OF APPROPRIATIONS.—If the total of the grants to be made under subsection (a) for any fiscal year—

"(1) to schools of medicine, osteopathy, and dentistry with approved applications exceeds the amounts appropriated under subsection (f)(1) for the grants, or

"(2) to schools of optometry, podiatry, and veterinary medicine with approved applications exceeds the amounts appropriated under subsection (f)(2) for the grants,

the amount of the grant for that fiscal year to each school under subsection (a) shall be an amount that bears the same ratio to the amount determined for the school for that fiscal year as the total of the amounts appropriated for that year under subsection (f)(1) or (f)(2), as the case may be, bears to the amount required to make grants in accordance with subsection (a) to each school referred to in clause (1) or (2), as the case may be.

"(c) MAINTENANCE OF EFFORT.—The Secretary shall not make a grant under this section to any school for a fiscal year beginning after June 30, 1974, unless the application therefor contains or is supported by reasonable assurances satisfactory to the Secretary that in the school year that ends during, or with the close of, that fiscal year, the school will maintain a first-year enrollment of full-time students that will be not less than the school's first-year full-time enrollment for the school year ending during, or with the close of, the fiscal year ending June 30, 1974. For purposes of this subsection, a student enrolled in the first year of the last three years of the training program of a school described in subsection (a)(1)(B), or a student enrolled in the first of the two years of the medical training program of a two-year school of medicine, shall be considered a first-year student.

"(d) ENROLLMENT DETERMINATIONS.—

"(1) For purposes of this part and part F, regulations of the Secretary shall include provisions relating to determination of the number of students enrolled in a school, or in a particular year-class in a school, or entering residencies in the practice of family medicine, as the case may be, on the basis of estimates or on such other basis as he deems appropriate.

"(2) For purposes of this part and part F, the term 'full-time student' means a student pursuing a full-time course of study leading to a degree of doctor of medicine, doctor of osteopathy, doctor of dentistry (or its equivalent), doctor of optometry (or its equivalent), doctor of podiatry (or its equivalent), or doctor of veterinary medicine (or its equivalent).

"(e) APPLICATIONS FOR NEW SCHOOLS.—In the case of a new school of medicine, osteopathy, dentistry, optometry, podiatry, or veterinary medicine that applies for a grant under this section in the fiscal year preceding the fiscal year in which it will admit its first class, the enrollment for purposes of subsection (a) shall be the number of first-year full-time students that the Secretary determines, on the basis of assurances provided by the school, will be enrolled in the school, in the fiscal year after the fiscal year in which the grant is made.

"(f) AUTHORIZATION OF APPROPRIATIONS.—

"(1) There are authorized to be appropriated $118,000,000 for the fiscal year ending June 30, 1975, $95,500,000 for the fiscal year ending June 30, 1976, and $82,914,000 for the succeeding fiscal year for grants under this section to schools of medicine, osteopathy, and dentistry.

"(2) There are authorized to be appropriated $6,600,000 for the fiscal year ending June 30, 1975, $5,500,000 for the fiscal year ending June 30, 1976, and $3,228,000 for the succeeding fiscal year for grants under this section to schools of optometry, podiatry, and veterinary medicine."

(b) Section 775(b) is amended by striking out "pharmacy,".

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START-UP ASSISTANCE AMENDMENTS

SEC. 202. (a) Section 771(a)(1) is amended by inserting before the period at the end of the first sentence thereof the following: "; except that for any fiscal year beginning after June 30, 1974, no grant may be made under this subsection except to a new school that has received a grant under this subsection for the preceding fiscal year".

(b) Section 771(a)(6) is amended in the first sentence by inserting before the period at the end thereof the following: ", $4,620,000 for the fiscal year ending June 30, 1975, and $3,000,000 for each of the next two fiscal years".

NATIONAL PRIORITY INCENTIVE AWARDS

SEC. 203. (a) Sections 775 and 776 are redesignated sections 776 and 777, respectively, and there is added after section 774 the following new section:

"NATIONAL PRIORITY INCENTIVE AWARDS

"SEC. 775. (a) FAMILY PRACTICE RESIDENCY GRANTS.—To each school of medicine and osteopathy eligible, in a fiscal year, for a grant under section 770, the Secretary shall make a grant, from the sums appropriated under section 770(f)(1) for that fiscal year, of $2,000 for each individual (i) who entered, in the preceding fiscal year, the first year of a residency in the practice of family medicine approved by the Council on Medical Education of the American Medical Association; and (ii) who, during the school year ending in that or the preceding fiscal year, received from the school a degree of doctor of medicine or doctor of osteopathy.

"(b) GRADUATE TRAINING IN SHORTAGE SPECIALISTS.—

"(1) In order to enable the Secretary to award grants to public or nonprofit private entities providing graduate or specialized education or training in the provision of health care (including education or training in systems or methods of health care delivery), there are authorized to be appropriated $23,800,000 for the fiscal year ending June 30, 1975, and $39,000,000 for each of the next two fiscal years.

"(2) Grants under this subsection may be awarded to an entity to plan, develop, and, as provided by paragraph (3), pay part of the cost to operate or participate in, for an initial period, a new or expanded program of education or training (accredited, certified, or approved by such professional bodies, and in such manner, as the Secretary may deem appropriate) in family medicine, pediatrics, internal medicine, or such other specialties for the delivery of health care services as the Secretary may determine to lack practitioners sufficient to serve a national need, including augmentation of stipends of individual participants in any such program who plan to specialize or work in the field in which they are to receive training under the program.

"(3) A grant under paragraph (2) for payment of part of the cost, for a fiscal year, to operate or (insofar as it may require the payment of operational costs) participate in a new or expanded program may be awarded only to an entity that has provided assurances satisfactory to the Secretary that there are sufficient non-Federal funds to pay the remainder of that cost for that fiscal year; that for each year a grant is awarded for such operation of or participation in a new or expanded program, the proportion of non-Federal funds employed in the operation of, or participation in, that program shall be increased over the preceding fiscal year; and, if the award is for the operation of a program, that there is a reasonable prospect that the program (or the program as expanded) will be continued, without Federal financial assistance, after eligibility for assistance under this subsection has terminated. The Secretary may not award grants under this subsection for defraying more than the first three years of the costs of operating or participating in any new or expanded program."

(b) Section 776 (as redesignated by this section) is amended (1) by striking out "or 773" each time it appears and inserting in lieu thereof "773, or 775(a)", and (2) by (A) striking out "and" at the end of subsection (d)(2), (B) redesignating subsection (d)(3) as subsection (d)(4), and (C) inserting a new subsection (d)(3) to read as follows:

"(3) contains, in the case of an application for a grant under section 775(a), a description of the activities to be undertaken by the applicant to

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assist and encourage its students to enter the practice of family medicine, and a certification by the applicant that it will use its best efforts to increase the number of its students applying for residencies in, and entering the practice of, family medicine; and".

(c) Section 770, as amended by this Act, is further amended (1) by adding before ", or" at the end of subsection (b)(1) the following: "(after reduction of the amounts appropriated by the total of grants to be made under section 775"; (2) by adding at the end of subsection (b) the following new sentence: "If the total of the grants to be made under section 775 for any fiscal year to schools of medicine or osteopathy with approved applications exceeds the total of the amounts appropriated under subsection (f)(1) for that fiscal year, the amount of the grant for that fiscal year to each such school shall be reduced proportionately."; and (3) by adding "and section 775" after "this section" in subsection (f)(1).

TITLE III—SPECIAL PROJECTS, HEALTH MANPOWER EDUCATION INITIATIVE AWARDS, AND FINANCIAL DISTRESS GRANTS

Consolidation of Special Projects Authorities

SEC. 301. (a)(1) Section 772(a) is amended in the matter preceding clause (1) by striking out "and podiatry" and inserting in lieu thereof "podiatry, nursing, and public health, and any training center for allied health professions".

(2) Section 772(a) is further amended (A) by striking out "or" at the end of clause (13); (B) by striking out the period at the end of clause (14) and inserting "; or" in lieu thereof; and (C) by adding after clause (14) the following new clauses:

"(15) assist in—

"(A) mergers between hospital training programs or between hospital training programs and academic institutions, or

"(B) other cooperative arrangements among hospitals and academic institutions,

leading to the establishment of nurse training program; or

"(16) provide appropriate retraining opportunities for nurses who (after periods of professional inactivity) desire again actively to engage in the nursing profession."

(3) Section 772(a)(3) is amended by inserting "nurse practitioners," before "physicians' assistants".

(4) Sections 772(a)(4) and 772(a)(5) are amended by striking out "in such health professions" and inserting in lieu thereof "or training in health care".

(5) Section 772(a)(6) is amended by striking out "in such health professions".

(6) Section 772(a)(8) is amended by striking out "and podiatry of," and inserting in lieu thereof "podiatry, nursing, and public health, and any training center for allied health professions of,".

(7) Section 772(a)(9) is amended by inserting "or training centers" after "such schools".

(b) Section 724 is amended by adding at the end thereof the following new paragraphs:

"(7) The term 'school of nursing' means a school of nursing as defined by section 843.

"(8) The term 'training center for allied health professions' means a training center for allied health professions as defined by section 795."

Consolidation of Special Project and Education Initiative Award

Appropriations Authorizations

SEC. 302. (a) Section 777 (as redesignated by section 203 of this Act) is redesignated section 778, and there is added after section 776 a new section to read as follows:

"Appropriations Authorized for Sections 772 and 774

"SEC. 777. There are authorized to be appropriated $110,000,000 for the fiscal year ending June 30, 1975, and $122,000,000 for each of the next two fiscal years for the purpose of making payments under sections 772 and 774."

(b) Sections 772(d) and 774(e) are repealed.

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EXTENSION OF FINANCIAL DISTRESS GRANT PROGRAM; INELIGIBILITY OF SCHOOLS OF PHARMACY; AMOUNT OF GRANT; TECHNICAL ASSISTANCE

SEC. 303. (a) Section 773(a) is amended (1) by striking out "and" before "$10,000,000", and (2) by inserting "and $5,000,000 for each of the next three fiscal years," after "1974,".

(b) Sections 773(b) and 773(d) are amended by striking out "pharmacy,".

(c) Section 773(b) is further amended by adding at the end thereof the following new sentence: "In the case of a school that has received a grant in the immediately preceding fiscal year, the sums of amounts granted to that school under this section for any fiscal year may not exceed 75 per centum of the sum of amounts granted to that school under this section for that immediately preceding fiscal year."

(d) Section 773(c) is amended by adding at the end thereof the following new sentence: "The Secretary may provide, to any school of medicine, osteopathy, dentistry, optometry, podiatry, or veterinary medicine which is in serious financial straits to meet its costs of operation or which has a special need for financial assistance to meet accreditation requirements, technical assistance to enable the school to conduct a comprehensive cost analysis study of its operations, to identify operational inefficiencies, or to develop or carry out appropriate operational or financial reforms."

TITLE IV—STUDENT ASSISTANCE

PRE-ADMISSION AND FOLLOW-UP ASSISTANCE TO THE DISADVANTAGED

SEC. 401. Section 774(b) is amended—

(1) in clause (2)(A) by inserting after "assisting them" the following "(including the payment to them of such pertinent stipends, with allowances for travel and for dependents, as the Secretary deems appropriate)"; and

(2) by striking out the matter following clause (2)(C).

SCHOLARSHIPS FOR SERVICE

SEC. 402. (a) Section 225(a) is amended by striking out "other units of the Service" and inserting in lieu thereof "such other uniformed or civilian Federal health service as the Secretary may determine is appropriate, and to promote the more adequate provision of medical care for persons who reside in areas determined by the Secretary, under section 329(b)(1), to have critical health manpower shortages".

(b) Section 225(b)(4) is amended to read as follows:

"(4) agree in writing to serve, as prescribed by subsection (e) of this section, (A) as a civilian member of the National Health Service Corps or in such other uniformed or civilian Federal health service as the Secretary may determine is appropriate; or (B) in an area determined by the Secretary, under section 329(b)(1), to have a critical health manpower shortage".

(c) Section 225(b)(3) is amended to read as follows:

"(3) except in the case of an applicant who enters into an agreement under clause (4)(B), be selected for civilian service in the National Health Service Corps or in such other uniformed or civilian Federal health service as the Secretary may determine is appropriate; and".

(d) Section 225(e) is amended (1) by amending the first clause of the first sentence to read "In accordance with his agreement under subsection (b)(4), a person participating in the Program shall be obligated following completion of academic training to serve as a civilian member of the National Health Service Corps or in such other uniformed or civilian Federal health service as the Secretary may determine is appropriate, or in an area determined by the Secretary, under section 329(b)(1), to have a critical health manpower shortage,"; (2) by striking out the second sentence; and (3) by amending the last sentence by inserting "Federal health" before the word "facility", by placing a period after the word "facility", and by striking out "of the Service or other facility of the National Health Service Corps."

(e) Section 225(f)(1) is amended by striking out "an active duty service obligation" and inserting "a service obligation" in lieu thereof.

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(f) Section 225(i) is amended to read as follows:

"(i) There are authorized to be appropriated $12,500,000 for fiscal year 1975, and $22,500,000 for each of the two succeeding fiscal years to carry out the Program."

FEDERAL CAPITAL CONTRIBUTIONS TO STUDENT LOAN FUNDS; DIRECT LOAN INTEREST RATE MADE EQUIVALENT TO INSURED LOAN INTEREST RATE; AND CLARIFYING CHANGE

SEC. 403. (a) Sections 743, 794D(e), and 826 are each amended by striking out "1977" each time it appears and inserting in lieu thereof "1980".

(b) Sections 741(e), 794D(b)(2)(E), 823(b)(5) are each amended by striking out "3 per centum" and inserting "7 per centum" in lieu thereof.

(c) Section 741(f)(1) is amended by adding at the end thereof the following sentence: "In the case of any individual who, on or after November 18, 1971, meets the requirements of subparagraphs (A) and (B) and who practices his profession as described by subparagraph (C) by virtue of his employment as a member of the National Health Service Corps, the individual shall be deemed to have entered into the agreement required by subparagraph (C) with respect to that practice."

TITLE V—EFFECTIVE DATE

SEC. 501. This Act is effective with respect to appropriations for fiscal years beginning after June 30, 1974, except for section 403(c) which is deemed to have become effective on November 18, 1971.

Mr. ROGERS. It is my understanding that about 35 percent of the practicing physicians are now in primary practice.

Dr. COOPER. Yes, about.

Secretary WEINBERGER. It is a little hard to say.

Dr. COOPER. Primary care.

Mr. ROGERS. Thirty percent of persons in residencies now are in primary care, is that right?

Dr. COOPER. In residencies, about 30 percent.

Mr. ROGERS. So if 90 percent of the current students entered primary care today, residencies today, only 38 percent of the total number of physicians in 10 years would be primary care. We are at 35 percent and we need 50 percent so, if we want to have an impact on delivery of care in the Nation, I think we must have the profession do something about it.

Secretary WEINBERGER. You are giving a nongovernmental commission awesome powers that I wouldn't want a governmental commission to have and I wouldn't want a guild to have.

Mr. ROGERS. Such groups accredit schools now. If you see what has been done in the past, it is not too much out of line.

Secretary WEINBERGER. I am afraid I will have to remain in solid disagreement with you.

Mr. ROGERS. Now, on a different subject, how many employees are in HEW regional offices?

Secretary WEINBERGER. Of the whole Department?

Mr. ROGERS. Yes.

Secretary WEINBERGER. We have 10 regional offices and I would suppose—I will have to get it exactly—but I would suppose we have something like maybe 20,000 or 25,000, or 30,000, roughly in that range.

[The following statement was received for the record:]

On duty as of January 18, 1975, there were 258 persons in health manpower programs in the DHEW Regional Offices.

Mr. ROGERS. How many work in the health manpower field?

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Secretary WEINBERGER. 270.

Mr. ROGERS. Has there been any reduction in the Washington health manpower staff due to regionalization?

Dr. ENDICOTT. I believe we moved about 230 to regional offices.

Mr. ROGERS. How large a staff remains in the Washington area?

Dr. ENDICOTT. 330.

Mr. ROGERS. You had 500 before?

Secretary WEINBERGER. Just in health manpower. That is what we are talking about.

Mr. ROGERS. Now how much of the health manpower initiative award moneys were turned over to regional offices for regional office initiatives last year? Wasn't it about 10 percent?

Secretary WEINBERGER. Yes.

Mr. ROGERS. What was this money spent for?

Secretary WEINBERGER. There were several principal purposes. One was in the area of educational development. There were also several contracts that were awarded from the regional office in support of additional training programs and projects of that nature.

Mr. ROGERS. Were any of those awarded out of the central office?

Secretary WEINBERGER. There were some from health funds that were spent out of the central office for specific kinds of contract activities related to developing special curriculum, for instance at a place like Michigan State University for the development of educational programs in underserved areas.

Mr. ROGERS. Do you know what the regional office has done? Do you know what each region has done?

Secretary WEINBERGER. We do have the data, for instance, on the physician-assistance training program. The brief answer to that is, yes, Mr. Chairman.

Of course, we have a communication network and we do know and are aware, as indeed we have to be for a number of reasons for accounting, what the regions are doing. We do not try to tell them what to do because we believe that they should operate under the way they have been delegated.

Mr. ROGERS. First I would like to have a breakdown of regional decisions where they have the jurisdiction, and I would like to know what has been done by the central office. I would like to know if there is duplication.

Why have you delegated such authority to the regional offices? It seemed to the committee this was not too heavy a load for one central office to carry.

Secretary WEINBERGER. It is not the heaviness of the load on any one particular program. It is the fact that you have an accumulation of a very large number of programs in the Department, well over 300, and it is also the basic philosophy that the people in the individual regions know their problems and should be able to deal with local government, local schools, local people on a direct decisionmaking basis.

[The following information was received for the record:]

REVIEW OF APPLICATIONS UNDER DECENTRALIZED GRANT PROGRAMS OF BUREAU OF HEALTH RESOURCES DEVELOPMENT, HEALTH RESOURCES ADMINISTRATION

BACKGROUND

Prior to the decentralization of several Bureau grant programs in the fall of 1973, the review of competitive applications was accomplished through pre-

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liminary consideration for technical merit by non-Federal peer review committees and final review by the appropriate National Advisory Council. The decentralization of Bureau programs required an adjustment in review procedures for 12 discretionary grant programs, including 3 health professions programs for which National Advisory Council review was not required. In addition, 6 formula-type programs were decentralized.

Rather than establish preliminary review committees in each of the 10 DHEW Regional Offices, it was determined to adopt a system of reader review to accomplish the preliminary merit review of applications. This initial review of competitive applications is the only aspect of the review system that has changed. All applications continue to receive the same reviews by PHS staff as in the past, except that staff is now based in the Regional Offices. This greatly enhances opportunities for closer liaison with applicants and a better understanding of their needs and capabilities. There has been no change in the National Advisory Council's review of applications.

READER SYSTEM

Under the reader system, qualified government and non-government experts are identified to review and comment on grant applications. Each competitive application is assigned to three to five readers who must submit a written report of their findings, recommendations, and a merit rating for acceptable proposals. The readers are furnished with standard instructions (developed for each specific grant program) for carrying out their review and preparing their written report. The reports are assembled by regional staff, who incorporate the reviews into a summary statement on each application which includes a summary of the proposal, staff comments, the readers comments and recommendations, any site visit reports and the regional recommendation. As in the past, the summary statements are provided to the National Advisory Council together with site visit reports and other pertinent documents. A copy of each application is also available to the Council should they request it.

STANDARDIZATION OF PROGRAM MANAGEMENT

To ensure consistent management of the decentralized grant programs, a manual ("Guide for Health Manpower Grant Programs—Regional Office Operations") was drafted at headquarters and forwarded to regional staff in the fall of 1973. The manual includes detailed information concerning administration of the grant programs, as well as specific instructions for each program to be provided to readers, formats for readers reports, site visit reports, summary statements, etc.

A copy of the general "Guide" chapter (Part I, Chapter 1) on grant application review procedures is attached, along with a sample chapter (Part IV, Chapter 7) on one of the decentralized grant programs (Health Professions Special Project Grants). Instructions to reviewers and formats for preparing materials required to be prepared by regional staff are found in the chapter exhibits.

OPERATIONAL IMPROVEMENTS

The complete "Guide" was revised in December 1973, following a series of regional meetings conducted by headquarters staff to brief regional office staff on operation of the decentralized programs. A few minor revisions and a complete re-draft of the construction grants section were made early in 1975 to keep the "Guide" current. Another complete revision of the "Guide" will be undertaken following the forthcoming enactment of new health manpower legislation. Detailed operational instructions are routinely furnished to the regional staff by the Bureau's headquarters staff. This has included specific instructions dealing with merit review under the decentralized programs (copy attached).

PHS Agencies and regional offices are currently implementing a new PHS Chapter (1-507) to the DHEW Grants Administration Manual, which formalizes recommendations of the Secretary concerning the objective review of grant applications. The policy includes a system of objective review involving persons outside the immediate organization in which the granting authority is vested, as well as the issuance by each principal operating component of internal rules and procedures for implementing such a policy. The implementation of this chapter (copy attached) as formal policy will be beneficial to all PHS granting programs, including the decentralized programs of the Bureau.

[Editor's note: The attachments referred to above may be found in the committee's files.]

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Mr. ROGERS. I don't find that true. In Atlanta they don't know any more what is going on in Florida than you do here. In some instances, they know even less.

Secretary WEINBERGER. We also have the question of how well any work is done in Washington, Atlanta, or Houston, but the simple fact of the matter is that with a Department as large and complex and diverse as ours, I don't think the constant restrictions we are having imposed on us—not just in this area but education, public assistance, vocational rehabilitation, and everything else—is serving the public well.

I think they are centralizing and forcing long delays with people who have no familiarity with the problem.

Mr. ROGERS. We can't determine who is making the decision. The regional offices say they don't know.

Secretary WEINBERGER. That is because of the constant attempts to defeat the decentralization we have done in the last few years.

Mr. ROGERS. I think it is a lack of competency. How many regions do we have now?

Secretary WEINBERGER. Ten.

Mr. ROGERS. I think it is more difficult to duplicate the expertise 10 times over what we could perhaps gather here in Washington when you are dealing with a limited number of entities.

Secretary WEINBERGER. The people deal not with this alone but with a lot of other things and I think they build their experience and competence by assignments. I don't think you do by assuming all the experience resides on the Potomac.

Mr. ROGERS. I think you bring competent people here and for the most part you have gathered some excellent people. We have great confidence in their competency here, but we don't know everybody you have gathered in the field and it is difficult for us to find out.

Secretary WEINBERGER. They don't wear different uniforms or anything of the kind. We recruit them by the same methods and we do have extraordinary and capable people here and we think the regions would be able to serve better if we assign that kind of competency.

Mr. ROGERS. Well, the expense in paying all those additional salaries when a smaller group could do the same work here in Washington——

Secretary WEINBERGER. There is not any duplication, there is simply desire.

Mr. ROGERS. Then why not abolish them?

Secretary WEINBERGER. You could abolish the regions and centralize in Washington but I think all the management and administrative problems we have now would be compounded at least to a magnitude of 150, and I think when you see any organization of this size and this complexity and with the diversity of the problems we have, the only way to manage effectively is to get the best people you can as close to the people involved in the decisionmaking and who know more about the priorities.

Mr. CARTER. The 10 regions I suppose in our country have a high recognition factor, is that quite true?

Secretary WEINBERGER. Maybe I don't understand the import of the question. You mean are they well known?

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Mr. CARTER. Yes.

Secretary WEINBERGER. We assume so.

Mr. CARTER. I want to inform you we have polled this committee last year and fewer than half knew where his region was.

Secretary WEINBERGER. I would hesitate to say that was not a representative sample.

Mr. CARTER. That is quite true. This committee has purview over the legislation concerning these regions and fewer than one-half knew where his region happened to be.

I am impressed by the expertise of the group which you have around you.

Secretary WEINBERGER. So am I. That is why they are here.

Mr. CARTER. I am not impressed with the expertise of the regions. they are people who are out there; we don't know them and certainly we are not famiilar with what they do.

Secretary WEINBERGER. To know them is to like them, if you have the opportunity to work with them.

Mr. CARTER. I was one of the few who knew where my region was and I know the director. I will not expound further on it; I would rather do that in private. I can't agree with you as to the expertise of these gentlemen.

The effectiveness of the amount of work they do I think it is——

Secretary WEINBERGER. We have personnel problems locally, regionally, and nationally. We try to resolve them.

Mr. CARTER. I am glad you recognize you know you have problems.

Secretary WEINBERGER. We do all over, but I have not noticed anything basically inferior about a person working in the regions. I have noticed the skill and efficiency of persons in Washington and we have tried to duplicate that.

Mr. CARTER. I would hope you would impart some of that knowledge and expertise to the regions.

Secretary WEINBERGER. Mr. Carter, I am beginning to sense you have had an unpleasant experience.

Dr. COOPER. I would comment on behalf of the regional people, Dr. Carter. There was considerable complaint a year or so ago about the process of the review of applications in this field which were interpreted as being of inferior quality in their operation. At that time, when the process was being initiated, the central council members did complain they were not satisfied with the quality of the review. This was undertaken at a time when we had imposed upon the regions a very short turnaround time to get a very large job done because of the change in the appropriation process. We think we are on top of that and have improved the quality of that process which will result in better service of the applications to the region.

I think you would find many know where the regional office is. And I think there will be a greater satisfaction here with the process.

Secretary WEINBERGER. The way to guarantee mediocrity is to refuse to permit the assigning of any meaningful kinds of duties. I think the operation of a 140,000-man Department with a budget of $118 billion in one office alone is totally undesirable.

The trend, and not just in this committee, has been going that way.

Mr. SCHEUER. Did you say it was $118 billion?

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Secretary WEINBERGER. Yes, sir.

Mr. SCHEUER. That is the budget, $118 billion?

Mr. KURZMAN. The current budget is less.

Secretary WEINBERGER. That is for the entire country and we feel we have to manage it in a way that organizations similarly large are managed.

Dr. ENDICOTT. I wonder if I may comment?

Mr. ROGERS. Certainly.

Mr. ENDICOTT. I was probably less than totally enthusiastic about the decentralization for a variety of reasons, one of which was I was not familiar with that type of operation, particularly coming from NIH, which does not operate through regional offices.

However, because of my concern, I watched this very carefully and have, since we started decentralization, visited every regional office at least once a year. I have taken particular pains to make inquiries of the institutions who seek funds, or technical help, or whatever from the manpower programs.

I must say that I was pleasantly surprised with the quality of people that we were able to recruit in the regional offices. Many of the central staff refused to go and took other positions so that we started with our newcomers who had to learn something about what they were to do.

I have found enthusiastic and complimentary comments coming from the universities and the college officials. And interacting directly with the staffs out there, I found they were extremely well informed and I thought quite properly motivated. As a program operator, I can see many advantages in a decentralized method.

We have talked about medical schools but there are 1,400 nurse training programs in the United States and over 2,500 institutions involved in the training of allied health personnel and, whereas it is relatively easy to become quite familiar with 100 institutions, it represents quite a different magnitude for them to become familiar with a large number of junior colleges and programs in that area. So there are tradeoffs and in the overall balance, if you were to ask me as a program operator what I would like to do to get the best administration, sir, I would say, let's leave it alone. I think it is working very well and it is working better every day.

Mr. ROGERS. Thank you.

Mr. Hefner?

Mr. HEFNER. Three questions. First, I would like to know what region North Carolina is in.

Secretary WEINBERGER. Frank Rochelle is the regional director for Atlanta which would include your area.

Mr. HEFNER. This would be almost as close to Washington as to Atlanta.

Secretary WEINBERGER. The regions, I might say, are practically uniform for the entire Federal Government. They are regional boundaries for almost all the Federal offices that have regional offices and the boundaries coincide.

Mr. HEFNER. How much authority does the Regional Director have? Is he able to make the decisions in the region without coming to Washington?

Secretary WEINBERGER. To the extent we have been allowed to do so, yes. In a great many areas we have been forbidden to do any decen-

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tralization and in some areas we are not allowed to decentralize. It has been counterproductive in that respect. The policy is to make each region a microcosm of the Department with each region having authority comparable to the Secretary over programs decentralized and developed to his administration. Some we do not, but we try not to be doctrinaire.

It is a simple matter of trying to manage an operation of a size that absolutely mandates decentralization to the greatest extent you can do so. We think it is better for the individuals, Governors, people, to be able to get a final decision from someone generally closer to home who is by reason of his assignment more familiar with the priorities than we here in Washington where we deal with the entire country.

We don't feel that everything we have to do is to be decentralized. We also, in every case where we have done so, have set up policy guidelines, policy directives, formulas, and we have open lines of communication. We have regional meetings with the regional directors and there is a full realization of the fact that some coordination is necessary.

But there is also a full realization that you can't administer an operation of this size from a single central office in Washington.

Mr. HEFNER. I understand, but still there are many decisions that still have to come to the God-head as such.

Secretary WEINBERGER. Yes; and everytime a bill is passed, more.

Mr. HEFNER. In other words, the regional director has limited jurisdiction?

Secretary WEINBERGER. He has limited authority by statute limitations.

Mr. ROGERS. If I may pursue that—what limitation is there on your regional people? Is it essentially up to you to delegate some or all of your authority to the regional offices?

Secretary WEINBERGER. The normal pattern, Mr. Chairman, has been that the Congress would pass a bill and ask us to administer it and enforce it. The way in which that was done would be left to the Department and we, in common with many other groups of comparable size—though there are not many of comparable size—would delegate certain——

Mr. ROGERS. I understand that. What I am saying is that we put no restrictions on you. Any restrictions in regions, you put on.

Secretary WEINBERGER. That is right.

Mr. ROGERS. So it is a Departmental restriction on manpower.

Secretary WEINBERGER. The thing I am addressing myself to is an attempt in the bill to carry forward undesirable practices.

Mr. ROGERS. I understand.

Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman. I will make just one brief comment in view of the hour.

I want to thank the Secretary for a comprehensive review and I think a stimulating one on this.

This question of whether we have enough physicians or nurses is a very baffling one to me. In one sense I think you could say we will never have too many doctors. It is like opening a super highway, the next day you need to open another. You create more demand.

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Also, with the knowledge explosion, it is so hard to know what services are going to be considered essential in the future and, with the changes that you point out in productivity and training, the past estimates we have based on numbers and statistics don't seem to mean anything.

I guess the question is how much the Federal Government should go toward encouraging the highest form of care or the least expensive form.

I just wonder if we don't need a new Carnegie Commission report. I am wondering if this council which we set up, isn't it under the Health Planning Act, the National Council?

Secretary WEINBERGER. Yes.

Mr. PREYER. Isn't this a question they might properly address themselves to?

Secretary WEINBERGER. I would think the health planning groups would be most anxious and apt to get into this field. I share your feeling. The projections are a very difficult and dangerous and tricky area. The problem is, if you don't try to do it and if you just operate on the basis of the present perceived needs, you are apt to end up with major, and we think quite undesirable, surpluses.

I don't think I share your feeling you can't have too many. I think you might well get in a situation where there are too many. I think you may be misallocating scarce Federal dollars to unnecessary purposes.

As I say, some Government projections have been wrong and it may be that some of these are not all that accurate. I do think they are within range and they are conservative, if anything, and I would certainly agree the health planning councils and others would want to address themselves to this problem, too.

Dr. COOPER. The proposed bills all also include a National Advisory Council for the manpower area with broad advisory powers as well so the activity of these two bodies would necessarily have to be coordinated.

Mr. PREYER. In the meantime, I would agree in this pluralistic system we should proceed with some care and not have sweeping solutions that may well prove to be wrong.

Secretary WEINBERGER. That is what we proposed, a slight downward trend of what we are doing because we hope that will give us the distribution we need.

Mr. ROGERS. Mr. Scheuer?

Mr. SCHEUER. This was a very stimulating and provoking statement. The time is late so I will ask only a couple of questions.

First, on page 33 you propose a special readmissions and scholarship program for the disadvantaged.

In New York City a few months ago one of our city universities had a medical services program with scholarship funds available for disadvantaged people. It was for a paraprofessional program of some kind and it was admittedly administered with a racial bias and it caused a great amount of bitterness and unhappiness and it was ultimately changed.

Would it be your view that a program with scholarship help for the disadvantaged be based on a criterion of the degree of need and on an

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objective criterion of ability and that such a program be administered on a nonracial basis?

Secretary WEINBERGER. I think it would have to be. We have all the basic elements that are designed to require that, the Bill of Rights and so on. I know some programs, in their eagerness to overcome a hundred years of discrimination, over-looked some of the problems involved in inverse discrimination.

We are aware of those and we have corrected the balance or revised the perception and I would certainly think any program of this kind would have to be administered on an objective basis with regard to need and potential ability of the student and so forth. You don't serve anyone by admitting a student on the idea because he wants to be admitted, he should be, regardless of any possibility of success.

I think it does a disservice in the sense it disappoints many and so forth. We would try to administer these and they should be administered within basic civil rights and title 9 regulations that now exist.

Mr. SCHEUER. Would it be your intent in your current programs that both education and medical education programs be administered on a colorblind basis?

Secretary WEINBERGER. That is the way it is being done.

Mr. SCHEUER. There has been evidence in the past there has been a racial skewing.

Secretary WEINBERGER. I call your attention to memorandum recently issued from the Office of Civil Rights and the regulations that will be forthcoming under title 9 and all the others that are designed to prevent inverse discrimination as well as discrimination.

Mr. SCHEUER. I would like to carry forward Congressman Preyer's question. It is very difficult to estimate the over-supply of medical professionals absent some concept of effective demand. Now in your testimony, on page 39, you talked about unemployment among nurses or an oversupply of nurses.

Yet I would be hard to put to describe a single place in this country, urban or rural, where general hospitals aren't desperately underserved or where the elderly in nursing homes aren't desperately underserved by nurses.

You talk about that on the last two lines. "It is clear that there is already some tightening in employment opportunities for nurses in some local markets." Certainly that is a question of effective demand. This is not a question of the need for nurses but a question of the dollars for nurses. We are on the brink of developing a national health program, be it insurance or some other kind of funding program.

But we will in the next year or year and a half be funding a nursing program. It seems to me we are going to have an overabundance of every kind of health service.

Secretary WEINBERGER. I think there will be a national health program within the next 2 or 3 years. We think it would increase the demand for health service by about 3 percent. We think it would bring about a distribution geographically and otherwise that will be beneficial.

Mr. SCHEUER. I don't know how you can talk about the kind of medical services personnel we are going to need without thinking about the system in which they are going to be placed. I don't see

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any evidence in your testimony, or much which is stimulating and creative——

Mr. ROGERS. If we are going to make the quorum call, we are going to have to run.

Mr. SCHEUER. Are we coming back?

Mr. ROGERS. If you could, would you put the question in writing?

Mr. SCHEUER. I will be happy to.

Mr. ROGERS. I also have some questions I would like to get in writing. Also I would like a comment on the reader system.

Mr. SCHEUER. I would be willing to miss this quorum call.

Mr. ROGERS. All right, you may continue.

I would like the policy you developed and submitted to OMB and which they rejected on the national standard for entering residencies and a National Residency Commission.

Secretary WEINBERGER. We will get that.

[The information requested was not available to the committee at the time of printing.]

Mr. ROGERS. Mr. Scheuer, will you adjourn the committee until 2?

Secretary WEINBERGER. I will not be able to be back at 2.

Mr. SCHEUER. I want to express to our chairman my thanks for his cooperation when one of these dynamic young freshmen are able to take over the Chair and preside.

Let me give you my perception as a freshman Congressman looking at the business of trying to quantify the need for medical personnel. It seems to me we have to think first about the system in which they are going to be placed. I believe we have to make structural changes in our system. You used the word "structural" once in your testimony on page 19, but it was in the context of structural problems, not structual changes, which is all right.

Secretary WEINBERGER. I would like to tell you some of the structural changes which we think will come about if the proper kind of health insurance is adopted.

We believe first of all you will have a substantial lessening for demand for hospitalization and untilization of hospitalization. You will have a substantial increase in home care and a substantial increase in medical care in rural areas. With this kind of readjustment, we believe this will be around an 8 percent increase in the total demand.

We assume the present manpower policies, modified as we indicated, would bring us to a balance in the 1980's.

Mr. SCHEUER. It seems you can't have manpower policies without other kinds of policies. As you say, in trying to design a health care system that puts the patients at the lowest level of appropriate sophisticated care. In other words, those that can be are treated at home, those needing an ambulatory clinic for treatment during the day get that; those needing a modest kind of long-term recuperative facility without intensive care get that; and only those needing the extensive and intensive facilities and personnel of a large hospital get that.

Secretary WEINBERGER. That is what we are working toward.

Mr. SCHEUER. A family doctor kind of role where the family doctor treats the patients in the locality but has the backing of the labs, and specialized services he may need. This kind of family doctor would

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have paraprofessional help, as you indicated, in a health services system where you extend professional skills through technology, wherever possible—through a telecommunications system that will enable paraprofessionals in a nursing home or rural area to link a patient to a centralized group of highly trained specialists.

Secretary WEINBERGER. These are very dramatic and magnificent possibilities in the future.

Mr. SCHEUER. Yes. I just left a hearing of NASA where they are involved in this situation.

Secretary WEINBERGER. A good example is the Alaskan Indian where you can only get in about once a year. It is a very dramatic achievement. We need to make greater use of it.

Mr. SCHEUER. It seems to me you really can't estimate your need for any one element of these medical personnel people until you design the system—going from the hospital with intensive care services to a neighborhood person with a year of training who is delivering services in the home—a system where you have a better mix of paraprofessionals.

And with your professionals, a better mix of technology, backing up manpower, and a major thrust toward preventive medicine rather than cure of illness. Until you design the system, I would think it is almost impossible——

Secretary WEINBERGER. It is a question of where you break into it because we have been a long time in designing national health insurance, probably 10 years, maybe more; during that time I don't think it was responsible not to try to do something.

We didn't do very much and as a result we have some imbalances which we are trying to correct.

Dr. Cooper mentioned a good point, that is we are attempting at the same time we are attacking the isolated issue of manpower—I would like Dr. Cooper to mention some of that.

Dr. COOPER. I think all of us in the planning functions in the departments are aware there needs to be, at the same time we consider each specific item, some overall conception of how the structure needs to go.

Mr. SCHEUER. I don't see that in this testimony.

Dr. COOPER. It is not in that document but in the planning office of the Secretary of Health, Education, and Welfare, these kinds of questions are being addressed and it is against the background we have reached our understanding of how we are trying to reach those objectives.

Mr. SCHEUER. I think if you could give us that basic framework it would be helpful.

Secretary WEINBERGER. I would like to have you see this piece of work.

Mr. SCHEUER. I would like to see it. It seems that is the indispensable piece that is missing.

Secretary WEINBERGER. It is possible that unkind people could attack that and say some of the kinds of things in that are wrong.

Mr. SCHEUER. But at least you provided a framework.

Secretary WEINBERGER. Indeed, we have and a great deal of work has gone into it. I am proud—although I had no personal participa-

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tion in the beginning stages—but I think it is a fine piece of work that indicates we had all of these broader issues in mind.

Dr. COOPER. At the end of the last session the members did receive some material on this but we have not provided it here this year.

Mr. SCHEUER. Would you provide it for this dynamic, promising young freshman?

You see we already have incentives for hospital overuse and waste. The Veterans' Administration not long ago put out a mandate that their hospitals have X percentage of occupants.

Secretary WEINBERGER. That was a requirement. That was a requirement that they have to maintain a certain level of occupancy.

Mr. SCHEUER. And it is ——— foolishness.

Secretary WEINBERGER. I am glad you said that.

Mr. SCHEUER. Yesterday I read your letter showing how the same is done in the private sector, the hospital administrator was urging attending physicians to load up the hospital. I hope you will be providing economic disincentives for overuse and waste.

Secretary WEINBERGER. If you insure home health care, doctors home visits, doctors office visits and you do not insure unnecessary hospitalization and overutilization and you have a sufficient contribution required from the users on a cost sharing factor, I think you would address a lot of these problems.

At the moment, it is the other way. There is direct inducement to send the man or woman to the hospital whether she needs it or not. The utilization regulations are trying to address these problems.

Mr. SCHEUER. Are they out?

Secretary WEINBERGER. Yes, they are and are causing a certain amount of activity.

Dr. COOPER. They were provided the first of February.

Mr. SCHEUER. May I be provided with a copy of that?

Secretary WEINBERGER. Yes, sir, we will get a copy to you this afternoon.[1]

Mr. SCHEUER. Thank you very, very much.

The hearing is recessed until 2 o'clock this afternoon.

[The following letter was received for the record:]

OFFICE OF THE SECRETARY,
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., March 10, 1975.

Hon. PAUL ROGERS,
U.S. House of Representatives,
Washington, D.C.

DEAR MR. ROGERS: During my testimony on health manpower legislation on February 20th, we spent insufficient time discussing the important specialty distribution problem. I am writing to explain and to reassert the Department's opposition to the regulatory mechanism established in H.R. 2956. The recent amendments offered in your Subcommittee do not address my concerns. Even in the unlikely situation that the Coordinating Council for Medical Education is unable to undertake the regulatory tasks and the responsibility is relegated to the Department, the fundamental deficiencies of the regulatory approach would remain overwhelming.

H.R. 2956 would limit the total number of first-year residency positions to 125% of the previous year's graduating class after 1979. I sincerely believe that

[1] Medicaid, Utilization Control of Care and Services—Rules and Regulations published in the Federal Register, Vol. 39, No. 231—Friday, November 29, 1974, by DHEW, Social and Rehabilitation Service. A copy of these rules and regulations may be found in the committee files.

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this type of restriction is not the appropriate way to deal with the inflow of Foreign Medical Graduates (FMGs). Although the phasing down to 125% will help the Department to assure continuing health care to those populations now being served by FMGs, the real challenge is to assure that those FMGs entering this country are as qualified as U.S. graduates.

If the Coordinating Council qualifies as the regulatory body, a fundamental difference would exist between the private accreditation bodies approved by the Office of Education and that proposed in H.R. 2956. Currently, accrediting bodies limit their concern to quality standards while H.R. 2956 will provide the private agency with quantity controls that could eliminate many programs which meet established quality standards. The accrediting body established in H.R. 2956 is empowered to determine the number of residency positions in every specialty and to approve programs so that the number of residencies in each specialty will be equitably distributed among geographic areas. Since the various constituencies of the private regulatory body could benefit significantly from its decisions, you would in essence be placing the regulated in a position as the regulator. History is replete with undesirable examples of what ultimately results from such a system.

Even more important than who controls the regulatory body is the lack of any real evidence that such an approach is desirable or even feasible. Regulation can be justified only when positive incentives fail to bring about the proper solution. Specialty maldistribution can be, and has been, dealt with by using positive incentives. Therefore, the creation of a regulatory body is, in my view, an unnecessary, unwarranted and hazardous overreaction to the specialty problem.

Let me review the problem and try to clarify more precisely why I believe positive incentives should be given a real chance. Certainly, a medical specialty problem exists, but we must not forget that it was only a few years ago that Federal attention was drawn to this problem. As recently as 1971, when the health manpower legislation was renewed, specialty maldistribution was not identified as a major problem requiring extraordinary Federal initiative and actions. The 1971 legislation did, of course, recognize and support the burgeoning specialty of family medicine, which was an initiative of the private sector. This leads me to wonder whether the family medicine specialty would have developed at all if the regulatory commission had been already in place.

The key feature of the specialty maldistribution problem is the imbalance between primary care and non-primary care specialties. In large part ,this imbalance has arisen because of the peculiar nature of the growth in graduate training over the last thirty years. Residency training developed in large hospital settings. As a result, inpatient, rather than ambulatory training, was emphasized.

An important factor reinforcing this primary care/non-primary imbalance is he financing of graduate medical education. The bulk of the revenue to meet the costs of residencies comes from third party payments. Insurance coverage is adequate to support inpatient residencies. However, inadequate insurance exists for ambulatory care today. Even when it does exist, it may not reimburse for educational costs of residency training.

To overcome those deficiencies, you were instrumental in establishing the family medicine residency program to finance the development of new residency programs. Over the last five years, more than 220 approved residency programs in family medicine have been established. The growth rate in the number of individuals entering these residencies is remarkable. Family medicine today is the fastest growing specialty. Whereas approximately one percent of U.S. medical school graduates went into family medicine five years ago, last year more than ten percent entered the first year of this specialty. Moreover, the applicants seeking positions in family medicine last year significantly exceeded the number of places available. Thus, I am confident that if we expand Federal support for such residency training and make funds available for undergraduate family medicine departments or administrative units, the percentage of U.S. graduates entering family medicine can reach 25% by 1980. With this growth plus the residencies in other primary care specialties, we expect to have over 50% of our first-year residencies in primary care by 1980.

The growth we have already seen accomplished in family practice points out the importance of proper financing of graduate medical education. As the Commission proposal in H.R. 2956 omits any attention to the financing of residencies, this could bring havoc to the entire process you have recommended.

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There are other significant weaknesses to the proposed regulatory body. The unaccountability of this body is one of the most glaring. The body is not even required to provide a methodology on how it reached decisions. Given our inability to define the need for medical specialists, it would seem crucial that any regulatory body divulge its determination process. In this regard, I think it is of interest that my staff has had discussions with Institute of Medicine personnel on their study pursuant to P.L. 93-233 to determine the appropriate specialty distribution. The Institute of Medicine staff has indicated that it is difficult, if not impossible, to justify any one specialty distribution as preferable over another.

In summary, the Administration believes this regulatory approach to be a premature and unwise overreaction to the specialty problem. Rather than create such a regulatory body, we should expand our effort of using positive incentives, which have worked in the past. Only after this approach has been tried and judged a failure, should we consider direct regulation. So as to fully explore the various alternative methods of distributing residencies and financing graduate medical education, the Department is prepared to embark immediately on a comprehensive study. The results of this study could be shared with the Congress during the life of the upcoming health manpower legislation. With such an analysis in hand, we could work together in developing a proper and accountable regulatory body if such an approach is found necessary.

Thank you for the courtesy shown to me during my testimony. Members of my staff and I will be most willing to engage in any further discussions with you on this problem.

Sincerely,

CASPAR W. WEINBERGER,
Secretary.

[Whereupon, at 12:30 p.m., the subcommittee recessed until 2 p.m., the same day.]

AFTER RECESS

[The subcommittee reconvened at 2 p.m., Hon. Paul G. Rogers, presiding.]

Mr. ROGERS. The subcommittee will come to order, please.

Without objection, the chair wishes to place in the record, as though read, statements submitted by congressmen Claude Pepper of Florida, James C. Cleveland of New Hampshire, and Christopher J. Dodd of Connecticut.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Chairman, the health needs of the American people are of the highest importance to all of us. Last year over $100 billion was spent on health services—$485 for every man, woman and child in our country. Our nurses all over the United States played a large part in aiding our ill and caring for the sick.

We in the 93d Congress realized the invaluable contribution that nurses make to our health care system, and we sent the Nurses Training Act of 1974 to the President for his signature last year.

President Ford chose to veto this essential legislation after Congress had adjourned. The main thrust of his argument—opposition to categorical nursing student assistance and institution support through capitation grants to nursing schools—are areas we had considered long and hard. It should be noted that the administration felt the same way in 1971, and vetoed legislation that was overruled to become Public Law 92-158.

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With authorizations to these crucial programs in nurse training and education expiring, it is again time to reaffirm our confidence in our nurses and the fine job they do to promote our health and well-being. Our need for qualified nursing personnel is growing more acute. Last year the Senate Committee on Labor and Public Welfare conducted a study concluding that the Nation presently needs 150,000 additional nurses, and may need close to 1,000,000 by 1980.

We are presently considering health measures that will require even greater numbers of nurses to amply provide health care to our people. The Health Maintenance Organization legislation passed last Congress requires the help of nurses in the areas of preventive and primary care. Our nurses also have a crucial job to do in baby clinics, family health centers, and in other ambulatory service facilities.

We in the 94th Congress will be considering national health insurance and other measures to improve health care. We must also act to insure that adequate numbers of nurses will be trained and available to carry out our plans. I have sponsored the Nurse Training Act of 1975, H.R. 2710, and I urge my colleagues to join with me in supporting this vital legislation. The Nurse Training Act of 1975 affirms our confidence in our nurses, and our realization of the acute need for the specialized services they provide. The bill authorizes construction, start-up, capitation, and special assistance grants which will aid the expansion of nurses training enrollments. Innovative curriculums encouraging concentration in areas of our greatest demand are mandated by this legislation.

Nurses perform an invaluable service to our people who need medical assistance. With a shortage of medical personnel in our rural areas, sometimes the nurse becomes the primary keeper of a county's health and well-being. With all the furor about health care these days, it is essential to realize the crucial role nurses have in utilizing services. Our nurses are called upon daily to administer and assist with the latest breakthroughs in medical technology while remaining a compassionate and calm human being, sometime in the face of the greatest human tragedies.

It is not an overstatement to say that being a nurse involves a special untiring strength and courage. We are all the better for their commitment. We should affirm our confidence in the nursing professions by speedy passage of the Nurse Training Act.

STATEMENT OF HON. JAMES C. CLEVELAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW HAMPSHIRE

Mr. Chairman and members of the subcommittee, I would like to address myself to a particular aspect only of the health manpower legislation before you; namely, the requirements for qualification for capitation grants by medical schools.

As the attached letter from the Dean of the Dartmouth Medical School will show, requirements that schools of medicine must either increase their enrollment by a certain percentage or conduct a program for the training of physicians' assistants in order to obtain assistance under this legislation cannot be met by all medical schools without lowering the quality of the programs offered.

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I therefore urge the subcommittee to provide assurance that a waiver of these requirements will not be unreasonably difficult to obtain by schools which have reached their physical capacity or have other serious problems in meeting the qualifications which would be detrimental both to teaching and to healing.

I submit for the subcommittee's consideration the following letter from Dr. James C. Strickler, Dean of the Dartmouth Medical School:

DARTMOUTH MEDICAL SCHOOL,
OFFICE OF THE DEAN,
Hanover, N.H., December 9, 1974.

Miss KATHIE CASWANDIK,
Rayburn House Office Building,
Washington, D.C.

DEAR MISS CASWANDIK: In response to your further inquiry about the enrollment of students at the Dartmouth Medical School:

The Dartmouth Medical School is one of the smallest, perhaps the smallest, medical school in this country. For several decades and until recently the school was a two-year medical school and as such offered only pre-clinical training to its students. The school's graduates transferred to other medical schools to complete their requirements for the M.D. degree. In the late 1960's, the Trustees of Dartmouth College authorized a return to an M.D. program. I say return because the school did offer a complete curriculum in medicine from 1797 until 1914 when it became a two-year medical school. This return to the full M.D. program is almost complete.

Enrollment at Dartmouth Medical School has increased significantly over the past several years. Class size and total enrollment for the period 1967 through 1977 are shown as follows:

DARTMOUTH MEDICAL SCHOOL

	Year I [1]	Year II	Year III	Total
1967-68	48	48		96
1968-69	53	47		100
1969-70	55	45		104
1970-71	53	52		105
1971-72	61	52		113
1972-73	64	52	18	134
1973-74	64	59	21	144
1974-75	64	60	32	156
1975-76	64	64	32	160
1976-77	64	64	64	192

[1] Includes new students only.

Note that the maximum enrollment is projected at 64 students per class. Only three classes are shown because the Dartmouth M.D. curriculum is a three-year program rather than the traditional four. Note that total enrollment is projected at 192 students. Counting "repeaters" and other students in special categories total enrollment will approximate 200.

Sizable hospital and ambulatory care facilities are required to teach medical students. The size and number of those facilities in and about Hanover, New Hampshire are barely adequate to accommodate the numbers of students we have projected for full expansion of the Dartmouth M.D. program. Our teaching hospitals, the Mary Hitchcock Memorial Hospital and the VA Hospital in White River Junction, Vermont, have a maximum of 640 beds. There is a rule of thumb that says a medical school should have about 10 hospital beds available for teaching for every entering student. The point is that our hospital facilities compared to those available to urban medical schools are relatively small, even allowing for the fact that their classes are somewhat larger. Furthermore, they have the potential to affiliate with many more hospitals than do we in a rural area where the health care system is widely dispersed geographically.

Further increases in enrollment, over those projected, would in my view and that of our clinical faculty compromise the efficiency, dignity, and quality of

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patient care at this medical Center. How many medical students should examine a patient? How many students should be crowded around a single hospital bed? These are the key questions.

Two final points:

1. The Dartmouth Medical School is accredited by the Liaison Committee of Medical Education for an entering class of 64 students. We could not matriculate additional students unless this accrediting body were to approve. I personally doubt that this approval would be forthcoming because our clinical teaching facilities are limited.

2. Last Saturday I discussed this matter of increased enrollment with the Joint Council of the Dartmouth-Hitchcock Medical Center. This Council includes the chief executive officers of the hospitals, the President of the Hitchcock Clinic as well as trustees of Dartmouth College and the Mary Hitchcock Memorial Hospital. The Council agreed unanimously that the Dartmouth Medical School should not be asked to admit more than 64 students per annum.

Please let me know if you would like additional information. I very much appreciate your help.

Yours sincerely,

JAMES C. STRICKLER, M.D.

STATEMENT OF HON. CHRISTOPHER J. DODD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mr. DODD. Mr. Chairman, I represent Connecticut's Second District which comprises most of the eastern half of the State. This district also has a health care situation that is quite frankly depressing. The statistics on the supply of trained medical personnel are outrageous, and the result of this shortage is an intolerable strain on the existing health care facilities. Needless to say, I strongly favor continued Government support for nurses training provided in the Nurses Training Act. Despite the opinion of other persons involved in deciding the fate of this legislation, I feel very strongly that health care is a vital priority for the United States.

I should first like to expand on my description of the dearth of health care facilities and personnel in my own district. I am sure that other Representatives will recognize a similarity to problems in other areas of the Nation. Currently there is 1 doctor for every 840 people in New London, in Middletown there is 1 doctor for every 590 people, and this is compared to 1 doctor for every 480 people in Hartford and 1 doctor for every 356 people in New Haven. In comparison to the rest of the Northeast region, the eastern Connecticut towns of New London and Middletown have the lowest ratio of doctors to population in the entire region. Furthermore, there are only 8 hospitals in this area with a combined total of only 1,449 beds. This is for an area that has a population of 555,800.

As one can easily imagine, this shortage places a considerable strain on the existing facilities. One alarming result is that many people, unable to obtain or in some cases afford medical care elsewhere, have turned to hospital emergency rooms to satisfy routine health needs. The emergency rooms are in turn less able to cope with the emergency cases for nonemergency use of these facilities drives up the cost of operating them, which must ultimately increase the cost of medical care in general.

The shortages in eastern Connecticut could very well forecast health care personnel shortages for the entire Nation. The future need for nurses in the United States is considerable. It is currently

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estimated that there is a need for 150,000 nurses today. In 1980, the number of nurses that will be required for adequate health care in this Nation is estimated at 1 million additional nurses, and this estimate does not include the possible required increases in the event of the creation of a national health insurance program. In contrast, President Ford has said that the number of active duty registered will increase by 60 percent over this decade without any further efforts on the part of the Federal Government. This was one of the reasons he offered for vetoing last year's Nurses Training Act. I have yet to verify the President's figures, but even assuming that they are correct, an increase of 60 percent is still inadequate in light of projected needs. Another reason the President offered for vetoing last year's act was that since most nursing students are at the undergraduate level, they will be eligible for Office of Education student loans. The President concludes that these students do not need a special program. This consideration entirely overlooks the objective of the act which is indeed to create a special program for nursing students in order to increase the number of nurses.

Beyond the need to increase the number of nurses is the importance of expanding the knowledge at the nursing force in this Nation. Nurses are now assuming an increasing role in the area of primary care of patients. This includes screening health problems, assessing health needs, managing programs of care within established standing orders of a physician, deciding if a physician's attention is needed for a patient, and providing health counseling and teaching. Furthermore, nurses are bringing health services to rural and urban communities where such services are inadequate or absent all together. For example, the American Nurses Association reports that "nurse practitioners provide much of the primary care at the pioneer Square inner-city clinic in Seattle serving a population of about 9,000." Nurses are also providing continuing care for stroke patients following hospitalization. This is just one example of the many roles being assumed by nurses today. They are also becoming increasingly important in the care and rehabilitation or maintenance of diabetics, heart attack patients, and persons suffering from mental illness. Expanding roles demand the kind of advanced education provided for under the Nurses Training Act. Projections show that there will be an increasing need for the number of nurses with a master's or other advanced degree. Many nurses today have less than a baccalaureate degree. If the supply of properly trained nurses is to keep pace with the ever-increasing educational requirements brought on by the expanding duties of nurses, then the legislation such as the Nurses Training Act is vital.

The Nurses Training Act of 1971 has shown that this type of program can be very successful. In just the first year of its implementation, the Nurses Training Act increased enrollments of nursing students by 25,000, and by 19,400 over 1972 in 1973. Graduation of these students increased by 4,783 in 1972 and by 7,600 in 1973 over 1972. In addition, more nurses have been able to get advanced education in new nursing roles such as pediatrics, nurse midwifery, and family nursing. Research into better nursing methods has improved the quality of patient care in this Nation. Finally, more minority students have been able to study for nursing careers. Yet more funding must come for-

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ward if these successes are to be continued, and national health care is to improve.

Yet, President Ford insists that we must consider spending priorities, and vetoed last year's renewal of the Nurses Training Act. The President has said that he would veto any new nonenergy spending by the Congress, but then he requests more aid for the war in Southeast Asia. The question appears to be whether or not President Ford's priorities are realistic. He is asking that the workers, the poor, and the elderly, those hit hardest by the current economic crisis, give up their social security benefits, their food stamps, and quality health care. He is asking that they give up this for a cause of questionable value to the United States in Southeast Asia. Perhaps President Ford does not see health care as a major national priority, but I do and most other Americans do. This is why I introduced a bill for continuing the Nurses Training Act. Soon health care will be too expensive for many Americans, especially the elderly who need it the most. Nursing students and schools have been hampered by funding uncertainties in the first few years of the act. As the American Nurses Association reports, only by continued congressional support for increased and continued funding can schools increase their enrollments. Just as medical costs have increased, so have the costs of medical education. The Congress and the Nation must not allow high educational costs to prevent an adequate number of people from receiving medical training. Only through programs with Federal financial assistance can an adequate number of such persons be assured. The Nurses Training Act is certainly a step toward this goal.

Mr. ROGERS. We are very pleased this afternoon to welcome back to the committee Dr. Philip R. Lee, who is director of the health policy program, University of California, San Francisco, and former Assistant Secretary of Health, Education, and Welfare for Health, a man who this committee has relied on a great deal in the past.

We are honored to have you with us and will be pleased to receive your statement. It will be put in the record at this point without objection.

STATEMENT OF PHILIP R. LEE, M.D., PROFESSOR OF SOCIAL MEDICINE AND DIRECTOR, HEALTH POLICY PROGRAM, SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Dr. LEE. It is a pleasure to have this opportunity to respond to the committee's request to discuss the major health manpower questions facing the country.

I would like to focus on the problems and the issues rather than the specifics in the proposed legislation.

I will submit my full statement for the record [see p. 384]. At the end of the statement there are two appendices with tables dealing with U.S. physician supply and distribution and a number of tables relating to foreign medical graduates that I will refer to during the course of my testimony [see p. 402].

Unless there is time at the end of the discussion of the issues to discuss my recommendations, I will just submit those for the record [see p. 426].

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Mr. ROGERS. That will be fine.

Dr. LEE. Last year the committee identified nine issues affecting the quantity and distribution of health manpower and health services. Those issues were: First, the need to insure financing stability of health professions schools and to increase manpower supply.

Second, the need to correct geographic maldistribution.

Third, the need to correct specialty distribution.

Fourth, foreign medical graduates.

Fifth, the need for physician assistants and expanded function dental auxiliaries.

Sixth, the need for students from disadvantaged backgrounds in health professional schools.

Seventh, the need for public health and health administration personnel.

Eighth, the need for allied health personnel.

And ninth, the need for proper implementation of health manpower legislation by the Department of Health, Education, and Welfare.

This committee and the health subcommittee in the U.S. Senate spent many hours during the second session of the 93d Congress grappling with these issues. The reports of these committees are the two most valuable sources of information currently available on the subject.

I want to take the opportunity at this time, Mr. Chairman, to commend the committee and particularly the committe staff who wrote the House committee report, which is a superb, invaluable document. It is "must" reading for anybody concerned with these issues.

Mr. ROGERS. Thank you, the committee was very pleased with the staff work on that as well.

Dr. LEE. My discussion of the issues today is from the perspective of a physician who believes that the need to provide good primary care for everyone is the major health care problem facing the country. In my statement, I deal with the problems of aggregate numbers, geographic maldistribution, specialty maldistribution, foreign medical graduates, and the problems of data, which are very serious. Also in the early portion of my statement I discuss primary care, what it is, and why we have the needs that we have in primary care.

In my full statement I deal with the problem of demands for medical care, discussing the impact of the medicaid and medicare programs on demand as well as the impact of the community mental health centers, the neighborhood health centers, the title V programs, including the maternal and infant care projects, children and youth projects, on demand and the way in which these programs have been utilized to correct some of the maldistribution problems.

One thing that we have learned, particularly from the neighborhood health centers and some of the children's health care programs, is the need for a team approach at the primary care level, particularly the physicians-nurse practitioner team. In addition, for those patients who have complicated social as well as medical problems there is the need to provide social as well as medical services in an integrated fashion at that primary care level.

In December of 1973 the committee in its hearings on national health insurance made clear the complex interrelationships between health manpower policy and policies on financing of medical care and the organization and delivery of care.

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Some of the questions that were raised in those hearings will have to be dealt with as this legislation evolves over the next year or two include:

What percentage of gross national product will be put into health services? What services will be provided and who will receive these services? How will providers be reimbursed for their services, that is, fee for service, prepayment, fixed hospital budgets? Will there be a more equal balance in reimbursement for ambulatory care and hospital based services? How will providers be regulated with respect to quality, utilization and cost control?

How you answer these questions will significantly affect the demand for physicians' services and for the services of other health professionals, as well as the demand for hospital and other institutional services.

The legislation you are now considering can have a profound effect on the Nation's ability to meet the demands for medical care that will be generated by national health insurance, the improvements in technology and the other forces affecting the quality of medical care that tend to increase demand.

In my statement I deal in some detail with the problems relating to the inadequacies of the health manpower data currently available. This is a critical issue which the committee must deal with.

In my statement I deal in some detail with the problem of aggregate supply of physicians. The data is not available for making unquestionably positive decisions.

Estimates of need depend on such things as the health status of the population, the ability of the people to use the services offered and the availability of those services to the population. The productivity of the physician is highly variable depending on the demand for services, the number of other health workers associated with the physicians, the facilities in which the services are provided, the means of remunerating physicians, and the individual styles of the physicians.

We know, for example, in underserved physician short areas physicians will see twice as many patients during the course of a year as they do in areas that are better served, such as the New England area. For example, physicians in the New England region will probably have 4,000 patient visits a year. In the Southeastern region, where there is a shortage of physicians, a physician may average 8,000 patient visits annually.

By working longer hours, seeing more patients per day, having more paramedical personnel associated with them, the physician in the unserved areas is more productive; but it stretches the capacity of those physicians to the limit when they have to work under those conditions.

We know the ratios of physicians to population do not reflect available services because they don't reflect the number of physicians who provide primary care, or those whose principal activity is primary care, nor do they reflect the many other physicians who provide only specialty or consulting services.

In the District of Columbia the physician to population ratios is over 300 physicians per 100,000 population, or about twice the national average. In spite of this, there are large segments within the District

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without adequate access to medical care. The physicians are not well distributed geographically in the District. In San Francisco the ratio is even higher, 530 physicians for every 100,000 population.

Mr. ROGERS. Excuse me, may I interrupt? These are the second bells for a record vote. We hope they will be the last this afternoon.

The committee stands in recess for 5 minutes. If members will return immediately it will be appreciated.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please.

We will continue hearing from Dr. Lee.

Dr. LEE. Thank you, Mr. Chairman.

Before you had to recess temporarily, I noted that in San Francisco, there are 530 physicians for every 100,000 people. That is more than double the statewide average, and it is more than three times the national physician-to-population ratio. In San Francisco, as in the District of Columbia, there are neighborhoods without adequate access to medical care because of geographic maldistribution within the city.

Ratios don't provide a reliable measure of the adequacy of health manpower. They are useful for comparative purposes, however.

The United States compares quite favorably in terms of physician-to-population ratios when compared with other countries (table 1). In the United States, physician supply has increased in the last 20 years (table 2). The physician-to-population ratio in 1950 was 141 per 100,000; in 1960, 136 per 100,000 population; and in 1970, 154 per 100,000 population. The impact of the Federal programs for the support of medical education, particularly those that were designed to increase the enrollments and increase output of physicians, is also evident (table 2).

Federal programs began in 1963 when Federal aid for facilities construction and student loans was first authorized. The first signs of enrollment increase were evident in 1965, and we are now seeing an accelerated impact of those policies designed to increase enrollments (table 3). They had a specific purpose, and I think they are achieving their objectives.

In projecting into the future, the Secretary this morning discussed the HEW projections, and there is an excellent document which DHEW has published, which the committee members may be familiar with: "The Supply of Health Manpower, 1970; Profiles and Projections to 1990."

In my statement submitted for the record, I give the details of many of the projections contained in that excellent monograph. The HEW projections are based on several assumptions; one is, that in the projections of aggregate supply, the supply of foreign medical graduates will be sustained at quite high levels. I will submit an additional table from the HEW document which indicates those supplies will increase from 60,000 in 1970 to 112,000 in 1980 and 164,000 in 1990 (table 7, app. 2).

Mr. ROGERS. This is foreign medical graduates?

Dr. LEE. Yes; and I will get into more detail on that when I deal with the problem. These HEW projections indicate that aggregate supply appears to be adequate. Projecting only the supply of the graduates of American schools, U.S. schools, both M.D.'s and D.O.'s, the

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figures come out quite differently. The aggregate supply of physicians is estimated to be 251,200 in 1970, increasing to 318,000 in 1980, 407,000 by 1990.

Those numbers will still provide, with the population growth and improvements in the quality of care, maintenance of the current physician-to-population ratios. The Federal policies that were instituted in the middle 1960's are going to have continuing benefits through the 1970's, 1980's, and 1990's in terms of the numbers of U.S. graduates available to provide medical care in the United States.

The HEW aggregate supply projections, as I indicated, included a significant segment of foreign medical graduates. Dr. Mark Blumberg, who is a physician now working with the Kaiser Health Plan, did a study for the Carnegie Commission, and he based his projections on a decline in the foreign medical graduates in the United States. His projections were based on the assumption that the number of foreign medical graduates immigrating would drop to zero by 1978. His future predictions were significantly different than those of the Department, with a much slower growth in terms of the aggregate supply of physicians.

The question of foreign medical graduates is really a very basic question for the committee and the Congress. We must recognize that the increase in the ratio of physicians to population in the United States in the last decade has been largely due to the influx of foreign medical graduates.

In my full statement, I deal at length with the policies that have permitted large numbers of foreign medical graduates to enter the United States. Actually, legislation was first introduced by Senator Fulbright in 1946 through amendments to the 1944 Surplus Property Act. In 1948, the United States Information and Education Exchange Act, the Smith-Mundt Act, authorized fuller exchange programs and created the exchange visitor program, which has been very important in relation to foreign medical graduates.

The number of foreign medical graduates began to increase substantially after World War II, and in 1957 the Educational Council for Foreign Medical Graduates was established to certify the basic qualifications for the foreign medical graduates to enter training in the United States.

This had some effect in improving the qualifications of those physicians coming to the United States. In 1965, there were further amendments which abolished the system of quotas based on national origin. This set in motion a transitional process which lasted 2½ years. Quotas were distributed on a first-come, first-served basis. The foreign medical graduates fell into two preference categories which provided further stimulation for their immigration into the United States. (Tables 1 and 2, app. 2.)

In 1965, the Labor Department determined that there was a physician shortage and eased the entry of foreign graduates into the United States. In that same year, medicare and medicaid were enacted.

Medicare and medicaid increased the demand for services and also guaranteed hospitals reimbursement for the costs of interns' and residents' services provided to medicare and medicaid beneficiaries. The number of intern and residency positions grew very rapidly, and there

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were a large number of unfilled positions. The Labor Department looked at those vacancies and said, in effect, "We have a shortage." The vacant positions became kind of a suction cup providing positions for foreign medical graduates who began to come into the United States in increasing numbers.

There are a number of tables in appendix 2 that provide more clinical information on foreign medical graduates in the United States. Table one (appendix two) illustrates the impact of the policy changes made with respect to foreign medical graduates in 1970. You will note the immigrants to the United States began to increase substantially after 1970. Many of the foreign medical graduates immigrating after 1970 were in the United States on foreign exchange programs; they weren't new immigrants. The result is that for the last 4 years, we have had more foreign medical graduates entering practice or training in the United States than we have had graduates of U.S. medical schools. The bulk of the foreign medical graduates are now entering as immigrants not on an exchange visitor agreement.

The status of foreign medical graduates has been confused and blurred so that many of these physicians who entered the United States for training in the early 1960's were found to still be in the United States in the early 1970's.

The impact of the expansion of the residency programs can be seen by looking at some figures. In 1950–51 there were 28,734 approved graduate training positions in hospitals in the United States; 68 percent were filled by U.S. and Canadian graduates, 7 percent by FMG's, and 25 percent were vacant (table 5, app. 2).

Twenty years later in 1972–73, there were 65,308 positions available, 58 percent filled by U.S. and Canadian graduates, 28 percent filled by FMG's, and 14 percent vacant.

Another important shift was occurring during this period. Initially most of the FMG's came from Europe and Latin America, but by 1972 almost 70 percent of the physicians admitted to the United States were from Asian countries. A very dramatic shift from 1965 when only 10 percent came from those countries (table 4, app. 2).

Mr. SCHEUER. Were they mostly from the Philippines?

Dr. LEE. The Philippines, India, Indonesia, Thailand, Korea, and Pakistan.

Mr. SCHEUER. Would you say a word about the quality of their medical education and their prior experience?

Dr. LEE. In my opinion the quality of medical education of foreign medical graduates in some schools, particularly the European schools, British, Swiss, some of the others, is equal to that in the United States. That is also true of the Canadian schools and it is true of some of the Latin American schools. In the medical schools from which the majority of these students come, however, their clinical experience is much less adequate than in U.S. schools and their performance on State boards, national boards, specialty boards and their performance on even the ECFMG examination is well below the graduates of U.S. medical schools.

Mr. SCHEUER. Excuse me, ECFMG?

Dr. LEE. Educational Council for Foreign Medical Graduates. FMG's have to take the ECFMG examination before entering U.S. training programs.

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Mr. SCHEUER. Is there a language problem?

Dr. LEE. Yes, but this is not the main problem. The American students who go to the foreign schools and take the ECFMG examination perform no better than, say, the foreign born student, indicating that the language is not the problem. It is the fact that they do not have an equivalent medical education, either basic science or clinical experience.

These generalizations do not apply to all the medical schools or to all the students because some of our most outstanding physicians are graduates of foreign medical schools.

The basic problem is that the FMG's preparation is not up to that in the American medical schools. We have a double standard of admission to residency training in the United States and a double standard of admission to medical practice. In addition, the foreign medical graduates have not contributed significantly to solving our health manpower problems. The majority of FMG's are in training or in other hospital-based positions. Two-thirds of the Asian FMG's are in hospital-based practice, either in residency practice or full-time hospital positions. Only about 20 percent of the U.S. and Canadian graduates are in similar positions. The European FMG's follow a pattern similar to U.S. and Canadian graduates. The foreign medical graduates are geographically maldistributed even worse than U.S. medical school graduates. The States with the highest physician-to-population ratios tend to have the largest number of foreign medical graduates (table 10, app. 2). The FMG's have gone into hospital-based specialties more so than the American and Canadian graduates (table 9, app. 2). They have gone into primary care specialties less often and are geographically maldistributed mostly in New York, Delaware, New Jersey, Illinois, and Rhode Island. At least 25 percent or more of the physicians in each of those States are graduates of foreign medical schools (table 10, app. 2).

Mr. SCHEUER. You mentioned that we have established two standards for admission both to the residency programs and to practice. Could you elaborate on that?

Dr. LEE. Yes; the foreign student, to get into a residency in the United States, has to take the ECFMG examination and has to come from a medical school that is listed in the *World Dictionary of Medical Schools*. To graduate, the medical student in the United States has to go to an approved medical school, approved in the United States after very careful peer review by people not from that school, and pass either State or national boards. Almost all students have taken the national boards which are considerably tougher than the ECFMG examination, plus they have had to graduate from their own schools and the standards in the United States are relatively uniform. I think we have a high quality product from the medical schools here. That is one factor.

State licensure is another test. There are a large number of foreign medical graduates who are unlicensed. The number estimated last year was around 10,000, and many of those are performing the services normally performed by licensed physicians (table 12, app. 2). They are not just technicians or physician assistants, they are performing physician services.

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It seems the quality aspect of this is an extremely critical one. The second aspect is that they have not contributed to the solution of our problems. As a matter of fact, they have made our problems worse.

Mr. SCHEUER. In what way?

Dr. LEE. The geographic maldistribution for FMG's is as bad or worse than U.S. graduates. They have not helped solve that problem. They don't go to the States in greatest need.

One other factor, is that there is an increasing number of American students who have not been admitted to U.S. medical schools who have had to go to foreign schools. That number is increasing. The last figures I had available indicated there was 3,600 such students abroad in 1969–70 and I am sure the figure is higher, possibly double that now. There has been a program developed to help those students return to U.S. medical schools. They have to pass the same examinations that the U.S. students have to pass who are in U.S. schools, namely, the national boards. This helps to provide an assurance that these students are up to U.S. standards. There are provisions in the proposed health manpower legislation to further enhance that training by funding programs in U.S. medical schools that would permit more of these American students in foreign medical schools to return and measure up to the standard in the U.S. schools.

Moving on from the foreign medical graduates, the second sort of critical problem, and one where I disagree strongly with Secretary Weinberger, is the specialty distribution of physicians. It was originally thought that increasing the aggregate supply of physicians would assure an appropriate distribution by specialists to meet the needs.

A variety of forces have been at work that have produced a very different result: serious shortages of primary care physicians; excess numbers of surgical specialists, such as general surgeons and neurosurgeons; disproportionate reimbursement for surgical services as opposed to primary care and large numbers of physicians performing sugery who have not had adequate surgical training.

I believe in every surgical subspecialty we have an excess supply of physicians. The American College of Surgeons has sponsored a study of surgery in the United States, including a study of surgical manpower. As part of this effort Dr. Osler Peterson of Harvard and his associates did a study of the supply, geographic distribution and work load of surgeons. Their data indicates both oversupply and maldistribution. I think you might want to get the data directly from Dr. Peterson because the data is very impressive.

Mr. ROGERS. Was this done for the College of Surgeons?

Dr. LEE. Yes.

Mr. SCHEUER. If we performed on an annual basis most of the operations or all the operations that reasonably should be performed, would we still have an oversupply? In other words, if there were some way of funding the operations that ought to be performed, would we still have an oversupply of surgeons?

Dr. LEE. The reason we have an oversupply of surgeons is that they are underemployed.

Mr. SCHEUER. Because there isn't the money to hire them to do certain operations?

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Dr. LEE. In certain geographic areas where there are fewer surgeons they do twice as many operations as do surgeons in areas where there are large numbers of surgeons in relation to the population, such as the Pacific Coast area and the New England area. The surgeons, to keep up their skills, have to perform a certain number of operations every year. If they don't perform an adequate number their skills will diminish. They are well trained and most of the surgical operations are performed by either board certified or board qualified surgeons. The number of operations by general practitioners in terms of the total is a relatively small amount.

By diverting more physicians into these surgical specialties, we do not have physicians available to provide primary care; or we find surgeons and other specialists providing primary care where primary care physicians are not available.

It is the diversion into these surgical and other subspecialty fields that is a problem. I do not believe that this specialty maldistribution can be corrected entirely on a voluntary basis, we need more primary care physicians and fewer surgeons and medical subspecialists.

In my statement submitted for the record, I deal in some detail with the declining ratios of primary care physicians to population—dramatic for general practitioners and not compensated for by increases in the internists, pediatricians, and obstetricians.

Rosemary Stevens, a professor at Yale, has stated the problem clearly. She said the training has changed from—

> One based on general undergraduate training and general practice to a complex array of specialists, each with his own training and examination system. Medicine, as no other profession, is now functionally fractional and internally stratified. The change is largely the product of the last 30 years.
>
> Not only has the march of specialism lengthened the training of the medical student to the present eight or nine years, it also has created an unwieldly superstructure of specialty board examinations, a crisis in graduate medical education, a haphazard assignment of educational and training responsibility, and acute manpower problems.

I completely agree with her statement.

There are a number of other factors. Students perceive that primary care is not an intellectual challenge. There has been an explosion of knowledge so that students don't want to be a "Jack-of-all-trades." They want to know a great deal about a given area. These are influential forces.

The current structure of medical education provides physician models who are largely specialists or subspecialists in institutions and not primary care models.

The shortage of primary care physicians is serious. In a study done by Shonfeld, Heston & Falk, it was estimated that the optimal number of physicians needed to provide primary care was 133 per 100,000 population. This is almost three times the estimates of the current national average. In contrast to the optimal number of primary care physicians estimated by Schonfeld, the average primary physician/population ratio for the United States and the ratio of general practioners to population in England was estimated to be 40 per 100,000 population in 1971.

In contrast to the primary care physician in the United States, the English general practitioner usually limits himself to home and office

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based care, referring all patients requiring specialty consultation or inpatient care to hospital based specialists. In addition, the British general practitioner has better organized home nursing and other social services to meet the needs of his patients.

He or she does not practice in the hospital but devotes his or her full time practice to primary care either in the office, in the community, or at home.

Mr. SCHEUER. Don't they also practice preventive care to a larger extent than we do?

Dr. LEE. I doubt it. The possibility is there but I don't think they do. Just as in the prepaid group practice programs in the United States, it is alleged they do more health maintenance and prevention but I don't believe that is the case.

The system of medical care significantly influences need for physicians services. If, for example, more nurse practitioners, physician extenders, and physician assistants working interdependently with the physician were available, significantly more services would be provided to more patients.

A change in the method of remuneration could improve the productivity of physicians, particularly increasing needed primary care services.

To determine the need for primary care physicians it has been suggested that the physician to population ratios in prepaid group practices be examined—Table 7. The Portland Permanente Medical Group, which is associated with the Kaiser Health Plan, there are 33 primary care physicians per 100,000 population.

The Permanente Medical Groups in Oakland and Los Angeles have 59 primary care physicians for every 100,000 people enrolled, and in the Group Health Association in Washington, D.C. there are 65 primary physicians for every 100,000 population.

The populations that each group serves are somewhat different, and the populations served by these groups are quite different than the general population—there are fewer older people, fewer poor people, and more working people in relation to the total population served. Why the differences between the Permanente Medical Group in Portland and the other cities? I really can't explain it.

Mr. SCHEUER. Would you elaborate on your statement that the guarantee of payment to nurse practitioners and physician assistants would be an incentive?

Dr. LEE. Adequate reimbursement of nurse practitioners and physician assistants would provide an important incentive for physicians to work with them and to bring these physician extenders into service with them. Increasing reimbursement of physician extenders for ambulatory care would improve the utilization of those personnel. Increased use of physician extenders could not only extend the medical service more broadly but could also improve the quality of service. Studies on nurse practitioners indicate that under appropriate conditions nurses do as good a job as physicians.

Mr. SCHEUER. Can you provide those studies for us?

Dr. LEE. Certainly we can [see p. 436].

Projecting into the future is the critical area with respect to specialization of physicians. We can look back at the record for the past

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20 or 30 years and project ahead, as HEW has done, and as Gerald Weber did for this committee last year—he was at the University of California at Berkeley, then, and is now with us at the University of California at San Francisco.

Dr. Weber looked at primary care specialists using only general practitioners, internists, and pediatricians in his estimates of primary care providers, and he noted that these providers increased from 103,000 to 104,000 in the two decades between 1950 and 1970. There was an increase of 12,000 in other medical specialties as compared to increases of 56,000 in other specialities such as laboratory medicine, pathology, and radiology. He also found that there had been an increase of 41,000 in the various surgical specialties during the same 20-year period.

Doctor Weber then examined the data on the number of physicians in training and projected those figures into the future. He estimated that the average physician would practice for 30 years. This would require 3.5 residents in training for every 100 physicians in a particular specialty for replacement.

In 1970 in general surgery there were 12.2 new trainees for every 100 physicians in practice, three times the replacement level. For primary care specialties the number of physicians in training was 4.5, just barely over the replacement level. The recent HEW projections confirm Dr. Weber's projections and indicate a decline in the percentage of physicians in primary care specialties from 44.2 percent in 1970 to 41.2 percent in 1980; 39.3 percent in 1990.

In his testimony this morning Secretary Weinberger said everything is going to work out fine if family practice residencies are expanded. Even if those increase optimally these ratios will be unchanged. As you pointed out this morning, Mr. Chairman, only 4 percent of the 51,568 residences offered are in family practice.

Those numbers, even if you double or triple them, rise only to 7,500; and it is not easy to triple the number of residencies. But even with that, these future projections would change relatively little.

Thus, projecting the impact of current policies, the problem of specialty maldistribution is going to grow steadily worse.

Now there are some hopeful signs: Developments of the family practice residency programs, development of family practice departments in the medical schools and the fact that the family practice board is the only one that is going to require recertification after the physician is certified, 5 years later he has to be recertified.

The fact that the American Board of Internal Medicine is paying a good deal more attention to primary care is another hopeful sign. Although these are hopeful signs I don't think there is the slightest likelihood that the present voluntary mechanisms will set any limit on the number of residency training positions available—reducing significantly the number of surgical training positions available or increasing the number of primary care training positions. Additional measures, such as those under consideration by this subcommittee will be needed.

Geographic maldistribution of physicians is a problem that has been without solution in every country of the world. We are not alone. Even in countries as different as Israel and the Soviet Union, with very

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much better physician-to-population ratios than the United States, the problem exists.

In Israel, a relatively small country geographically, physicians won't work in the rural areas. We also have been relatively unsuccessful here.

In my testimony submitted for the record I detail the very significant differences in the geographic distribution of physicians both by region, by State, and within States. In California, for example, as of December 31, 1973, there were 38,749 active non-Federal physicians in California. That is a ratio of 189.9 physicians per 100,000 population, considerably better than the nationwide average.

The ratios ranged from 203 in the major metropolitan areas to 82.8 in the isolated rural areas. The range was from 530 in San Francisco to zero in rural Alpine county. It is a northern county with 650 people and no doctor. Another county, Medoc County, had two general practitioners serving over 8,000 patients.

The distribution of specialists providing primary care, internists, pediatricians, obstetricians and general practitioners illustrates the problem of meeting the needs in small towns and rural areas. Internists, pediatricians, and obstetricians settle in the metropolitan areas or in lesser metropolitan areas. In the isolated rural areas and isolated semirural areas, there are very few internists, almost no pediatricians and few obstetricians. The general practitioner is better distributed in relation to the population in metropolitan, adjacent isolated semirural and isolated rural areas. This pattern of geographic distribution is another reason that family practice residencies are important. Internists, pediatricians, and obstetricians tend not to settle even in towns of less than 10,000 people. General or family practitioners will settle in those areas. No physicians seem to settle in areas smaller than 1,000 people because of certain circumstances or conditions. In a study done for the AMA on factors that influence people to settle in rural areas it was found that prior exposure, professional relationships, economic factors, and demand for services were important.

In the remainder of my testimony submitted for the record I deal with some of the alternatives developed to deal with the problem of geographic maldistribution: area health centers, loan forgiveness, and the National Health Service Corp. Loan forgiveness programs have been quite unsuccessful to date. The major reason is that students were not informed about the provisions permitting loan forgiveness. This morning Secretary Weinberger indicated that with a change in that policy there is a significant improvement of physician participation in the loan forgiveness program.

The best program that has been developed to deal with this problem is the National Health Service Corps. I give some facts and figures in the testimony and you have had more available.

The decentralization of medical education has been developed in such States as Wisconsin and Indiana and last year in your hearings on health planning, the dean of the Indiana University Medical School detailed the results of that program. What they have achieved there is impressive. They have 56 community hospitals and 140 private physicians who are involved as preceptors in their program. Virtually all of their senior medical students, in recent years, over 90 percent, spent

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at least 2 months in these decentralized programs. They have almost doubled the number of internships in the State. They have 90 percent of those positions filled by the graduates of U.S. medical schools and the State is retaining an increasing percentage of its medical school graduates.

Last year 60 percent of their own graduates, the graduates of the University of Indiana Medical School, were staying in Indiana. That is a State that was supplying California, Florida, and Arizona with physicians at very low cost to California, Florida, and Arizona.

Illinois has taken a different approach to the decentralization of medical education. There are many States that are now looking at the Indiana program as a possible alternative for meeting their needs.

In the statement submitted for the record I also discuss some of the issues related to nurse training. I just want to make one point there which is that we need to look at the relationship of the nurse practitioner programs and the primary care physician training programs as cooperative ventures. You know that with separate legislative authority, those tend to be separate. In practice they need to be together in area health education centers, in community hospitals, and university medical centers. There should be programs for physician extenders, physician assistants and/or nurse practitioners in training with physicians.

The country has a large pool of nurses. Many nurses, including graduate nurses, are not in nursing practice, providing a talent potential there for dealing more effectively with the problems.

Many of the geographic maldistribution problems are the same in nursing as they are in the other health professions. Most of the States oversupplied with physicians have a better supply of nurses, those that are undersupplied with physicians have a relatively small supply of nurses.

My summary and recommendations are in the statement submitted for the record [see p. 426]. I would like to stress several recommendations.

The Congress must set a limit on the number of residencies and create a mechanism so that if the existing Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education do not prove to be effective for controlling residencies, there will be an alternative mechanism which comes into play. I do not believe it will be done on a voluntary basis.

There are multiple specific actions that should be taken to deal with the problems posed by the increasing number of foreign medical graduates. The immigration laws need to be changed and made more restrictive. Every physician that goes into residency training should meet the same requirements; the Department of Labor should indicate that there is no longer an aggregate shortage of physicians so that the movement will not be as accelerated as it currently is, and finally the reimbursements under medicare and medicaid should limit reimbursement for approved residency positions and fund only those positions. Now the Federal Government is underwriting close to 50 percent of the costs of residency training through these mechanisms—through Medicare and Medicaid principally.

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There are a number of other recommendations that I am submitting with my statement, but I did want to stress the recommendation related to residency training and foreign medical graduates.

[Testimony resumes on p. 430.]

[Dr. Lee's prepared statement, appendixes, and summary and recommendations, referred to, follow:]

STATEMENT BY PHILIP R. LEE, M.D.[1]

Mr. Chairman and members of the Subcommittee on Health and the Environment:

It is a pleasure to respond to your request to discuss the major health manpower problems facing the country. These problems translate into health manpower policy issues facing this Subcommittee and the Congress as you consider extension and revision of the Health Manpower Training Act of 1971 and the Nurse Training Act of 1971.

Last year the Committee identified nine issues affecting the quality, quantity and distribution of health manpower and health services it considered to be of major importance. The issues were:

1. The need to insure financial stability of health professions schools and increase manpower supply.
2. The need to correct geographic maldistribution.
3. The need to correct specialty distribution.
4. Foreign medical graduates.
5. The need for Physician Assistants and Expanded Function Dental Auxiliaries.
6. The need for students from disadvantaged backgrounds in health professional schools.
7. The need for Public Health and Health Administration personnel.
8. The need for Allied Health Personnel.
9. The need for proper implementation of health manpower legislation by the Department of Health, Education and Welfare.

This Committee and the Health Subcommittee in the U.S. Senate spent many hours during the second session of the 93rd Congress grappling with these issues. The reports of these committees are the two most valuable sources of information currently available on the subject. I want to take the opportunity to commend the Committee and particularly Committee staff who drafted the report. I consider it essential reading for anyone seriously concerned with the issues.

THE NEED TO PROVIDE PRIMARY MEDICAL CARE

I will discuss the problems of physician manpower, particularly aggregate numbers, geographic maldistribution, specialty maldistribution, and foreign medical graduates from the perspective of one who believes that the need to provide good primary care for everyone is the major health care problem facing the nation.

Recognition of the problem in the United States has been slow for a number of reasons, including: (1) the lack of a clear and widely accepted definition of primary health care (2) the lack of adequate data on health manpower, particularly data related to the actual activities of physicians in patient care; (3) the growing emphasis on scientific achievement, technical skill and specilization in medicine; (4) the growing dependence of physicians on institutonally based technologies, such as radiological and laboratory services; and (5) the long separation of curative medicine from public health and preventive medicine.

In addition to discussing the problems related to physician manpower I will briefly discuss some of the problems related to nursing services and nurse training.

It is necessary to discuss each issue separately, but we must recognize their interrelationship. Health manpower policies cannot be separated from policies related to the organization, delivery, and financing of health care. In examining the questions of supply and distribution it is essential to keep the demand side of the equation in mind.

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[1] Professor of Social Medicine; Director, Health Policy Program, School of Medicine, University of California, San Francisco.

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Before turning to a discussion of the health manpower issues, I want to say a few words about primary care. Doctor Alberta Parker has contributed very significantly to our understanding of primary care. She has stated:

Primary health care serves as the entry point to the personal health care system; provides the full range of health services adequate to meeting the majority of daily personal health needs, including preventive health maintenance, dentistry, podiatry, and social work; and assures continuity and coordination of all the personal health care needed.

Primary medical care is identical except it does not provide the full range of services; it provides only physician, paramedical and auxillary services.

Primary care physicians include general and family practitioners, pediatricians, internists, and obstetrician-gynecologists. Although they may, on occasion, provide consultant or specialized services, the bulk of their practice is general medical care.

Secondary medical care is medical care that does not care for common everyday conditions, but focuses on the less common problems that require a combination of specialized skills, knowledge and complex equipment. It can be provided in hospitals or ambulatory settings, such as group practice clinics, hospital outpatient departments or specialists' offices.

Tertiary medical care is medical care largely limited to uncommon conditions that require highly specialized personnel and equipment, such as those found in university medical centers and large teaching hospitals. (23)

THE DEMAND FOR MEDICAL CARE

Turning from definitions to issues, I want to begin with a brief discussion of the demand for medical care and impact of Medicare, Medicaid and national health insurance on that demand.

Medicare and Medicaid were enacted in 1965 as amendments to the Social Security Act. They were designed to increase the access of the aged and the poor to medical care. With a reduction in the financial barriers there was an increased demand for physician's services and for hospital care. Because of the rapid increase in the number of public assistance recipients since 1967, the total number of Medicaid recipients rose from 9.5 million in 1967 to 23.5 million in 1973. Financial barriers to access had been eliminated for millions of poor people. The demand for care rose rapidly, but cost increases were more rapid.

Medicare presented a different picture. Financial barriers to access were always part of the program in terms of the supplementary medical insurance premium, the deductibles on both physician's and hospital's charges, the limited payment for physician's services and the hospital coinsurance. Despite these financial barriers and the fact that the number of aged Medicare beneficiaries has been about 20 million, costs have risen rapidly. The increased costs are related to more services, improved quality and increased prices. Last year Medicare benefits were extended to individuals with end-stage renal disease and to those covered under Social Security who are under age 65 and permanently disabled.

Because of the increased demand generated by Medicare and Medicaid and the fact that both programs reimbursed hospitals for the services provided by interns and residents in training, these programs expanded rapidly. Residency programs, particularly, grew rapidly. In 1965–66, the year before Medicare and most Medicaid programs began, the total number of residencies offered was 38,750 with 31,095 positions filled. By 1972–73, the positions available had risen to 51,658 with 45,081 filled. The increase of 14,000 physicians in residency training in this seven year period exceeded the increase in the twelve years before Medicare and Medicaid.

Maternal and Child Health Programs, Crippled Children's Services, Maternal and Infant Care, Children and Youth, Family Planning, Community Mental Health Center and Neighborhood Health Center projects have all had an impact on access to care. Expenditures for these programs are dwarfed by Medicare and Medicaid, but we have learned a great deal from these efforts. One lesson has been the value of the team approach to medical care. In addition to physician services, the neighborhood health center utilizes the team approach with nurse practitioners, community health aids and nurse midwives. In expanded facilities clinical laboratory and radiologic services are available. Since the definition of health care is not limited to provision of medical services, nutrition and social

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services are also important elements in a neighborhood health center program. For many patients with complex social problems, these services can become as important as medical services.

We have learned from the Neighborhood Health Center Program that nurse practitioners and community health aids can render invaluable assistance to physicians. Their availability can extend the geographic reach of services and provides access to care for individuals who would otherwise be without services or could obtain them only with the greatest difficulty and at a cost to their health.

Medicare, Medicaid, Community Mental Health Centers, and neighborhood health centers are fairly new programs, created in the 1960's. The Maternal and Child Health program was authorized under Title V of the original 1935 Social Security Act forty years ago. The programs under this title accounted for expenditures of $440 million in 1973—twice that of the Neighborhood Health Center Program, but only about two percent of the Medicare and Medicaid expenditures.

Although these programs do not appear to be directly related to health manpower, they can play a significant role in addressing health manpower issues. They can be used to improve the distribution of services to areas currently underserved. Through reimbursement to hospitals for intern and resident salaries, they can also be used to improve the current geographic distribution of physicians in training and they can also be one means to help correct the current shortage of training positions for physicians in family practice and other primary care specialties.

This Committee, in its examination of the key issues as they relate to national health insurance in December 1973, made it clear that it understands the relation between health manpower policy and policies affecting the organization and delivery of health care services and appreciates the complexity of these problems. There are a number of questions related to national health insurance, the answers to which will influence health manpower requirements and policies:

1. What percentage of the Gross National Product will be put into health services?
2. What services are to be provided?
3. Who will receive these services?
4. How will providers be reimbursed for their services (i.e., fee for service, prepayment, fixed hospital budgets), and will there be a more equal balance in reimbursement for ambulatory care and hospital based services?
5. How will providers be regulated with respect to quality, utilization and cost control?

How we answer these questions will significantly affect the demand for physicians' services and for the services of other health professionals, as well as the demand for hospital and other institutional services.

The legislation you are now considering can have a profound impact on the nation's ability to meet the demands for medical care that will be generated by national health insurance, the improvements in technology and the other forces affecting the quality of medical care.

DATA PROBLEMS

In attempting to discuss the need for physicians and other health professionals, it is necessary to use numbers and ratios that seem to confuse rather than illuminate the issues. In developing policy alternatives, it is necessary to recognize the serious problems that remain because of the limitations of available health manpower data.

A major obstacle facing the Congressional committees and others concerned with health manpower policies is the lack of adequate health manpower and health care data and an agreed upon set of assumptions as to what numbers of health professionals and distribution patterns will provide adequate, accessible care to all individuals. The two-volume record from the hearings held by this Committee last May and June attests to the abundance of information, opinions and statistical studies which are readily available. However, the absence of both a basic data base and defined criteria for determining the adequacy of numbers of health professionals and their distribution requires the development of policy to be derived from educated guesses. This process leaves the issue vulnerable to a broad spectrum of interpretations and recommendations.

Many of the inquiries into questions of numbers of physicians and their distribution, both geographically and by specialty, utilize data collected from the

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American Medical Association (AMA). This data is among the best available in the country. Due to revisions in the AMA's classification of physicians (made in 1968) it is difficult to draw comparisons between data gathered before and after that year. Additionally, survey data collected by the AMA depend on the physician to identify his area of specialization. While a physician may indicate that he provides services in several specialty areas, the published data refers only to the primary specialty of each physician surveyed.

Even if it were possible to determine the percentage of time spent by each physician in the practice of his primary specialty area, provision of primary care and other defined services, one is still left with the even more perplexing problem of determining appropriate physician-population ratios and specialty and geographic distribution patterns. The problem of determining the number of physicians currently providing primary medical care and the number needed to provide such care illustrates the problems. It has been estimated by Dr. Robert Huntley of Georgetown University (13) and Dr. Alberta Parker of the University of California that there are approximately 40 physicians providing primary care for every 100,000 people in the United States. (23)

In attempting to estimate what the ratio should be, the ratios in prepaid group medical practices (PPGP) providing a comprehensive range of health services to a defined patient population have been studied. The distribution of physicians to this patient population cannot be directly applied to the nation's health care system for a variety of reasons. The socioeconomic and demographic characteristics of the PPGP patient population vary from those of the population at large. Patients over the age of 65 are substantially underrepresented. Primary care is most often provided in PPGP's by specialists rather than general practitioners. Depending on the volume of services required by the PPGP patient population, the organization may purchase certain specialty services as needed, rather than maintaining the specialist on the PPGP staff. The distinctive financial, benefit, reimbursement and organizational characteristics of PPGP's must all be recognized when extrapolating their experience nationwide. Additionally, PPGP physician statistics do not include physicians engaged in training, teaching, research or other activities such as public health administration. Data from several group practice plans indicate the ratio of primary care physicians per 100,000 population varies from 33 to 65/100,000, while the total ratio of physicians to membership varies from a low of 69 to a high of 104/100,000 population (Table 7—tables in text all appear in Appendix one except those on foreign medical graduates which are in Appendix two).

A second technique for projecting physician requirements is based on epidemiological studies of illness distribution. This procedure was utilized by Schonfeld, Heston and Falk of Yale University in 1972 to estimate the number of physicians required per 100,000 population for the adequate provision of primary care. The Schonfeld study developed data on the incidence and prevalence of conditions requiring primary care from information provided by the National Center for Health Statistics. This data was then used to survey internists and pediatricians as to the services required for the defined conditions and the amount of time required for each procedure. This method is based on the physician's estimates of needs rather than extensions of existing ratios which primarily reflect demand. At the same time, however, the technique is limited by the use of physician survey data and does not provide an accurate reflection of actual physician and consumer behavior patterns in the seeking of medical care. (26)

As with the procedures of extrapolating from prepaid group practice data or utilizing the epidemiological approach, a model approach for all states or localities is subject to similar pitfalls. One finds considerable variance among geographic areas in demographic characteristics, income levels, numbers and types of physicians, and behavior patterns of both physicians and patients. Each of these factors must be accounted for in determining the area's health manpower requirements. Physician productivity must also be considered. Available statistics indicate that physician-population ratios in doctor-rich areas are growing at a faster rate than those of doctor-poor areas. At the same time, it has been estimated by Professor Reinhardt that the average physician in a doctor-rich area sees 4,808 patients annually, while the physician in the doctor-poor area will have as many as 8,408 visits per year. This substantially larger patient load is in part a result of longer working hours and demand straining supply in underserved areas. However, it does serve to fill the gap between doctor-rich and doctor-poor areas and must be taken into account (24).

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AGGREGATE SUPPLY OF HEALTH PROFESSIONALS

Data on the optimum number of health professionals needed to provide medical care is not available, nor can any absolute answers be obtained. The answers will depend both on the nature of the population served and the system within which the services are provided.

Estimates of need are dependent on several variables: the health status of the population; the ability of people to use the services offered; and the availability of those services to the population. The productivity of physicians is highly variable, dependent on demand for services, the number of other health workers associated with the physicians, the facilities in which the services are provided, the means of remunerating physicians, and the individual style of the physicians.

The Department of Health, Education, and Welfare has estimated that there were 1.3 million health professionals in the United States on December 31, 1970. They project increases to 1.9 million in 1980 and to 2.5 million in 1990. Active physicians were projected to increase from 323,000 in 1970 to 446,800 in 1980 and 593,800 in 1990 (10). These projections were based on the assumption that upon expiration of current legislation, the amount of overall public and private funding provided would be such as to maintain at least the current level of professional school enrollment and the supply of foreign medical graduates. These aggregate figures are of little help in developing a national health manpower policy or deciding how best to meet the nation's need for physicians.

We know the ratios of physicians to population do not reflect available services because they do not reflect the number of physicians available and providing primary care nor do they reflect the number who provide only specialty or consulting services. Even in an area like the District of Columbia which has a physician/population ratio of over 300/100,000 (twice the national average), there are large segments of the population without adequate access to medical care. The same can be said for San Francisco with a ratio of 530 physicians per 100,000 people. These ratios also do not show that doctors in areas with fewer physicians work longer hours, employ more paramedical or auxiliary personnel, see more patients per hour and more patients per year than doctors in areas where the supply of physicians is greater.

Although ratios do not alone provide a reliable measure of medical manpower adequacy, they can be useful for general comparative purposes as long as their limitations are recognized. Significantly large disparities can suggest discrepancies in adequacy of various levels of service. Internationally the United States compares favorably with other countries in terms of physician/population ratios (Table 1). The comparison shows the United States to be relatively well supplied with physicians. Aggregate supply appears to be adequate. The impact of federal aid for health professions education has been an important factor in increasing the numbers of U.S. physicians. According to DHEW statistics, the U.S. physician/population ratios for 1950, 1960, and 1970 were 141/100,000 and 158/100,000 respectively. (Table 2). Throughout the last ten years of federal support for health manpower education, a primary concern has been to increase the overall supply of health profesionals. As recently as 1971, when the current health manpower law was enacted, experts were estimating shortages of 50,000 physicians.

The impact of federal aid for medical education and the stimulus given to increased enrollments is evident on an examination of the data since 1960–1961. In 1960–1961 there were 86 medical schools in the United States graduating 6,994 students. By 1963–1964 when federal aid was first authorized the number of schools had grown to only 87 and the number of graduates to 7,336. The impact of federal assistance has been particularly evident since 1965–1966. By 1971–72 the number of medical schools had increased to 108 and the number of graduates to 9,551 (Table 3). By 1972–1973 four more schools were added and the number of graduates had risen to 10,391. Since 1963, Federal programs have assisted in the building of 21 medical schools.

While it seems clear that national health insurance will result in an increased demand for physicians and other health professionals to provide these services, there are no definitive answers to the questions of how many, what types, and where to locate them.

It is surprising that very few studies have been done on the anticipated increase in demand for physician services as a result of national health insurance. Depending on the type of program enacted, physician requirements may range from as few as 400,000 (an increase of approximately 50,000) to as many as

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400,000 (an increase of approximately 150,000) physicians by 1980. The Department of Health, Education, and Welfare anticipates the physician supply by 1980 will be between 433,600 and 459,900. The ratio of physicians to population would rise from the 1970 level of 158.6 physicians/100,000 population to 191–202 physicians/100,000 population by 1980 (10).

Earlier projections by Dr. Mark Blumberg for the Carnegie Commission on Higher Education, based on assumptions that are different from those of the Department of Health, Education and Welfare, indicate significantly lower physician to population ratios than those projected by DHEW. Doctor Blumberg projected ratios of 169.5 to 190.4 physicians per 100,000 population by 1987. Dr. Blumberg based his projections on the assumption that immigration of foreign medical graduates would decline to 0 by 1978 and DHEW projections continued immigration at high levels (4).

The question of how many foreign medical graduates will enter the United States is a key one, and one that must be resolved by policy makers at the national level. It is federal policy that permits the large influx of foreign medical graduates and federal payments to hospitals for patient care that pay the salaries for many of these hospital-based physicians.

FOREIGN MEDICAL GRADUATES

In addition to the rapid increase in the graduates of United States medical schools during the past decade, there has also been a great increase in the number of graduates of foreign medical schools in training and practice in the United States. (Appendix two provides a statistical summary of the FMG situation in the U.S., including Table 6 which shows this increasing number of FMG's). Some have looked upon immigration of foreign medical graduates as an important source to meet health care needs in the United States. It has been shown that most of the increase in the ratio of physicians to population is due to the influx of foreign medical graduates. Increases in production of United States medical graduates alone would have only kept pace with population growth, not raised the ratios. I would encourage the committee to look at the data on foreign medical graduates and then decide on a course of action which is more appropriate than developing projections which heavily rely on the continued flow of foreign medical graduates into the United States.

In discussing the issue of foreign medical graduates, it is first necessary to place the issue in a historical context. The history is important because it indicates, to some extent at least, why we are where we are, and it suggests what can be done.

Prior to the Second World War there were few graduates of foreign medical schools taking advanced training in the United States. In 1946 Senator Fulbright introduced amendments to the Surplus Property Act of 1944 that provided for an international educational exchange, including support for foreign students to come to the United States to study. In 1948 the United States Information and Education Exchange Act (Smith-Mundt Act) was enacted authorizing a fuller exchange program and creating the Exchange Visitor (J Visa) immigration category. This did not have much impact on medical school admissions, but it did bring an increasing number of foreign medical graduates into internship and residency programs which began to expand rapidly.

It was originally assumed that the students or trainees who came into the United States under exchange visitor programs would all be part of government-sponsored programs. Gradually the boundaries of eligible programs expanded until any sponsor could apply to the Secretary of State to obtain exchange visitor program status. The program was based on the premise that persons would come to the United States for training and then return to their homelands. They would not be brought in to meet U.S. health care needs.

House staff foreign medical graduates fell under the exchange visitor program because:

They were not considered to be coming to an established institution of learning—even if their program was affiliated—and therefore were not eligible for a student visa.

They did not fall under the H visa category which applied to persons with ability to perform a needed service in the United States.

The sponsoring institutions made the selection of exchange visitors in their programs. This became a popular vehicle for hospitals to bring in foreign medical

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graduates. By 1961 there were 2,735 exchange visitor programs and 1,300 of them were sponsored by hospitals. Many hospitals had previously expanded their capacity to provide training for physicians who were returning from World War II. When the veteran population declined, the hospitals needed a new source of trainees—and this was to be the foreign medical graduate. The number of foreign medical graduates doubled between 1950 and 1952. It doubled again by 1958 and again by 1967 to fill the expanding number of approved internships and residencies.

The Educational Council for Foreign Medical Graduates was established in 1957 to certify the basic qualifications of foreign medical graduates to enter training. The ECFMG was not officially recognized by the Immigration and Naturalization Service and physicians could still enter the country without holding the minimal criteria of adequacy as defined by the American medical profession.

By 1960 the concerns of the Nation regarding exchange visitor programs turned from national security to U.S. manpower shortages and the "Brain Drain" from foreign countries.

The guidelines for admitting foreign medical graduates were often changing and were very flexible so that waivers to the law were considered more the rule than the exception.

Before 1965, immigrating physicians were included in the U.S. quota for total immigration from their home country. The exchange visitor program was not subject to national quotas and was thus used as a vehicle for many foreign medical graduates to come into the United States. The 1965 act abolished the system of quotas based upon national origin—in a transitional process which would last two and one half years. By 1968, the quotas were distributed on a first-come, first-served basis with special preference and nonpreference categories.

Foreign physicians fell under two of the preference categories: Members of professions or persons with exceptional abilities in science and art; and persons with skills which are in short supply in the United States (Table 2, Appendix two).

With the new quota system, the allocation of immigrants from Asian countries was enlarged from what it had been under national quotas. The mix of immigrants changed both nationally and for foreign medical graduates. Before WWII the flow of physician migrants was small and primarily from advanced to developing countries. Since 1946, the flow has reversed with developing countries now losing health manpower to developed countries.

Prior to the 1965 immigration amendments, almost 50 percent of FMG's entering the United States came from countries in the Western Hemisphere (28 percent from Europe) and only 10 percent from Asia. In 1972, 70 percent of the FMG immigrants came from Asian countries (Tables 3 and 4, Appendix two). The major countries of origin for these foreign medical graduates are India (representing 18% of all FMG's), the Philippines (14%), and Korea (7%). While the United States enjoys a physician-population ratio of 158 physicians per 100,000 population, India has 20 physicians, the Philippines has 75 and Korea estimates 37 physicians for every 100,000 individuals. Despite the limitations of international comparisons and the need to address questions of distribution, these figures indicate a significant disparity between the professional resources of the United States and the countries from which it receives its FMG's.

In 1965, the Labor Department determined that there was a physician shortage in the United States, thus easing entry of foreign medical graduates into this country. This determination allowed physicians to apply to the Immigration and Naturalization Service for a visa without first applying for Labor Department clearance. The change in the Immigration Law in 1965 had allowed those foreign medical graduates entering the United States for training to obtain an immigrant visa rather than an exchange visitor visa, thus leaving them a broader spectrum of options when their training is completed.

For foreign medical graduates the distinction between immigrant status and exchange visitor status has been so blurred by waivers and exceptions that it is very easy for the foreign medical graduate to switch from one category to the other if forced to enter the United States as an exchange visitor.

The programs to recruit graduates of foreign medical schools for internship and residency positions began after the Smith-Mundt Act in 1948 and the creation of the exchange visitor (J visa) immigration category. By 1950, 722 graduates of foreign medical schools filled 10 percent of the available internships and 1,350 filled 9 percent of the available residencies. By 1952, the number of both interns

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and residents who were graduates of foreign medical schools doubled; and, as a percentage of the available positions, their numbers rose to about 20–25 percent of the total, where it was to remain until 1965 (Table 5, Appendix two).

While the percentage of internship and residency positions filled by foreign medical graduates remained relatively stable, the numbers increased steadily, rising from 1,116 interns and 1,350 residents in 1950–51 to 2,361 interns and 9,133 residents in 1965–66 (Table 5, Appendix two). The great majority of these residents entered as exchange visitors (J visas) rather as immigrants. Between 1962 and 1965, 17,285 foreign medical graduates entered as visitors and 8,151 entered as immigrants.

The same year that the Department of Labor determined that there was a physician shortage and eased the entry of foreign medical graduates into the United States, Medicare and Medicaid were enacted. Medicare and Medicaid increased the demand for services and also guaranteed hospitals reimbursement for the costs of interns' and residents' services provided to Medicare and Medicaid beneficiaries.

Following these events, the number of residency positions offered rose from 38,750 in 1964–65 to 51,658 in 1972–73. Of the 51,658 positions available now, only 45,081 are filled. The number filled in that period by foreign medical graduates rose from 8,153 to 14,471 (Table 5, Appendix two). The increase of 6,300 in 8 years was more than double the increase in the preceding 8 years. Foreign medical graduates represented 32 percent of all residents in 1972–73. In 1967, for the first time, the number of foreign medical graduates entering the United States exceeded the number of graduates of U.S. medical schools. It was not until 1971, however, that the number entering as immigrants exceeded the number entering as exchange visitors.

Several forces were at work: hospitals increasing the number of residency positions because payment for their services was assured; the Department of Labor declaring a shortage because of the unfilled positions; and increasing numbers of foreign medical graduates coming into those positions because the positions were available and they were permitted to come either as immigrants or under special J visas. Over the past 22 years, internships and residencies combined have increased 127 percent. During this same period, the number of medical school graduates has increased by 70 percent. In 1950–51 there were 28,734 approved training programs in United States hospitals. Sixty-eight percent were filled by U.S. and Canadian graduates, 7 percent by FMG's and 25 percent were vacant. In 1972–73 there were 65,308 positions, 58 percent of which were filled by U.S. and Canadian graduates. Twenty-eight percent were filled by FMG's and 14 percent were vacant. If only U.S. and Canadian graduates were available to fill these positions, 42 percent would have remained vacant.

Many hospitals have developed exchange visitor programs which entitle them to sponsor FMG's who wish to train in the United States. Unfortunately, the intention of the hospital is often more one of meeting staffing requirements to maintain the daily operation of the facility than one of providing a well planned and staffed education program. Sixty-seven percent of the positions filled by FMG's in 1972 were in programs not affiliated with a medical school. As long as the number of intern and resident positions far exceeds the number of American medical graduates, the incentive for bringing in large numbers of foreign medical graduates to fill vacant slots will remain.

No matter what the immigration status of a foreign medical graduate when (s)he enters the United States, many remain well beyond their anticipated stay. In 1971, J. S. Millis indicated that forty-three percent of FMG's entering the United States intended to remain here. (21). Data from the AMA registry shows that 84 percent of the FMG's identified in the registry as residing in the United States in 1963 were still residing in the U.S. in 1971. For those FMG's who were in training status in the United States in 1963, 74 percent were residing in this country eight years later.

The issue of foreign medical graduates does not simply arise because of the numbers entering the United States or their countries of origin. The fact is, however, that this great influx of foreign medical graduates has contributed very little to solving the critical problems of geographic maldistribution of physicians and the relative shortage of physicians in primary medical specialties.

There are important differences in the role of FMG's and the graduates of U.S. and Canadian medical schools that diminishes their potential impact in meeting the health care needs in the United States, particularly the need for

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primary medical care. According to the Department of Health, Education, and Welfare, only about one-third of all FMG's were in office based practice in 1970 as compared with about two-thirds of the active physician graduates of U.S. and Canadian medical schools. Almost one-third of all FMG's were interns or residents, about 2½ times the proportion of Canadian and U.S. graduates. Adding to the interns and residents the FMG's who were full time physicians on hospital staffs, 50 percent of all FMG's were hospital based as contrasted to 23 percent of U.S. graduates and 21.8 percent of Canadian graduates (Table 8, Appendix two).

Within the aggregate supply there were substantial differences in the activities of physicians from European and Asian countries. The FMG's from Europe and other developed countries had an activity distribution similar to U.S. and Canadian graduates while two-thirds of FMG's from Asian and other developing countries were hospital based. Increasing numbers of FMG's are coming to the U.S. from Asian countries.

Most of the foreign medical graduates in residency training seem to be distributed much as the American medical school graduates' residencies are distributed. More important, when it comes to practice, where do they go? Well, they largely practice where the graduates of American medical schools practice. They largely practice in the States with the highest physician-to-population ratio. FMG's are disproportionately located in the New England, Middle Atlantic and East Central regions of the United States. Well over one third of all FMG's are located in New York, New Jersey and Pennsylvania. Although FMG's represent only 17 percent of all physicians in the United States, they represent over 25 percent of physicians in New York, Rhode Island, New Jersey, Illinois and Delaware (Table 10, Appendix two).

For instance, the 10 states with the largest number of foreign medical graduates in practice have 137.5 physicians per 100,000 population in office-based practice while the 10 states with the lowest number of foreign medical graduates have only 86.1 per 100,000 population in the national average was 122 in 1970, the year this data was gathered.

For the United States as a whole, 14.9 percent of practicing physicians were foreign medical graduates in 1962. In nonmetropolitan areas the percentage was 8.6 and in metropolitan areas it was 16.1 percent. A similar pattern was still evident in 1970 (Table 11, Appendix two). In other words, the foreign medical graduates don't contribute to a solution to the maldistribution problem.

An examination of specialty choices by foreign medical graduates is also of interest. In some specialties, such as physical medicine, anesthesiology, and pathology, the percentage of foreign medical graduates exceeds the average for U.S. graduates. The primary care specialties have about one-third of the residency positions filled by foreign medical graduates. This percentage is similar to the number occupied by U.S. graduates (Table 9, Appendix two).

The issue most often advanced in the debate regarding FMG's is the difference in training and background between American and foreign medical graduates and the influence of this difference on quality of care. The United States medical graduate (USMG) brings to a graduate program basic medical knowledge and a substantial amount of clinical experience. (S)he is capable of reaching diagnostic conclusions from the time (s)he enters the program. Since the USMG was educated in an American institution (s)he understands the ethics and the cultural and social patterns within the American hospital setting. (S)he is able to learn quickly from his/her peers because (s)he already feels comfortable in the clinical surroundings and, besides speaking English, understands nonverbal communication among the hospital personnel. The problem for the FMG is further aggravated by the fact that many either speak English poorly or not at all when they enter residency programs.

In contrast, the ability of the foreign medical graduate to become an integrated member of a graduate program is inhibited by a combination of performance characteristics and external forces. The majority of FMG's who enter the United States residency programs have had minimal clinical experience. The FMG's often have acquired less medical knowledge than their American counterparts, as well. The disparity in medical knowledge between the USMG and the FMG can be illustrated by FMG performance on the Educational Council for Foreign Medical Graduates (ECFMG) medical knowledge examination and on state licensing examinations. It is projected that the questions included in the ECFMG exam could be answered correctly by ninety-eight percent of the United

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States 4th year medical students. Roughly forty percent of the FMG's taking the exam pass the first time. Ultimately sixty-six percent pass the test; however, the majority of those who pass score only slightly above the minimum passing grade.

Current procedures for certifying FMG's have created a system of dual standards for admission to graduate medical education in the United States. The quality of the American medical school graduates' education and performance is based on a series of indicators including accreditation of educational programs, national medical college admissions tests and other standards for entrance, faculty evaluation, and Parts I and II of the National Board Examination. In contrast, the Educational Council for Foreign Medical Graduates bases its certification on only two criteria:

—fulfillment of all requirements of a medical school listed in the *World Dictionary of Medical Schools* published by the World Health Organization;

—an examination constructed by the National Board of Medical Examiners.

This dual standard of admissions criteria supports a dual standard of quality as well. The ECFMG examination does not provide an adequate measure of professional competence. The performance of FMG's on the examination compares poorly with USMG performance on the same questions. The Task Force of Foreign Medical Graduates of the Association of American Medical Colleges has reiterated the recommendation that all applicants for admission to U.S. graduate medical programs be required to pass the same qualifying examinations. Such a requirement would have the effect of reducing the number of FMG's to those whose performance was at a level equivalent to USMG's. The results of the Federation Licensure Examination (FLEX) of the Federation of State Medical Boards, which is now utilized as the state licensure examination by nearly all of the states, show a similar disparity. For the FLEX examinations given between June 1968 and December 1972, eighty-five percent of USMG's passed, while only fifty percent of the FMG's attained a passing score.

An increasing number of FMG's are taking the ECFMG examination in the United States and are therefore not certified before entering the U.S. They form a medical underground of persons working in the health professions without certification. Many of these persons have direct patient care responsibilities. Recently, Weiss and his associates estimated that, in addition to the approximately 10,000 unlicensed physicians determined by the AMA to be working in the health field, another 9,000 were so occupied. The Weiss study also indicated that many of these individuals have direct patient care responsibilities and, because of their background, often perform medical or surgical procedures for which they have not been licensed (Tables 12 and 13, Appendix two).

Finally, there is the growing number of U.S. citizens who have not gained admission to medical school in the United States, and have entered foreign medical schools. The numbers have increased from 1,730 in 1954–1955 to 3,368 in 1969–70, and I am sure that figure is higher today. Many of the students met the admission requirements for the U.S. medical schools but were not admitted because of insufficient numbers of places. Some of these students receive a medical education which is comparable to that in the United States. However, all too many of the students are receiving a less than adequate education. This problem is clearly illustrated by the fact that United States citizens who graduate from foreign medical schools perform as poorly as FMG's on qualifying examinations for residency training and licensing.

SPECIALTY DISTRIBUTION

It was originally thought that increasing the aggregate supply of physicians would assure an appropriate distribution by specialty to meet the nation's health care needs. A variety of forces have been at work that have produced a very different result: serious shortages of primary care physicians; excess numbers of surgical specialists, such as general surgeons and neurosurgeons; disproportionate reimbursement for surgical services as opposed to primary care and large numbers of physicians performing surgery who have not had adequate surgical training. The fee for service system in the United States, combined with the growth of private health insurance and publicly supported medical care programs, has resulted in more and more emphasis on high cost, inpatient hospital care. During the hearing on the health policy and planning legislation last year, Dr. Paul Elwood of Minneapolis noted that 64 percent of the medical

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care dollar is spent on illnesses costing $1,000 or more. All of this has been a stimulus to specialization.

Because of the steady decline in the number of general practitioners in the past 40 years and the gradual increase in other primary care physicians, the United States has a relatively low ratio of primary care physicians to population. In 1931, there were 90 general practitioners per 100,000 population. Thirty-two years later this ratio had declined to 37/100,000 population. Between 1963 and 1971 the absolute numbers of general practitioners declined by almost 20,000 and the ratio fell to 24 general practitioners per 100,000 population in 1971. In this same period general internists increased from 3,567 in 1931 (a ratio of 3/100,000 population) to 21,144 in 1961 to 23,829 in 1971 (a ratio of 12/100,000 population). General pediatricians increased even more slowly from 1,396 in 1931 to 9,255 in 1963 to 10,742 in 1971 (5/100,000 population). Combining these three provides a ratio of 41 primary care physicians per 100,000. A study by Dr. Robert Huntley of the Georgetown School of Medicine indicated that in 1970 there were 41.2 office-based patient care physicians whose practices were devoted largely to primary care for every 100,000 population (13). Even when we add the 60 percent of the 12,000 osteopathic physicians engaged in primary care, the shortage is evident. In terms of percentages, primary care physicians, including obstetrician-gynecologists constitute 45 percent of all physicians, but only 39 percent of physicians in training (Table 5).

These statistics do not prove a physician shortage, but they are consistent with the view that there is a shortage of primary care physicians.

In addition to the factors already noted, the manner in which medical education, particularly graduate education, is governed is important. Professor Rosemary Stevens of Yale University has described the problem:

"The structure of medical education, training, and development has changed from one based on a geenral undergraduate training and general practice to a complex array of specialists, each with his own training and examination system. Medicine, as no other profession, is now functionally fractional and internally stratified. The change is largely the product of the last 30 years.

"Not only has the march of specialism lengthened the training of the medical student to the present eight or nine years, it also has created an unwieldy superstructure of specialty board examinations, a crisis in graduate medical education, a haphazard assignment of educational and training responsibility, and acute manpower problems." (21)

At the present time, a medical school graduate has almost no restrictions on his specialty selection decision. A number of studies have attempted to sort out why certain specialties are more attractive than others, but the problem is complex and multi-dimensional. One often cited factor is the exclusive availability of the subspecialist role model: that is, the student does not see primary care practitioners, even in pediatrics and medicine, and hence is not aware that primary care practice is an alternative. A related factor is the present system of residency and fellowship training which exposes the physician in training to only specialty or subspecialty care experiences. Even in the subspecialty area he may have very little idea of what his professional practice will encompass.

In any event primary care practice seems to connote several things to the young physician: a lack of intellectual challenge equal to that of many specialties, longer and more unpredictable working hours, less peer support and the reality of having to deal with a number of patients who are not "really sick" and have a poor response to the usual curative therapies.

Another problem which underlies many decisions to seek subspecialty training is influenced by the explosion of new knowledge in medicine. Medical facts learned by the third year student are often out dated by the time residency training is completed. One way to deal with this problem is to pick a circumscribed field and learn "all there is to know" in that area. The primary practitioner on the other hand must know a little about many different fields. The "jack of many trades, but master of none" appears to be applied often to the primary practitioner. Though it is seldom stated and over-simplified here, we believe this is an influential factor in avoiding primary care practice.

Senator Edward Kennedy, in remarks to students and faculty at the Yale University Medical Center, summed up the dilemma:

"Perhaps the nature of medicine has changed so dramatically, and the knowledge explosion has been so staggering, that primary care is simply not a viable alternative to specialization by our young physicians. But the function of the

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primary physician is as important to our people today as it ever was. Perhaps we need to develop new kinds of institutions, training different kinds of professionals to fulfill that function.

"But is it not equally possible that the current structure of our medical center predetermines the specialization of its students? Is it not possible that modification of that orientation could alter the values and goals of medical graduates?" (16).

The adequacy of the present supply of primary care physicians has been the subject of dispute. The problem is compounded by the geographic maldistribution of physicians and physician directed services, the influx of foreign medical graduates who have helped meet some of the needs for primary care physicians, and the fact that most physicians, including surgeons and a variety of surgical and medical subspecialists provide some primary care.

Estimates of the number of physicians needed to provide primary care vary widely. In a widely cited study, Schonfeld, Heston and Falk estimated that the optimal number of physicians needed to provide primary care was 133 per 100,000 population. (26). This is almost three times estimates of the current national average. In contrast to the optimal number of primary care physicians estimated by Schonfeld the average primary physician/population ratio for the United States and general practitioners in England was estimated to be 40 per 100,000 population in 1971. In contrast to the primary care physician in the United States, the England general practitioner usually limits himself to home and office based care, referring all patients requiring specialty consultation or inpatient care to hospital based specialists. In addition the British general practitioner has better organized home nursing and other social services to meet the needs of his patients. One can only speculate on how different systems of care and means of remunerating physicians affect the general practitioners ability to meet the needs of the population for primary medical care.

Even with prepaid group practices the ratio of primary physicians to population varies widely. The range extends from Group Health in Washington, D.C. with a ratio of one primary care physician per 1540 persons enrolled (or approximately 65 physicians per 100,000 people) in the plan, to the Permanente Medical Group in Portland with a ratio of 1:3020 or 33 primary care physicians per 100,000 people. (Table 7).

The question of how many primary care providers are needed cannot be answered exclusively by statistics on physicians because of the important role that can be played by nurse practitioners and physicians' assistants. In the 1960s a number of programs were initiated to train nurse practitioners and physicians' assistants. Their purpose was to serve as physician extenders by assuming responsibility for routine health maintenance, preventive medicine, well baby and child care, diagnosis and treatment of common minor illnesses and the long term care of patients with chronic disease.

The response of patients, parents and consumer groups to both physicians' assistants and nurse practitioners has been excellent, but the response of many physicians still are less than enthusiastic. Although the response of patients demonstrates an interesting aspect of the consumer provider interaction, and that is, solving the problem or dealing with it in a compassionate and competent manner is more important than the credentials of the person providing the service, it does not assure a place for these practitioners. Economic barriers, legal restrictions in many states and jurisdictional disputes add to the conservative attitudes of physicians to limit the future value of nurse practitioners and physicians' assistants in meeting primary medical care needs.

Because post graduate medical education now emphasizes specialty and subspecialty training, the development of an adequate corps of primary care physicians requires a major shift in medical education, including both medical schools and residency programs. Until this occurs, and students are presented with different ideas about primary care practice, the actual rate of change will be limited and slow.

Projecting current trends in residency training programs results in a continuing relative shortage of active primary care physicians and a relative excess in a number of specialties.

Dr. Gerald Weber of the University of California, San Francisco, has done an excellent review of the distribution among specialists. He used only general practitioners, internists, and pediatricians in his estimates of primary care providers and he noted that these providers increased from 103,000 to 104,000 in the two

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decades between 1950 and 1970. There was an increase of only 12,000 in other medical specialists as compared to increases of 56,000 in other specialties such as laboratory medicine, pathology, and radiology. He also found that there had been an increase of 41,000 on the various surgical specialties during the same period. (31)

The trend of the 1950's to 1970's in terms of excess production of specialists, particularly surgeons, and an inadequate output of primary care physicians is evident in future projections based on residency training. Professor Weber observed that if the average physician practices 30 years, it will require 3.5 residents in training to eventually replace every 100 physicians in a particular specialty. In 1970, general surgery had 12.2 new trainees for each 100 physicians, while the combined primary care specialties of general practice, internal medicine, and pediatrics had only 4.5 physicians in training for every 100 in practice. The recent projections by DHEW indicate a decline in the percent of physicians in primary care sepcialties from 44.2 percent in 1970 to 41.2 percent in 1980 and 39.3 percent in 1990. Even with revised supply projections, with a large increase in the number of future family physicians, DHEW projects a decline in the percentage of primary care physicians from 44 percent in 1970 to 42 percent in 1990. (10)

At the present time, approximately 35 percent of all residencies that are filled are in the primary care specialties, including general practice, pediatrics, internal medicine, and obstetrics and gynecology. These residences currently number about 16,000. The American Medical Association has recommended an increase to 50 percent of all residencies in these fields. I full support the recommendation. This shift cannot occur overnight, but in view of the fact that there has been an increase of 10,000 in the total number of residencies available in the past 5 years, it should be possible to increase primary care residencies by at least 5,000 in the next 5 years while reducing surgical residencies by an equal amount or more.

The failure of existing medical specialties, particularly pediatrics and internal medicine, to deal effectively with the problems of primary care and the decline of general practice in the United States during the past 30 years has resulted in the emergence of family practice as a rapidly growing primary care specialty.

To date, more than half of the 108 medical schools in the United States have departments or other academic units teaching family medicine and/or family practice. Many of the residency programs are in university affiliated hospitals, but few have developed in university medical centers. Although the number of family practice residency programs has grown rapidly in recent years it still represents less than two percent of the 50,000 residency positions available.

Internists and pediatricians in the United States both consider primary care to be one of their principal responsibilities. Training programs do not, however, reflect the realities of practice. Several years ago the American Board of Internal Medicine initiated a new evaluation procedure that reflected the pressure toward subspecialization and the decreased stature of a career in general internal medicine. It is estimated that 70 percent of the present internal medicine trainees plan to qualify in a subspecialty. This will aggravate the present overemphasis on subspecialty training as opposed to general internal medicine and may result in more physicians moving toward family practice or a shift of primary care responsibilities to nurse practitioners and physicians' assistants. In pediatrics the present situation is somewhat different, but pediatrics appears to be following the pattern of internal medicine with the training of more and more subspecialists.

The university medical center as it is presently structured does not provide a suitable setting for delivery of primary medical care. It is argued pursuasively by Alpert and Charney that the setting of the primary care program, the care facilities, the organization of the staff and its relationship to the secondary and tertiary care system and to its patient population are crucial to its success. Without the basic structure which is representative of modern medical practice, the content of primary care is not easily learned. (3)

The major content areas of primary care education have been identified by Alpert and Charney and divided into three broad chronological categories:

—Short term (one day to one month)—emergencies, common infections, acute hospitalization and minor surgery;

—Intermediate (two weeks to three months)—initial phases of chronic illness, behavorial problems, observation of practice, health education and peer review;

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—Long term (two months to years)—the family management of chronic illness, growth and development, team work, work with consumers and patient care research.

It is clear from the Alpert-Charney analysis that the present short term rotations for medical students in clinical clerkships are suitable for only some of the problems in primary care. The same is true of residency rotations, particularly the low priority accorded ambulatory care experiences and the opportunity to follow patients longitudinally. Model practice settings provide additional opportunities to improve the medical students' and residents' experience. Better organization of existing programs, even in traditional hospital settings can, however, significantly enhance the opportunity for improved training in primary care.

GEOGRAPHIC MALDISTRIBUTION

Although the development of policies to improve the distribution of physicians among specialties seems achievable, locating health professionals where they are needed geographically has been a problem without a solution. Geographic maldistribution is a long standing problem. As time passes, differentials between urban and rural areas and between areas of physician scarcity and surplus are increasing.

The ratios of physicians with patient care as their primary activity per 100,000 population illustrate the geographic maldistribution problem only in very gross terms. The recently published DHEW figures reveal a national average of 156 physicians per 100,000, with regional variations from 133 in the South to 195 in the Northeast.

Variations in physician to population ratios are also seen in the ratios of dentists and nurses to the population. The East-South Central states region has only about half as many physicians, dentists and nurses relative to its population as the Middle Atlantic states or the New England states (Table 4).

The variation between states is even greater than the regional variations, with the high of 236 physicians per 100,000 population in New York and the low of 89 physicians per 100,000 population in Mississippi. The District of Columbia has a ratio of physicians to population even higher than New York State. The states with the highest ratios of all active physicians to population also tend to have the highest ratios of primary care physicians to population.

It was originally thought by many that merely increasing the supply of health professionals would create, through competition, an appropriate distribution of health professionals both geographically and by specialty. Since the traditional laws of supply and demand do not operate efficiently in the health care system, the maldistribution problem has become magnified by the increases in numbers of providers encouraged by federal support.

The problems of specialty maldistribution and geographic distribution are linked, but the solution of one problem will not necessarily solve the other. Although no agreement has been reached on the causality of the linkages between location decisions and specialty choice, the existence of an interrelationship between them is obvious. The linkage is further expanded by the fact that the problem of specialty maldistribution basically relates to a lack of primary medical care.

Neither regional nor state figures reveal the maldistribution between urban and rural areas in almost every state. California is a good example. As of December 31, 1973, there were 38,749 active non-federal physicians in California or a ratio of 185.9 physicians/100,000 population. The ratios ranged from 203.8/100,000 in the major metropolitan areas to 82.8/100,000 in the isolated rural areas. The variation between counties is even more extreme, from a high of 530.9 physicians/100,000 population in San Francisco to zero/100,000 in rural Alpine County with no physicians serving a population of 650 people. The lowest physician/population ratio, aside from Alpine, was in Modoc County, where two physicians serving 8,475 persons represented a ratio of 23.6/100,000 (18). In general, the counties with the poorest ratios of physicians to population are those with the poorest ratios of primary care physicians to population. There are some exceptions. For example, in some states, such as Idaho and Wyoming, with very low total physician to population ratios we find that they rank 14th or 15th nationally in their ratios of primary care physicians to population (Table 6).

The ratios illustrate rather extreme differences between geographic areas, but it must be remembered that in some urban areas there is a high percentage of the aged, the chronically ill and the poor who require more medical care.

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San Francisco represents a special case because it is both a regional referral center for most of Northern California for highly specialized services and it is the major center for the training of residents.

The degree of geographic maldistribution between states would be intolerable if it were not for the fact that the variation in the ratios of primary care physicians to population is not nearly as great. The range appears to be from a high 62 primary care physicians/100,000 in the Pacific Region to a low of 40 in the East South Central Region.

It is not enough to look at gross ratios in order to determine the nature or extent of the problems created by specialty and geographic maldistribution. It has been pointed out in a study by the Southern Regional Council that although the South is generally short of physicians, some counties are seriously short of primary care physicians or have no doctors at all. The report pointed out that of 75 Arkansas counties, five have no internist and 62 have no pediatrician and 59 no obstetrician/gynecologist. Of Alabama's 67 counties, 41 are without an internist, 45 without an obstetrician/gynecologist and 44 without a pediatrician.

In cities such as Boston, Detroit, and Chicago physicians have been moving from the inner city to the suburbs and clustering their offices in downtown commercial districts or adjacent to community hospitals, while increased numbers of poor blacks move into the central cities to be served by hospital out-patient clinics and emergency rooms.

The lack of primary care providers is the core of the geographic maldistribution problem. People can often travel for specialty consultations and when required, hospitalization and surgery. These services require a larger population base than many communities offer. At the same time, these communities need direct access to providers who can care for a major proportion of their health problems or properly refer them for specialized care, when necessary. These health professionals are primary care providers whose location in underserved areas could go a long way toward alleviating the maldistribution problem.

Specialization complicates the problem of geographic maldistribution because specialists tend to settle in areas of large population concentrations. The choice of location is apparently related to two forces: the overall tendency of all physicians to locate their practices in medium and large communities and the specialists' need to have access to large numbers of patients who require specialized services. Although general practitioners and family practitioners are attracted to towns of 1,000 to 10,000 population, they are not attracted to rural communities of less than 1,000 people.

The tendency of internists, pediatricians, and obstetricians, all of whom may be providers of primary medical care, to settle in the metropolitan areas is illustrated by the data from California (Table 8). General practitioners, in contrast, are much better distributed in relation to the population in metropolitan, adjacent, isolated semirural and isolated rural areas (Table 8).

A variety of studies have been conducted concerning factors which influence location decisions of health professionals. There appear to be five major factors that influence physician choice:

(1) Environmental factors—quality of life in the community, non-professional attractions;

(2) Prior exposure (medical school, residency, native to area);

(3) Professional relationships—consultants, university affiliation;

(4) Economic factors;

(5) Demand determinants—need for services.

The development of policies to influence location decisions must also consider the problems associated with practice in underserved areas. One cannot assume that the populations of these areas will ever be able to attract or support more than one (or several) family physicians and other health professionals. Under the existing structure of the health care system, the practice of health professionals in underserved areas is dramatically different from the exposure one receives in training. Third party reimbursement is often limited, in many cases, to specialty procedures. The provider is isolated from frequent peer contact and opportunities for continuing education. There is the need to rely on less technical equipment since facilities may be too far away for routine procedures, and available equipment may be less sophisticated. Exacerbating these problems is the fact that, if there is no one to replace him or her, the provider is on call twenty-four hours a day.

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Physicians in underserved areas spend longer hours in practice than their colleagues in well doctored areas; they employ more auxiliary personnel, they see more patients per hour and they see more patients annually. This greater patient load can help to make up for the shortages, but one must wonder about the quality of medical care that can be provided under such circumstances.

Knowledge of these variables has had significant impact on the location decisions of physicians up to the present.

The additional factors concerning lifestyle in underserved areas (especially rural areas) must be considered as well. Individuals have differing levels of needs and preferences regarding the variety of cultural and social activities and amenities offered by a community. Through exposure, some persons develop an appreciation for lifestyles very different from their past experiences. It is questionable, however, how many of those who have remained in underserved areas were predisposed in some way toward the lifestyle and how many were converts.

A variety of projects to encourage location in geographically underserved areas were supported under the Comprehensive Health Manpower Training Act of 1971. These included Area Health Education Centers, projects to improve the geographic distribution of physicians, training programs for physician assistants and projects providing experience in the team approach to medical care. Each activity supported affects primarily health professional students. Part of the basis for these programs is to provide an experience for students which could eventually become a significant factor in location decisions. Such an experience is either one of learning certain skills which are required of health professionals practicing in underserved areas (often in primary care) or being directly exposed to the practice environment in an urban or rural underserved area. It is recognized that the training of health professionals (including interns and residents) to provide care in these areas requires a reorientation away from traditional hospital based experiences.

The current distribution of residents places the majority in larger teaching hospitals which provide secondary and tertiary care in metropolitan areas which are in geographic proximity of a medical school. This is due, in part, to the fact that the minimum population base needed to support a medical school is estimated at 600,000 people.

Area Health Education Centers (AHEC's) have provided the opportunity to take health professions students and interns and residents out of the traditional training environment and into a community program in an underserved area. The AHEC program develops linkages among medical schools and community health care resources (clinical teaching centers, community colleges, public health agencies, individual practitioners). It provides community-based exposure for health professional students. At the same time, it increases peer contact for providers in the area and offers continuing education opportunities. These last two factors can be of major significance in the ability of an underserved area to attract and retain health professionals.

The National Health Service Corps (NHSC) began as a Congressional action and has been modestly supported since it began in 1971. This program is directed toward graduates of health professions schools. It provides scholarships to students who, in turn, agree to provide services in a designated underserved area for a specified period of time after graduation. Since that time the NHSC has approved 397 sites and placed 240 physicians in 183 communities. By the end of 1974 it was expected to have assigned 405 health professionals, including 264 physicians to 275 communities. By 1976, it is projected that the NHSC will have 902 physicians in the field, staffing 452 new sites. The objective is not merely to place a federally employed physician in a community for two years, but to have the community retain the physician and have a self sufficient program within a few years.

In addition to the National Health Service Corps, financial incentives to provide service are also offered under the student financial assistance program. Repayment obligations for student loans can be cancelled through service in underserved areas (one year of service for each year of loans received). The effectiveness of loan forgiveness provisions in placing health professionals in underserved areas has been seriously questioned. This issue was the subject of two evaluation studies which were submitted for the public record of the 1974 health

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manpower training hearings before the Subcommittee on Public Health and Environment:

—General Accounting Office: *Congressional Objectives of Federal Loans and Scholarships to Health Professions Students Not Being Met* (9).

—CONSAD Research Corporation: "An Evaluation of the Effectiveness of Loan Forgiveness as an Incentive for Health Practitioners to Locate in Medically Underserved Areas." (19).

The GAO questioned recipients of Health Professions Student Assistance Program (HPSAP) loans and scholarships for 1972–73. Eighty-eight percent of these students did not know of the program when they applied to or enrolled in school. Sixty-three percent of the recipients came from families with an annual income above the highest level considered to be low income for the program. Although the legislation mandated that loans and scholarships go to students with financial need, the awards for this support have been "inconsistent and arbitrary," resulting in benefits not reaching the proper recipients.

The GAO study went on to document the negligible impact of loan forgiveness provisions on the graduate's location decision. Most students did not learn of the provision before graduation. At that time, few found the offer attractive enough to change their plans. From 1965 to 1972, 30,000 out of 93,800 medical and dental students received assistance from HPSAP. Of those, only 86 physicians and 133 dentists took advantage of the loan forgiveness option. Eighty-two percent of these stated that they would have chosen the same practice location regardless of the option.

Lack of information regarding the loan forgiveness option was considered to be a significant factor influencing the effectiveness of the provision.

The conclusions of the CONSAD study, which looks closely at state loan programs, support the GAO findings. Moreover, the study points out that the Health Professions Educational Assistance Act loans (with their forgiveness provision) have not displaced state programs which require the student to agree to provide service before receiving the loan (similar to the NHSC). This suggests that medical students may assign a higher utility to the availability of a loan during medical school than to forgiveness of the loan after medical school.

The findings of these studies indicate that programs like the National Health Service Corps which require the student to agree to provide service at the time he or she receives financial assistance have a much greater potential for meeting their objective of placing graduates in underserved areas.

This assumption is substantiated by comparing the response to loan forgiveness provisions over a seven year period with 1973 applications for scholarships tied to service obligations:

NHSC—1,000 applications for 345 scholarships.

Armed Forces—5,100 applications; 2,911 funded.

Physician Shortage Scholarship Program—1,000 plus applicants for 395 scholarships

Loan Forgiveness 1965–72—option chosen by 219 of 30,000 recipients.

Another approach was adopted by the State of Indiana and it is attracting widespread attention by states, particularly those that were losing the majority of their medical school graduates to other states. The program was a multifaceted one which began by an effort to develop a statewide coordinated plan and which gave initial priority to the development of internship and residency programs in community hospitals that previously were without such programs.

The state's only medical school played a key role in the development and implementation of the plan with the medical profession, community hospitals, community groups and the state government. The results have been impressive.

Before the program was initiated in 1967, there were 428 interns and residents in hospitals in two cities in Indiana. During the academic year 1973–74 there were 697 interns and residents (over 90 percent of the available positions filled by graduates of U.S. medical schools) in seven cities throughout the state.

A statewide biomedical communications system has been established involving 150 community libraries, 50 community hospitals and 11 university campuses.

The medical school curriculum has been modified and senior medical students take elective courses in 56 community hospitals as well as in over 140 private physicians offices. In recent years, over 90 percent of the senior medical students have elected to spend at least two months in one of these programs and in the past year 60 percent of the class spent over six months involved in these programs away from the main medical center campus.

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The results are beginning to show. The improved geographic distribution of teaching hospitals and the participation of 140 physicians in their own offices has exposed students to opportunities they have not perceived at the medical center. In each of the four years before 1974, 55 percent of the Indiana University Medical School graduates remained in the state for graduate training. In the past year the figure rose to 62 percent. Among the 700 interns and residents in Indiana, 92 percent are graduates of U.S. medical schools. This is in striking contrast to many other midwestern and eastern states. In addition, the number of physicians practicing in Indiana has risen by 10 percent in the past four years while the population increased by only three percent.

Finally, because of the expansion of graduate and continuing education programs and the development of basic sciences for first year medical students in selected universities throughout the state it has been possible for the medical school to increase freshman (and eventually medical school) enrollment by more than 20 percent.

One final note should be added regarding the number of health professionals needed to provide service in underserved areas. Questions of numbers are not unique to the problem of specialty maldistribution. The numbers game can be played with geographic maldistribution with similar results. How many health professionals and in what combinations will be required to meet the needs of underserved areas? How many students can be expected to remain in underserved areas? Will proposed programs have a permanent effect on geographic distribution patterns or will they all provide primarily temporary relief? The answers to some of these questions will be more statistically accurate than others, but a substantial gray area of doubt remains which must somehow be addressed in the development of policies directed toward a more equitable geographic distribution of health professionals.

NURSE TRAINING

I would like to spend a few minutes discussing the companion legislation which covers nursing manpower. There are now approximately 1,128,000 registered nurses in the United States. 70% or 795,000 of these are employed as nurses. 300,000 nurses are presently not working today for various reasons ranging from lack of available child care to poor work incentives. In addition, there are 344,000 licensed practical nurses, 79% of whom are employed. Licensed practical nurses work almost exclusively in the hospital setting. In nursing, like medicine, the result of earlier federal programs has been a rapid increase in the numbers of new nurses. In the past 10 years the number of registered nurses has increased by 230,000 or by one-third. The increase in licensed practical nurses is even more dramatic, almost 80%.

Nurses, however, are not well distributed geographically. A few states have almost three times as many registered nurses per capita as some others. It is interesting that those states with fewer registered nurses tend to have a better per capita ratio of licensed practical nurses. However, ten states have significantly poorer per capita ratios of all trained nursing personnel, as well as medical personnel.

The distribution of nurses and their motivations for practice are another area which needs to be studied. Unlike medicine, there is in nursing a significant underutilized manpower pool. Educators must continue to research effective ways of attracting these nurses and maintaining the special knowledge of this group.

We must also look at ways to achieve more equitable geographic distribution of nurses. If the legislation clearly addresses these issues, then I do not believe the continued mandatory expansion of nursing schools required by capitation will be necessary.

If the authorized monies are all appropriated, I believe the present level of payments at 16% is adequate. Loan forgiveness for shortage area practice should be continued and expanded. Nurse traineeship recipients are another manpower source that might be considered for shortage area service.

The nursing leaders who spoke before this committee at the May, 1974 Health Manpower hearings spoke clearly to the need for more advanced training opportunities for nurses. The legislation addresses this problem quite well. However, I would like to mention a few of the problems in primary care where changes in the legislation might have greater impact.

First, the demands of primary care practice today require a team effort. Most often mentioned teams include small groups of physicians or groups of physicians

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and physician extenders (nurse practitioners and physician assistants) working together. I believe that nurse practitioners can make a valuable contribution through their specialized knowledge of well child care, health education and understanding the impact of chronic illness on the individual. Nurse practitioners are being trained in areas of medicine which have not received adequate attention: particularly pregnant women, young children and the aged. If health teams are to be successful, the training of primary care physicians and physician extenders (both physician assistants and nurse practitioners) must be jointly undertaken. This is an important area for nursing schools and medical schools to work closely together, and for the legislation to have a consistent approach.

Equally as important as joint training experience is consideration as to where practitioner programs are located. Like residency programs, nurse practitioner programs should be distributed geographically to meet the health care needs of the people. A successful family nurse practitioner program in northern California is now re-training nurses from underserved rural communities. All of this program's graduates have remained in these communities. This program also illustrates the value of retraining experienced nurses who are already settled in their communities. The commitment to primary care practice is an important consideration for nurse practitioners as well as physicians. I am including for the Record a recent article by Ms. Fenley and Dr. Andurs who direct the above mentioned program (Appendix Four).

Recently there has been much discussion as to the slow physician response to utilizing physician extenders in practice. Three reasons for this problem can be identified: previous physician experience, legal constraints, and reimbursement for physician extenders. I have discussed the need for joint physician-nurse practitioner training programs. The legal constraints are under the authority of the states. The Congress, however, does have the power to legislate changes in the reimbursement mechanism for services rendered under Medicare and Medicaid. This would enable physicians to employ more nurse practitioners and extend the services of the practice by as much as 50%. I strongly urge the committee to look at the possibility of paying directly for the services of nurse practitioners and physicians assistants who are graduates of recognized programs and are working with primary care physicians.

Another way that the expertise of nursing might be utilized is in the legislation dealing with Area Health Education Centers. These programs are now mandatorily tied to medical schools. Now the inclusion of nursing groups is variable. By strengthening this relationship, the opportunity to train nurses in geographically remote sites improves. Retraining and continuing education opportunities for nurses already settled in these areas could also be increased.

APPENDIX ONE

Table 1.—International Comparison of Reported Physician/Population Ratios, 1969
Table 2.—Trend in Number of Active Physicians (M.D. and D.O.) and Physician/Population Ratios: Selected Years December 31, 1950–72
Table 3.—Trend in Number of Schools, Enrollments, and Graduates for Medical and Osteopathic Schools: Academic Years 1960–61 through 1971–1972
Table 4.—Geographic Distribution of Physicians, Dentists and Nurses
Table 5.—1972 Physician Speciality Profile
Table 6.—Comparison of Rank Order of States by Ratio of Physicians to Population for Total Physicians (A) and for Primary Health Care Physicians (B) United States, 1971
Table 7.—Number of Physicians and Support Specialists and Ratio to Membership—1970 Selected Prepaid Group Plans
Table 8.—Number and Ratio per 100,000 Population of Active Nonfederal Physicians by Type of Geographical Area and Medical Specialty (Predominantly Primary Care): California, July, 1969

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TABLE 1.—*International comparison of reported physician/population ratios, 1969*

[Number of physicians per 100,000 population]

North America:		Eastern Europe:	
Canada	141	Bulgaria	[2] 183
United States [1]	155	Czechoslovakia	145
Western Europe:		Hungary	[2] 191
Austria	[2] 182	Poland	146
Belgium	155	Romania	129
Denmark	145	Yugoslavia	95
Finland	95	Other:	
France	130	Australia	118
Federal Republic of Germany	[2] 170	Israel	[2,3] 245
Netherlands	122	Japan	111
Norway	141	New Zealand	115
Sweden	130	U.S.S.R.	[2] 231
Switzerland	138		
United Kingdom:			
England and Wales	121		
Northern Ireland	131		
Scotland	133		

[1] This ratio includes only professionally active physicians. It is not clear whether figures for the other nations have been similarly adjusted.

[2] Denotes nations reporting a higher physician/population ratio than was reported by the United States.

[3] Includes physicians who are registered in Israel but do not reside or practice there.

Source: World Health Organization (1972), table 2.1. Reinhardt, V. E. Health Manpower Forecasting: Current Methodology and its Impact on Health Manpower Policy. In Institute of Medicine Manpower for Health Care, Washington, D.C. National Academy of Science, 1974. p. 46.

TABLE 2.—TREND IN NUMBER OF ACTIVE PHYSICIANS (M.D. AND D.O.) AND PHYSICIAN/POPULATION RATIOS: SELECTED YEARS DECEMBER 31, 1950–72 [1]

Year	Number of active physicians [2]	Total population [3] (in thousands)	Active physicians per 100,000 population	Number of active M.D.'s	Number of active D.O.'s [4]
1950	219,897	156,472	141	208,997	10,900
1955	240,153	170,499	141	228,553	11,600
1960	251,933	185,370	136	239,757	12,176
1961	259,267	188,303	138	246,689	12,578
1962	264,947	191,236	139	254,316	10,631
1963	272,502	194,169	140	261,728	10,772
1964	280,461	196,858	142	269,552	10,909
1965	288,671	199,278	145	277,575	11,096
1966	297,097	201,585	147	285,857	11,240
1967	305,453	203,704	150	294,072	11,381
1968	307,882	205,758	150	296,312	11,570
1969	314,706	207,863	151	302,966	11,740
1970	323,203	209,539	154	311,203	12,000
1971	NA	----------	NA	[5] (318,699)	NA
1972	NA	----------	NA	[6] (320,903)	NA

[1] Department of Health, Education and Welfare "The Supply of Health Manpower. 1970 Profiles and Projections to 1990." Washington, D.C. Department of Health, Education, and Welfare, 1974 p. 31.

[2] Excludes physicians with address unknown and those with activity status not reported.

[3] Includes civilians in 50 States, District of Columbia, Puerto Rico, and other outlying areas; U.S. citizens in foreign countries; and Armed Forces in the United States and abroad.

[4] The decline in the number of active D.O.'s between 1961 and 1962 reflects the granting of some 2,400 M.D. degrees to osteopathic physicians who had graduated from the University of California College of Medicine at Irvine when it was the College of Osteopathic Physicians and Surgeons. These physicians are included in the count of M.D.'s beginning in 1962

[5] Excludes 3,529 physicians "not classified." If the percent active among all physicians is applied to the "not classified" physicians, the estimated number of active physicians would be 322,026.

[6] Excludes 12,356 physicians "not classified." If the percent active among all physicians is applied to the "not classified" physicians, the estimated number of active physicians would be 332,530.

Source: All data for 1950, 1955; population for 1960–70: National Center for Health Statistics. Health Resources Statistics: Health Manpower and Health Facilities, 1971. DHEW Publication No. (HSM) 72-1509. U.S. Government Printing Office, 1972. 1960–62 active physicians: Pennell, Maryland Y. Statistics on Physicians, 1950–63. Public Health Reports 79: 905–910, October 1964. 1963–67 active D.O.'s: National Center for Health Statistics. Health Resources Statistics. Health Manpower and Health Facilities, 1968. Public Health Service Publication No. 1509. U.S. Government Printing Office, 1968. 1962–72 active M.D.'s: Roback, G.A. Distribution of Physicians in the United States, 1972. Chicago, American Medical Association, 1973. Also prior annual editions. 1968, 1969 active D.O.'s: Interpolated by BHRD, Division of Manpower Intelligence. 1970 active D.O.'s: Unpublished data provided by the American Osteopathic Association.

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TABLE 3.—TREND IN NUMBER OF SCHOOLS, ENROLLMENTS, AND GRADUATES FOR MEDICAL AND OSTEOPATHIC SCHOOLS: ACADEMIC YEARS 1960-61 THROUGH 1971-72 [1]

Academic year	Medical schools				Osteopathic schools			
	Number of schools	Total enrollment	First-year enrollment	Graduates	Number of schools	Total enrollment	First-year enrollment	Graduates
1960-61	86	30,288	8,298	6,994	6	1,944	496	506
1961-62 [2]	87	31,078	8,483	7,168	5	1,555	439	363
1962-63	87	31,491	8,642	7,264	5	1,581	433	367
1963-64	87	32,001	8,772	7,336	5	1,594	441	355
1964-65	88	32,428	8,856	7,409	5	1,661	472	394
1955-66	88	32,835	8,759	7,574	5	1,681	464	360
1966-67	89	33,423	8,964	7,743	5	1,763	480	405
1967-68	94	34,538	9,479	7,975	5	1,823	509	427
1968-69	99	35,833	9,863	8,059	5	1,879	521	427
1969-70	101	37,669	10,401	8,367	6	1,997	577	432
1970-71	103	40,487	11,348	8,974	7	2,151	623	472
1971-72	108	43,650	12,361	9,551	7	2,304	670	485

[1] DHEW: ibid. p. 32.

[2] College of Osteopathic Physicians and Surgeons in Los Angeles became the University of California College of Medicine at Irvine in 1961-62. The latter school granted its first M.D. degrees to senior students who were to graduate in June 1962.

Source: Medical schools: Medical Education in the United States, 1971-72. "Journal of the American Medical Association" 222: 961-1076, Nov. 20, 1972. Osteopathic schools: American Osteopathic Association, Office of Education. "Educational Supplement March 1973." Also prior annual editions.

TABLE 4.—GEOGRAPHIC DISTRIBUTION OF PHYSICIANS, DENTISTS AND NURSES [1]

Region	Ratio per 100,000 population		
	Physicians	Dentists	Nurses
New England	164	55	509
Middle Atlantic	171	59	395
South Atlantic	113	37	276
East-North Central	122	46	300
East-South Central	86	32	176
West-North Central	117	47	324
West-South Central	102	33	182
Mountain	121	45	334
Pacific (includes Hawaii and Alaska)	155	57	322

[1] Ratios in 1967 (physicians), 1968 (dentists), and 1966 (nurses).

Source: Center for Health Policy Studies, National Planning Association. "Chartbook of Federal Health Spending," Washington, D.C., National Planning Association, 1974. p. 23.

TABLE 5.—1972 PHYSICIAN SPECIALTY PROFILE

	Number	Percentage
All M.D's	[1] 320,903	100.0
Primary care	144,046	45.0
General and family practice	55,343	17.2
Internal medicine	47,994	15.0
Pediatrics	20,507	6.4
Obstetrics and gynecology	20,202	6.3
Surgical care	70,207	22.0
General surgery	30,989	9.7
Other surgery	39,218	12.2
Other specialties	72,098	22.0
Miscellaneous	34,547	11.0

[1] Includes 12,356 active M.D.'s "not classified" by AMA.

Source: Roback, G.A., Distribution of Physicians in United States, 1972 AMA, Chicago, 1973. Endicott, K. M. The Distribution of Physicians Geographically and by Specialty. In: Institute of Medicine "Manpower for Health Care," Washington, D.C., National Academy of Science, 1974, p. 60.

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TABLE 6.—COMPARISON OF RANK ORDER OF STATES BY RATIO OF PHYSICIANS TO POPULATION FOR TOTAL PHYSICIANS (A) AND FOR PRIMARY HEALTH CARE PHYSICIANS (B) UNITED STATES, 1971

State [1]	(A) Total physicians [2]			(B) Primary health care physicians [3]					
	Number	Ratio [4]	Rank order	General practitioners	Internists	Pediatricians	Total number	Ratio [4]	Rank order
11 highest ratio States:									
District of Columbia	2,501	344	1	165	269	76	510	70.2	1
New York	36,370	198	2	4,409	3,530	1,466	9,405	51.2	3
Massachusetts	9,825	171	3	1,281	906	381	2,568	44.8	12
California	33,010	166	4	6,388	3,376	1,422	11,186	56.3	2
Connecticut	4,985	163	5	588	547	245	1,380	45.0	11
Maryland	6,167	157	6	720	556	255	1,531	38.9	25
Colorado	3,318	148	7	575	296	173	1,044	46.6	8
Vermont	666	145	8	129	75	28	232	50.7	4
Rhode Island	1,318	142	9	183	136	71	390	42.1	17
Hawaii	1,009	137	10	182	105	76	363	49.2	5
Pennsylvania	15,646	132	11	3,029	1,241	518	4,788	40.4	20
11 lowest ratio States:									
Indiana	4,738	90	41	1,518	312	156	1,986	37.7	31
Wyoming	301	89	42	120	23	6	149	44.2	15
Oklahoma	2,277	88	43	575	197	91	863	33.5	44
Idaho	625	86	44	248	49	28	325	44.6	14
North Dakota	521	85	45	171	49	20	240	39.2	23
South Carolina	2,160	85	46	620	149	96	865	33.9	43
Arkansas	1,589	82	47	556	111	49	716	37.0	34
Alabama	2,747	80	48	680	227	136	1,043	30.2	51
Alaska	214	75	49	72	20	15	107	37.5	32
Mississippi	1,652	75	50	539	106	77	722	32.7	47
South Dakota	484	73	51	187	35	19	241	36.4	37
Total United States	261,335	128		49,528	23,829	10,742	84,099	41.2	

[1] 50 States plus Washington, D.C. included.
[2] Non-Federal physicians in patient care.
[3] Non-Federal, office-based general practitioners, general internists, general pediatricians.
[4] Number of physicians per 100,000 population.

Source: Parker, Alberta. Dimensions of Primary Care: Blue Prints For Change. In Andreopoulus, S. (ed.) "Where Medicine Fails: A Look at Primary Care in the United States," New York. John Wiley, 1974, p. 38.

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TABLE 7.—NUMBER OF PHYSICIANS AND SUPPORT SPECIALISTS AND RATIO TO MEMBERSHIP—1970 SELECTED PREPAID GROUP PLANS

	HIP	Kaiser			Group Health, Puget Sound	Group Health Association, D.C.	Harvard Community Health Plan
		Oakland	Los Angeles	Portland			
Membership (thousands)	780	962	900	145	136	75.5	36
PRIMARY PHYSICIANS							
Family practitioners	116	114	[1] 391		40		
Internists	190	297		34	18	34	18
Pediatricians	172	158	138	14	15	15	
Total primary	478	569	529	48	73	49	18
Percent of all physicians	64	57	59	48	57	73	52
Ratio of primary physicians to membership	61/100,000 (1:1,630)	59/100,000 (1:1,690)	59/100,000 (1:1,700)	33/100,000 (1:3,020)	54/100,000 (1:8,860)	65/100,000 (1:1,504)	50/100,000 (1:2,000)
SPECIALTY SUPPORT							[2]
Obs./gyn	86	92	100	10	14	7	
General surgeons	47	72	90	18	8	8	
Orthopedists	31	44	26	5	5		
Radiologists	31	35	27	3	4	2	
Ophthalmologists	23	30	20	3	3		
Otolaryngologists	16	23	20	3	4		
Psychiatrists	16	20		1			3.6
Urologists	8	14	20	3	3		
Dermatologists	8	28	20		4		
Plastic surgeons		2					
Neurologists		7	10				
Neurosurgeons		7		1	2		
Anesthesiologists		31	10	4	4		
Pathologists		15	10	1	3	1	
Physiatrists		8	10				
Total specialists	266	428	363	52	54	18	16.4
Ratio of specialty support to membership	34/100,000 (1:2,930)	44/100,000 (1:2,250)	40/100,000 (1:2,480)	36/100,000 (1:2,800)	40/100,000 (1:2,520)	24/100,000 (1:4,190)	45/100,000 (1:2,200)
Total number of physicians	744	997	892	100	127	67	34.4
Ratio of total physicians to membership	95/100,000 (1:1,050)	104/100,000 (1:970)	99/100,000 (1:1,010)	69/100,000 (1:1,450)	93/100,000 (1:1,070)	89/100,000 (1:1,130)	96/100,000 (1:1,050)

[1] Internists included in count of family practitioners.
[2] All individual specialty support figures not available.

Sources: Figures for all plans except the Harvard Community Health Plan for 1970 and were computed from Mason, H Manpower Needs by Specialty, Journal of the American Medical Association, 219, 1621–1626, Mar. 20, 1972. Figures for Harvard Community Health Plan are for 1973 as per Dorsey, J., Personal Communication, June, 1973. Parker, Alberta, idib. p. 41.

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TABLE 8.—NUMBER AND RATIO PER 100,000 POPULATION OF ACTIVE NONFEDERAL PHYSICIANS BY TYPE OF GEOGRAPHICAL AREA [1] AND MEDICAL SPECIALTY (PREDOMINANTLY PRIMARY CARE): CALIFORNIA, JULY 1969 [2]

Specialty	Greater metropolitan		Lesser metropolitan		Adjacent		Isolated semirural		Isolated rural		Total	
	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio
nternal medicine, pulmonary diseases, gastroenterology, allergy, cardiovascular disease	3,666	31.6	1,279	19.7	133	10.0	40	8.0	----------	----------	5,118	25.7
Pediatrics, pediatric allergy, pediatric cardiology	1,402	12.1	575	8.9	55	4.1	8	1.6	----------	----------	2,040	10.2
Obstetrics and gynecology	1,302	11.2	600	9.2	69	5.2	20	4.0	----------	----------	1,991	10.0
General practice	4,641	40.0	2,231	34.4	640	48.0	263	52.6	15	66.7	7,790	39.1
Total, primary care [3]	11,011	94.9	4,685	72.2	897	67.3	331	66.2	----------	66.7	16,939	85.0
Total—All physicians	21,977	189.4	9,171	141.3	1,466	109.9	561	112.2	17	75.6	33,192	166.4
Primary care, percent of total [3]	50.1	----------	51.1	----------	61	----------	59	----------	88	88	51	----------
General practice, percent of total	21	----------	24	----------	44	----------	47	----------	88	88	23.5	----------

[1] Counties included in geographical areas: Greater metropolitan: Alameda, Contra Costa, Los Angeles, Marin, San Diego, San Mateo, San Francisco. Lesser metropolitan: Fresno, Kern, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Joaquin, Santa Barbara, Santa Clara, Solano, Yolo. Adjacent: Amador, Calaveras, Colusa, Eldorado, Imperial, Kings, Lake, Madera, Merced, Monterey, Nevada, San Benito, San Luis Obispo, Santa Cruz, Sonoma, Stanislaus, Sutter, Tulare, Ventura, Yuba. Isolated semirural: Butte, Del Norte, Glenn, Humboldt, Inyo, Lassen, Mendocino, Modoc, Plumas, Shasta, Siskiyou. Isolated rural: Alpine, Mariposa, Mono, Sierra, Trinity.

[2] Compiled from California Medical Association, "Characteristics and Distribution of Physicians in California," June–July 1969, Feb. 19, 1970.

[3] As described in the text, CMA data group certain other specialties with internal medicine and pediatrics. Therefore, the number of primary care physicians in this table is overstated.

Source: Lipton, A. J. California Health Manpower. An Overview of Trends and Policy Issues. Santa Monica, Rand Corp., 1974, p. 39.

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APPENDIX TWO

SUMMARY OF THE FOREIGN MEDICAL GRADUATE SITUATION IN THE UNITED STATES [1]

The attached charts provide a numerical summary of the foreign medical graduate situation in the United States. They include:

1—Foreign Physicians Admitted to the United States in Comparison with the Number of U.S. Medical Graduates, 1962–1973.

2—Number of Physicians Admitted to the United States Each Year, 1969–1973, by Visa Status at the Time of Admission.

3—Number of Foreign-Trained Physicians in the United States, by Geographic Region of Graduation: December 31, 1970.

4—Physicians Admitted to the United States as Immigrants, 1965 and 1972, by Region of Last Permanent Residence.

5—Occupancy of AMA Approved Internships and Residencies, 1950–51 to 1972–73.

6—Trend in Supply of Total Physicians in the United States, by Country of Graduation: Selected Years, December 31, 1959–72.

7—Supply of Active Foreign Trained Physicians: Actual and Projected 1975–90.

8—Number of Active Physicians, by Major Professional Activity and Country of Graduation: December 31, 1970.

9—Percent Distribution of Active Physicians and of First Year Residents, by Specialty and Country of Graduation from Medical School: 1970.

10—Number of Physicians by Location and Country of Graduation: December 31, 1970.

11—Foreign Medical Graduates in Metropolitan and Nonmetropolitan Areas of the United States, by Region of Origin, 1970.

12—Medical Underground: Physician Manpower in the United States, 1971.

13—Estimated Number of Immigrant Physicians Unknown to AMA by Year of Admission to U.S.

TABLE 1.—FOREIGN PHYSICIANS ADMITTED TO THE UNITED STATES IN COMPARISON WITH NUMBER OF U.S MEDICAL GRADUATES, 1962-73 [1 2]

Fiscal year	U.S. medical graduates	Foreign physicians [3]			
		Total	Immigrants	Nonimmigrant exchange visitors	Other nonimmigrants
Total	97,809	101,066	43,089	55,360	2,617
1962	7,168	5,767	1,977	3,970	(4)
1963	7,264	6,730	2,093	4,637	(4)
1964	7,336	6,767	2,249	4,518	(4)
1965	7,409	6,172	2,012	4,160	(4)
1966	7,574	6,922	2,552	4,370	(4)
1967	7,743	8,897	3,326	5,204	367
1968	7,973	9,125	3,128	5,701	296
1969	8,059	7,515	2,756	4,460	299
1970	8,367	8,523	3,158	5,008	357
1971	8,974	10,947	5,756	4,784	407
1972	9,551	11,416	7,143	3,935	338
1973	10,391	12,285	7,119	4,613	553

[1] Sources, unpublished data from the U.S. Department of Justice, Immigration and Naturalization Service; J.A.M.A. 226(8): 910, 1973.

[2] Source: Williams, Kathleen and Lockett, Betty, "Migration of Foreign Physicians to the United States: The Perspective of Health Manpower Planning." International Journal of Health Services, vol. 4, No. 2 (1974) p. 217.

[3] Including Canadians.

[4] Not available.

[1] These tables are to supplement and update the summary on foreign medical graduates which I submitted to this committee in May 1974 and which appear on pages 368–379 of the *Health Manpower and Nurse Training—1974* record of hearings held before the Subcommittee on Public Health and Environment.

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TABLE 2.—NUMBER OF PHYSICIANS ADMITTED TO THE UNITED STATES EACH YEAR 1969-73, BY VISA STATUS AT TIME OF ADMISSION [1]

Category	1969	1970	1971	1972	1973	Total, 1969-73
IMMIGRANT VISAS						
3rd preference:						
Admissions	761	544	564	540	676	3,085
Adjustments	125	166	557	840	948	2,637
6th preference:						
Admissions	69	84	90	44	17	304
Adjustments	40	46	273	247	88	694
Total with occupational preference	996	840	1,484	1,671	1,729	6,720
Others	1,760	2,318	4,272	5,473	5,390	19,213
Total	2,756	3,158	5,756	7,144	7,119	25,933
NONIMMIGRANT VISAS						
Distinguished merit and ability	62	83	178	231	350	904
Other temporary	20	100	47	25		192
Trainees	217	174	173	82	178	824
Exchange visitors	4,460	5,008	4,784	3,935	4,613	22,800
Transferees			9	10	25	44
Total	4,759	5,365	5,191	4,283	5,166	24,764

[1] Source: Dublin, Thomas. "Foreign Physicians: Their Impact on U.S. Health Care," Science, vol. 185 (Aug. 2, 1974), p. 408.

Original Source: Annual reports (Immigration and Naturalization Service, U.S. Department of Justice, Washington, D.C., tables 8A and 15B).

TABLE 3.—NUMBER OF FOREIGN-TRAINED PHYSICIANS (M.D.) IN THE UNITED STATES, BY GEOGRAPHIC REGION OF GRADUATION: DEC. 31, 1970 [1]

Region of graduation	Number [2]	Percent distribution
All regions	63,400	100.0
Africa	1,130	1.8
Asia	21,000	33.1
Canada	6,170	9.7
Europe	24,760	39.1
Latin America	9,930	15.7
Oceania	400	.6

[1] Source: Haug, J. N. and Martin, B. C. "Foreign Medical Graduates in the United States, 1970." Chicago, American Medical Association. 1971.

[2] Includes both active and inactive physicians.

Note: Figures may not add due to independent rounding.

Source: DHEW: ibid., p. 33 (see table II).

TABLE 4.—PHYSICIANS ADMITTED TO THE UNITED STATES AS IMMIGRANTS, 1965 AND 1972, BY REGION OF LAST PERMANENT RESIDENCE [1]

Region of last permanent residence	1965		1972	
	Number	Percent	Number	Percent
Europe	568	28.2	912	12.8
North and Central America	848	42.2	696	9.7
South America	348	17.3	263	3.7
Asia	205	10.2	4,996	69.9
Africa	31	1.5	222	3.1
Other	12	.6	55	.8
Total	2,012	100.0	7,144	100.0

[1] Source: Dublin, ibid., p. 409.

Source: Unpublished tabulations of the National Science Foundation, based on data of the Immigration and Naturalization Service, U.S. Department of Justice.

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TABLE 5.—OCCUPANCY OF AMA APPROVED INTERNSHIPS AND RESIDENCIES 1950–51 TO 1972–73[1]

Year	Number of positions			
	Total offered	Filled by U.S. and Canadian graduates	Filled by foreign graduates	Vacant
INTERNSHIPS				
1950–51	9,370	6,308	722	2,340
1955–56	11,616	7,744	1,859	2,013
1960–61	12,547	7,362	1,753	3,432
1965–66	12,954	7,309	2,361	3,284
1970–71	15,354	8,213	3,339	3,802
1972–73	13,650	7,239	3,924	2,487
RESIDENCIES				
1950–51	19,364	13,145	1,350	4,869
1955–56	26,516	17,251	4,174	5,091
1960–61	32,786	20,265	8,182	4,339
1965–66	38,979	22,765	9,133	7,074
1970–71	46,584	26,495	12,968	7,121
1972–73	51,658	30,610	14,471	6,577
INTERNSHIPS AND RESIDENCIES COMBINED				
1950–51	28,734	19,453	2,072	7,209
1955–56	38,132	24,995	6,033	7,104
1960–61	45,333	27,627	9,935	7,771
1965–66	51,933	30,074	11,494	10,358
1970–71	61,938	34,708	16,307	10,923
1972–73	65,308	37,849	18,395	9,064

Original Source: "Medical Education in the United States 1972–73"; "Journal of the American Medical Association;" 1973; p. 939.

[1] Source: Dublin, ibid., p. 412.

TABLE 6.—TREND IN SUPPLY OF TOTAL PHYSICIANS (M.D. AND D.O.) IN UNITED STATES, BY COUNTRY OF GRADUATION: SELECTED YEARS DEC. 31, 1959–72[1]

Year	Total physicians[2]	U.S. trained	Canadian trained	Other foreign trained	
				Number	Percent of total physicians
1959	255,170	234,595	5,421	15,154	5.9
1963	289,188	252,619	5,644	30,925	10.7
1967	322,045	270,179	6,050	45,816	14.2
1969	338,942	NA	NA	53,552	15.8
1970	348,328	284,937	6,174	57,217	16.4
1971	359,373	290,023	[3] 6,236	62,214	17.3
1972	NA	NA	NA	68,009	----

[1] From DHEW, ibid., p. 33.
[2] Includes both active and inactive physicians.
[3] Unpublished data from the American Medical Association.

Source: M.D.'s 1959: Stewart, William H. and Pennell, Maryland Y. Health Manpower Source Book 11. Medical School Alumni. U.S. Government Printing Office, 1961. M.D.'s 1963, 1967: Theodore, C. N. and Haug, J. N. Selected Characteristics of the Physician Population, 1963 and 1967. Chicago, American Medical Association, 1968. M.D.'s 1969–72: American Medical Association. Profile of Medical Practice. 1973 and prior annual editions. Chicago, The Association 1973. D.O.'s 1959, 1971: Estimated by BHRD, Division of Manpower Intelligence. D.O.'s 1963–70: National Center for Health Statistics. Health Resources Statistics. Health Manpower and Health Facilities, 1971. DHEW Pub. No. (HSM) 72–1509. U.S. Government Printing Office, 1972.

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TABLE 7.—SUPPLY OF ACTIVE FOREIGN TRAINED PHYSICIANS, USING BASIC METHODOLOGY AND ALTERNATIVE ASSUMPTIONS: ACTUAL 1970; PROJECTED 1975–90 [1]

Projection series	1970	1975	1980	1985	1990
Number of active foreign trained physicians:[2]					
Basic methodology	60,000	86,000	112,000	138,000	164,000
Alternatives:					
Low	60,000	80,000	99,000	118,000	137,000
High	60,000	92,000	125,000	158,000	191,000
Rate per 100,000 population:[3]					
Basic methodology	29.4	40.0	49.3	57.7	65.4
Alternatives:					
Low	29.4	37.4	43.8	49.5	54.8
High	29.4	42.6	54.9	65.8	76.0

[1] From: DHEW, ibid., p. 53.
[2] Includes Canadian trained physicians.
[3] Resident population as of July 1 for 50 States and the District of Columbia.

Note: DHEW health manpower projections, 1970–90. Basic projection: Based on assumption that the active 1970 base of FMG's would experience a net yearly increase of 5,200 through 1990 (including Canadians). High projection: Based on assumption that the active FMG base (including Canadians) of 59,966 in 1970 would increase by 5,200 in 1971 (as it actually did) but would then rise subsequently by an arbitrarily chosen increment of 6,600 a year through 1990. Low projection: Based on assumption that the supply of foreign trained physicians would increase by the same average yearly net increment observed in 1963–70. The active FMG's (including Canadians) in 1970 would therefore increase by the already achieved 5,200 increment of 1971 but thereafter would increase by only 3,800 a year through 1990.

Source: 1970 foreign trained physicians: Haug, J. N., and Martin, B. C., Foreign Medical Graduates in the United States, 1970. Chicago, American Medical Association, 1971. Population: U.S. Bureau of the Census. Current Population Reports, Series P–25, Nos. 468, 477, and 483.

TABLE 8.—NUMBER OF ACTIVE PHYSICIANS (M.D.), BY MAJOR PROFESSIONAL ACTIVITY AND COUNTRY OF GRADUATION: DEC. 31, 1970 [1]

Major professional activity	Number of active physicians by country of graduation			Percent distribution		
	United States	Foreign	Canada	United States	Foreign	Canada
All activities	251,240	54,420	5,550	100.0	100.0	100.0
Patient care	225,620	48,190	4,720	89.8	88.6	85.0
Office based	167,950	20,980	3,510	66.8	38.6	63.2
Hospital based	57,670	27,210	1,210	23.0	50.0	21.8
Interns, residents	33,970	16,650	610	13.5	30.6	11.0
Full-time staff	23,700	10,560	600	9.4	19.4	10.8
Medical teaching	4,450	1,010	140	1.8	1.9	2.5
Administration	10,670	1,190	300	4.2	2.2	5.4
Research	8,320	3,290	320	3.3	6.0	5.8
Other	2,110	470	60	.8	.9	1.1
Not classified	70	280	10	(2)	.5	.2

[1] From: DHEW, ibid., p. 36.
[2] Less than 0.05 percent.

Note: Figures may not add to totals and subtotals due to independent rounding.

Source: Haug, J. N., and Martin, B. C., "Foreign Medical Graduates in the United States, 1970." Chicago, American Medical Association, 1971.

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TABLE 9

PERCENT DISTRIBUTION OF ACTIVE PHYSICIANS (M.D.) AND OF 1ST-YR RESIDENTS, BY SPECIALTY AND COUNTRY OF GRADUATION FROM MEDICAL SCHOOL: 1970[1]

Specialty	Active physicians (M.D.) (Dec. 31)				1st-yr residents (Sept. 1)		
	Total	U.S. medical graduates	Canadian medical graduates	Other foreign medical graduates	Total	U.S. and Canadian medical graduates	Other foreign medical graduates
All active M.D.'s:							
Number	311,203	251,237	5,548	54,418	14,556	10,199	4,357
Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0
General practice[2]	18.6	20.1	13.9	12.4	1.9	.5	2.1
Medical specialties	20.8	21.2	15.6	19.4	31.1	31.2	28.6
Dermatology	1.3	1.4	1.5	.7	1.4	1.9	.3
Internal medicine	13.5	13.9	9.4	11.7	20.9	21.6	19.3
Pediatrics[3]	6.1	5.9	4.7	7.0	8.1	7.8	11.2
Surgical specialties	27.5	28.1	23.6	22.9	36.3	38.1	32.8
General surgery	9.6	9.6	8.3	9.7	17.3	16.5	19.1
Neurological surgery	.8	.8	1.4	.8	1.0	1.0	.8
Obstetrics and gynecology	6.1	6.1	6.1	5.6	5.9	5.3	7.2
Ophthalmology	3.2	3.5	3.8	1.5	3.2	4.3	.6
Orthopedic surgery	3.1	3.4	3.7	1.6	3.6	4.7	1.2
Otolaryngology	1.7	1.6	2.3	1.2	1.6	2.0	.6
Plastic surgery	.5	.5	.6	.4	.8	.9	.6
Thoracic surgery	.6	.6	.5	.7	.9	1.0	1.0
Urology	1.9	2.0	1.9	1.4	2.1	2.3	1.8
Other specialties	33.3	30.6	41.9	45.4	30.6	29.2	36.0
Anesthesiology	3.5	2.9	4.7	6.1	4.7	3.3	8.0
Child psychiatry	.7	.6	1.4	.8	1.2	1.3	1.0
Neurology	1.0	.9	1.6	1.2	1.9	2.1	1.7
Psychiatry	6.8	6.2	10.2	9.2	9.5	10.3	7.7
Pathology	3.4	2.7	4.5	5.8	5.1	3.2	9.6
Physical medicine and rehabilitation	.5	.4	.5	.9	.7	.3	1.5
Radiology	3.4	3.6	3.2	2.6	6.2	7.3	3.8
Therapeutic radiology	.3	.3	.3	.4	.2	.3	.2
Miscellaneous	13.7	13.0	15.5	18.3	.9	1.1	.5

[1] DHEW, ibid., p. 58.
[2] Includes family practice.
[3] Includes pediatric allergy and pediatric cardiology.

Source: Active physicians: Haug, J. N. and Martin, B. C. Foreign Medical Graduates in the United States, 1970. Chicago, American Medical Association, 1971. 1st-yr residents: American Medical Association, Director of Approved Internships and Residencies, 1971-72. Chicago, The Association, 1971.

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TABLE 10.—NUMBER OF PHYSICIANS (M.D.) BY LOCATION AND COUNTRY OF GRADUATION: DEC. 31, 1970 [1]

Region, division, and State	Number [2] by country of graduation			Percent by country of graduation			Percent distribution		
	United States	Foreign	Canada	United States	Foreign	Canada	United States	Foreign	Canada
All locations	270,600	57,200	6,200	81.0	17.1	1.9	100.0	100.0	100.0
United States	264,240	54,620	5,980	81.3	16.8	1.8	97.6	95.5	96.5
Northeast	69,580	26,030	2,260	71.1	26.6	2.3	25.7	45.5	36.9
New England	18,440	4,150	840	78.7	17.7	3.6	6.8	7.3	13.9
Connecticut	4,620	1,270	190	76.0	20.9	3.1	1.7	2.2	3.1
Maine	900	170	110	76.1	14.7	9.2	.3	.3	1.8
Massachusetts	10,230	2,000	350	81.3	15.9	2.8	3.8	3.5	5.7
New Hampshire	860	150	100	78.1	13.2	8.7	.3	.3	1.6
Rhode Island	1,080	500	60	66.2	30.2	3.6	.4	.9	1.0
Vermont	760	70	40	87.1	6.2	4.7	.3	.1	.7
Middle Atlantic	51,140	21,880	1,420	68.7	29.4	1.9	18.9	38.2	23.0
New Jersey	7,570	3,220	130	69.3	29.5	1.2	2.8	5.6	2.2
New York	27,800	15,950	1,060	62.0	35.6	2.4	10.3	27.9	17.2
Pennsylvania	15,780	2,710	220	84.3	14.5	1.2	5.8	4.7	3.6
South	76,440	10,010	770	87.6	1.5	.9	28.2	17.6	12.6
South Atlantic	40,850	7,220	550	84.0	14.9	1.1	15.1	12.7	8.9
Delaware	540	220	20	69.3	27.7	2.9	.2	.4	.4
District of Columbia	3,250	780	40	79.9	19.1	1.0	1.2	1.4	.7
Florida	9,510	1,770	170	83.1	15.4	1.5	3.5	3.1	2.7
Georgia	5,090	430	20	91.7	7.8	.4	1.9	.8	.4
Maryland	7,140	2,250	130	75.0	23.6	1.4	2.6	3.9	2.1
North Carolina	5,700	310	60	93.9	5.1	1.0	2.1	.5	1.0
South Carolina	2,560	100	10	95.9	3.7	.4	1.0	.2	.2
Virginia	5,590	900	70	85.4	13.7	1.0	2.1	1.6	1.1
West Virginia	1,470	460	20	75.3	23.8	.9	.5	.8	.3
East South Central	13,110	870	60	93.4	6.2	.4	4.8	1.5	1.1
Alabama	3,220	150	10	95.3	4.4	.3	1.2	.3	.2
Kentucky	3,190	350	20	89.7	9.7	.6	1.2	.6	.4
Mississippi	2,000	70	10	96.3	3.2	.4	.7	.1	.2
Tennessee	4,700	310	20	93.5	6.1	.4	1.7	.5	.3

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TABLE 10.—NUMBER OF PHYSICIANS (M.D.) BY LOCATION AND COUNTRY OF GRADUATION: DEC. 31, 1970—Continued [1]

Region, division, and State	Number [2] by country of graduation			Percent by country of graduation			Percent distribution		
	United States	Foreign	Canada	United States	Foreign	Canada	United States	Foreign	Canada
West South Central	22,480	1,930	160	91.5	7.9	.7	8.3	3.4	2.6
Arkansas	1,920	30	10	98.4	1.3	.3	.7	(3)	.1
Louisiana	4,480	260	30	93.9	5.5	.7	1.7	.5	.5
Oklahoma	2,780	110	20	95.7	3.6	.7	1.0	.2	.3
Texas	13,310	1,540	110	89.0	10.3	.7	4.9	2.7	1.7
North Central	59,750	14,030	1,280	79.6	18.7	1.7	22.3	24.5	21.0
East North Central	41,010	11,550	930	76.7	21.6	1.7	15.2	20.2	15.1
Illinois	11,610	4,540	170	71.1	27.8	1.1	4.3	7.9	2.8
Indiana	4,950	470	40	90.6	8.6	.8	1.8	.8	.7
Michigan	8,560	2,380	430	75.3	20.9	3.8	3.2	4.2	7.0
Ohio	11,000	3,520	230	74.6	23.9	1.5	4.1	6.2	3.7
Wisconsin	4,890	640	50	87.6	11.5	.9	1.8	1.1	.9
West North Central	18,740	2,480	360	86.9	11.5	1.7	7.1	4.3	5.9
Iowa	2,710	320	30	88.5	10.6	1.0	1.0	.6	.5
Kansas	2,580	300	30	88.7	10.3	1.0	1.0	.6	.5
Minnesota	5,300	650	200	86.3	10.5	3.2	2.0	1.1	3.2
Missouri	5,280	980	50	83.7	15.6	.8	2.0	1.7	.8
Nebraska	1,780	70	10	96.6	3.8	.4	.7	.1	.1
North Dakota	530	90	40	80.0	13.8	6.2	.2	.2	.7
South Dakota	560	70	0	88.4	11.1	.5	.2	.1	.1

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West	58,480	4,550	1,670	90.4	7.0	2.6	21.8	8.1	27.0
Mountain	11,780	780	190	92.4	6.1	1.5	4.5	1.4	3.1
Arizona	2,610	280	50	88.8	9.6	1.6	1.0	.5	.8
Colorado	4,080	260	50	92.9	5.9	1.2	1.5	.5	.8
Idaho	700	10	10	97.1	1.5	1.4	.3	(2)	.2
Montana	740	30	10	94.4	3.8	1.8	.3	.1	.2
Nevada	560	10	20	93.6	2.4	4.0	.2	(2)	.4
New Mexico	1,240	130	20	89.4	9.1	1.5	.5	.2	.3
Utah	1,510	40	20	96.1	2.7	1.1	.6	.1	.3
Wyoming	350	10	10	95.1	3.6	1.4	.1	(2)	.1
Pacific	46,700	3,770	1,470	90.0	7.3	2.8	17.3	6.7	23.9
Alaska	300	20	0	93.5	5.2	1.2	.1	(2)	.1
California	37,480	2,980	1,180	90.0	7.2	2.8	13.9	5.2	19.2
Hawaii	1,000	200	30	80.9	16.4	2.7	.4	.4	.5
Oregon	2,980	140	60	93.7	4.4	1.9	1.1	.3	1.0
Washington	4,940	430	190	88.8	7.7	3.5	1.8	.8	3.1
Possessions	1,410	1,410	10	49.8	49.9	.4	.5	2.5	.2
Other [4]	4,908	1,180	190	78.4	18.6	3.0	1.8	2.1	3.1

[1] Source: DHEW ibid. p. 37-38.
[2] Includes both active and inactive physicians.
[3] Includes physicians with APO-FPO addresses and with address unknown.
[4] Less than 0.05 percent.

Note: Figures may not add to totals and subtotals due to independent rounding.

Source: Haug, J. N. and Martin, B. C. "Foreign Medical Graduates in the United States, 1970." Chicago, American Medical Association, 1971.

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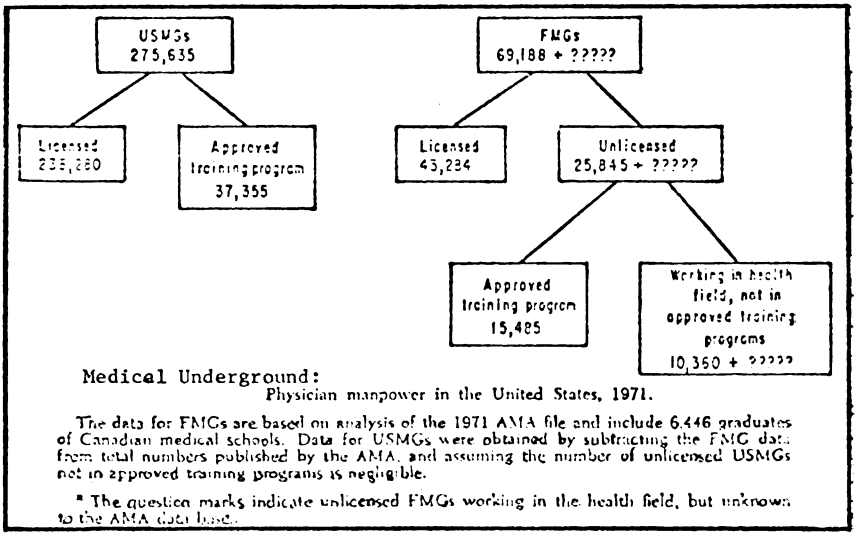
TABLE 11.—FOREIGN MEDICAL GRADUATES IN METROPOLITAN AND NONMETROPOLITAN AREAS OF THE UNITED STATES, BY REGION OF ORIGIN, 1970[1]

		SMSA		Non-SMSA		Unkonwn	
		Number	Percent	Number	Percent	Number	Percent
All regions	[2] 52,217	51,053	89	5,186	9	978	2
Europe	24,756	21,898	88	2,555	10	303	1
Americas	9,927	8,912	83	1,312	13	423	4
Asia, total	20,829	19,368	93	1,235	6	226	1
India and Pakistan	4,741	4,543	96	157	3	41	1
All other	16,088	14,825	92	1,078	7	185	1
Africa	1,301	1,216	93	68	5	17	1
Oceania	404	379	94	16	4	9	2

[1] Source: Williams and Lcokett: p. 230.
[2] Excluding Canadians.

Source: Haug, J. N., and Martin, B. C.; "Foreign Medical Graduates in he United States, 1970?"; AMA, Chicago; 1971.

TABLE 12



Medical Underground:
Physician manpower in the United States, 1971.

The data for FMGs are based on analysis of the 1971 AMA file and include 6,446 graduates of Canadian medical schools. Data for USMGs were obtained by subtracting the FMG data from total numbers published by the AMA, and assuming the number of unlicensed USMGs not in approved training programs is negligible.

[a] The question marks indicate unlicensed FMGs working in the health field, but unknown to the AMA data base.

Same as Table 13. Kleinman, Joel, Weiss, Robert, Felsenthal, Dan. "Physician Manpower Data: The Case of the Missing Foreign Medical Graduates," Medical Care, Vol. 12, No. 11 (Nov. 1974), p. 909.

TABLE 13.—ESTIMATED NUMBER OF IMMIGRANT PHYSICIANS UNKNOWN TO AMA BY YEAR OF ADMISSION TO UNITED STATES

Year admitted	Estimated number unknown (±standard error)	Estimated percent unknown (±standard error)	Total immigrant physicians
1961–65	2,125 (±437)	23.7 (±4.9)	8,964
1966–68	3,388 (±441)	38.2 (±5.0)	8,858
1969–71	3,608 (±515)	36.5 (±5.2)	9,888
All years	9,121 (±806)	32.9 (±2.9)	27,718

Source: Kleinman, p. 914.

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APPENDIX THREE

MAJOR FEDERAL LEGISLATION AFFECTING HEALTH PROFESSIONS TRAINING, 1930–71

Year	Title	Summary of provisions
1930	Ransdell Act	Consolidated Federal biomedical research activities under the National Institute of Health.
1937	National Cancer Act	Authorized the new National Cancer Institute to "conduct and foster" research on cancer, and to provide fellowships for cancer researchers.
1943	Nurse Training Act (Public Law 78–74)	Established Cadet Nurse Corps.
1944	Public Health Service Act	Public health activities consolidated into 1 act. NIH received legislative authority to conduct a broad program of biomedical research. Represented conscious policy choice to use universities as a base for the advancement of biomed cal knowledge.
1946	National Mental Health Act (Public Law 79–487).	Authorized the training of personnel to provide mental health services.
1948	National Heart Act	Authorized the National Heart Institute to establish fellowships and provide grants for training and instruction related to heart disease.
1956	Health Amendments Act of 1956	Title II provided for professional nurse traineeships.
1963	Health Professions Educational Assistance Act (Public Law 88–129).	Authorized matching grants for construction and renovation of teaching facilities in eight categories of health professional schools. Authorized loans for students in medical, dental, and osteopathic schools.
1964	Nurse Training Act (Public Law 88–581)	Authorized construction and renovation grants for teaching facilities in nursing schools, limited capitation grants for diploma schools, special projects grants for upgrading nursing education, special traineeship program, and student loan programs.
1965	Health Professions Educational Assistance Amendments of 1965 (Public Law 88–290).	Authorized basic and special improvement grants to 5 types of health professional schools for increased enrollment. Provided for loans to low-income students to continue their education in health professional schools.
1965	Medicare and Medicaid (titles XVIII and XIX of the Social Security Act).	Through Federal support of medical care costs for the aged and indigent, provided financial relief to health professional institutions through 3rd-party payments, which unified the rate structure and permitted salaries of house staff to increase.
1966	Veterinary Medical Education Act (Public Law 88–709).	Extended provisions of Health Professions Educational Assistance Act of 1963 to schools of veterinary medicine.
1968	Health Manpower Act of 1968 (Public Law 90–490).	Extended provisions of Health Professions Educational Assistance Act of 1963 and the Nurse Training Act of 1964. Bonuses provided for increased enrollment. Special project grant authority expanded to include awards for financial distress.
1970	Health Training Improvement Act of 1970 (Public Law 91–519).	Authorized special funds for medical and dental schools in financial distress. Modified the institutional grant provisions to be responsive to new schools.
1971	Comprehensive Health Manpower Training Act of 1971 (Public Law 92–157).	Authorized capitation grants for health professional schools; initiative awards to alleviate manpower shortages in underserved areas; special project grants to expand or improve training; increased loans and scholarships; traineeship and fellowship grants in family medicine.
1971	Nurse Training Act of 1971 (Public Law 92–158).	Extended most of provisions of Public Law 92–157 to schools of nursing.

APPENDIX FOUR

Special Article—Assistants to Primary Physicians in California

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Presented in part at the 1974 Family Practice Refresher Course, sponsored by the Department of Family Practice and Postgraduate Medicine, University of California, Davis, School of Medicine.

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The mid-level practitioner movement is no longer experimental; nurse practitioners and physicians' assistants in California have proved to fill a necessary and viable professional role in the delivery of primary health care. The physician's assistant law (AB2109) and the Experimental Manpower Act (AB1503) have facilitated the training and functioning of these new health care professionals; more comprehensive laws are still needed to permit optimal utilization. National agen-

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cies for approval of teaching programs and testing of individual graduates will play an increasing role in the accreditation and certification procedures. Professional role difficulties, issues of sex and questions of delegation of responsibility are being resolved and it is hoped that a more equitable and patient-oriented system is evolving.

Any survey of health care in California or in this nation shows that we are still plagued by a deficit in primary health care.[1-3] The mid-level practitioner movement is essentially the explosive response to this need.[4,5]

Deficit of Primary Physicians

The lack of health care is easily visible in the poorer states, yet even in wealthy California, in spite of our eight growing medical schools (the University of California's five and three private ones) and in spite of the influx of physicians into California from elsewhere (two thirds of California's physicians come from outside California), the deficit is still major.[6-8]

Part of the problem is a maldistribution of specialties. Surveys using "ideal" physician to population ratios in Northern California [9] and the entire state [10] show that there is a general geographic deficit of primary care physicians and surplus of some specialities such as general surgeons. Whether it is a rural area, such as Glenn County with its one physician to every 2,200 people, or a large city, like San Francisco with one doctor to every 204 people,[10] all sectors of the population, and particularly the lower economic groups, suffer from an unavailability of sufficient numbers of primary health care professionals.[11-13]

This shortage has its historical beginnings in the Flexner report of 1910 [14] which scorned the preceptor method of medical education and which, inspired by the explosion of medical knowledge, encouraged increased specialization among physicians. The military's World War II deferment policies for residents in specialty training and preferential ranking of drafted specialists furthered the drift from primary care practice. Progressive tightening of hospital privileges also made the general practitioner a second class citizen. These factors precipitously decreased the numbers of primary care physicians.

A CHANGE OF EMPHASIS TO PRIMARY CARE

Fortunately, over the last ten years there has been an awakening to the need to provide more comprehensive health care to greater numbers of people.[15-18]

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The American Board of Family Practice, incorporated in 1969, finally established a specialty in primary care, and today 203 approved family practice residencies are training some 2,500 residents across the United States and turning away many applicants.[19] These programs continue to grow in numbers and respectability.

MID-LEVEL PRACTITIONERS, PART OF THE ANSWER

Even with more physicians, however, it has become obvious that the delivery of primary care solely by physicians is inappropriate. First, overburdened primary care doctors often have needed help as they find themselves buried in episodic care. Furthermore, many patient needs such as health education, health maintenance, diagnosis and therapy of common diseases and the whole gamut of socioeconomic factors can be just as expertly handled by nonphysicians whose educations focus on these areas.[4] Thus the mid-level practitioner movement has grown in order to supply these auxiliary and supplementary health care professionals.[20-25]

Within this group of mid-level practitioners, two general names have emerged in California: the nurse practitioner and the physician's assistant. We feel the distinction between the two is arbitrary and the political more than functonal. As the California Nurses' Association explains, the physician's assistant may be said to extend the medical services provided by the physician, while the nurse practitioner provides, in addition, a different and complementary dimension to the care process based on prior background in nursing.[26] Physicians express different preferences which we feel are more often emotional than rational.

The breadth and depth of capabilities and responsibilities of these mid-level practitioners bridge that traditional gap between physicians on the one hand and registered nurses, licensed vocational nurses and health aides on the other.

This is not new ground, of course. For centuries there have been people who functioned in this area. In Russia, feldshers date back to the 15th century and have had established schools for over 100 years.[27] Busy physicians have always worked with nurses and office assistants who, formally trained or not, performed tasks that by law should have been done only by an MD. The mid-level practitioner movement, then, in addition to being a response to society's needs, is an effort to legitimize these mid-level responsibilities through the establishment of educational curricula, certification and back-up legislation.

THE UCD FAMILY NURSE PRACTITIONER PROGRAM

The Family Nurse Practitioner Program in the Department of Family Practice at the University of California, Davis, is one of the pioneering programs in the nation in the development and preparation of nurse practitioners. It began in 1969 as a Master in Public Health program for baccalaureate degree nurses, initially at the School of Public Health in Berkeley. After one year of operation, the program moved to the Davis campus.

It is an 18-month program which includes one year of didactic instruction and clinical practice, followed by a six-month internship. The curriculum consists of specified units in medical history taking; physical examination; pathophysiology; diagnosis and treatment of common problems; clinical management of selected,

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stable, chronic diseases and preventive medicine. Each student must demonstrate understanding of the subject matter and competence of clinical skills in these units to be certified.

Students are selected for the program so as to include nurses most apt to practice in areas of need. Primary care providers in rural areas, particularly family physicians, are asked to identify candidates for the program. Original requirements as to the type of registered nurse (RN) degree received—whether diploma, Associate in Arts (AA) or Bachelor of Science (BS)—have been dropped. Students with baccalaureate degrees may pursue a master's degree through extra course work, and non-baccalaureate nurses receive university credit which may be applied to a bachelor's degree.

While the program primarily trains students from California and southern Oregon, some selected students are being trained to become the core faculty for similar programs in other states. Presently we have two black nurses in training for a rural program in Tuskeegee, Alabama.

In order not to interrupt the delivery of care in the areas from which these (California) candidates are selected, the program has developed a work and learn teaching program in which, with University direction, community physicians teach the students. One day a week the students travel by car or chartered plane to the Davis campus for intensive didactic instruction by the full-time University faculty. Their physician preceptors, all members of the clinical faculty of the Department of Family Practice at Davis, supervise their acquisition of clinical skills while working with them in their private offices the rest of the week.

The program is currently involved in further decentralization of the educational program into rural areas through the development of satellite training sites, strategically located in medical centers in rural areas. The first such program is in Santa Rosa, where nine nurses from coastal rural areas of California visit for their once-a-week lectures rather than going to Davis. Their professors are physicians and nurse practitioners who live and work in Santa Rosa. The curriculum is the same as that delivered in Davis.

The work and learn method in decentralized areas is an attempt to guarantee better distribution of skilled health care professionals, improve primary health care in rural areas, and increase the relevancy of the curricular material. In addition it provides excellent experimental models of health care systems which are being studied. For example, we have analyzed the comparative academic success of nurses with varying educational backgrounds and found no significant difference between baccalaureate and non-baccalaureate RNs in the grades they received. It appears that motivation and on-the-job training are much more important than academic degree in determining how well the student does in class.

ARE MID-LEVEL PRACTITIONERS LEGAL NOW?

The history of establishing the legal status of nurse practitioners and other physician extenders in California has been a rather slow and tortuous process with much debate over territorial rights.[28] In California, as elsewhere, the Board of Medical Examiners administrates the activities of the practice of medicine, and the Board of Nursing Education and Nurse Registration regulates nursing activities. These mid-level practitioners, bridging the gap between the two professions, do not clearly come under either group's jurisdiction, although legislation is underway to establish the authority.

PHYSICIAN'S ASSISTANT LEGISLATION

For the non-RN mid-level practitioner, the physician's assistant law (AB2109, Duffy), which was passed in 1970, established the regulatory authority as the California State Board of Medical Examiners. It covers physician's assistants and medex, who are graduates of a two-year college program and generally not RNs, although many have military corpsman backgrounds. The legislation sets the precedent for limiting the numbers of such assistants to two per physician and requires that the physician be approved as a supervisor.

Physician's assistants are limited in the scope of tasks permitted; for example, pelvic and endoscopic examinations are prohibited. The law requires that the physician be present with the physician's assistant under most circumstances.

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There are five training programs for physician's assistants in California, three of them in primary care (at Stanford, at the Charles Drew Center in Watts of the University of California at Los Angeles and at the University of Southern California).

EXPERIMENTAL MANPOWER LEGISLATION

Legislation covering mid-level practitioners with RN degrees has been even slower to emerge, possibly because the RN was already a licensed health care professional. In 1972, AB1503 (Duffy), now Chapter 1350 of the California Health and Safety Code, established a mechanism for the approval of allied health personnel training programs under the Experimental Manpower Act. Most nurse practitioner programs in California are now operating under this law. Our program at Davis was the first to be approved under this act, and since then some 33 programs throughout California have been accepted.[29] As of December 1973, there were 120 graduates or prospective graduates of family nurse practitioner programs in California.[30]

The statute establishes the legality of a physician's delegating tasks to a nurse practitioner trainee, as long as the physician is "immediately available for consultation either personally or through electronic means." This permission to include the telephone or two-way radio allows the nurse practitioner much greater geographic independence than the physician's assistant has. It is a more permissive law in that it provides for greater breadth of function.

MODIFICATION OF THE NURSE PRACTICE ACT

A bill amending the Nurse Practice Act of 1939 (AB3124, Duff) was signed into law in June 1974. It gives clear authority for those functions and procedures which have had common acceptance and usage, as well as setting the stage for the expanded medical role of the RN. AB2879 (Duffy), which also has been signed by the governor, includes more precise definitions of "common acceptance." Yet neither bill specifically recognizes the nurse practitioner, nor do they cover the more specialized roles of the highly trained family nurse practitioner, pediatric nurse practitioner, adult nurse practitioner, obstetric-gynecologic nurse practitioner and psychiatric mental health nurse practitioner.[31]

NURSE PRACTITIONER LEGISLATION

AB3187, another bill introduced by Assemblyman Duffy (February 1974), was the most definitive attempt to date to formalize the identity of the nurse practitioner. It proposed the establishment of a Council of Nurse Practitioners under the Department of Consumer Affairs, rather than under either the nursing or medical boards of the state. It provided for curriculum requirements and accreditation of training programs, licensure of nurse practitioners who were RNs or licensed vocational nurses (LVN) graduated from these training programs, and disciplinary proceedings. Membership of the council was to be seven members. One RN, one LVN, one MD, one RN who was director of a nurse practitioner program, one RN with advanced clinical training, one MD on a medical school faculty and one public member.

Unfortunately, AB3187 was defeated. Territorial disputes threatened it since its conception. The California Nurses' Association formally testified against this bill in March before the Assembly Health Committee[31] on the grounds that it would have given authority over nursing practice to an independent regulatory agency. Proponents of the bill argued that the separate council it proposed would have been a more representative group. We agreed with this stand because we believed the council would have provided a prototype for future health science boards of examiners with much-needed broad representation of various kinds of providers as well as consumers.

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While some people feel that the expansion of the Nurse Practice Act under AB3124 is sufficient, we feel there is still great urgency for legislation which will regulate standardized, competency-based educational programs and licensure and certification specifically for mid-level practitioners.

From various points of view, some legislation is desperately needed. To the consumer of health services, laws are essential to guarantee the public that these mid-level practitioners have specific skills and knowledge, as well as to encourage the production of these much needed primary health care providers. For the physician, legislation granting certain authority to the mid-level practitioner will permit the delegation of many time-consuming tasks and the extension of new health care services. And for the mid-level practitioner who is presently in training or who enters such a program in the future, the certification is needed to afford formal recognition of training, capabilities and financial worth.

NATIONAL STANDARDS FOR MID-LEVEL PRACTITIONERS

The National Board of Medical Examiners now has an examination for assistants to the primary physician which will undoubtedly play an increasingly important role in the training and certification of these professionals. Physicians who pass National Board examinations find this acceptable in almost every state in lieu of board examinations for state licensure,[32] and many medical schools use the national examination instead of their own finals or as an additional requirement for graduation. All states recognize national specialty board testing. This, trend, if applied to nurse practitioners, will certainly simplify the process and permit greater mobility of professionals.

In December 1973, the National Board of Medical Examiners conducted the first such certifying examination for assistants to the primary physician. Of the 880 candidates who took the test, 68 percent received their training in physician's assistant programs and 9 percent in nurse practitioner programs. The mean standard score was 494 points, the standard deviation 84. The minimum score for passing was 400; 85.5 percent passed. Fourteen graduates of our Family Nurse Practitioner Program took the examination; they all passed, with a mean standard score of 536.[33]

The analysis of test scores by the Board showed (as did our own experience with baccalaureate and non-baccalaureate nurses) that educational background is not the essential ingredient. No significant differences in scores were found among examinees trained in physician's assistant, medex and nurse practitioner programs. Those with clinical experience acquired after graduation, however, scored higher than those without this experience. The Board saw this result as evidence of the relevance of the examination, since it appeared to measure knowledge and skills actually used and improved in the clinical environment.[33]

WHO CERTIFIES PROGRAMS NATIONALLY?

The only national standards for mid-level practitioner programs are those adopted by the American Medical Association's House of Delegates in late 1971, and set out in *The Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician*.[34] This was the collaborative effort of the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Society of International Medicine, all of which sponsor the Joint Review Committee on Educational Programs for the Assistant to the Primary Care Physician. The Committee evaluates applications for accreditation, and the American Medical Association's Council on Medical Education, upon the Committee's recommendations, accredits programs.[35] The Council on Medical Education was recognized in February 1974 by the United States Office of Education as the national accrediting agency for these programs.

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In March, the Council on Medical Education approved our Davis program, actually the first and, to date, the only nurse practitioner program to be approved by this group. The only other program in California that has received the Council's approval is the medex program of the Charles Drew Postgraduate Medical School, University of California at Los Angeles. As of June 1974, a total of 43 programs for assistants to the primary care physician had been approved nationally.

ACCEPTANCE OF MID-LEVEL PRACTITIONERS

Patient acceptance of nurse practitioners and physician's assistants has been so favorable that it is no longer an issue; various studies show that when the role of the med-level practitioner is properly introduced to the patient there is uniform acceptance.[36,37] Furthermore, their contribution to improved and more comprehensive health care is well established.[38]

The major deterrent to wider use of the mid-level practitioner has been the lack of acceptance by physicians.[39] Often doctors in greatest need of help and in areas of greatest care deficit are the ones most threatened by the formally trained mid-level practitioner. Fortunately, as the usefulness and competence of these professions become more widely known, physician acceptance is following. We have been impressed by our own preceptors' overwhelming enthusiasm for their mid-level colleagues once they have had a chance to work with them.

CHANGING ROLES

Physicians have traditionally been selected for being self-reliant, competitive individuals, not for their ability to work cooperatively with others, especially others with less formal education. Their medical school training has always encouraged their authoritarian qualities. Yet today, as all our institutions are doing, medicine is undergoing change.

The historical authority of the physician, due to his education and legal responsibility, is breaking down because of various factors. Health care providers are organizing; health care is thought of more and more as a public right; payment systems are beginning to emphasize payment for total care rather than for specific physician services. In short, health care is becoming less provider oriented and more consumer oriented.

Realistically, in office relations the physician is still the employer, the boss in the sense of legal and medical responsibility. This dominance is particularly evident in the physician's reluctance to delegate tasks.[40] The nurse, traditionally taught to take orders, frequently finds it difficult to take the aggressive role needed to make decisions.[40] On the other hand, there is a trend in the nursing profession to seek freedom from physician dominance and to demand more independent status.[41]

BATTLE OF THE SEXES

Role conflicts are exaggerated by traditional male and female images: the *male* doctor, physician's assistant and medex; the *female* nurse and nurse practitioner.[42] It is true that at present women are restricted to defined roles within the health care delivery system.[42] Yet we have had experience working with men and women filling all ranges of professional roles; we have found that the roles are inevitably determined much more by the setting in which they work than by sex or prejudicial images. We have men and women in our Family Nurse Practitioner Program, and women are joining the traditionally male medex programs in increasing numbers. There is an obvious trend in medical schools to accept more women. Fortunately the stereotypes are breaking down as sex lines are crossed. When roles are finally defined by patient oriented functions, rather than traditional professional images, many of these problems will be resolved.

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DEPENDENCE, INDEPENDENCE AND INTERDEPENDENCE

The degree of dependence or independence of the mid-level practitioner with respect to the physician is a balance between legal limitations and capabilities. Ideally it is determined by the specific competencies of the persons involved.

In practice, mid-level practitioners have proved to be competent and capable of handling many patient problems alone, within the prescribed protocols worked out by the physician. Our Family Nurse Practitioner graduates reported that in 70 percent of patient visits, they were the only professional the patient saw.[43] All patient contact activities were under the general supervision of the physician, of course, and most patients seen on a continuing basis or with complications also saw the physician. Others have also reported on the increasing ability of mid-level practitioners to extend physician services in a fairly independent manner.[40,45]

What we see as the ideal is the physician and mid-level practitioner as colleagues who work together as members of a larger primary health care team.[25,44,45] Our plea is for greater interdependence of all members of the team.

COMMUNICATION AND SUPERVISION

An essential for safe and effective utilization of the nurse practitioner, as well as for good office relations, is satisfactory communication between the mid-level practitioner and the physician. Delegation of tasks, whether directly or through protocols and consultation, should include sufficient supervision to assure that the nurse practitioner collects pertinent data, accurately interprets the data and recognizes deviations from the normal and understands his or her limitations in diagnosis and therapy.[30]

HOW ARE MID-LEVEL PRACTITIONERS PAID?

Most mid-level practitioners are paid a straight salary by a physician or institution. Few data are available on the size of salaries in California, but a limited survey done in the summer of 1974 showed that in 19 private practices in Northeastern California the mean annual salary received by mid-level practitioners was $12,390; four reported salaries below $12,000, and the maximum was $18,000.[46] A national study by Scheffler and Stinson showed a mean of $9,869 and a range of $4,599 to $21,362; women physician's assistants at that time started at salaries averaging $2,200 less than men physician's assistants, and after two years' experience the gap widened to a difference of $4,550.[47] An American Medical Association study of 1973 salaries across the nation showed a mean annual rate of $11,560 and a range of $7,200 to $22,500; however, there was still an average difference of $2,040 between salaries of men and women physician's assistants.[48] We may conclude that although sex discrimination in salaries is disappearing slowly, the upward trend of salaries in general signifies increasing recognition of the utility of mid-level practitioners.

Some physicians have worked out salaries for various allied health workers as a percentage of volume or by profit-sharing arrangements based on the team's or the individual member's performance. A few physicians share risks of loss and profit with all the professionals in the office.

Unfortunately, to date the performance of mid-level practitioners, like that of physicians, has usually been gauged by traditional fee-for-service financing, under which preventive medical measures are either not included or poorly remunerated. One of the greatest challenges facing the health care system is the development of financial incentive systems that reward quality of care and emphasize preventive medicine and patient education.

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Summary and Recommendations

Health professions training

The major health manpower issues to which I have referred in my testimony include:

(1) the need to insure the financial stability of health professions schools and increases the aggregate supply of health manpower
(2) geographic maldistribution
(3) specialty maldistribution
(4) foreign medical graduates
(5) the need for physician's assistants, nurse practitioners and other intermediate health practitioners
(6) the need for allied health personnel
(7) the need for public health and health administration personnel
(8) the need to provide educational opportunities in health professions schools for socioeconomically disadvantaged students
(9) the need for the Department of Health, Education, and Welfare to properly implement the health manpower legislation

In the testimony, I have chosen to emphasize:

(1) the need to provide primary medical care as the most important health care problem facing the country
(2) the impact of federal health-related programs on the demand for medical care
(3) problems of data and lack of adequate information
(4) aggregate supply of health manpower
(5) geographic maldistribution
(6) specialty maldistribution
(7) foreign medical graduates

I have also briefly discussed problems related to nurse training and nursing services.

The policy alternatives for resolving these issues fall under a variety of categories, each of which impacts on a different aspect of training or practice:

(1) financial incentives for students
(2) financial incentives for providers
(3) medical education and training
(4) professional environment in the community
(5) general environment in the community
(6) legal requirements, sanctions and controls

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In my recommendations I will focus on specific measures which fall under several of these categories. Before any specifics are mentioned, however as a first priority it is incumbent upon the Congress to establish a clear federal health manpower policy including an explicit recognition of the role of the federal government in health manpower developments, including the direct support for education costs in health professions schools. That policy might begin with the statement that all citizens have the right to adequate health care and that it is the responsibility of the federal government to assure access by providing core support for the development and deployment of manpower in the major health professions in cooperation with state and local governments and the private sector.

The federal government has the responsibility to maintain the integrity of the institutions which educate health professionals as well as assuring adequate levels of high quality health professionals. The problems of geographic and specialty maldistribution can be most effectively addressed at the residency level and through appropriate incentives to practitioners.

Nurse practitioners and physician's assistants are essential elements of the health team. They can increase the productivity of a physician and extend the geographic reach and scope of services. Physicians and intermediate health practitioners should be considered interdependent rather than independent providers of care. The most effective ways of meeting the future needs for an adequate number of primary care physicians is to sustain the output of United States medical schools, expand the programs to train nurse practitioners and physicians assistants and increase the number of approved residences in primary care while decreasing them in surgical and other specialties where excess supplies are already evident.

Foreign medical graduates have contributed little to resolving the problems of geographic and specialty maldistribution in the United States. The double standard which has been applied to FMG's makes it incumbent upon federal policy makers to develop an appropriate policy for addressing this problem. Equal educational opportunities must be open to women and minorities. Accomplishing this goal must be given equal weight with resolving the other major health manpower issues which I have discussed.

The evidence presented to the committee last year would indicate that the present level of capitation support—or 20 percent of net education expenditures—is the minimum level needed to sustain current and projected enrollment through the 1980's. In order to receive this support, schools must comply with the Civil Rights Act in offering equal educational opportunities to women and minorities. Although there has been significant progress in this area, equal opportunity is not a fact of life in every health professions school in the United States.

Capitation payments equal to 20 percent of net education expenditures would be considered basic institutional support for health professions schools. The committee should then seriously consider raising the payments to the level recommended by the Institute of Medicine—up to one-third of net education expenditures—for those schools which engage in projects of national significance. Including such projects under capitation grants relieves schools from continuously having to fill out applications for individual special projects. It would be to everyone's advantage to eliminate this wasted effort.

The activities for which schools would receive an increased level of capitation payments should include:

(1) improving distribution of residency positions among specialties so that at least 50 percent of the residency training programs in the medical school and its affiliated teaching hospitals are in primary care (general medicine, general pediatrics, family practice, and obstetrics-gynecology).

(2) establishment of family practice residency programs which offer at least 12 first year positions annually.

(3) offering students the opportunity for exposure to practice outside of the medical center through service in public hospitals, community health centers, clinics in underserved areas and preceptorships such as those offered by the University of Wisconsin and the University of Indiana.

(4) development of new programs in Area Health Education Centers or hospitals in underserved areas, particularly residencies in primary care specialties. The actual development and expansion of Area Health Education Centers should remain one of a few separate special projects.

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(5) projects which encourage and support the development training programs for nurse practitioners, physician's assistants, nurse midwives, and other intermediate health practitioners. These should be created in conjunction with primary care training programs in order for students to learn to function effectively as members of an interdisciplinary health team.

The activities mentioned to this point will have direct or indirect effects on both geographic and specialty maldistribution. The interrelationship between the two problems makes it difficult to propose a solution to one which will not, in some way, affect the other. In addition to those directed toward specialty and geographic maldistribution, two final projects should be included in the list of those qualifying for increased capitation support:

(1) increased support should be given to schools to admit students from underserved areas and from socioeconomically disadvantaged groups whose medical care needs have not been adequately met by those traditionally admitted. This would mean the admission of more women, minority and rural students. Although student loans and scholarships would be covered under separate provisions, it should be noted that there must be adequate support available through those means which are not specifically tied to service commitments so that disadvantaged students can be assured of completing their training while not being forced to provide service in underserved areas in return, unless they choose to do so.

(2) schools would also be supported for projects to train physicians in the appropriate use of prescription drugs. Such programs would utilize clinical pharmacologists and clinical pharmacists, trained in pharmacy schools, for instruction on either the undergraduate or graduate level.

Although changes in undergraduate medical education are necessary to meet the need for an improved distribution of health profesionals, both geographically and by specialty, significant changes will be required in graduate medical education if these and other critical health manpower issues are to be resolved.

SPECIALTY DISTRIBUTION

Policies to correct specialty maldistribution should focus on the absolute numbers and distribution among specialties of residency positions. The committee is faced wth three choices:

(1) do nothing regarding residency training.

(2) mandate that professional organizations in the private sector take responsibility for establishing the total number of residency positions to be available on a national and regional basis and the specialty distribution among residencies.

(3) mandate an expanded role for the Department of Health, Education, and Welfare in establishing, approving, and financing residency programs.

Since the federal government pays a major portion of stipends for residents through the Medicare and Medicaid programs, I believe that the only effective way to address the problem is to give HEW a larger role in setting the total number of residency positions and determining the distribution of those positions both geographically and by specialty.

The number of first year residency positions should not exceed 110 percent of graduates from United States medical schools in a given year. Based upon annual recommendations of the Coordinating Council on Medical Education, the Secretary of HEW should be authorized to establish the number of residency positions which would be eligible for reimbursement under federal health insurance programs and assign the number of positions to the various specialties and among geographic regions. At least 50 percent of residency positions should be in primary care (general medicine, general pediatrics, family practice, and obstetrics-gynecology).

LOCATION OF HEALTH PROFESSIONALS IN GEOGRAPHIC AREAS WHERE THEY ARE NEEDED

No single solution has been found for the problem of geographic maldistribution. The issue must be addressed with multiple actions. These include the Area Health Education Center program, decentralization of medical education (particularly residency programs), loan and scholarship forgiveness for service in underserved areas and the National Health Service Corps.

Of all of these efforts, the best solution currently available is a vastly expanded National Health Service Corps program. The National Health Service Corps

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should develop effective linkages with the Neighborhood Health Center Program, Maternal and Infant Care Program and other organized activities designed to provide adequate access to care in underserved areas.

Loan and Scholarship programs should continue to offer loan forgiveness in return for service. Since the lack of response to loan forgiveness options has been related to the absence of information to students regarding such provisions, these programs should be required to provide a written notification to every applicant for student assistance of the loan forgiveness option.

FOREIGN MEDICAL GRADUATES

An adequate supply of United States trained medical school graduates is essential to provide the necessary number of phyicians needed in the United States. I believe that enrollment increases currently projected by United States medical schools will achieve first year enrollments of close to 15,500 by 1980–81 and 16,000 by 1983–84 if federal financial assistance is maintained. With increased federal support, first year enrollments could be increased by at least an additional 1,000 students by 1979–80 and by an additional 2,000 students by 1983–84. I do not think that these additional places will be required to meet the nation's health manpower needs, but that is a decision to be made jointly by Congress and the states in funding programs and by the medical schools in responding to national needs.

Even if the supply of foreign medical graduates stabilizes at present levels for the next several years and then declines to not more than 10 percent of the total U.S. supply, the ratio of physicians to population would remain close to the 1975 ratio. As Professor Rashi Fein of Harvard has cautioned, immigration laws should not be based upon physician shortages since the preceived shortage is, to a great extent, a problem of maldistribution.

The approach I recommend to Congress for resolving the problems associated with FMG's is a multidimensional one including the following actions:

(1) The Department of Labor should be urged to re-examine the health manpower situation to declare that there is no longer an overall physician shortage in order that the Department of State will no longer be able to authorize visas of foreign medical graduates without Department of Labor clearance.

(2) The 1965 Amendment to the Immigration Act of 1952 should be amended to assure that foreign medical graduates whose primary activity is office or hospital based patient care no longer be given preferential immigration status under the two preference categories:

—members of professions or persons with exceptional abilities in science and art

—persons with skills which are in short supply in the United States

The type of provision recommended here would continue to give entry preference to physicians engaged in needed biomedical research but it would limit the ability of foreign medical graduates to enter the United States in numbers which are in excess of the nation's needs or demands. If the committee wishes, I will be happy to provide specific language for such an amendment.

(3) To assure the American public an adequate standard of care, I recommend, as a minimum, that all physicians be required to pass, at an acceptable level, either the National Board Examination (Parts I, II, and III) or the FLEX examination. The examination given by the Education Council for Foreign Medical Graduates (ECFMG) should be eliminated.

(4) Support should be provided for the development of programs to allow those United States citizens who were qualified to study in American medical schools, but because of space restrictions, were forced to go abroad for medical education to return to the United States for their third and fourth years of medical school. Special remedial programs should be provided for students from this group whose foreign medical education did not adequately prepare them to enter the third year of training in a United States medical school.

THE NEED FOR INFORMATION

Data problems and lack of information regarding current and future supply and distribution of health professionals are recognized by everyone. I believe

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that the types of proposed studies regarding physician distribution and the National Health Service Corps are essential to intelligent policy development. I would recommend that the committee take one further step and establish a national health professions personnel data base. The Secretary of HEW should be authorized to make grants to states for the development of a uniform reporting system to include data on all health professionals. This data base would provide consistent information for evaluating and projecting the supply, specialties and geographic distribution of health professionals.

NURSE TRAINING

1. There is an acute need for studies of the following problems in nursing manpower.

A. Incentives and motivations of nurses to settle in certain geographic areas.

B. Mechanisms which are effective in bringing the 300,000 unemployed nurses back into the work force.

2. Capitation eligibility for schools to maintain enrollment rather than expand enrollment. Enrollment expansion might be considered a special project.

3. Loan forgiveness for shortage area service in primary care should be expanded and possibly considered as a requirement for certain traineeships which are available to nurse practitioner students.

4. Nurse practitioner programs should be closely affiliated with primary care physician residency programs.

Equal attention should be given to the location of these programs in relation to the unmet need for health care.

5. Reimbursement for physician extender Medicare and Medicaid should be authorized.

Mr. ROGERS. Thank you very much for a very helpful and excellent statement. The committee and staff will go over your statement and recommendations in detail.

Mr. Hefner?

Mr. HEFNER. I have no questions.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman. This is certainly an excellent presentation. I enjoyed it thoroughly. However, you presented several problems I don't know that the solutions are also there. Dr. Lee.

How would you manage geographic distribution?

Dr. LEE. I think I would give the first priority to expansion of the National Health Services Corps and the National Health Service Corps scholarship program. I do not think poor students, in order to go to school, should have to sign up for one of those scholarships. Alternative sources of scholarship funds should be available for the first year or two. Once they know they will make it through school they can start taking out loans.

I don't believe we should require poor students to join the National Health Service Corps in order to obtain financial aid. That should be open equally to everyone, it should be voluntary and it must be adequately funded. At the local level the National Health Service Corps should be integrated with area health education centers, community hospitals, neighborhood health centers, and the number of the other programs developed to reach out to underserved areas. It has to be linked with a system of care. You just can't put graduates out there to practice without an adequate support system. They are making significant efforts now to do that.

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Second, increasing the number of area health education centers to improve the geographic distribution of residency training programs; and three, the development of primary medical care residency programs, particularly in the family practice, because physicians in family practice will be more likely to move into underserved geographic areas.

We have to have physicians trained with the appropriate kind of skills. We need to modify the admission policies in our medical schools to select more students from underserved areas not just underserved populations, such as minority groups.

While increasing the number of women admitted, we are still proportionately low on the number of students from small towns and rural areas, particularly low-income white students from those areas.

Mr. SCHEUER. Do you find that when you educate and train a low-income student from a rural area, he is more likely to go back to the area after his training is complete?

Dr. LEE. For many it is not a low-income area, it is home and they will earn a very good income.

Mr. SCHEUER. Does he find it more congenial going back there and is he more apt to go back than someone looking for a new experience?

Dr. LEE. Evidence indicates he—or she—is more likely to go back particularly if he—or she—has had his residency training in an adjacent area and if he—or she—had some undergraduate medical training there.

The student from New York City is not likely to go to Wyoming to practice. The student who comes from Caspar or Laramie, Wyo., if he goes to the University of Colorado and has the opportunity to go back home for a residency, is more likely to go back there to practice. The data is not very solid, but it certainly seems to be the case.

Mr. CARTER. How would you control specialty distribution?

Dr. LEE. I think first of all you have to set a limit on the number of residencies in the United States. There are an excessive number of positions now. I would limit the number of first year residencies to 110 percent of the graduates of American Medical Schools. Next, the unfilled positions should be eliminated. Congress must also create a mechanism that can allocate the residency positions by specialty; and I think that the process proposed in the legislation could accomplish that. As a minimum and immediate objective, at least 50 percent of the residency positions should be allocated to primary care specialties; internal medicine, pediatrics, family practice, and general practice. I also support the committee recommendation of last year that there should be an additional 7 percent in OB/GYN, bringing the total to 57 percent.

Mr. CARTER. Would you consider OB/GYN in primary care?

Dr. LEE. Yes, I would. I think about 20 percent of their practice is referral or consulting practice. Most of their practice is in the primary care of women of child-bearing age and older, who keep returning for continuing care.

Mr. CARTER. I have one question, how again would you manage FMG's?

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Dr. LEE. First of all there needs to be a change in the immigration laws. Congress or the State Department should eliminate the preference which is now given to physicians to immigrate into this country. We do not have a shortage of physicians. We have a maldistribution by specialty and geographic area. We do not have a shortage. The rationale for the original legislation permitting the influx was because there was shortage in physicians in the United States. I think that should be changed.

There should be changes which would permit somebody who comes in on an exchange visitor visa for training. They should not be allowed to immigrate while they are in the United States, which thousands are doing at the present time.

Foreign medical graduates should be required to pass the same examination that the graduates of an American medical schools must pass in order to enter a residency training program. This change would probably drop the number of FMG's in half or maybe down to 20 or 30 percent of its present level as soon as that examination was instituted, provided a sufficiently high standard was set on the score they had to make on the examination.

I think those things would help to deal with the problem of FMG's. I think eliminating the excessive number of residencies—which is really the thing that brings them here—will go a long way to reducing the numbers.

Mr. CARTER. Thank you for a most helpful presentation.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. I agree with Dr. Carter, this is very helpful and useful. I just have one question. Did I understand you to say there would be more foreign medical graduates entering medical practice in this country in the last 4 years than the United States trained physicians?

Dr. LEE. Yes, sir, if you look at table 1, appendix 2 you can see the exact figures.

Mr. SCHEUER. Is there a page on that?

Dr. LEE. It is in appendix 2, table 1.

In 1970 the number of U.S. graduates was 8,367. The number of foreign physicians admitted to the United States in that year was 8,523. In 1971 and 1972 and 1973 the number of foreign medical graduates, if you look at that table, exceeded the number of graduates of U.S. medical schools.

The most significant factor in the last 3 years was in the immigrant category, not in the nonimmigrant exchange visitors, where those numbers increased most dramatically—more than doubled since 1970.

Mr. PREYER. Well, the Secretary this morning seemed to say that we shouldn't try through any sort of arbitrary ways to restrict the number of foreign medical graduates, although he would agree with your suggestion about requiring the same examinations but he seemed to say there was something morally wrong with it, that it conflicted with the ideals of our country to attempt to restrict free immigration in that way. Isn't there also something fundamentally wrong, morally or ideally, or some other way with a country this size and with our facilities taking more than half of its graduates, half of its people in the medical practice from foreign graduates?

Dr. LEE. We permit physicians to enter out of proportion to other people from the countries from which they come—from the Philippines, Korea, Thailand, Indonesia, and a number of other countries—

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because of the present laws that permit the physicians to be in a special status because they are in an occupation which is declared to be in short supply in the United States, or because they have special skills.

Under both those categories FMG's are permitted to enter more easily than anybody else who might want to immigrate. We have made them unequal to the other citizens from those countries.

Mr. PREYER. The law, as far as democratic ideals go, it is discriminatory to the other citizens.

Dr. LEE. One alternative would be to open immigration totally—which I don't think the Secretary favors although he will have to speak to that—but this proposal is just to equalize it.

Mr. PREYER. Thank you, Dr. Lee, I appreciate your testimony very much.

Mr. ROGERS. Mr. Scheuer.

Mr. SCHEUER I was very stimulated by your testimony, Dr. Lee, as I am sure we all have been for the years in which you have been giving us topflight leadership.

I have very little to add in reference to your testimony, it has been thoroughly covered.

I would like to ask you in connection with the discussion of family planning yesterday, since you played such a significant role in the development of family planning services in the Federal Government what would your view from the mountaintop be on how that program worked, how it served the constituent group and how it ought to be funded, whether it ought to be expanded, how the delivery of services should be organized, should the plan be furnished by the cities and States as the Secretary said yesterday?

Dr. LEE. I think the program worked very well. It provided access to millions of women to a very much needed service which they have sought on a voluntary basis and to which they clearly had inadequate access earlier. As you know, in the middle 1960's I was not particularly in favor of a categorical approach to family planning.

Mr. SCHEUER. I had forgotten that.

Dr. Lee. Generally that worked, and I think eventually the family planning services need to be integrated into more comprehensive services. The needs are so critical, the benefits of those services are so significant to the patients receiving them that I think it is essential to continue a categorical program until at least the underserved populations have the same access to services that the average middle class person has in the population.

That is not yet true and I think it would be a great mistake to turn the financing and policy guidance over to the States through revenue sharing or any other means.

Mr. SCHEUER. States and cities?

Dr. LEE. Yes. It didn't work before and clearly it will not work now. I think it would be a very, very serious setback. I think we would see adverse impacts in relation to infant mortality and in maternal and child health that would be clearly demonstrable if Congress backed away from the approach taken in 1970. It is clearly too soon to do that. 1980, maybe, but not 1975.

Mr. SCHEUER. Can you give us a percentage of the group to be reached, the total number of women in child bearing years who depend on this service and who are not being reached?

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Dr. LEE. I don't have the figures in my head.
Mr. ROGERS. Maybe you could supply this for the record.
Dr. LEE. Yes, I will supply that for the record.
[The following letter was received for the record:]

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO,
SCHOOL OF MEDICINE,
San Francisco, Calif., March 19, 1975.

Hon. PAUL ROGERS,
U.S. House of Representatives,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: During the recent hearings on health manpower I was asked by Congressman Scheuer, "Regarding family planning programs, can you give us a percentage of the group to be reached, the total number of women of child bearing age that depend on this service and are not being reached?"

In the initial estimates that were made in the mid 1960's, it was estimated that there were approximately 5 million women who would fit this description and by the early 1970's less than half of these women were receiving needed services. Revised estimates add significantly to the numbers of persons in need of subsidized family planning services. The best estimates from the Planned Parenthood Federation of America indicate that that number is now nearer 11 million than 5 million.

They estimate that there are about 9.2 million low and marginal income women aged 15–44 at risk of unwanted pregnancy (defining "low and marginal income" as below twice the official poverty level). In FY 1974, about 2.8 million of them were served in organized clinics and an estimated 2.8 million were served by private physicians. The total served, then, was about 5.6 million, or about 60% of those in need.

Thus, about 3.6 million low and marginal income remain unserved. In addition, there are about 1.7 million sexually active teenagers in families with incomes above twice the property level in need of services, and it is doubtful in more than 300,000—400 are receiving *them*.

I'm deeply concerned regarding the proposals that family planning programs be moved from categorical financial support to revenue sharing. Studies currently underway by the Southern Regional Council indicate very clearly that revenue sharing funds do not go for social services of this type. The funds have gone for the construction of facilities and they are now going primarily to offset inflationary increases in salaries of police, firemen, and other municipal, county, and state employees. In my opinion it would be a disaster to transfer family planning services, which mean so much to the health and well-being of the individuals served, to a non-categorical revenue sharing approach and I hope that these services will be provided through revenue sharing.

I hope this information will be helpful.

Sincerely yours,

PHILIP R. LEE, M.D.,
Professor of Social Medicine.

Mr. ROGERS. Any further questions? For the record, I would like your thinking on what should be done for the malpractice situation.

Dr. LEE. I might ask my father, who has become very much interested in that problem and has developed some ideas, to write you directly about that and I will discuss with my colleagues, Lew Butler, Mike Parker and others you know and we will give you our ideas.

[The following information was received for the record:]

MALPRACTICE, A RATIONAL SOLUTION

It is not necessary to reiterate that the situation brought about by the tremendous awards in malpractice suits is a serious one. Nor is any useful purpose served by attempting to place the blame. Essentially the miraculous achievements of modern medicine have led the public to believe that any condition can be cured by one of the new wonderful drugs, so there is almost universal over-expectation as to the possible results. Also, it is almost always true that

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any drug, or indeed any other treatment modality, is dangerous almost in proportion to its potential efficacy. So there have been many drug reactions and also many side effects of surgery which have been seriously damaging to patients. From this has developed the attorney who specializes in such cases and, human nature being what it is, at times instigates such actions. Then, too, the juries assuming that the insurance company will pay and swayed by the lawyers who have acquired much skill in this field, award enormous judgments. To pay these the insurance companies must increase premiums until now the burden has become almost more than can be borne.

All recognize the bad state of affairs. The diagnosis is clear enough. A cure is what is needed.

And a cure can be found. The example furnished by industrial accident insurance in which Wisconsin led the way but which has been brought to a very high point of efficiency in California furnishes the guide. The old "adversary" system should go. Also, the fiction that a jury can, with any amount of coaching by lawyers, be competent to judge whether in fact malpractice has been committed and then what the award should be, recognized and a new approach found.

Allegations of malpractice should all be referred to and judged by a board of experts. This board should be composed of physicians and laymen who are especially trained just as are the boards that judge industrial accidents. The facts should be laid before this board (which should be an established state agency) without emotionalism or forensic oratory, and the board would then determine whether there had been actual malpractice. Then the board should determine the extent of the injury and what the proper award should be. This award should be paid from the funds of a state malpractice insurance agency. The funds would be derived from fees paid into it by every participating physician. These fees or, if one prefers, these insurance premiums, should be determined by the actuarial experience, and because there would be no legal fees and no insurance company profits to pay, would consequently be much less than today. The elimination of capricious, frivolous and actually fraudulant claims would insure that a just figure would be arrived at.

An additional benefit which is now lacking would be the determination if the physicians were really at fault, or were poorly trained or incompetent, and if this was found to be the case, appropriate action could be taken by the board. This action should be revocation of license to practice, curtailment of activities in which the physician might be permitted to engage, or the imposition of a requirement for additional training if indicated. Now we have the preposterous situation where a physician may be assessed a million dollar malpractice verdict and goes on practicing just as he did before. This is palpably absurd.

This solution calls for legislative action to set up a state malpractice insurance fund, a state malpractice board of experts, and the requirement that all physicians contribute to the fund enough to meet all demands on it. By this means the injured patient will be justly awarded damages, the guilty physician will be punished, and all the present con game features will be eliminated.

RUSSEL V. LEE, M.D.,
Palo Alto Medical Clinic, Palo Alto, Calif.

Mr. ROGERS. If we limit FMG's through residencies and so forth, do you think it would be too traumatic a change, over the next 3 years, to bring about a reduction from the 200 percent that we have now down to a 125 percent—I know you said you would recommend 110—but I am thinking not only of the training but also the impact on the delivery of care. In other words, I think we need to look at what happens in delivery at the same time we are thinking about training.

Dr. LEE. I agree and in some States, for example New Jersey, New York, Rhode Island, you can't turn it off like that. I agree with that.

Mr. ROGERS. If you could let us have something specific on that.

Dr. LEE. On the timing of the reduction?

Mr. SCHEUER. Would you also address yourself to a distinction that I think exists between the use of FMG's in for profit hospitals and in voluntary hospitals and if you could give us some insight into how some restrictions on the entry of new FMG's into this country would open up places in our medical services delivery system for young

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Americans who would very much like to have a career in health services, but who are now denied that possibility because there simply is not the opportunity for them to serve.

Dr. LEE. All right.

Mr. ROGERS. You might give us a figure such as whether we should phase it in in increments of say 135, 125.

Dr. LEE. All right [see below].

Mr. ROGERS. As I understand it, you feel off-campus training is a good procedure?

Dr. LEE. I do. I think it is essential for quality medical education.

Mr. ROGERS. Should every medical student participate in off-campus training?

Dr. LEE. If you have a university hospital I think it is essential to provide undergraduate students with other experiences in public hospitals, neighborhood health centers, private physician offices, a variety of other settings in which medical care takes place. The university teaching hospital is largely focused on tertiary care so we can't provide the range of services.

Mr. SCHEUER. Would you provide the student experience working with nurse practitioners and assistants and so on?

Dr. LEE. Yes, they are better able to work with them after they are in practice if they worked with them in training.

Mr. ROGERS. Do you think it is essential to maintain Federal support of our medical schools and universities?

Dr. LEE. Yes, sir. I think that the present level of support, according to the evidence which you have accumulated, is adequate to prevent financial distress. I think the only question is how many requirements do you want to make in exchange for that amount of support for the educational costs.

Mr. ROGERS. Thank you very much. Your testimony has been most helpful and we may be back in touch with you for other advice.

Dr. LEE. It is always a pleasure.

Mr. ROGERS. Thank you, we appreciate your being here.

[The following answers to specific questions were received for the record:]

ANSWERS TO SPECIFIC QUESTIONS ASKED BY CHAIRMAN ROGERS

(1) Could you provide studies to the committee which show that under the appropriate conditions, nurse practitioners could do as good a job as physicians?

The following studies demonstrate that under appropriate conditions nurse practitioners perform as well as physicians in the delivery of primary health care. The article by Dr. Lewis contains a more extensive review of the literature on the subject. The other studies demonstrate that nurse practitioners, as well as physician assistants, can perform effectively in a variety of practice settings and with several types of physicians, including family practitioners, pediatricians and internists. I am attaching copies of these articles for your information.[1]

(1) Duncan, Morris; Smith, Ann; and Silver, Henry. "Comparison of the Physical Assessment of Children by Pediatric Nurse Practitioners and Pediatricians." *American Journal of Public Health*. Vol. 61:1170–1176 (June 1971).

(2) Lairson, Paul; Record, Jane; and James, Julia. "Physicians Assistants at Kaiser: Distinctive Patterns of Practice." *Inquiry* 11:207–219 (September, 1974).

(3) Lewis, Charles. "Evaluating the Performance of Intermediate Level Health Workers." in *Intermediate Level Health Practitioners*. Lippard and Purcell (ed.) Josiah Macy Fdn. Baltimore: Port City Press, 1973.

(4) Spitzer, Walter; Sackett, David; Sibley, John; Roberts, Robin; Gent, Michael; Kergin, Dorothy; Hackett; Brenda; and Olynich, Anthony. "The Bur-

[1] The articles may be found in the committee files.

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lington Randomized Trial of the Nurse Practitioner," *New England Journal of Medicine* 290:251–256 (January 31, 1974).

(2) If residencies are limited, is it too traumatic to reduce from 200 percent to 125 percent in three years? What should be the timing of the reduction (how many years and the amounts to be reduced in each phase)?

I believe that a reduction from the present level of first year residencies to 125 percent of the graduates of U.S. medical schools in a three-year period is too rapid a reduction. Assuming that the 200 percent figure is correct, I would suggest a 15 percent annual reduction in the number of residencies. The first year reduction would then be to 185 percent, the second year (1977) to 170 percent, the third year (1978) to 155 percent, and the fourth year (1979) to 140 percent. The fixed level of 125 percent would be reached by 1980. This would provide ample time to make the transition in a fair and equitable manner. It would also provide time for a review by the Congress to determine the appropriateness of the reduced level.

(3) Is there a distinction between the use of Foreign Medical Graduates in for-profit and their use in voluntary hospitals?

I have found no evidence in the literature to indicate that there is a difference.

(4) Would restrictions on entry of Foreign Medical Graduates open up places in our health care delivery system for Americans who want a career in this area, but are now denied that because there is not the opportunity to serve?

The opportunities are already available for physicians, so it is not likely that this would increase the opportunities for medical graduates. It would, however, increase the opportunities for nurse practitioners, psychiatric nurses, physicians' assistants, and other physician extenders who have the skills to perform many of the services now performed by foreign medical graduates. In a number of hospitals, residency positions that are filled by foreign medical graduates could, in fact, be filled by well-trained physicians' assistants, whether these were orthopedic assistants, neurosurgical assistants, or intensive care nurses. These are a few examples of the kinds of hospital activities that nurses or physicians' assistants could assume in place of foreign medical graduates.

Mr. ROGERS. The next witness is Dr. James E. Bates, president of the Pennsylvania College of Podiatric Medicine and vice chairman of the Federation of Associations of Schools of the Health Professions. You may be joined by colleagues.

We would welcome them at the table if they desire. Would you identify them and introduce them to the committee and for the reporter's benefit?

Doctor, we welcome you and your colleagues to the committee, and we will be pleased to receive your statements.

STATEMENT OF JAMES E. BATES, D.P.M., PRESIDENT, PENNSYLVANIA COLLEGE OF PODIATRIC MEDICINE AND VICE CHAIRMAN OF THE FEDERATION OF ASSOCIATIONS OF SCHOOLS OF THE HEALTH PROFESSIONS, ACCOMPANIED BY NORMAN E. WALLIS, O.D., ASSOCIATION OF SCHOOLS OF COLLEGES OF OPTOMETRY; RAYMOND D. COTTON, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH; HOWARD OAKS, D.D.S., AMERICAN ASSOCIATION OF DENTAL SCHOOLS, VICE PRESIDENT FOR HEALTH SCIENCES, STATE UNIVERSITY OF NEW YORK AT STONY BROOK; GARY L. FILERMAN, PH. D., ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION; AND MABEL A. WANDELT, NATIONAL LEAGUE FOR NURSING

Dr. BATES. Thank you, Mr. Chairman, gentlemen. My name is James E. Bates, President of the Pennsylvania College of Podiatric Medicine. I am the vice chairman of the Federation of Associations of Schools

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of the Health Professions and it is in that capacity that I am presenting testimony today. The Federation is comprised of the following eleven associations: American Association of Colleges of Osteopathic Medicine; American Association of Colleges of Pharmacy; American Association of Colleges of Podiatric Medicine; American Association of Dental Schools; American Society of Allied Health Professions; Association of American Medical Colleges; Association of American Veterinary Medical Colleges; Association of Schools and Colleges of Optometry; Association of Schools of Public Health; Association of University Programs in Health Administration; and National League for Nursing.

Those who would like to identify themselves at the table, please do so for the record.

Dr. WALLIS. Norman E. Wallis, Association of Schools and Colleges of Optometry.

Mr. COTTON. Raymond D. Cotton, Association of Schools of Public Health.

Dr. OAKS. Howard Oaks, American Association of Dental Schools, Vice President for Health Sciences, State University of New York at Stony Brook.

Dr. FILERMAN. Gary L. Filerman, Association of University Programs in Health Administration.

Ms. WANDELT. Mabel A. Wandelt, National League for Nursing.

Mr. ROGERS We welcome all of you to the committee. We appreciate your presence and, if you have statements, they will be accepted in full and made a part of the record.

Dr. BATES. There are other people in the room who are bashful and don't want to sit at the table.

Mr. ROGERS. If they have statements they would like to have made a part of the record, we will accept those in full and they will be included at the proper point in the record [see p. 447].

Mr. SCHEUER. Is Dr. John Cooper in this group?

Mr. ROGERS. No, he will be on next.

Dr. BATES. We urge speedy enactment of this legislation, that would continue the Federal investment in programs that are essential to the provision of adequate numbers of well-qualified health manpower.

ACCOMPLISHMENTS

First of all, I would like to pay tribute to the Congress for its leadership in providing the legislative authorities needed to expand and maintain our health manpower training capacity. We have witnessed an unprecedented expansion in our resources for the training of health manpower.

Since 1958, when institutional support—based upon a formula which took into account the total number of enrolled students—first became available for schools of public health, the number of accredited schools has gone from 11 to 18. At the same time, the number of graduates has more than quintupled.

Since 1963, when the Health Professions Educational Assistance Act was signed into law, the number of graduates in the professions covered by that Act have increased by two-thirds.

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Since 1964, when the Nurse Training Act was enacted, the number of graduates in nursing have increased by four-fifths. [See table 1.]

TABLE 1.—NUMBER OF GRADUATES, 1963–64 AND 1972–73, FOR THE HEALTH PROFESSIONS PARTICIPATING IN HPEA AND NTA

Profession	Number of graduates	
	1963–64	1972–73
Total	49, 625	82, 246
Medicine	7, 336	10, 391
Osteopathic medicine	355	649
Dentistry	3, 213	4, 230
Optometry	336	688
Pharmacy	2, 195	5, 331
Podiatric medicine	97	259
Veterinary medicine	834	1, 271
Nursing	33, 259	59, 427

Source: Public Health Service.

Progress also has been achieved since the enactment of the Allied Health Professions Personnel Training Act in 1966, but attention in the training of allied health personnel has been focused on the advanced training of leadership personnel and improvements in the quality of training rather than an increase in the number of graduates.

FUTURE NEEDS

More than a decade has elapsed since the enactment of the Health Professions Educational Assistance Act and the Nurse Training Act. The Allied Health Professions Personnel Training Act dates to 1966. Legislation supporting schools of public health has been on the books for 17 years.

Provisions should be made for the continued growth of our health manpower training capacity, but the rate of growth over the past decade should be significantly diminished unless new modes of health care are necessitated by national health insurance. Future needs are summarized in Attachments A and B, that excerpt findings of two recent publications of the Federal Government: (1) "The Supply of Health Manpower 1970, 1970 Profiles and Projections to 1990," DHEW Publication No. (HRA) 75–38, December 1974; and (2) "Occupational Manpower and Training Needs," revised 1974, Bulletin 1824, U.S. Department of Labor, Bureau of Labor Statistics.

These pubications predict the growth of practitioners in the health professions based on past experience, the continuation of present levels of Federal support, and other assumptions which are set forth in the attachments.

The supply of health manpower is not merely a matter of the numbers game. In the field of medicine, and to a lesser extent in nursing, for example, we are relying too extensively at present on graduates of foreign schools who are inadequately prepared in comparison with graduates of schools in this country.

We hope that the health manpower legislation approved by the Congress will recognize that priority should be given to maintaining the current levels of enrollment and enhancing the quality of training as opposed to continuing the present rate of growth.

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We recognize that the geographic distribution of health manpower is a pressing problem and we pledge full cooperation to the solution of this problem. It should be alleviated, at least in some degree, by the implementation of the health planning and health resources development program. The provisions of H.R. 2958 that continue the National Health Service Corps will also assist in bringing health services to geographic areas that are underserved.

Although the 1975 budget for HEW proposes no funding for public health training or allied health manpower, and extremely limited nurse training funds in 1975, the grant cycle is underway and application forms are being processed. No recission papers have yet been transmitted to the Congresss as required by the Budget Reform Act. It is, of course, extremely difficult for the affected schools to plan ahead with respect to meeting their educational responsibilities. The funds made available for health manpower by the continuing resolution for 1975 have not been allocated.

Our recommendations are as follows:

(1) FASHP strongly recommends that the legislation provide for a transitional year of authorities in 1976 and implementation of new authorities in the years 1977 through 1979. We understand that the continuing resolution on appropriations that expires February 28, 1975, will be extended to June 30, 1975 prior to the end of this month.

(2) FASHP recommends that adequate provision be made for scholarships to assist in the enrollment of disadvantaged students in all of the health and allied health professions covered by the Health Professions Educational Assistance Act, the Nurse Training Act and the Allied Health Professions Personnel Training Act.

(3) FASHP recommends that institutional support based on educational costs be awarded to maintain the existing level of enrollments and quality of training and that financial incentives be provided to meet special needs in the areas of expanded enrollment, geographic distribution or type of employment/specialty.

(4) FASHP recommends that the term full-time students be defined as full-time equivalent students in the case of schools of public health with appropriate adjustments of appropriation levels.

(5) FASHP recommends that institutional support should provide for the increased educational costs of schools that have converted from 4- to 3-year programs, and

(6) FASHP recommends that the authorization for appropriations for institutional grants for graduate programs under the proposed section 791 of the PHS Act be increased to a minimum of $3 million.

In concluding, let me again express our appreciation for your leadership and assistance in the enactment of legislation to increase our supply of health manpower.

Representatives of the organizations that comprise the membership of the Federation are here to answer questions.

[Attachments A and B follow:]

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ATTACHMENT A

TABLE 5.—SUPPLY OF ALL ACTIVE HEALTH PROFESSIONALS, USING BASIC METHODOLOGY: ACTUAL 1960 AND 1970; PROJECTED 1980 AND 1990

Year	All health professions	Physicians (M.D. and D.O.)	Dentists	Registered nurses	Optometrists	Pharmacists	Podiatrists	Veterinarians
				Number active				
1960	1,029,620	251,900	90,120	527,000	16,100	117,800	7,000	19,700
1970	1,329,120	323,200	102,220	723,000	18,400	129,300	7,100	25,900
1980	1,885,370	446,800	126,170	1,099,600	21,800	146,100	8,500	36,400
1990	2,484,410	593,800	154,910	1,466,700	28,000	179,900	13,000	48,100
				Percent distribution				
1960	100.0	24.5	8.8	51.2	1.6	11.4	0.7	1.9
1970	100.0	24.3	7.7	54.4	1.4	9.7	0.5	1.9
1980	100.0	23.7	6.7	58.3	1.2	7.9	0.4	1.9
1990	100.0	23.9	6.2	59.0	1.1	7.2	0.5	1.9
				Rate per 100,000 population [1]				
1960	572.1	140.0	50.1	292.8	8.9	65.5	3.9	10.9
1970	652.1	158.6	50.2	354.7	9.0	63.4	3.5	12.7
1980	830.8	196.9	55.6	484.5	9.6	64.4	3.8	16.0
1990	991.3	236.9	61.8	585.2	11.2	71.8	5.2	19.2

[1] Resident population as of July 1.

Note: Figures may not add to totals due to independent rounding.

Source: For sources of manpower data in this table, see tables in chapters on each profession.

Assumption 1. Upon expiration in FY 1974 of the Comprehensive Health Manpower Training Act of 1971, aggregate public and private funding will be adequate to at least maintain (though not necessarily to increase) the productive capacity of professional schools needed to ensure the continuation of enrollments at the level resulting from this Act. This assumption accounts in part for the projection of a slightly lower rise in physician supply for the 1980's. Since the current legislation concerns itself with enrollment increases through academic year 1974–75, the impact of the legislation (unless altered) upon the Nation's supply of M.D.'s and D.O.'s will be felt through the latter 1970's. Enrollment increases upon expiration of the current legislation are still assumed to occur, but at a reduced pace. The assumed enrollment growth for the remainder of the projection period, consequently, results in a silghtly slower expansion of the M.D. and D.O. pool in the 1980–90 period.

Under the basic methodology, consequently, first-year enrollment in U.S. medical schools is projected to grow from 11,348 in academic year 1970–71 to 14,339 in 1974–75; 15,321 in 1979–80; and 16,811 in 1986–87. With assumptions about attrition among students (See Chapter 3), the projections of first-year enrollment result in a total graduate input of approximately 270,000 M.D.'s over the next two decades. The number of M.D.'s graduating is projected to rise from 8,979 in 1970–71 to 15,920 in 1989–90, an increase of 77 percent. This compares with an increase of 28 percent between academic years 1960–61 and 1970–71. Similar increases for osteopathic graduates are also projected for the next 20 years.

Assumption 2. U.S. medical and osteopathic schools will be financially able to maintain the projected output of graduates. Projections for first-year enrollments and subsequently for graduates become meaningful only to the extent that existing and assumed new schools remain financially able to accommodate these numbers. Compared to that for most health professions however, private and non-Federal public funding for medical and osteopathic schools promise to represent a presence that will be most supportive to educating and producing future streams of physicians into the existing pool.

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In recent years there has been a substantial increase in the number of young people expressing interest, and actively seeking careers, in health occupations. The pressure this exerted on enrollment in health professions and allied educational programs, specifically in the area of physicians, is likely to be forceful. For example, applications for admission to medical school now approximate three times the number of first-year places available. In addition, the whole set of dynamics surrounding the increased role of the female and racial-ethnic minorities in the functioning of our society provides a strong forcing function to encourage continued and perhaps sharply increased non-Federal financial support to medical education.

Assumption 3. Foreign trained M.D.'s will continue to increase the U.S. supply annually in approximately the same numbers as they did in 1970–71. If so, the projected growth in their number would account for slightly less than two-fifths of the total growth in physician supply over the 1970–90 period, similar to the substantial input accounted for by foreign medical graduates (FMG's) during the 1960's. This means that foreign trained physicians (including the Canadian trained),[1] would represent almost one-third of all active physicians in 1990, compared to about one-fifth in 1970.

More specifically, the supply of active U.S. trained physicians alone is projected to increase by 166,600 or by over 60 percent, over the projection period—from 263,200 in 1970 to 429,800 in 1990. In contrast, the supply of all active FMG's in the United States is projected to nearly triple by 1990, growing from about 60,000 in 1970 to 164,000 in 1990. This rapid growth among the FMG population represents an average yearly gain of about 8 percent (compounded), corresponding quite closely to the 9 percent yearly increase registered during the 1963–70 period.

Assumption 4. The supply flow will be generally unaffected by any significant changes in the health care delivery system.

ATTACHMENT B

1972 EMPLOYMENT AND PROJECTED 1985 REQUIREMENTS FOR SELECTED HEALTH PROFESSIONS

Profession	1972 employment	1985 requirements
Dentist	105,000	140,000
Dental assistant	115,000	155,000
Dental hygienist	17,000	50,000
Optometrist	18,700	23,300
Physician [1]	330,000	485,000
Veterinarian	26,000	37,000
Nurse	748,000	1,050,000
Physical therapist	18,000	32,000
Dietitian	33,000	44,000
Hospital administrator	17,000	26,600
Pharmacist	131,000	163,000
Podiatrist	7,300	8,400

[1] Includes medical and osteopathic physicians.

Source: "Occupational Manpower and Training Needs" revised 1974. Bulletin 1824 U.S. Department of Labor.

Mr. PREYER [presiding]. Thank you very much.

Mr. Scheuer?

Mr. SCHEUER. Thank you, Mr. Chairman.

Dr. Bates, on page 3 in the third paragraph, you say that we ought to diminish significantly the rate of growth of our health manpower training capacity unless new modes of health care are necessitated by national health insurance. Could you elaborate on that?

[1] Ideally, it would be most desirable if this document could present throughout separate data on U.S. trained physicians and medical graduates from foreign schools, including Canadian schools. This would be consistent with the legislative mandate of the Bureau of Health Resources Development (BHRD) for funding professional education only in U.S. schools. Unfortunately, such separation cannot be fully achieved because certain published data on physicians, such as internship and residency statistics, often combine statistics on U.S. trained M.D.'s with counterpart data on graduates of Canadian schools. In these instances, it is not possible to separate out the relevant information for U.S. trained M.D.'s alone.

Source: *The Supply of Health Manpower*, 1970 Profiles and Projections to 1990, DHEW Publication No. (HRA) 75–38, December 1974.

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Dr. BATES. I suspect we might find some division on this.

I think the concern on the part of most institutions is the requirements for expanded enrollments every year. The schools were being forced to accommodate more students than they had the space or the ability to provide a quality education for. I think that is part of the problem. It becomes a concern to all the professions.

Someone else may want to speak to that.

Mr. SCHEUER. Don't you think there is an answer for that other than diminishing the rate of growth? It is not written in the stars that you have to diminish the quality of your health education. There is nothing in the Federal regulations saying you have to diminish the quality of the education.

Dr. BATES. It is appearing to go hand in hand.

Mr. SCHEUER. With what?

Dr. BATES. If you have a facility—this is not a good example—a facility that holds 100 students and each year you are required to take 10 percent more students, you divide into two sections to accommodate the 110.

Mr. SCHEUER. How do they require you to take more students?

Dr. BATES. The current legislation requires it. We are suggesting that the legislation should not mandate additional increases each year as a prerequisite for being part of the program.

Mr. SCHEUER. If they mandate it, they should mandate the funds to build the facilities and provide the services so you are maintaining if not improving the quality of education.

Dr. OAKS. I am representing the American Association of Dental Schools. There has been a significant expansion in the numbers of students enrolled in American medical schools. It varies from profession to profession due to factors you can all understand. The concern about the services that could be demanded under national health schemes leads us to have a reservation on that. The influx of dental students has been almost 50 percent. We are not sure it should continue to increase by 50 percent in the next decade.

Mr. SCHEUER. What is the base you use for increasing dental personnel?

Dr. OAKS. One is the ratio of practitioners to population.

Mr. SCHEUR. We are still getting kids who come to the military services by draft or by volunteering who have never seen a dentist. Their mouths are so bad they can't even eat a piece of red meat.

Dr. OAKS. Thank you for the example. I am sure all of you realize there is a tremendous need for services and demand for care. All evidence indicates the two factors leading to that——

Mr. SCHEUER. You have to distinguish between care and effective care. The guy with the buck in hand can get effective care. You have to distinguish.

Dr. OAKS. The demand for care would rise very sharply if the ability to pay for care and the accessibility and availability to pay for care and the accessibility and availability of the care were there to meet it.

Mr. SCHEUER. The whole point some of our witnesses seem to be missing—and that I personally feel Secretary Weinberger is also missing—is that unless all three of us and the other members of this committee are hit by a single truck in the next year or two we are

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going to be reporting out to the House and the House presumably is going to pass and the President is going to sign some kind of national health care program. It is going to be funded, whether by insurance or general revenues, who knows, God in his wisdom couldn't tell us now.

But I think as sure as night follows day we are going to have a national health program. When that happens you are going to create a funding mechanism for the health care everybody wants and needs equally distributed as Secretary Weinberger says. If we don't have the personnel to deliver that care and an institutional system that delivers it with some kind of rationale we are going to be in a heck of a fix in this country and it seems to me what all of you ought to be doing is addressing yourselves in part to what level of health care training we ought to have in terms of numbers—assuming that we are funding a program to provide health care for all Americans.

Dr. OAKS. I would agree and I don't believe the dental profession could currently meet the demand by erasing the difference between need and demand. That is why we have a reservation with this particular recommendation.

Mr. SCHEUER. It is really the same question on page 4, your second full paragraph, "Priority should be given to maintaining the current levels of enrollment and enhancing the quality of training as opposed to continuing the present rate of growth."

I don't believe those things are mutually exclusive. If the American public wants a national health care program, they have to create the institutions and health care to deliver it. It is perfectly silly for us to say we are going to work very hard for the next year creating a funding mechanism and for us not all to be addressing ourselves to creating the systems to distribute the care and the people to provide it. I don't believe at all that enhancing the quality of training is inconsistent with present rates of growth or what I believe we need is considerably enhanced rates of growth in the volume of medical care professionals and nonprofessionals that we should be turning out.

Ms. WANDELT. I would like to speak to that. The comments by the Secretary this morning referred to downgrading the support for undergraduate training versus graduate training. The attention, as far as nursing is concerned, has focused on graduate preparation in nursing. It seems to me that we are talking about graduate level preparation and the training of nursing practitioners who have been used really in terms of an extension of the physician and the aspect of care that he provides for people.

But there is another aspect of care that nursing provides for people. I think that if we are talking about quality education, expanded health insurance, and our concern in relation to care for the aging, we must recognize the people for whom life is being prolonged are going to need continuing nursing care. We must be concerned with nursing care in nursing homes where you have so little professional nursing care and where you have the nurse who could be providing the primary care and the recognition of when there is need for medical care.

In all of these kinds of nursing care the education takes place at the undergraduate level and I think that it would be a mistake to focus support only on graduate education as far as nursing is concerned.

Mr. SCHEUER. Thank you very much, Mr. Chairman.

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Mr. ROGERS. I must say I agree with that. I don't think we will have any idea of the real need for nurses until we look at some of these nursing homes. I know in my own area they simply cannot get enough nurses. The VA hospital in Miami, which I recently visited, has a terrible shortage of nurses.

Mr. SCHEUER. I recall to you the Secretary's testimony this morning that we have unemployment among nurses.

Ms. WANDELT. If we are thinking in terms of quality of care, we cannot talk only in terms of numbers. If you talk about nursing personnel, then indeed you have a large number. But there have been studies that demonstrate the quality of care is related to the ratio of professional nurses to nonprofessional nursing personnel, in other words, related to the quality that you have.

Mr. SCHEUER. Mr. Chairman, I just want to say how much on point you are on one item I don't think we recognize enough. As we extend life we extend the need, almost in geometric proportion, for health services. I spent a day talking to the British Public Health Service and or Dr. Stevens of the British Medical Association, I said, "Is there any way we could quantify a national health program?" He said, "No, because since you extend life you have an absolutely unquantified number of people who wouldn't be around if you didn't extend life. As you give them more years, they have arthritis, head colds, broken hips and all the ailments human beings are subject to which they wouldn't have if you hadn't extended their life in the first place."

So it will be an exploding need for medical and health services of all kinds if we are successful in prolonging human life, which you and your conferees will tell us we are capable of doing.

Ms. WANDELT. Prolonging life isn't only prolonging life in terms of the aged. It is prolonging life in terms of the infant or the victim of a motorcycle accident and other things.

Mr. SCHEUER. When you save a life then you have a full life time that will require nursing care from time to time.

Mr. COTTON. I would like to pick up on a word that Congressman Scheuer used in describing one element of the administration's testimony, that was bizarre. I don't think there is anything more bizarre than that statement with respect to nonsupport of schools of public health. When you talk of HMO's, PRO's, whatever, you are going to need people to collect data, the nuts and bolts technicians of those systems as well as the primary care deliveries and these are the people that schools of public health produce.

Now in the one hand the administration, even the administration proposes various enhancements of health care delivery programs and on the other hand proposes the elimination of support to schools of public health.

One other—we have a written statement which we will submit for the record [see p. 459]—but the schools of public health have enjoyed the longest history of institutional support of any of the health professions schools in the country, over 17 years. Rightly or wrongly schools have built this funding into their support.

There are only a few schools in the country. Three are in one State, but only 15 States have schools of public health. It seems a serious question to a lot of people whether the other States should invest in

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schools of public health or whether the appropriate funding mechanism is indeed the Federal Government. We believe that your bill, Mr. Chairman, is the appropriate way to go and we support it very, very strongly.

Dr. OAKS. As you know, the American Association of Dental Schools supported your bill in the last session of Congress. We are prepared to do so now, with the usual concern to Mr. Scheuer's question, that capitation not to be tied directly to an enrollment increase unless there are suitable provisions for waiver of those schools that would be unable to meet it without losing credit.

Mr. ROGERS. We provide a waiver clause as well as options in return for capitation.

Dr. OAKS. If we may we will submit a written statement [see p. 454]. I think we have only one reservation with the remote site training question which has been a prominent feature relating to osteopathy and dentistry.

The maldistribution problem is at least as severe in dentistry as in the other fields. We are concerned if a portion of the capitation must be spent for offsite training. This would, in fact, serve to dilute the effect of institutional education.

Mr. ROGERS. Now we have found that the practitioners almost universally subscribe to off-campus training.

Dr. OAKS. I think that all of us in dental education believe offsite training is very valuable. The majority of schools require it. It is typically done by hospitals. Our only question has to do with spending money beyond what is already being done. We are for the principle but not for the restraint.

Mr. ROGERS. What about the level of support for optometry, is there any problem with that?

Dr. WALLIS. Thank you for bringing that concern up. We have serious concern for the support of optometry. We are rather unique in that 50 percent of our schools are free standing independent institutions not State related. At my own college we receive minimal State support but several of our other institutions receive none. Wyoming receives only about $185 a year for support per student. Dr. Bates' institution is in a similar situation. The interesting thing is that two proposed new schools have been deferred, one in Birmingham and one at the State University of New York. They have found in projecting their costs of education at a conservative level that it is around $15,000 per student a year.

Unfortunately, the IOM study of optometry has some big problems and what we consider our costs for the future and what we consider comparable costs in terms of our education with dentistry are not adequate in terms of the capitation level. We would respectfully request the committee to consider elevating the capitation support for optometery from $700 per student to $1,500.

The cost of that would be approximately 0.7 percent of the 1974 appropriated amount and I think the benefits would be significantly——

Dr. FILERMAN. You raised a question about the level of authorization.

Mr. ROGERS. I knew I shouldn't have brought up the issue of capitation.

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Dr. FILERMAN. I want to call your attention to the sixth recommendation in the federation testimony, the last one that refers to section 791, the provision referring health administration. Since the last time we talked with the committee, you passed a planning bill which we estimate is going to generate a need for 5 or 6,000 new planning agency professionals. I am sure you remember from the discussions in the testimony relevant to that bill that major concern has been the quality of staffing available to those agencies and the competency of those agencies to deliver the task which that piece of legislation places on their shoulder.

Under 314(c), the authority of last year, there was Federal support for planning education. That is now terminated. The only Federal authority for any support for either planning or administration is that small authorization that is currently in your bill which is an historical breakthrough in the sense that it is the first time there has been any such authorization in any bill.

We are very grateful for that and think it is an excellent start. But we think that that appropriation is inadequate. Even if fully funded, it will only lead to support at a level of about $55,000 per school which really isn't going to help them do much particularly in terms of adding what we think are going to be incredible demands for community level technical assistance to planning agencies, HMOs and other delivery organizations.

So we are asking that the authorization level be increased from $1.75 to $3 million which we think is very modest but very realistic.

Mr. ROGERS. Thank you very much.

Gentlemen, thank you and I thank the nurses for being here. We appreciate this testimony. It has been most helpful. Any statements will be received for the record for the next five days.

[Testimony resumes on p. 465.]

[The following statements and letter were received for the record:]

STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY

In 1971, the Congress started a revolution in health manpower education. Pharmacy schools were mandated to "emphasize clinical pharmacy, drug use and abuse, and clinical pharmacology" in their educational programs. The revolution has brought many improvements in health care to thousands of Americans because pharmacy students are now involved in the care of individual patients. Physicians are still responsible for the total health care of the individual patient. But clinical education has taught both pharmacists and physicians that there are limits to their abilities to single-handedly solve every health problem. Where drugs are concerned, pharmacists and physicians are beginning to learn that they can do a better and less expensive job if they work as a team.

The Association wants the educational process which is responsible for this revolution to continue. Better and less expensive health care has long been sought after by the Congress. The pharmacy programs—capitation grants tied to requirements for clinical education, special project grants, loans and scholarships for students, and construction grants—fashioned by Congress in 1971 have made these improvements possible. The programs deserve continued support.

This year pharmacy schools have enrolled 29,436 students in professional programs which makes the student or school eligible for Federal support. Over 7,080 pharmacy students will graduate in 1975.

Great uncertainties in Federal funding caused by illegal impoundments, rescission proposals, and total elimination of new health profession scholarships, have caused traditionally reliable student population forecasting methods to become obscure. Based on the schools' total capacity, subject to new space being developed, it is estimated that pharmacy schools will enroll these numbers:

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School year:	Total number of students
1975–76	30,600
1976–77	31,800
1977–78	32,400
1978–79	33,000
1979–80	33,300

Authorization amounts for pharmacy schools should be large enough to equitably apportion various program funds so that the final net amount received by each school is enough to make a difference.

The Institute of Medicine Cost Study provided an equitable approach for the allocation of capitation grant funds which the Subcommittee rejected last year. A reconsideration of that cost study or an updated one is in order. The Subcommittee may want to make future authorization levels dependent on the outcome of future cost studies so that the level of Federal funding can be established to permit Congressional priorities to receive proper attention.

What are the specific improvements and accomplishments being made in pharmacy schools? Look at last year's statement submitted to this Subcommittee [1] or make a phone call to a Dean of a pharmacy school in your state, or to one in a neighboring state (only 44 states, the District of Columbia and Puerto Rico have pharmacy schools). The Subcommittee will be pleased at the progress.

The values of these programs should also be made available to practicing pharmacists in the form of extended continuing education seminars. Re-educating persons in the field will speed the benefits to the public.

The Association has recently reorganized its internal structure to make it more responsive and more representative of faculty, deans, students and teaching specialists. As a part of this process, the Association has begun to adopt policy statements to guide the Association's relations with others.

A policy statement on health manpower is attached to this submission. It states that pharmacy schools want to be full participants in solving the nation's health problems. It points out how health care can be made better and less expensive if pharmacy schools can do what they are capable of doing. Programs in health communications, product selection, patient information, therapeutic management, clinical pharmacy, drug distribution systems, and information systems are all drug related educational components which the pharmacy schools want to improve or strengthen so that drug-related health care can be made better and less expensive.

Pharmacy has its detractors because some people have been exposed to bad pharmacy practice or no pharmacy practice. Some of these detractors are administration staff people who have consistently eliminated pharmacy schools from major health manpower support reforms.

Deciding the role of the Federal government in supporting pharmacy schools is a challenge to professional politicians in a time of inflation, recession and burgeoning Federal deficits. The Association once submitted a proposal to the Department of Health, Education and Welfare which would have broken even at a five (5) percent level of efficiency. Had the program been funded, and 100 percent effective as it was in its pilot stage, a mere $2 million investment would have saved $80 million in Medicaid hospital and drug costs, while immeasurably improving the health and general well-being of close to 10,000 aging persons in nursing homes. Choosing not to fund a program with such great potential for success is a political decision. The Association believes that decision was a mistake.

Those kinds of costs savings are possible in a number of different ways if today's pharmacists are properly utilized in health care. The Association knows the Congress will not ignore any ideas to make health care better and less expensive.

The Association knows that tough political decisions have to be made if the American economy is to be improved. The Association knows that state government budgets are being pared to the bone. State university asking budgets hardly cover increased fuel costs and three (3) percent salary increases in many cases, but even these are being cut by state legislators. The Federal govern-

[1] See p. 997 of "Health Manpower and Nurse Training—1974," Pt. 2, Serial No. 93-100, hearings before the Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, 93d Congress.

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ment's taxing power and resources are the only sources of stable support for a health care revolution, which was started by the Congress. The Association asks the Congress to keep this in mind when the members draft and vote on the Health Manpower Act of 1975.

A POLICY STATEMENT ON HEALTH MANPOWER LEGISLATION—AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY

The American Association of Colleges of Pharmacy is a nonprofit educational society representing the 73 accredited colleges of pharmacy in the U.S. AACP has adopted a positive approach to the nation's health services problems and recognizes the academic privilege to address problems theoretically through basic research, but it also accepts and endorses the need to take pragmatic and immediate action to relieve the problems at hand. While limiting its advocacy to the needs of its own constituency, the Association recognizes that its aspirations can only be achieved by working cooperatively with the other health professions.

Manpower Supply: In recent years, colleges of pharmacy have undergone significant enrollment increases. These have come in response to federal incentives and as a product of the labor market. AACP believes that the supply of professionally educated pharmacists is at, or very near, the level required to effectively serve the current demand for traditional pharmaceutical services. The output of pharmacy education may be characterized as the geographically *most well deployed*, and certainly the *most accessible*, of all health professions in relation to the needs of patients-consumers. The Association endorses keeping the pharmacist close to primary health care needs and endorses in principle those proposals which encourage recent graduates to serve in areas of greatest need. (See Appendix I)

Colleges of pharmacy are still in the midst of a dramatic transition in their professional academic programs. Essentially, the change can be characterized as an increased emphasis on direct patient care, as well as consultative services to other health professions. On an institutional level, the transformation involves a move from traditional didactic and laboratory methods toward an improved and more effective educational experience such as clinical instruction and the group, personalized modalities. This approach which can best be developed in an interprofessional environment, provides improved patient care but also leads to higher educational costs. To have the reorientation in pharmaceutical education fully impact on the health care of Americans, it must influence the 130,000 pharmacy practitioners as well as students. It is reasoned that it is more cost/effective to upgrade and better utilize existing health professionals than to create whole new categories of specialized personnel. The situation demands a retraining as well as a training component.

The key to pharmacy's potential contribution as a national resource for health care lies not only in its numbers, accessibility and consumer acceptance, but also in the fact that its practitioners are especially well prepared to address one of the most important of the nation's health problems—drug utilization. Evidence abounds that Americans misuse, over use, under use and inappropriately use drugs. The difficulties arise at both the practitioner and the patient level. The outcomes adversely affect therapy, as well as costs. The following sequence of events from the drug use process are offered to demonstrate the role or potential role of the pharmacist:

Health Communications: Being in the most visible and accessible of health professions, the pharmacist is in an ideal position to provide information on a wide variety of health information topics. His role can easily extend beyond that of a generalist, to that of a triage function which would direct potential health problems to the most appropriate component of the health care system. (Appendix II)

Product Selection: Presently there is great concern over the costs, relative quality and effectiveness of drug products. The pharmacist can, and in many cases already does, select the appropriate drug product after the prescriber has written an order. Even before the product selection decision, the pharmacist should be prepared to advise the prescriber on therapy and to refer therapeutic problems and potential problems to them after treatment has been initiated. Drug allergies, adverse drug reactions, drug interactions, are included among the problems to be addressed. The pharmacist's awareness of multiple prescribers and patient use of non-prescription drugs allows him to serve uniquely as a monitoring agent. (Appendix III)

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Patient Information: Even when drugs are properly prescribed, there is ample evidence that patients do not properly utilize their medication. A properly informed pharmacist with good communication skills is required to instruct patients in correct drug use and to insure that proper utilization is implemented. It should be noted the failure of the patient to correctly follow their plan of therapy (non-compliance), is an important factor in the overloading of the health care system and this contributes to escalating costs.

Therapeutic Managament: For many persons, drug use is not an irregular occurrence, but a continuing activity. This is true for many chronic conditions, which are forming an increasing portion of the total health care needs. Pharmacists can carefully monitor therapy and this includes inquiries concerning effectiveness and potential problems. In some cases, these roles would include the evaluation of therapy and the initiation of adjustments (with proper referral), the ordering of laboratory work and the evaluation of results, and the involvement in interprofessional decisionmaking that would serve as a physician extender resource. (Appendix V)

In order to prepare future pharmacists and provide appropriate continuing education and technical support for those already in practice, it is essential that colleges of pharmacy receive federal support to assist in improving the quality and effectiveness of education. The changing nature of pharmacy education, the need to improve the efficiency of education in the biomedical sciences, the desire to integrate education with practice, are all positive motivating factors in the request for such support. While every effort will be expended to develop intrainstitutional support, it is recognized that the economic constraints being placed upon the enterprise of higher education are such that only limited advances are foreseen for the near future. This fact, of course, increases incentives to develop outside resources. Some specific needs which require support are outlined:

Faculty Expansion: New clinical education programs require for lower student/faculty ratios than have been traditional in colleges of pharmacy. Moreover, the transition in pharmacy education requires more than the addition of the qualified pharmacist-practitioner-teacher to faculties. Experts must be added not only in the disciplines of pharmaceutical education but also through solo and/or joint appointments in such areas as clinical pharmacology, pathology, medicine, nursing, and health care organization.

Clinical Pharmacy Programs: The clinical concept is basic in the proposed advance of pharmacy education. It is essential that clinical orientation pervade the total development and it is important that colleges continue to develop advanced education and practice model roles to supplement the basic undergraduate program and to spearhead advances into new service areas. Such programs improve educational quality that lead to long-range progress.

Clinical Teaching Facilities: A number of colleges of pharmacy require new or refurbished physical plants. However, most colleges possess a basic building suitable for the conduct of the program. At the same time a number of colleges with adequate physical plants are located on campuses without academic centers. Some of these colleges will require construction funds to facilitate a move and new physical facilities at a health center side. Others remain on campus but will move a portion of their program to sattelite patient care settings. These institutions will require funds for developing physical facilities and communications linkages at an appropriate site.

Drug Distribution Systems: Some of the outstanding advances in pharmaceutical technology have been in the packaging and distribution systems developed for service in hospitals, extended care facilities and now being proposed for ambulatory services. The results of implementing these services is such that GAO is demanding their inclusion in federally financed drug programs. Teaching one to use these systems requires something more than a didactic presentation. Experience with a working system is required and the appropriate equipment and instruction personnel must be added to the resources of pharmaceutical education.

Information Systems: The provision of patient information requires that students and practitioners not only develop subject matter oriented knowledge, but also a knowledge of information sources and their use. On-hands experience with working systems and a general knowledge of information technology are required. In many cases these resources are not available to the colleges and must be purchased from outside suppliers for use in institutions which may be formally affiliated with the teaching program.

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Educational Research and Development: The trend toward increasing clinical instruction, the demands to reach a widely dispersed practitioner population and the need to economize on basic science curriculum without losing scientific competence, calls for the greater application of education technology. Efforts must be undertaken to develop education systems directed toward competency based education objectives. It would be foolhardy to advance upon any of the proposed changes in pharmacy education without carefully evaluating each step. A continuing research program is required to aid in focusing upon optimum educational objectives and in quantifying progress (or the lack of it) and in measuring outcomes.

In summary, American Association of Colleges of Pharmacy has adapted progressive, and patient-oriented posture toward its academic programs and toward the role which its graduates fill in serving society. It does not shrink away from significant innovation in teaching, research, and/or the reorganization and third-party financing of services. On the contrary, it accepts the challenge and welcomes the opportunity to participate fully in these developments.

The following series of brief technical appendices to the Health Manpower Policy Statement are available on request from the American Association of Colleges of Pharmacy:

Topic	Author
I. Manpower	Christopher A. Rodowskas, Jr., Ph.D., Director, Pharmacy Manpower Information Project, American Association of Colleges of Pharmacy.
II. Health Communications	Mickey C. Smith, Ph.D., Chairman, Department of Health Care Administration, University of Mississippi.
III. Product Selection	John L. Colaizzi, Ph.D., Chairman, Department of Pharmaceutics, University of Pittsburgh.
IV. Patient Information	David A. Knapp, Ph.D., Chairman, Department of Pharmacy Administration, University of Maryland.
V. Therapeutic Management:	
A. Economic Considerations	Alan M. K. Cheung, Pharm. D., Associate Clinical Professor, University of Southern California.
B. Clinical Services	William A. Miller, Pharm. D., Associate Professor of Clinical Pharmacy, University of Tennessee.

SPECIAL COMMITTEE ON A HEALTH MANPOWER POLICY STATEMENT

Allen I. White, Ph.D., Chairperson, AACP President and Dean, College of Pharmacy, Washington State University.

Tom S. Miya, Ph.D., AACP President-elect and Head, Department of Pharmacology and Toxicology, Purdue University.

Lawrence C. Weaver, Ph.D., AACP past-president and Dean, College of Pharmacy, University of Minnesota.

William J. Kinnard, Jr., Ph.D., Chairman of AACP Committee on Government Affairs and Dean, School of Pharmacy, University of Maryland.

Norman A. Campbell, J. D., Ph.D., AACP Committee on Government Affairs and Chairman, Department of Pharmacy Administration, University of Rhode Island.

Norman R. Farnsworth, Ph.D., AACP Committee on Government Affairs and Head of Department of Pharmacognosy and Pharmacology, University of Illinois.

Kenneth F. Finger, Ph.D., AACP Committee on Government Affairs and Dean, College of Pharmacy, Assistant Vice President for Health Sciences, University of Florida.

Andy S. Stergachis, AACP Committee on Government Affairs, pharmacy student, College of Pharmacy, Washington State University.

William J. Skinner, J.D., Legislative Liaison Representative, American Association of Colleges of Pharmacy.

Christopher A. Rodowskas, Jr., Ph.D., Executive Director, American Association of Colleges of Pharmacy.

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STATEMENT OF AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE

The American Association of Colleges of Podiatric Medicine respectfully calls attention to its testimony presented to this Subcommittee at its health manpower hearing on May 23, 1974. Rather than repeat that entire statement, the Association here wishes to update some of that information and comment specifically about H.R. 2956, the health manpower bill currently under consideration by the Subcommittee.

Last year when we testified, we supported the concept of capitation authorization amounts being based on a uniform percentage of net education expenditures for the respective professions as determined by the Institute of Medicine (IOM) of the National Academy of Sciences in its study "Costs of Education in the Health Professions." Subsequently the Subcommittee decided not to base capitation on IOM figures but rather to group the professions in various categories for the purpose of capitation authorization.

That new approach caused this Association to seek equitability for podiatric medicine by other means. Since the Subcommittee in its mark-up session decided on three groupings of professions for capitation amounts, the full Committee on Interstate and Foreign Commerce, to improve equitability, agreed to advance podiatric medicine from the lowest category to the middle category. This change, also reflected in H.R. 2956 which is before you, satisfactorily establishes equitability for the profession in capitation authorization.

The Association was extremely careful in selecting data to offer in support of podiatric medicine's case. For example, we could have used the "constructed cost" approach, documenting our case with an amount we determined through a study conducted by an independent research firm but commissioned by the Association. Although that figure is much higher, and we feel that it is supportable, it also tends to be self-serving since the Association paid for the study.

We decided to utilize IOM figures which represent historical facts rather than constructed figures of "what should be." The attached table from the IOM study clearly indicates that podiatric medicine was inequitably funded under the expired 1971 Act. Moreover, since the net education expenditures for podiatric medicine were closer to those of veterinary medicine than to either optometry or pharmacy, podiatric medicine and veterinary medicine should be grouped together.

We are pleased that the Committee recognized the logic and fairness of the amendment placing podiatric medicine at the $1,500 level for capitation, grouping it with veterinary medicine and public health. (Schools of public health were not included in the original IOM study; supplementary, more cursory report for these schools was submitted to the Subcommittee at the Chairman's request.)

RELATIONSHIP OF CAPITATION FUNDING TO NET EDUCATION EXPENDITURES, 1972–1973[1]

Profession	Net education expenditures per student	Average capitation grant	
		Amount	Percent
Medicine	9,700	1,961	20
Dentistry	7,400	1,982	27
Osteopathy	7,000	1,346	19
Veterinary medicine	5,550	753	14
Podiatry	4,900	403	8
Optometry	3,100	333	11
Pharmacy	3,050	386	13

[1] From Institute of Medicine Report on "Costs of Education in the Health Professions."

We feel, however, that a table on page 23 of the Committee Report (No. 93–1509) summarizing capitation in the bill reported out of full Committee (the same as H.R. 2956) contains some invalid comparisons. IOM net education expenditures for 1972–73 in the table are compared with authorization levels in the bill for 1974–75 and subsequent years. Comparisons are made of costs in one year to proposed funding for other years. Only if those net education expenditures for each profession remained the same in later years or changed in the same proportion (highly unlikely, we feel) would the percentages provide valid comparisons. Moreover, because of podiatric medicine's enormous efforts to improve quality of education in recent years, which also would be reflected

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in costs, we believe the percentage for podiatric medicine identified in the table is an inflated figure.

Summary Table from Committee Report 93–1509, Page 23.

TABLE 10.—CAPITATION FISCAL DATA

School	Cost per student per 10M study [1]	Fiscal year 1974 obligation		1975 budget request		H.R. 17084	
		Per student	Percent 10M [2]	Per student	Percent 10M [2]	Per student	Percent 10M [2]
Medicine	$9,700	[3] 1,878	19	1,500	15	2,100	[4] 22
Osteopathy	7,000	[3] 1,942	28	1,500	21	2,100	[4] 30
Dentistry	7,400	[3] 1,935	26	1,500	20	2,100	[4] 28
Public health	9,800	[5] 1,530	16	0	----------	1,500	15
Veterinary medicine	5,550	1,495	27	900	16	1,500	27
Podiatry	4,900	684	14	400	8	1,500	31
Optometry	3,100	684	22	400	13	700	23
Pharmacy	3,050	684	22	0	----------	700	23

[1] Institute of Medicine cost study.
[2] Rounded to nearest percent.
[3] Reflects $4,000 capitation award for graduating students.
[4] Based on fiscal year 1975 and fiscal year 1976 authorized amounts, fiscal year 1977 award for those schools is $2,000 per student and the percent of costs for medicine, osteopathy and dentistry for fiscal year 1977 will be 21, 29, and 27 percent respectively.
[5] Based on sec. 309 formula grants to schools of public health divided by full time enrollment in 1973–74 school year.

We believe that the level of capitation for podiatric medicine in H.R. 2956 is justified and fair. We appreciate the consideration we enjoyed by the Committee in adopting that change in the 93rd Congress. We urge the Subcommittee to retain the same authorization amounts for capitation in new legislation.

It should be noted that even if such a potential increase in capitation is funded, colleges of podiatric medicine remain severely short of funding to meet a moral obligation to educate students commensurate with their scope of practice as professionals. This Association therefore is actively seeking other means of funding to augment Federal sources. We believe it to be in the national interest to develop additional sources of revenue. Moreover, we think other professions may be able to benefit from the studies we are now conducting.

Of concern to the Association is financial assistance for students of podiatric medicine. Students today find themselves under enormous financial pressures. The attached table shows the situation at one college of podiatric medicine, typical of the problem facing students at all the colleges. Notice that in the face of documented need which increased 110% in four years, Federal student aid decreased 21% during the same period, resulting in an enormous unmet need for financial assistance. Some students are to the point in need that they are unsure whether they can complete their professional education although they may already have completed one, two, or even three years. Dropping out for financial reasons would be tragic not only for the students themselves but also for the nation which has invested in their education and which sorely needs their professional services.

A 4-YEAR COMPARISON OF THE FEDERALLY FUNDED FINANCIAL AID PROGRAMS

[A sample]

	School year		Percent increase/ (decrease)
	1971–72	1974–75	
Students requesting aid	90	203	+125
Average identified need per student	$2,040	$4,300	+110
Approximate Federal aid available [1]	170,000	134,000	−(21)
Federal aid available per student	1,890	890	−(112)
Average per student unmet need	150	[2] 3,410	+2,200

[1] Programs include health professions scholarships, loans and college work/study. The Federal Government phased out the health professions scholarship program ($31,400 in 1971). The health profession loan program decreased from $97,400 (distributed among 90 students) in 1971, to $93,000 (distributed among 150 students) in 1974. The result: students requesting health professions aid received $.25 on $1.00 demonstrated need after deducting $2,500 from every student's total unmet need. This year's work/study allocation of $25,000 was $47.00 less than it was 4 years ago.
[2] Adding State Guaranteed Loans will reduce this figure approximately $1,500.

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Colleges of podiatric medicine, being so financially strained themselves, cannot provide substantive student aid.

A particular problem relating to student aid involves scholarships. Although authorized under the expired Act, health professions student scholarships are being phased out, only already established recipients of Federal scholarship support being eligible to receive continued scholarship funding. In the face of this dilemma, colleges are urged to recruit minority students so as to improve their representation within the professions upon graduation. Most potential students representing minorities, however, come from financially deprived homes. Even if adequate student loans were available to them, therefore, many potential minority students would not enter a college when financial obligations not only are foreign but also provide a feeling of insecurity.

Legislation before the Subcommittee would increase the authorization for National Health Service Corps scholarships. The AACPM supports this approach to a voluntary effort of amelioration of geographic maldistribution. The legislation, however, would continue authority in the Secretary of HEW to determine the professions for which to obligate the scholarship funds. Judging from past experience and recognizing a limitation in funding for this purpose, it appears unlikely under the proposed legislation that students of podiatric medicine would have this assistance made available to them. We therefore urge the Subcommittee to devise some mechanism which will provide some Federal scholarship support for students whose professions are not selected for assistance under the National Health Service Corps.

The AACPM is very grateful to this Subcommittee and, indeed, the entire Congress for its efforts in developing Federal programs for the health professions generally and podiatric medicine specifically. We also appreciate your efforts to expedite health manpower legislation so as to eliminate uncertainties under which we currently exist. If additional questions arise, the Association would be pleased to respond to them.

We respectfully request that this statement be made part of the written record of these hearings.

Statement of The American Association of Dental Schools

The American Association of Dental Schools appreciates the opportunity to present the Association's views on H.R. 2956 and H.R. 2958 for the consideration of the Subcommittee on Public Health & Environmental. Although we have been unable to obtain copies of either bill, it is our understanding that the provisions of the two bills, in combination, are essentially the same as those contained in the bill passed last year by the House of Representatives. Because we testified extensively in the hearings last year, this statement will be limited to a summary of our Association's current views with respect to specific major provisions of the bills.

CAPITAL SUPPORT

The AADS supports the extension of the existing authorities for grants, guaranteed loans and interest subsidies to assist in the contruction of teaching facilities for health professions schools.

We welcome the proposal to establish a uniform level of federal participation in construction costs, since as we understand it, this provision would allow schools requiring new or remodeled facilities to compete for the maximum level of federal participation without the need for the "major" enrollment increase specified under previous legislation.

However, unless the authorization levels specified in the bill can be substantially increased, we would favor a lower level of maximum participation so that a larger number of schools might be assured of at least some measure of support for the renovation and rehabilitation of their physical facilities.

We would suggest, too, that projects to construct dental schools in any of the 19 states now without schools be given the same assurances of maximum federal participation and priority that are provided for medical school projects of a similar nature.

INSTITUTIONAL ASSISTANCE

Capitation Grants. Our Association fully accepts the philosophy embodied in H.R. 2956 that health professional schools are a national resource and that as

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such, they not only are appropriate objects of federal financial assistance but they also bear a special responsibility to address the major health manpower problems of the nation. In our opinion, however, these problems can be most successfully addressed through use of the project grant mechanism, which provides the flexibility needed to accommodate the widely varying capabilities of individual schools. We remain convinced that capitation support should be contingent upon only two conditions, maintenance of first-year enrollments and maintenance of non-federal support levels, and that its principal objective should be to assist the schools to become the financially viable institutions they must be if they are to meet the nation's manpower needs.

The requirement that schools either expand first-year enrollment or offer a program for the training of expanded function dental auxiliaries in order to qualify for capitation grants will pose difficult and frequently insoluble problems for those schools that are operating with impacted facilities. That dental schools are offered the option of doing one or the other will not necessarily help, since an over-crowded dental school that is unable to increase the size of its first-year class will find it equally impossible to expand its dental auxiliary training programs.

Although the bill provides for the waiver of this requirement when a school cannot meet either condition without lowering the quality of education it provides, a similarly worded provision in the previous law was so rigidly interpreted by DHEW that a number of schools were forced to accept additional students in the face of warnings that these increases threatened their continued accreditation. In light of this, we urge a change in the wording to require the issuance of a waiver in those situations in which an official accrediting body has determined that the acceptance of additional students would so affect the quality of education as to lower the school's accreditation status.

The second requirement that, beginning in the second year, each school use 25% of its capitation grant for the training of dental students and expanded duty dental auxiliaries in areas geographically removed from the main site of training, will undoubtedly further objectives which we all agree are desirable; unfortunately, it will also seriously dilute the amount of support available for the basic operations of the school itself.

We would reiterate our position: The capitation grant should be an entitlement grant designed solely to strengthen the basic financial position of the school. Enrollment increases and remote-site training, while both necessary and desirable in themselves, can best be funded on their own merits using discretionary monies.

The Association would also like to comment on the provision requiring payback of capitation support by students in the years immediately following completion of their training. Instead of reimbursing the Treasury, we would favor having each student reimburse his school on a year-for-year basis for the capitation support received by the school because of his enrollment. The fund so established could then be restricted and replenished as necessary by the federal government to compensate the schools for losses to the fund resulting either from defaults or from the cancellation of the pay-back obligation of students who elect to serve in a shortage area. Once the fund so established reached a plateau, the amount of new federal support needed annually would be minimal. Although dental schools are willing to serve as agents of the government in securing students' assurances to practice in shortage areas, they would strongly resist any move to make them responsible for policing these agreements.

Although we are on record as recommending that capitation for dental schools be set at 40% of the average net education cost per dental student as determined in the IOM study of educational costs, the Association now believes this recommendation to have been premature. We have become concerned about the small number of dental schools included in the sample and, therefore, about the validity of some of the findings as they relate to all dental schools. We now believe that further study is needed and that uniform cost analysis methodologies need to be developed and used by all health professions schools in order that capitation can eventually be based on the net educational costs of individual schools. Meanwhile, a continuation of parity payments to all MOD schools as provided for in the current bill presents the most equitable approach to capitation support.

We would urge that the capitation amounts for dental and expanded function dental auxiliaries students be not less than the levels of the last three years. Further, we recommend that for schools establishing or enlarging existing expanded function dental auxiliary training programs, the capitation amount for

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each additional student enrolled be set at half the amount specified for dental student capitation.

Judging by past experience, it is entirely possible that the amounts appropriated for capitation support will be considerably less than the amounts authorized. The Association recommends that a new provision be added to the bill which would permit a proportionate decrease in any enrollment assurances required as a condition for receiving capitation support.

Finally, we would like to point out that those schools which responded to the incentives in the present law to convert to an accelerated three-year curriculum have just begun to receive the sums authorized in support of this effort. Since the new authority would base capitation solely on enrollments, we believe that the federal commitment to schools which adopted the three-year curriculum should be honored by setting the capitation amount for their presently enrolled students at four-thirds of the basic capitation figure.

Financial Distress Grants. We believe the elimination of the authority for financial distress grants would contribute to the overall objective of financial stability by encouraging schools not only to develop good management practices but also to seek firm and stable bases of non-federal support.

Special Project and Contract Support. As we noted earlier, the AADS acknowledges the responsibility of dental schools to work for the solution of the dental manpower and service problems that confront the nation, but we are convinced that project grants and contracts, targeted to the solution of these problems, is the best mechanism for supporting the schools' efforts to meet those responsibilities.

With respect to the needed increase in aggregate supply, we feel that project grants could be used to support the expansion of enrollment in those schools which have the capability for such an undertaking without encumbering other schools with responsibilities which they cannot adequately meet.

We believe that the special project mechanism should also be available to support the development and implementation of programs to provide training for undergraduates in underserved areas removed from their main training site. Stipend support should be provided to meet the students' living expenses, if needed, and funds should be available to pay travel and other expenses incurred by faculty and students. Also, grants for this purpose should permit the payment of travel and other necessary expenses in programs in which private practitioners serve as preceptors.

We recommend, too, that the authority contained in the bill for support of area health education centers be modified to provide for dental sponsorship of AHEC's in situations where such sponsorship is appropriate. We believe that the AHEC could serve as an effective instrument for dealing with the maldistribution of dental personnel.

Although dentistry still has an equitable balance between primary and specialty care, so many more dental graduates are seeking specialty training that this balance could soon disappear. For this reason, we are particularly pleased that the family medicine residency program is broadened in the current bill to include support for residencies in general dental practice.

The Association supports the proposed extension and amendment of the authority to provide assistance to individuals from disadvantaged backgrounds. However, We believe that programs supported under this authority would be considerably more effective if stipend support were available to meet the living expenses of students who could not otherwise accept the opportunities afforded them.

STUDENT ASSISTANCE

The Association supports the extension of both the scholarship and the direct loan and guaranteed loan authorities as modified in the current bills, although we do have some reservations about the guaranteed loan program, since students most in need of financial assistance have great difficulty in obtaining loans, notwithstanding the federal guarantee. We would like to recommend one change in the loan repayment authority. We suggest that this authority be modified to permit full repayment of educational loans—60% repayment for two years of service in a shortage area, 80% for three years, and 100% for four years of service.

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Statement of the Association of American Veterinary Medical Colleges (AAVMC)

I. AMERICA NEEDS ANIMALS

Our nation is blessed with many natural resources. One of the major resources which has been developed and which the nation enjoys in many different ways is its animals. This situation obtains in great measure because of the natural resources and because there has been the human intelligence, ingenuity, and willingness to foster and encourage this development.

Animals in the American life-style play many different and important roles. Their part in the diet of the average American is common knowledge and nearly every page of newsprint carries something related to human nutrition either on a local or on a global level. Animal fiber, for purposes other than nutrition, plays a less prominent role, but in light of the world energy situation bodes to assume the importance it once occupied as natural fibers require much less energy to put them in a condition for human use than do synthetic fibers. The statement "Food is fundamental" is not a cliché but is and always has been a fundamental maxim that will become increasingly important and evident to our nation—and to the world—as the human population continues to grow. The ability and capacity to produce food is the single most important asset that the United States has today among the nations of the world. While this nation can't produce enough to feed the world, its own production capacity coupled with its technological talents and the sociological sensitivities of the contemporary world population portend ways to cope realistically, and hopefully successfully, with the human population/food-and-fiber-need complex. It is not enough that animal protein production be adequate quantitatively. It must also be available to the consumer in a condition that will not cause sickness. Thus attention must be paid from conception to consumption and the chain has many links which require veterinary medical input.

Laboratory Animals, which include any and all appropriate species for a given problem, will continue to assume ever greater importance in the days ahead. As the need and desire continue to supply safe and effective biological and pharmaceutical products for use in both humans and animals, the need for testing in animals will continue to grow. Animal models of human disease are a well recognized and accepted scientific route to the elucidation of many human ailments. Currently there are over 100 such models and this aspect of comparative medicine, which involves veterinarians and many other health scientists, has made great contributions to the health, well-being, and increased life expectancy of the nation's citizenry, and its contributions are only beginning.

Companion animals, whether for recreational purposes or for more intimate companionship have always held a significant position in American family life. These creatures serve a great variety of needs and their numbers are increasing at a significant rate. In addition to the role they play as close companions, the smaller species (primarily dogs, cats, and pet birds) account for approximately 4 billion dollars annually in the nation's economy. The role of the dog and the cat as role-models for growing young Americans in experiencing first-hand such things as responsibility, compassion, growth, disease, death, and other similar emotions and biological processes is indeed important but impossible to assess in quantitative terms. Small companion animals are finding an ever-expanding role in the rehabilitation and amelioration of problems of the emotionally disturbed. With an ever-increasing number of older citizens in our population the role of these small companion animals in providing tangible and meaningful associations for these people is real and significant.

Wildlife and zoo animals are of extreme importance as recreational and educational resources in our society. Survival and maintenance of these animals becomes increasingly difficult in a changing American ecology but they must be preserved! Health management is paramount in this survival and this means veterinary medical expertise.

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II. VETERINARY MEDICAL EDUCATIONAL RESOURCES

There are currently 19 functional educational programs leading to the D.V.M./V.M.D. degree in the United States. These are located in 18 different states with two (2) in the State of Alabama (Auburn University and Tuskegee Institute). All but two (2), Tuskegee Institute and the University of Pennsylvania, are a part of state supported universities and were implemented primarily to provide veterinary medical manpower for their respective states. As the need for veterinary medical manpower is a national need these schools/colleges must provide for this need and thus in the truest sense are *national resources*. Under these circumstances it is most logical that in meeting this national need some reasonable portion of funding for the ongoing maintenance and operation of the programs be underwritten at the national level. This did in fact come about in 1970 and in the intervening five years federal funds have been made available for those schools/colleges able and willing to increase enrollments. First-year enrollments have increased by approximately 20 percent over this period with correspondinng increases in the number of veterinarians graduated once the four-year educational cycle was completed. These increases, if maintained along with the anticipated new schools being planned at the University of Florida, the University of Tennessee, Mississippi State University and Virginia Polytechnic Institute, will go a long way toward meeting the veterinary medical manpower needs cited in the National Academy of Sciences' 1972 publication, "*New Horizons for Veterinary Medicine.*"[1] Without this sustained financial assistance many schools/colleges will be forced to reduce enrollments and the source of most of such reductions would be among out-of-state applicants.

Many if not all of the schools have reached upper enrollment limits based on physical facilities, including equipment, and faculty and support-man-power needs. To require additional enrollment increases at this time to maintain eligibility for assistance would be unrealistic and very likely counter productive since, as indicated above, many of the schools would need to reduce the size of their programs both in the number of students admitted and the number of faculty and support personnel, if the financial assistance is reduced.

There certainly is no lack of interest in veterinary medicine among the youth of the nation. Data for the year 1973–74 show that the percent of applicants admitted varied from 8 percent at the University of Illinois (1,124 applied and 86 were admitted) to 28 percent at Louisiana State University (128 applied and 36 were admitted) which accepted its first class that year. Thus on the average only one in every seven who apply can be accommodated and this ratio continues on an upward trend. To have to reduce the number of admissions in the face of the need for veterinary medical manpower and the tremendous interest in the profession on the part of aspiring young Americans would seem to fly in the face of good judgment and rationality.

III. THE NEEDS OF VETERINARY MEDICAL EDUCATION

A. *Construction.*—There continues to be a need for additional facilities and for the upgrading and modernization of current facilities. Provision should be made to provide 80 percent of the construction costs for teaching facilities for educating veterinarians in a state which has no such facilities.

B. *Student Assistance.*—This program in the past has served a vital need and continues and will continue to do so. It is believed most appropriate to have such a program administered through the respective universities and colleges as contrasted with dealing directly with the individual student.

C. *Capitation Grants.*—Enrollment increases have been effected through this mechanism and as indicated earlier first year classes have increased in size by over 20 percent since 1970. Faculty and supporting staff are being employed with support from this source to accommodate the enrollment increases which now exist throughout the curriculum. Without some such support many schools will find it necessary to reduce enrollments as staff support cannot be provided to manage the programs. Based on cost analysis of educational programs in veterinary medicine recently completed under the auspices of the Department of Health, Education, and Welfare, $1,500 for each full time student enrolled each year is the minimum that should be considered. For reasonable planning purposes and to effect maximum benefit from this program there needs to be a strong indication of continuing commitment.

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[1] *New Horizons For Veterinary Medicine.* National Academy of Sciences, Washington, D.C. 1972.

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D. *Special Projects.*—These have served a useful purpose and have permitted significant developments in several areas which otherwise would have gone untouched. Provision for their continuance is important with reasonable criteria for eligibility to compete. It is, of course, appropriate to include in this category special means to engage individuals from disadvantaged backgrounds in all of the health professions' educational programs, but these grants should not be restricted to this purpose.

E. *Start Up Grants.*—A number of new schools of veterinary medicine are in the formative stages (University of Florida, University of Tennessee, Mississippi State University, Virginia Polytechnic Institute and State University). Support should be made available to enable such institutions to participate in a start-up program when the financial problems of operation are the greatest.

F. *Traineeships.*—Post D.V.M. traineeships are vital to the profession and the areas that it serves. Emphasis on increased student enrollments, the increase in the number of schools, and the need for ever increasing numbers of speciality trained people in the ecological/environmental concerns of our society have combined to cause some very serious manpower shortages in many of the speciality areas. This is a critical matter now and will need significant support over the next ten years if the tasks confronting the profession and the society are to be reasonably met.

STATEMENT OF DR. LESTER BRESLOW, PRESIDENT, ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

INTRODUCTION

Mr. Chairman and distinguished members of the Committee, the Association of Schools of Public Health greatly appreciates this opportunity to submit its views on H.R. 2956, the Health Manpower Act of 1975. For the record, my name is Dr. Lestor Breslow and I am Dean of the School of Public Health at UCLA and President of the Association of Schools of Public Health.

The Association of Schools of Public Health counts among its membership the 18 accredited public health schools in the United States, one school that is close to accreditation (University of Massachusetts), and, as an affiliate organizational member, the Association of Teachers of Preventive Medicine. For your information, we have attached a list of our member Schools.

We are extremely pleased to state that our views, in general are supported by the American Public Health Association, an organization we are proud to be associated with on a professional basis. In addition, the APHA may be submitting their own complete written statement for the record.

Mr. Chairman, we submit this statement today in an attempt to offer our advice regarding what this Committee can do to help support, foster, and improve professional public health education in this country. We know, Mr. Chairman, from your recent statements at the University of North Carolina School of Public Health and elsewhere that you are a friend and supporter of public health education. Furthermore, we are cognizant of the support that schools of public health enjoy from other members of this Committee as they themselves expressed during the hearings on H.R. 9341 last July 24th and 25th (see "hearings on H.R. 9341" Serial #93-57 [1974]).

The need to recognize and solve the health problems which occur in a group and community environment requires education by a faculty comprising professionals skilled in various disciplines, including social and natural sciences, interpersonal relationships, and administrative management working together in an interdisciplinary setting. As far back as 1958 the United States Congress realized that the breath of resources necessary to develop a quality school of public health would make it difficult and inefficient for each state to have its own school. Thus, the 18 existing schools constitute a national resource serving all 50 states, the Commonwealth of Puerto Rico, the overseas territories, and our international commitments.

The 1958 Congressional action was taken, in part, because financial constraints were making it extremely difficult for the then 11 accredited schools to meet the needs for graduates or to accept more than a reduced percentage of qualified applicants. Funds derived from tuition payments and from state appropriations or endowment funds were quite inadequate to meet the educational needs at that time. Then, as now, the situation was aggravated by the increasing number of applicants stimulated by Federal and state programs designed to expand governmental health programs.

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The Federal support program that began in Fiscal Year 1959 was designed to help the schools accept more of the steadily increasing number of applicants, chiefly by supplying the extra funds needed for teaching faculty and teaching support. Existing schools responded promptly to the Federal request by expanding student bodies. In addition, new schools were opened.

In 1958, there were 1,230 students enrolled and 772 graduates (11 schools), while in 1971–1972 there were 2,159 graduates (17 schools), (Table I) almost three times the number 14 years earlier. Since 1969, as personnel needs of local, state and Federal agencies have mounted, the enrollment has increased even more sharply.

In the Fall Term of 1969, in the then 16 schools (the University of Washington began admitting students in 1970 and Illinois in 1972) the enrollment was 3,438. In contrast, the Fall Term enrollment in 1972 was 5,320, an increase of 50% in the three years (Table I). This increase, at a time when many other university graduate schools were remaining level or had decreasing numbers of applicants, was clearly related to expanding public interest in health care, and expanding demand for the graduates of our Schools.

During the 17 years this program of Federal support for schools of public health has been in effect, the schools have changed substantially to keep pace with demands for new and different kinds of personnel. With the mounting problems of aging, for example, more attention has been given to non-infectious and chronic diseases. With the growing complexity of industrial processes and occupational disease, greater emphasis has been placed on environmental and occupational health. With lower death rates in infancy and childhood, more work has been done in family and population planning, although there is yet much to be done!

At the same time long-standing public health programs, such as control of communicable diseases, protection of food and water supplies and protection of maternal and child health, are still vitally important in the community. One has only to read of instances like the recent recurrence of typhoid fever in Florida and diphtheria in Texas and Seattle, the detection of dangerous foci and poliomyelitis in inner city areas, the disturbingly high rates of venereal diseases, the reports of food poisoning outbreaks and the failure to apply uniformly advances in knowledge of maternal and child health, to realize that neglect of traditional public health programs presage as severe dangers to the public as neglect of fire protection might.

In more recent years, there have been great changes in still other direction. Passage of major health legislation expanding personal health services, health planning, the program of bloc grants as well as project grants to state health agencies and the development of neighborhood health centers, has required much larger numbers of administrators, managers and new types of support personnel who understand that health prevention and restoration cannot be approached purely as a market phenomenon. The need will be further increased by any advances in the national health insurance area, by the growing numbers of HMO's by PSRO, and by the tremendous research efforts in Cancer and heart disease.

All of the schools of public health have adapted their teaching programs well beyond previously traditional areas to prepare their graduates for new and expanded responsibilities at all levels of government and private (usually non-profit) agencies. These personnel, administrators, planners and specialists from almost every discipline in the natural and social sciences, are prepared to work in such areas as: comprehensive health planning; organization and delivery of health services; family and population planning; nutrition; health problems of the aging; drug abuse and alcoholism; control of quality of health facilities; health education of the public.

Regardless of what agency of government may have responsibility for environmental protection, the very fact that popular attention has shifted to non-health aspects of our natural resources—air, water, land—make it vital that the human health aspects of the environment not be neglected.

Moreover, passage of the Occupational Safety and Health Act has imposed an even greater government responsibility for worker health. Schools of public health will need to meet expanded demand for industrial hygienists, industrial nurses, air pollution control experts and administrators of occupational health programs.

Much of the greatest current public concern in regard to health has been over the high costs of medical and hospital care. Thus, schools of public health have given priority to preparing personnel capable of attacking these problems. Cer-

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tainly by primary attention to better methods of prevention and by better planning and organization of curative and rehabilitative services high costs can be contained.

An approach which is purely an "indemnity-insurance" solution may succeed in spreading costs but will not succeed in taking advantage for society of available knowledge which can lower health costs by helping prevent people from getting sick in the first place.

CURRENT NEED FOR PERSONNEL

In former years, information could be readily obtained from the Public Health Service on vacant budgeted positions in health departments, as one measure of personnel need. The last full scale study on this, carried out for the Third National Conference on Public Health Training 1967, indicated that vacant *budgeted* positions, just in state and local official health agencies (not even including nonprofit community agencies), for which the post description required one year of graduate training in public health, far exceeded available or anticipated supply. With growing population and expansion of programs like Medicare and Medicaid, and the introduction of new ones like PSRO, the ratio of unfilled positions to available graduates is probably even higher today.

Since the 1967 study, there have been no national scientific studies to establish accurately the precise shortages. Nevertheless, studies carried out in a number of states, such as that carried out by a Legislative Study Commission in North Carolina have established needs for personnel far in excess of graduates available.

As part of a study of where graduates of schools of public health are now working and of a series of facts relating to their training, a table has been prepared of the place of employment of the 1962–72 graduates. (Table II). This Table was constructed by coding addresses of graduates from which the employment category could be deduced. The data will, of course, need to be corrected when the questionnaires are returned and analyzed, but even this rough assumption gives an idea of the order of magnitude of the various categories.

What is most striking is the wide variety of employment these graduates have in government, universities and other forms of public service throughout the health care system.

In addition to tabulated data available, another practical measure of need is the number of requests that come to educational institutions for graduates in a particular field. At the University of Michigan, for example, the largest school of public health in the country, every program of study reports more job inquiries and more requests for graduates than are available. As one example, last year there were 50 urgent requests for Masters of Public Health who had specialized in Industrial Hygiene, yet there were only 5 graduates in that field that year.

Decentralization of services to state and local levels will require that these units of government directly engage the services of many new people skilled at planning, developing, implementing, and evaluating health service programs. Guidelines and supervision previously provided at the national level must now be prepared and implemented at every local level of government. This emphasis has been recommended by the Administration in several of their budget messages. It is an endeavor which will not conserve public health manpower; it will require vastly increased numbers. In the long run this increase in personnel and their increased emphasis at the local level, may bring enormous benefits to the people served by health agencies and programs. But the personnel to implement this concept are simply not now available.

LEGISLATIVE SITUATION

In 1972, when testifying on a Senate bill to extend Sections 306 and 309, Assistant Secretary DuVal, speaking for the Administration, raised no questions about the validity of Federal aid to professional education in public health. He did ask that the legislation be extended for one year to allow these sections to be considered in conjunction with other expiring legislation. Furthermore, the President indicated concretely his support for the program by proposing, in his original 1972–1973 budget, increases in levels of support—almost 7% for Section 306, student support, and almost 20% for Section 309, institutional support. On the basis of hearings and testimony, the Congress further increased these levels, indicating that both the executive and legislative branches were aware of increasing need for trained health personnel.

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The 1973–1974 budget, submitted on January 29, 1973, proposed a complete reversal of previous policy, calling for no extension of the legislation and for complete termination of all aid under Sections 306 and 309 as of June 20, 1973. In its wisdom, the Congress did indeed extend these Sections for one year. Funds were appropriated by the Congress and included by the Congress in HEW FY 1974 budget. Since July 1, 1974, 306 and 309 have been extended by repeated Continuing Resolutions. Unfortunately, the Administration is again requesting the elimination of support programs for schools of public health and their students.

H.R. 2956: HEALTH MANPOWER ACT OF 1975

Mr. Chairman, we now wish to turn our attention to the above mentioned bill which was introduced by you and other members of this Subcommittee.

In general, we think this is a superb piece of legislation and one that all of the schools of public health will want to support. We believe that this bill encourages the finest aspects of the health manpower production system while at the same time seeking to change—by evolution rather than revolution—those aspects of the system that need improvement. We applaud this approach and we will do what we can to assist in its implementation should it be enacted into law.

We begin our specific comments with Title III of the bill. We believe that Section 303 of the bill (p. 18) is correct in concept. However, we note with disappointment that there is no room for growth in the appropriations sections. We would recommend, therefore, appropriations for FY 1975, 1976 and 1977, $8 million, $10 million and $12 million. This, we believe, would be consistent with the growth in student population now taking place.

In regard to Title IV, Grants for Health Professions Schools, we should like to reiterate once more our general support for the approach taken by H.R. 2956. We do, however, have a number of specific questions and for your convenience we enumerate them below:

(1) We believe that Section 770(a)(3) (p. 55) should be amended to read "$2000 per each full-time *equivalent* student enrolled in such school." We request the higher capitation level based upon the fact that the average cost per year for educating a student in a school of public health is approximately $12–13 thousand, as determined by the Institute of Medicine study which you, Mr. Chairman, requested. Were the Federal government to seek a level of support equal to 30% of the cost of education, the amount for capitation would be $3000. We believe that our request, under the circumstances, is modest indeed. Should the Congress accept this higher level, the authorization section (770[f][2]) should be adjusted accordingly.

In addition, we are recommending that this Subsection take note of the fact that an increasing amount of the education in schools of public health is done on a part-time basis. By providing such educational opportunities for persons who are working full or part-time, each school of public health better serves its region. Our request here is that the legislation take note of this significant activity on the part of schools of public health.

(2) In regard to the apportionment of appropriations (Section 770[c], as amended, [page 39]), we wish to note that we disagree in principle with this concept. At this point in history we think that all of the schools of the health professions and certainly the schools of public health need a higher degree of certainty for their fiscal operations. We believe that it is absolutely necessary for appropriate planning that the schools know as closely as possible how much financial support to expect from the Federal government. Therefore, we think that the capitation section ought to be written as an entitlement. The fact that your bill, Mr. Chairman, has carefully sought to adjust the capitation levels in accordance with the actual levels you feel are necessary, supports our position in this matter.

(3) Regarding the definition of "full-time students" on pages 57 and 58 of the bill (Section 770[d][2], as amended), we wish to address ourselves to the phrase "graduate degree in public health or equivalent degree." We hope this Committee will make it clear in the report on the final bill that the 18 schools of public health offer a rich variety of programs in more than a score of areas of public health. We hope that in the implementation of this section the Administration will not attempt to exclude such programs as biostatistics, epidemiology, maternal and child health, etc., which together are the building blocks of public health.

(4) With regard to Section 791(c)(2)(B) (p. 100, lines 3–6), we wish to comment upon the accreditation requirement called for by that section. The Association of Schools of Public Health and the Association of University Programs in Hospital Administration have agreed that eligible for assistance under Section

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791 should be defined as: "institutions other than schools of public health that offer graduate education for public health professionals *and are accredited by an organization recognized for that purpose by the Commissioner of Education.*" ASPH does not believe it wise to lock program (as opposed to "school" or "university") accreditation into law.

CONCLUSION

Mr. Chairman and members of the Committee, we represent institutions whose raison d'etre is to serve the public welfare. In that respect our goals coincide with the goals of the members of this Committee. Our students and our faculty members have chosen to devote their lives to improving public health both here in the United States and throughout the world.

Through our Association and through other mechanisms, the schools of public health constantly reexamine what they are doing in light of how they perceive the needs of this country. We make no claim that all wisdom resides in the schools of public health. Indeed, we welcome the suggestions of all interested parties to help us adjust our activities to better serve the public good. We look forward to indepth interaction with the Congress of the United States and the Executive Branch.

We gratefully appreciate this opportunity to offer our views to the members of this distinguished Subcommittee regarding the legislation that is now before you.

Thank you.

TABLE I.—ENROLLMENT AND GRADUATES, U.S. SCHOOLS OF PUBLIC HEALTH, 1958-72

	Students enrolled	Degrees granted
Fiscal year ending:		
1958	1,230	772
1963	1,848	798
1968	3,363	1,337
1969	3,525	1,548
1970	3,483	1,735
1971	4,131	1,782
1972	4,802	2,159

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TABLE II.—ESTIMATED DISTRIBUTION BY EMPLOYMENT IN 1972 OF PUBLIC HEALTH GRADUATES FROM 1962-72

Employment category	Number	Subtotal percent	Total percent
Federal			14.1
Directly related to public health (HEW, HSMHA, UPSHS, etc.)	876	6.1	
Other Federal, not directly related to public health (State Department, Trust Territories, AID, FCC, AEC, etc.)	158	1.1	
Peace Corps	29	0.2	
Veterans Administration	43	0.3	
Armed Forces (includes armed forces hospitals)	919	6.4	
State	1,408		9.8
Local (includes RMP, CHP, city, municipal)	1,652		11.5
Foreign (includes nonpublic health, e.g. Ministry of Education	1,063		7.4
Extranational (WHO, UN, OAS, NATO, SEATO, etc.)	230		1.6
Hospitals and ambulatory care facilities (except university hospitals, USPHS and armed forces hospitals)	3,348		23.3
Universities			25.4
Schools of public health	1,149	8.0	
Medical and nursing schools and hospitals where teaching is primary activity	1,379	9.6	
Other university	1,121	7.8	
Industry (includes profitmaking organizations, e.g. engineering, pharmaceutics, communications)	359		2.5
Health-industry (includes public health directed profitmaking organizations, e.g. insurance and casualty firms	57		0.4
Foundations	417		2.9
Professional organizations	29		0.2
Nonprofit organizations (Kaiser Permanente, Blue Cross, etc.)	86		0.6
Labor unions	0		0.0
Self-employed	43		0.3
Total	14,366		100.0

Source: Personal communication from Dr. Arthur H. Richardson, project director, ASPH-BHME contract study. Estimates are based on a weighted extrapolation of the distribution by employment of 5,771 graduates who had codable addresses. The remaining 8,595 graduates (14,366 in all during the 1962-72 period) were either listed by home addresses or had addresses not codable by employment category.

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SCHOOLS OF PUBLIC HEALTH IN THE UNITED STATES

Below is a listing of the names, deans, addresses and phone numbers of the Schools of Public Health in the United States and Puerto Rico.

University of California at Berkeley: Dean Warren Winkelstein, Jr., Dean and Professor of Epidemiology, 19 Earl Warren Hall, School of Public Health*, Berkeley, California 94720, 415/642-2523.

University of California at Los Angeles: Dean Lester Breslow, School of Public Health*, Center for the Health Sciences, Los Angeles, California 90024, 213/825-6381.

Columbia University: Dean John Bryant, School of Public Health*, 600 West 168th Street, New York, New York 10032, 212/579-3929.

Harvard University: Dean Howard Hiatt, School of Public Health*, 677 Huntington Avenue, Boston, Massachusetts 02115, 617/734-3300 (Ext. 501/502).

University of Hawaii: Dean Jerrold Michael, School of Public Health*, 1940 East-West Road, Honolulu, Hawaii 96822, 808/948-8491.

University of Illinois: Dean Paul Q. Peterson, School of Public Health, at the Medical Centers*, P.O. Box #6998, Chicago, Illinois 60680, 312/996-6620.

The Johns Hopkins University: Dean John C. Hume, School of Hygiene and Public Health*, 615 North Wolfe Street, Baltimore, Maryland 21205, 301/955-3540.

University of Loma Linda: Dean Mervyn G. Hardinge, School of Public Health*, Loma Linda, California 92354, 714/796-7311 (Ext. 3711).

University of Michigan: Dean Richard Remington, School of Public Health*, Ann Arbor, Michigan 48104, 313/764-5424.

University of Minnesota: Dean Lee D. Stauffer, School of Public Health*, 1325 Mayo Memorial Building, Minneapolis, Minnesota 55455, 612/373-8065.

University of North Carolina: Dean Bernard G. Greenberg, School of Public Health*, Chapel Hill, North Carolina 27514, 919/966-1113.

University of Oklahoma: Dean Philip E. Smith, College of Health*, 624 Northeast 15th Street, Oklahoma City, Oklahoma 73190, 405/271-4688.

University of Pittsburgh: Dean Herschel E. Griffin, Graduate School of Public Health*, 111 Parran Hall, Pittsburgh, Pennsylvania 15261, 412/624-3000.

University of Puerto Rico: Dean Jose Nine-Curt, School of Public Health*, G.P.O. Box #5067, Medical Sciences Campus, San Juan, Puerto Rico 00936, 809/765-3991.

University of Texas: Dean Reuel A. Stallones, The School of Public Health*, Health Science Center at Houston, P.O. Box #20186, Houston, Texas 77025, 713/792-4425.

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ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION,
Washington, D.C., February 20, 1975.

Hon. PAUL G. ROGERS,
House of Representatives,
Washington, D.C.

DEAR MR. ROGERS: By its recognition of the need to improve health administration schools, your health manpower bill moves toward another major contribution by you to the public health of this country. The field of health administration recognizes this major step and appreciates your efforts and those of the Committee.

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*Fully accredited as a School of Public Health.
**Not yet accredited as a School of Public Health.

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We recommend the following adjustments in the bill as introduced which will help insure the accomplishment of its objectives:

The appropriations level for health administration programs is very low and will not produce the results you are seeking. Solid projections indicate that full funding at the authorized level will provide only about $50,000 per program next year. To provide the services, particularly technical assistance to planning agencies and HMO's which is needed at the community level, a higher level of support should be provided. We recommend a minimum level of $3,000,000 for the first year.

We recommend the inclusion of health administration students in the loan program of the National Health Service Corps, as they are included in the scholarship program.

Third, we would like to ask, to avoid ambiguity later on, that health administration be specifically named among the fields participating in the minority project grant program.

We thank you for your consideration.

Sincerely yours,

GARY L. FILERMAN, Ph. D.,
Executive Director.

Mr. ROGERS. The next witness will be Dr. John A. D. Cooper who is President of the Association of American Medical Colleges, accompanied by Dr. John Sherman and Mr. Charles Fentress. We welcome all of you and will be pleased to receive your testimony.

Your statement will be made a part of the record.

STATEMENT OF JOHN A. D. COOPER, M.D., PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY JOHN SHERMAN, M.D., AND CHARLES FENTRESS

Dr. COOPER. Thank you.

The Association of American Medical Colleges is grateful for the opportunity to comment on legislation to modify and extend the Federal role in the education of health professionals. Federal assistance is vital if medical schools are to continue providing health professionals to meet the Nation's health needs, particularly because of the increasing difficulty institutions are finding in meeting rapidly rising costs.

The association is the national organization of institutions engaged in the formal education of M.D.'s at the undergraduate and graduate levels. It is comprised of all of the 114 medical schools in operation in the United States, 400 of the major teaching hospitals, and 58 academic societies, which encompass the teaching and research faculties of academic medical centers.

In hearings conducted by the subcommittee during the last session of Congress, the association presented a lengthy statement on Federal support for educational programs in the Nation's medical schools. The proposals made at that time have been modified on the basis of a report by the AAMC Task Force on Health Manpower which was adopted by the executive council at its meeting on January 16, 1975. The new recommendations by the association are incorporated in H.R. 3279, introduced by Chairman Rogers.

I might add almost all the recommendations given by Dr. Lee in his testimony are in H.R. 3279.

We earnestly hope that its provisions are incorporated in the legislation adopted by the Congress.

The association has two general concerns with the reconsideration of health manpower legislation. It recommends: (1) early enactment of

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legislation; and (2) a 4-year bill providing a simple 1-year extension of the Comprehensive Health Manpower Training Act of 1971 for fiscal year 1975 and new provisions for the subsequent 3 fiscal years.

Early enactment is critical to permit continuity of effort by health professional schools. Adequate time for planning by both students and institutions is required if objectives of the legislation are to be met and Federal funds are to be used efficiently and effectively.

The principal reason for requesting a 1-year extension of previous programs is to assure that badly needed funds will flow to the medical schools during the current fiscal year. Administrative requirements seriously delay implementation of programs enacted by the Congress and signed into law. After enactment of the 1971 health manpower legislation, the required publication of regulations in the Federal Register and development of application procedures required 7 months.

If this situation prevails with this legislation, the medical schools would not be able to receive support under it during fiscal year 1975. An extension of the Comprehensive Health Manpower Training Act of 1971 for the current fiscal year would permit current regulations and administrative processes to be used and thus reduce the delay in the flow of funds. Although funds for some manpower programs are available through the appropriations continuing resolution, it is not clear what level of support can be provided through this mechanism. Unless the language in a new continuing resolution is modified, it is possible that capitation grants to medical schools should be reduced from the average level of $2,000 provided last year to a level of $1,200 per student.

Such a sharp drop coming on short notice and during a period of high inflation rates and general economic uncertainty would have a very serious impact on the medical schools. A more orderly process would be for the provision of funds in fiscal year 1975 through a supplemental appropriations bill for the programs authorized in an extension of the recently expired act H.R. 3279 extends the authorities of Public Law 92–157 for 1 year.

The association recognizes that problems in health care are centered in part, around the aggregate supply of physicians and other health professionals, the distribution of physicians geographically and by specialty, and the quality of services provided—and that medical schools can contribute to their solution. The association also believes that diversity is a strength of American medical education and that each school can make its greatest contribution to the solution of these problems in different ways, depending on its particular characteristics.

Capitation is recommended in the bill as the fundamental form of institutional support for medical schools. The level of support is based on the net educational costs as determined by the method developed by the Institution of Medicine in a study mandated by the Congress.

One-half of the capitation grant would be given to help maintain the ongoing programs of the medical schools.

The other half of the capitation grant would be given to schools that undertake additional activities directed toward increasing the aggregate supply of physicians or physician extenders, and modifying the geographic and specialty distribution of physicians.

Continuing Federal capitation support for educational programs

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is critical during these times of severe financial stress on the medical schools.

This is particularly so if we are to maintain the high quality of medical education about which Dr. Philip Lee spoke so eloquently.

I would like to introduce some information we received from Dr. Mueller of Johns Hopkins of the pressure being put on these institutions. He reports on the cost of oil, gas, and electricity for Johns Hopkins University. In 1972–73, those costs were $667,685. They are estimating $1.8 million for 1976.

In a 3-year period there has been practically a tripling of the costs. Similar experiences have been noted in the costs of chemicals and other materials necessary to carry on quality medical education.

We do not agree with Secretary Weinberger that this is the time to reduce the level of support to medical schools. The results would be really disastrous.

I would also point out that one State in the Union, California, is now considering the closing of one of the State medical schools. The board of regents has determined that it may be impossible for them to provide the level of support that would be required to maintain the number of schools which they now have.

Mr. ROGERS. How large is that student body?

Dr. COOPER. I can't tell you, but the entering class would probably be in the neighborhood of 100.

As a result of initiatives taken by medical schools with the assistance of Federal funds, the number of physicians and new health professionals will increase dramatically. The physician population ratio will increase from 140 per 100,000 in 1970 to over 200 per 100,000 in the 1980's, even if the influx of foreign medical graduates is severely curtailed. This increase is the result of the great expansion in medical school class size which began in 1968. The results of this increase in class size are now appearing as physicians enter independent practice after completing their training.

The main thrust to obtain a better distribution of physicians and other health professionals recommended in the bill is through the expansion and strengthening of the National Health Service Corps. The association is convinced that any realistic assessment of need in shortage areas can be adequately met through voluntary approaches if adequate incentives are provided. The provisions in H.R. 3279 will make it possible to meet these goals. We are very pleased Dr. Lee agrees with that approach.

The association recommends that an increase in the umber of primary care psysicians be effected by two means: providing support for training programs in family medicine, general internal medicine, general pediatrics, and obstetrics-gynecology; giving the Secretary of the Department of Health, Education, and Welfare, with the approval of an advisory group, authority to designate the number and type of accredited residency positions eligible for support through reimbursement for health care. These authorities are provided in H.R. 3279.

The association believes that the problems associated with the large influx of foreign medical graduates into the United States can most effectively be handled by regulating their immigration by removing special reference visas for alien physicians. H.R. 3279 would accomplish this goal.

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We recommend, in addition, that the legislation be further strengthened through additional provisions which would give better assurances that the foreign physician is adequately prepared professionally and has the required command of the English language, which would restrict the institutions at which he could receive training to those properly qualified to meet his needs, and which would reimpose former requirements for the conversion of student exchange visas to permanent immigration visas.

The details of the additional language we would recommend in the legislation are given in the written statement we have.

I think that concludes our presentation. We will be happy to answer any questions.

[Testimony resumes on p. 475.]

[The attachment to Dr. Cooper's statement follows:]

COMMENTS AND RECOMMENDATIONS—H.R. 3279 PROVISIONS

CAPITAL SUPPORT

Construction

Grants and guaranteed loans with interest subsidies are continued.

Maximum grant assistance is 80 percent.

Emphasis for assistance: ambulatory facilities for primary care teaching; replacement or modernization of existing teaching facilities; new construction required for enrollment increases.

Grant authorization is $100 million annually.

Guaranteed-loan interest subsidy authorization is $1–$2–$3 million.

Comments

The Association feels strongly that the appropriateness of a federal role in the construction and maintenance of medical school facilities parallels the federal role in the support of undergraduate medical education. And, as in the case of undergraduate medical education, the cost of capital expansion also is shared by the federal government, State and local governments, and the institution itself, and various private and other outside sources.

The recommendations of the AAMC include continued grant support because teaching facilities are inherently cost-generating rather than income-producing. As a result, income from the operation of such facilities is not available to amortize the cost of the facility. Thus debt financing for such facilities is totally inappropriate. At the same time, other types of facilities, such as ambulatory care centers, are potentially income-generating, and thus could produce funds which could be applied to offset some debt financing. For that reason, the Association also recommended continuing the program of loan guarantees and interest subsidies. The recommended funding levels are based on a professional judgment of an appropriate federal share of the cost of maintaining the existing physical plant of the schools, plus an allowance for new construction of ambulatory care facilities needed for the expanding number of primary care programs being established by academic medical centers.

STUDENT ASSISTANCE

National Health Service Corps Scholarships

Year-for-year service requirement, minimum two years' service, in the Corps or elsewhere at the discretion of the Secretary.

Private practice option, with federal guarantee of Corps salary.

Penalty for failure to serve is twice the amount of outstanding assistance.

Recruitment bonus of $15,000 for previous nonparticipants who agree to serve at least two years in a shortage area and who have completed residency training.

Re-enlistment incentives are to be provided through the uniformed services special pay structure as enacted in PL 93–274 (up to $13,500 per year).

Extension bonus for participants agreeing to remain in shortage area as private practitioners of $12,500 for one-year extension, $25,000 for two years or more, such funds to be available for equipment, renovation of facilities, and certain operating expenses.

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Period of service is to begin at the completion of residency training for participants engaged in training in family medicine, general internal medicine, general pediatrics, or obstetrics-gynecology, or such other fields as are determined by the Secretary through his annual report on health personnel needs to be in short supply, and at the end of the second post-M.D. year for other participants unless deferred by the Secretary.

Authorization is $50–$100–$150 million.

Health Professions Loans

Mandatory notification of loan forgiveness.

Loan ceiling is tuition plus $3,000.

Assistance available only to students with exceptional financial need.

25 percent forgiveness per year of any educational loan for practice in a shortage area designated under section 329.

Interest rate is increased from 3 to 5 percent.

Authorization is $30–$30–$30 million.

Health Professions Scholarships

Scholarship ceiling is tuition plus $3,500.

Assistance available only for first- and second-year students of exceptional financial need.

Authorization is $30–$22.5–$15 million.

Shortage Areas Scholarships

To be phased out, with only previously assisted students eligible for financial aid.

Authorization is such sums as may be necessary.

Loans, Scholarships for United States FMG's

To be repealed.

Comments

The Association is committed to the goal that there should be equality of opportunity for students wishing to attend medical school. A major barrier denying equal opportunity is the high cost of medical education that must be borne directly by the student. To help offset the cost, the health professions loan program and the health professions scholarship program were created and have come to constitute a major source of student aid for medical students. Since their implementation, the medical profession has been enriched by the addition of students with a greater diversity of socioeconomic backgrounds.

The Association now recommends a package of student assistance programs which places major emphasis on service-commitment scholarships while retaining unconditional health professions loans and scholarships for the initial years of the student's education. The Association firmly believes that previous experience with oversubscription for National Health Service Corps scholarships will continue and will result in large numbers of applicants for an expanded program. Funded at the levels recommended by the Association, the National Health Service Corps scholarship program should provide a substantial number of health professions students—approximately 2,500 annually at current scholarship rates—obligated to serve in the presently designated 547 shortage areas. Newly proposed recruitment bonuses could be used to attract physicians to these areas almost immediately in contrast to the time required by other provisions of the proposed legislation. At the same time, unconditional student aid has been retained for those students with truly exceptional financial needs. This approach is designed to permit continued broadening of the socioeconomic mix of health professions students without subjecting them to an undue national service burden.

INSTITUTIONAL ASSISTANCE

Capitation

Up to ⅓ of medical schools' net education expenditures as determined by a procedure developed in a study by the Institute of Medicine under 1971 health manpower legislation. (Current determination is $3,250.)

$1,000 for physicians' assistants.

Authorization for undergraduates (M & O) is $186–$194–$201 million.

Authorization for physicians' assistants (M & O) is $2–$3–$4 million.

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Authorization for phasing out enrollment bonus students in such sums as may be necessary.

Conditions for Capitation

Eligibility for first-half of capitation payment requires maintenance of enrollment and maintenance for non-federal financial support.

Eligibility for second-half of capitation payment requires, in addition, assurances of carrying out at least one project in each of any two of the following areas:

1. *Aggregate supply*—

(a) Increase first-year medical student enrollment by the greater of 5 percent or 10 students over a base year, provided that a school may offer an equivalent number of advanced standing places to students otherwise eligible for admission who previously were enrolled in non-M.D. programs or in schools outside the United States; or

(b) Establish a physician assistant or nurse practitioner training program of at least 25 students, or expand an existing program by at least 25 percent.

2. *Geographic distribution*—

(a) Increase first-year enrollment of students from shortage areas as determined by section 329 by 10 students over a base year; or

(b) Establish or expand a program satisfactory to the Secretary of undergraduate and/or graduate training at an off-campus site serving a shortage area. Such a program may be an area health education center, support of an NHSC Health Care Delivery Unit, or a remote-site care experience.

3. *Specialty distribution*—

(a) Increase annually primary care residency positions (defined to be family practice, general internal medicine, general pediatrics, and obstetrics-gynecology) in affiliated general hospitals (including university hospitals) by at least 5 percent of all residencies in all such hospitals, so long as the percentage of such positions is less than 50 percent; or

(b) Maintain primary care residency positions in affiliated general hospitals (including university hospitals) at 50 percent or more of all such positions; or

(c) Establish or expand one or more undergraduate programs satisfactory to the Secretary devoted to education in primary care in an ambulatory care setting. Conditions are to become effective beginning in the 1976–77 academic year.

Start-up, Conversion

To be phased out, with only previously assisted schools eligible for aid. Authorization is such sums as may be necessary.

Deficit Sharing

Authorization is $20 million annually.

Comments

Undergraduate medical education is composed of interacting elements integral to a unified process leading to the M.D. degree. The elements of this process are the instructional activities covering the imparting of disciplinary and interdisciplinary subject matter through lectures, seminars and laboratory exercises; participation in the care and management of patients; and training in research methods for the solution of problems in health. The cost of the elements is high, and in the past has been shared by the federal government, state and local governments, medical schools themselves through tuition and endowment income, private foundations and others. The federal role has been justified because of the national mobility of physicians, because of the unequal ability of states to maintain uniformly high quality medical schools, and because of an underallocation of resources to medical education by other public and private sources of support.

Since 1971, federal support of the education activities of health professions schools has been provided through a capitation grant. Through this device, the government acknowledged the legitimate public interest at the national level in the continuity and integrity of health professions educational institutions. The capitation grants have enabled the schools to respond to national needs. In doing so, the schools have expanded their facilities and have made commitments to new

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faculty and new programs which now must be sustained if the objectives are to be achieved. In addition, through the device of capitation, the government recognized the value of the establishment of a creative partnership between itself and the academic health centers for the purpose of permitting leverage through which national purposes could be achieved.

The Association is now proposing to continue the creative partnership in a modified form which combines pure and conditional capitation. Furthermore, the Association is proposing to deal with the vexing problem of capitation levels by relying specifically—in detailed legislative language—on a procedure for determining net educational expenditures developed in a study by the Institute of Medicine of the National Academy of Sciences as mandated by the Congress.

Providing a portion of the capitation support essentially without requirements other than maintenance of effort and normal financial accountability continues the federal responsibility for meeting some part of basic undergraduate medical education costs. This is a concept originally recommended by the Carnegie Commission on Higher Education, endorsed by the Administration, and supported by the Association. It is a concept also supported by the Institute of Medicine to (in its words): "help assure the stability of both the public and private institutions and the maintenance of proportionate levels of state assistance, tuition, and the philanthropy."

Coupling a portion of the capitation support to compliance with certain conditions acknowledges the schools' responsibility to contribute improvements to the nation's health care particularly with respect to aggregate personnel supply, geographic distribution, and specialty distribution. The responsibility of the schools goes beyond mere numbers of M.D. graduates; it includes the kinds of training experiences available for medical students and the kinds of health care delivery systems being developed to provide needed health services. The Association is confident that past achievements can be sustained and that new achievements can be recorded under its proposed capitation system in assisting the development of new kinds of physicians and improved methods of delivery.

GEOGRAPHIC DISTRIBUTION IMPROVEMENT ASSISTANCE

Health Manpower Education Initiative Awards

Revised to support area health education centers which are to be used for remote-site undergraduate and graduate training in primary care, for continuing medical education of local health personnel, for general health education of the public, provided that each such center be located in an underserved area and include participation by a medical school.

Authorization is $40–$70–$75 million.

Shortage Area Support

Provide project-grant assistance for academic medical centers to provide professional support and backup services for health care personnel or organizations, such as NHSC Health Care Delivery Units, in underserved areas designated under Section 329.

Authorization is $10–$20–$30 million.

SPECIALTY DISTRIBUTION IMPROVEMENT ASSISTANCE

Primary Care Residencies

Authorization is $40–$50–$60 million.

Primary Care Training

Provide project-grant assistance for undergraduate training in primary care in ambulatory settings.

Authorization is $10–$15–$20 million.

Comments

The Association believes there is a useful role for the project-grant approach to financing selected activities in health professions schools. This approach recognizes the incremental cost to the school of such a project and clearly separates the financial support for the project from the general pool of financial support for the basic undergraduate medical education program. Special projects serve as a vehicle for the health professions schools to participate in constructive change in the interest of improving the health and health professions education of the

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nation. Competitive rather than formula awards strengthen the entire health professions education system by ensuring heterogeneity; homogeneity would produce rigidity and resistance to any change. Competitive awards also allow research and demonstrations without total system involvement.

This set of programs, some of them new and some old, is proposed as a supplemental to the recommended optional capitation conditions also dealing with geographic distribution and specialty distribution. The two sets of proposals are completely independent and yet could be used by schools in a complementary fashion. The independence of the two sets of proposals means that a school electing a geographic distribution project as a capitation activity, for example, has no automatic claim to geographic distribution improvement assistance and may not even choose to apply for any, although it could. The complementarity of the two sets of proposals could be demonstrated by a school which bypassed a geographic distribution capitation activity in one year while receiving geographic distribution improvement assistance, and which at a later time elected a geographic tion capitation project based on new capability established through the earlier assistance award.

OTHER SPECIALIZED ASSISTANCE

Special Projects

Continue present project categories, and add the following new categories:

Improve sensitivity of health care personnel to cultural attitudes toward health of persons with limited English-speaking ability;

Improve sensitivity of health care personnel to health problems of females;

Increased emphasis on rehabilitation medicine and sensitivity to health problems of handicapped persons;

Increased emphasis on the aging process and sensitivity to health problems of aged persons;

Encourage experienced health care personnel to locate in underserved areas.

Authorization is $75 million annually.

Recruitment of Disadvantaged Students

Provide project-grant assistance for recruitment of disadvantaged students.

Authorization is $20 million annually.

Bilingual Training Centers

Provide project-grant assistance for up to four bilingual health training clinical centers in affiliation with academic medical centers.

Authorization is $2.5 million annually.

General Health Education

Provide project-grant support for projects to educate the public about health.

Authorization is $5–$10–$15 million.

Comments

This series of programs provides project-grant support for efforts to deal with a range of other important national health problems. Again, some of the programs are new and some old. They are grouped by the Association separately from programs dealing with geographic and specialty distribution because they deal with different, and separate, sets of issues. The issues are important, but medical schools have differing capabilities for dealing with them. Unlike geographic and specialty distribution, which are nationwide problems requiring nationwide remedial efforts, these problems may be dealt with effectively on a school-by-school basis. Thus they are not suggested as optional capitation activities.

OTHER PROVISIONS

National Advisory Council Membership

Revise the composition of the 20 appointed members to be 12 representatives of health professions schools, including at least six persons experienced in academic health center administration; two full-time health professions students; and six members of the general public.

FMG Immigration

Amend the Immigration and Nationality Act to remove special preference visas for alien physicians.

Graduate Medical Training

Designate the Liaison Committee on Graduate Medical Education as the agency

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responsible for accrediting graduate medical education programs. Authorize the Secretary with approval of a special advisory group to designate the number of accredited residency positions which are to be eligible for third-party reimbursement.

Health Manpower Report

The Secretary with approval of a special advisory commission is directed to report annually to the Congress on national health personnel needs by professions, by specialty, and by geographic region. The advisory commission shall consist of 10 persons appointed by the Secretary who by their training and experience are eminently qualified to assess health personnel needs, provided that no member of the group shall be an employee of the federal government.

National Health Service Corps

Provide that Corps delivery of health services is to be through 4–5 physician Health Care Delivery Units, comprised of physicians and appropriate other health personnel.

Application for a Unit would be by an underserved area or group of areas, after consultation with the appropriate medical society, which can provide assurances of sharing the cost of providing and equiping adequate facilities for a Unit provided that the Secretary may waive the cost-sharing requirement if a community is financially unable to meet it.

Underserved areas in remote locations with populations unable to support a Unit may enter agreement with an existing Unit to provide services on a circuit-rider basis.

Underserved areas covering large distances may enter federal cost-sharing agreements to provide appropriate communications and transportation systems.

Health Care Delivery Units may enter agreements with academic medical centers to provide backup for activities and develop appropriate referral patterns for patient requiring specialized care; to provide technical assistance in the development of appropriate communication and transportation networks; to provide continuing education for Corps personnel; to provide education for the public on health.

Authorization is $25–$35–$50 million.

These recommendations have been grouped together because each has an important—perhaps critical—contribution to make to solving national health personnel problems, and none involves Federal assistance to health professions schools. Three of the recommendations deal with the overarching national problems of geographic distribution, specialty distribution and foreign medical graduates.

In the 1974 debate over improving geographic distribution, there was agreement that the National Health Service Corps was the best available method for providing personnel for underserved areas. Little attention was paid in the debate to the Corps health care delivery methods. Since then, the Association has looked more closely at those methods and has developed some important recommendations for change. The present health services delivery methods used by the Corps and the presently required community involvement in, and support of, Corps activities should be revised. Instead of assigning individuals to underserved areas, the Secretary should assign NHSC Health Care Delivery Units. Such a unit would be composed of 4–5 physicians and appropriate numbers of other health personnel, including physicians' assistants and nurse practitioners. Instead of passively requesting Corps personnel, an underserved area (or group of areas) would be required to share with the Federal Government the cost of providing and equipping adequate facilities for a health care delivery unit. (This requirement could be waived by the Secretary when its imposition was beyond the financial resources of the applying area or group of areas.) Shortage areas, or groups of such areas, eligible for a health care delivery unit should have sufficiently large numbers of people to support such a unit. A circuit-riding option should be available for isolated areas, which would be served by personnel from the closest health care delivery unit. Appropriate communications and transportation systems would be provided, at shared government-community expense, in areas covering large distances. Health care delivery units could charge on a fee-for-service or prepayment basis. Such a proposed reorganization of NHSC services delivery would allow continued peer communication and time-off coverage, would help to diminish cultural shock for Corps personnel, would help to provide for quailty assurance through peer audit, journal clubs, etc., would provide a services delivery nucleus large enough to permit the assignment of undergradu-

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ate and graduate medical training experiences, and would improve the utilization of new health professionals within the Corps.

In the 1974 debate over improving specialty distribution, there was agreement that some national group should be charged with supervision of graduate training positions. The reasons were to insure a close matching of residency positions and numbers of U.S. medical school graduates, and to distribute specialty training according to national needs. Opinions differed as to whether the national group should be Federal or non-Federal. Now the Association is proposing a mechanism that incorporates both Federal and non-Federal elements. The Federal element is the HEW Secretary: the non-Federal element is a special advisory panel composed largely of experts and others from outside the government. Together they would carry out the previously agreed-upon purposes. It seems clear that at present there is an excess number of residency positions. In 1972, for example, of the 20,000 first-year positions offered, 60 percent were filled by U.S. graduates; the rest were filled with foreign graduates or were vacant. There also seems to be general agreement that at present there are too few primary care physicians—in family practice, general internal medicine, general pediatrics, and obstetrics and gynecology—and too many surgeons. These twin problems of residency numbers and distribution are the ones that the Secretary and the Advisory Panel would work together to correct. Their principal tool would be money: only accredited positions designated by them would be eligible for third-part reimbursement. The Association is confident this recommendation would be effective. Once in place and functioning, it should work to reinforce and to support similar efforts by the schools at improving specialty distribution carried out as capitation activities or special projects.

Foreign medical graduates comprise an excessively large proportion of physicians in the United States. For example, in 1972, one-fifth of all physicians in the United States were graduates of foreign medical schools; one-third of all residents in U.S. hospitals were graduates of foreign medical schools, and nearly half of all physicians newly licensed to practice were graduates of foreign medical schools. Fifteen years earlier, less than 6 percent of all physicians in the United States were graduates of foreign medical schools. Many FMG's come to the United States for graduate medical training, and thus efforts to more closely match residency positions and U.S. medical school graduates will have some effect on training opportunities for FMG's. Some FMG's come to the United States and find positions with various public health care institutions; thus availability of graduate training positions has little effect on these FMG's. The Association's recommendation requires alien physicians who are applying for permanent residence to pass the same examination that American students must take and to demonstrate competence in English and provides that their admission be contingent on a finding by the HEW Secretary that the admission will not lead to a surplus of practitioners in a specialty or geographic area in which there is no present or projected need. It is estimated that the Association's proposal covers some 6,000 of the 7,000 alien physicians who entered the United States as immigrants in fiscal 1973. In essence, the FMG problem is an immigration issue and it is best dealt with through immigration laws.

The Association recommends that the provisions of H.R. 3279 be strengthened with regard to the immigration of foreign medical graduates by adding the following provisions:

1. Commencing July 1, 1976, the sponsorship of FMG's coming to the United States for graduate medical education as exchange visitor physicians should be limited only to accredited U.S. medical schools or to other accredited schools of the health professions;

2. The U.S. Government should enter into agreements with the governments of other countries in which the U.S. medical education system agrees to provide specific types of graduate medical education for individual physicians who have been designated to fill key educational, governmental or other professional posts in that country. Within the framework of government agreements, individual educational institutions in this country should make appropriate agreements with recognized educational agencies and institutions in other countries. Candidates selected for such educational experience in the United States would be required before entering into such training to meet standards of professional preparation established by the U.S. educational institutions and accrediting agencies; would be committed to return to their home countries on the completion of the agreed upon educational program; and would be assured of previously specified academic,

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governmental or other professional appointments on their return to their home country.

3. The issuance of an exchange visitor visa should be contingent upon each FMG applicant submitting to the U.S. sponsoring educational institution acceptable evidence that he meets its standards of educational attainment; has demonstrated the potential to adapt to the cultural milieu in which he will be studying in the United States, as well as an effective mastery of the English language; and, if his educational experience is to include training at the level of hospital residency, that he has met a minimally acceptable standard of professional competence for assuming responsibility for patient care under supervision;

4. The duration of graduate medical education in the United States of all exchange visitor physicians should be specified in advance of entering into such training; be limited in general to two years or less; and be subject to extension only on the request initiated by their governmental and institutional or agency sponsors, assuring them of employment on completion of the extended training period;

5. Amendments enacted in 1970 to the Immigration and Naturalization Act that permit exchange visitors to convert a temporary visa granted for educational and cultural exchange purposes to permanent immigrant status should be repealed; and

6. The granting of H–1 temporary visas to FMGs should be restricted to foreign nationals of "distinguished merit and ability" who have been invited by universities and other appropriate institutions and agencies to teach and to conduct research.

These Association recommendations would apply to the approximately 5,000 exchange visitor physicians who annually enter the United States. They presumably come to the United States for medical training unavailable in their countries, intending to return to their countries and practice. In fact, under authority of the 1970 immigration law amendments, many exchange visitor physicians seek to change their status to permanent immigrant, thus denying their home countries their newly acquired medical services. In many cases, exchange visitor physicians come from countries with severe physician shortages, and with poor records of personal health of the population. Again, this is essentially an immigration issue, and thus is best dealt with through immigration laws.

Mr. ROGERS. Thank you for your excellent statement and for providing us with the thinking of the association.

Mr. SCHEUER. No questions.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. It is good to hear from the good doctor again. No. questions.

Mr. ROGERS. Do you agree there should be a limitation on residencies?

Dr. COOPER. Yes, we would propose, however, as I think you suggested in your discussion with Dr. Lee, that an advisory body working with the Secretary determine the rate at which a limitation in the number of residencies could be effected.

We have done a survey of some of the major teaching hospitals associated with medical schools. In some cases it will be difficult to shift very rapidly the distribution of residency slots. This can be in part remedied by providing an adequate number of other health professionals to help carry out some of the functions which residents now carry out.

We think this problem which is now being studied by the Institute of Medicine should be given to the Secretary and an advisory group to make certain they develop the most effective and rational plan in reducing the numbers and redistributing the number of slots among the various specialties.

Mr. ROGERS. The Secretary doesn't want the ball.

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Dr. COOPER. I think you ought to give it to him and see. This is one I think he can't regionalize, either.

Mr. ROGERS. I think it would be well for you to let us have your thinking as to how this should be done, over what time period, what steps should be taken. And what the impact on the provision of services might be.

[The information requested was not available to the committee at the time of printing.]

Mr. ROGERS. As I recall, you feel that one-half of capitation should be unattached and that it simply should be turned over to the school?

Dr. COOPER. Yes, sir; because as we have tried to point out, the schools are under extreme financial pressure and just to maintain the level of their ongoing programs, they are going to have to have support.

In addition to that, we think—and I could give you my assurance—that most, if not all, of the institutions will carry out the various requirements for the additional amount of capitation that is provided.

I think one of the things we must remember is that the appropriations process never meets the authorization levels granted by a committee; and that even with the levels that we have suggested, we really anticipate a substantially smaller level of capitation with no strings tied to it than the schools are now receiving.

Mr. ROGERS. But you would agree that we still want to accomplish certain goals?

Dr. COOPER. No question about it.

Mr. ROGERS. I would think that the American people would want some assurance that the Federal support would be used to accomplish nationally perceived goals.

Dr. COOPER. Our proposal is that some of the support be provided to institutions to help them stay open, so that we can meet national goals by maintaining what we already have. In addition to that, that schools should be provided with funds which would enable them to expand and extend the programs which they are already engaged in for meeting some of the problems of geographic and specialty distribution and aggregate supply.

Mr. ROGERS. I wonder if any studies have been done as to the actual need for the medical services provided by each of our institutions in relation to the base populations served?

Dr. COOPER. Yes; but unfortunately they are not coordinated programs. There have been a number of studies carried out by schools on physician needs. The State of Washington carried out such a study as have other States.

There is a very extensive study, apparently, underway by the National Center for Health Statistics which may be available, as I understand it, next year. It will report on a national survey of health care needs and the way in which those needs can be met by health professionals.

Mr. ROGERS. What I am thinking about, we still are using the very antiquated method of saying how many physicians we should produce or how many we need simply by 200 or 100,000 which doesn't really mean anything.

Maybe the 100,000, that particular 100,000 in that locality with the environmental setting and so forth, and the particular problems of the

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area they may need 5,000 physicians for 100,000 to give proper care. This committee is under a handicap and in fact the whole medical community is, in trying to project needs when we go simply on a basis of numbers. Often many of those that they list as practicing are not really practicing or they may not be taking any new people at all as exists often in my area; many doctors simply have a full load and they are not going to take any more even though your population increases.

Dr. COOPER. As you and I have discussed on previous occasions, the significantly increased output of the medical schools, which began in 1968, is just now appearing. These physicians are just now entering into independent practice, and the numbers of physicians in relationship to the population will continue to increase. We really have had no experience with what is going to happen with this substantially larger number of physicians.

We have maintained a physician population ratio of 130 to 140 per 100,000 for a great number of years. Now this is going up and will continue to go up very rapidly during the next two decades. I think it will continue for as far ahead as we can see. And we still don't know what effect the increased output that has been supported by these Federal funds is going to have, either on geographic distribution or on specialty distribution.

We do agree that other methods for trying to solve geographic and specialty distribution are needed. Nevertheless, a physician-population ratio of 200 per 100,000 we have never had any experience with.

Mr. ROGERS. Other nations have.

Dr. COOPER. Well, relatively few. The U.S.S.R. has 230.

Mr. ROGERS. Austria, Israel, there are a few.

Mr. SCHEUER. Scandinavian countries, I would think.

Dr. COOPER. No; they are lower. Great Britain, lower. Canada, lower. There are only three health professionals per physician in the U.S.S.R. In this country we have 10 health professionals to each physician.

Mr. ROGERS. They probably don't have as many foreign medical graduates, do they?

Dr. COOPER. No; although they have a fair number, I don't think they stay. They train a fair number of medical students from Africa and have a large medical school devoted to these students.

Mr. ROGERS. They don't stay?

Dr. COOPER. No.

Mr. SCHEUER. They have a better distribution of their talents, they have ways of telling people where to go that we don't have.

Dr. COOPER. They still have problems, though, and in parts of Siberia, there are still no fully qualified physicians. They do assign students for a period of 5 years after graduation and after that time they have some opportunities to move around. It is a much more efficient system than hopefully we will ever have in this country.

Mr. ROGERS. I assume your 200 per 100,000 includes foreign medical students?

Dr. COOPER. No; it includes the foreign medical graduates in the country now. Even if we were to reduce emigration we would still have those foreign-trained physicians. The ratio of physicians to population would be much higher, around 220 to 225 per 100,000, with con-

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tinued immigration of FM60 at the level of the average of the last 5 years.

Mr. ROGERS. Tell me this, how have faculties increased within the last 10 years; has there been any increase in faculties?

Dr. COOPER. There has been a substantial increase in the number of faculty members.

Mr. ROGERS. Shouldn't we have held them at a certain level just as you think we should hold practicing physicians? If we have 200 per 100,000, maybe we should hold faculty at 20 per 500 or something. I just wonder if that should be equated, or hasn't there been a comparable increase?

Dr. COOPER. In 1963, basic science and clinical faculty totaled 13,671; in 1973, it was 33,550. During this period, the basic science faculty doubled, the clinical faculty, about two and a half times.

I would point out that through both the interests of society and also some of the actions of the Congress, considerably more demands have been placed on the academic medical center. New faculty has not been added just to educate medical students.

Mr. ROGERS. Many have. As I recall, instructors increased 4 to 1. I saw some figures about a year ago, comparing the faculty increase to the student body. It was rather a dramatic increase. I was just making the point that I am not sure that the figure of 200 per 100,000, which seems to be large to you—in view of the change in society, and the change of demands, and with national health insurance—could be equated any better than maybe the dramatic increase in faculty to the student body.

Dr. COOPER. This is like saying——

Mr. ROGERS. I presume the quality has been improved?

Dr. COOPER. That the total number of employees of General Motors divided them by the number of people involved in Cadillac production, would be the ratio of workers to the number of Cadillacs produced, which is not true.

Mr. ROGERS. I don't think you use a mechanized system in medical education. I don't think you have a line that everybody just stamps something on the student; it is a more personalized thing.

What was the basis for your increased faculty?

Dr. COOPER. The major increase in faculty has come about because of noneducational programs which the medical centers are now involved in.

In addition, the number of other students for whom a major part of the education involve the medical school faculty have increased much more dramatically than the number of medical students. The full-time equivalent in the last 5 or 6 years has gone up from 76,000 to 109,000. Thus, there has been a substantial increase in the number of other kinds of students. Affiliated hospitals are delivering more than 25 percent of all inpatient care in the country and a rapidly increasing proportion of all of the outpatient care. With the development of medical practice by the faculty——

Mr. ROGERS. The care that those facilities are delivering is not all being done by medical school facilities, though. Don't your residents deliver much of that care?

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Dr. COOPER. Right; the number of residents has gone up but residency programs require supervising physicians and instructors.

Mr. ROGERS. That is what I am saying. You have dramatically increased all of this teaching paraphernalia compared to the student bodies.

Any other questions?

Thank you so much. Your testimony has been most helpful and we will be in touch, I am sure, to get your views and help as the committee acts on this bill further.

This concludes the hearings for this afternoon. We appreciate your patience.

We will adjourn until 10 tomorrow morning.

The committee stands adjourned.

[Whereupon at 4:50 p.m., the subcommittee adjourned to reconvene at 10 a.m., Friday, February 21, 1975.]

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HEALTH MANPOWER PROGRAMS

FRIDAY, FEBRUARY 21, 1975

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

The subcommittee met at 10 a.m. pursuant to notice, in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. ROGERS. The subcommittee will come to order, please.

This morning we are continuing our hearings on health manpower legislation.

The problems of geographic maldistribution, specialty maldistribution, and the influx of foreign medical graduates are of great concern to this subcommittee. One of the principal reasons for these problems in the lack of coordination of medical residency training programs in the United States.

The total number of residency positions in the United States far exceeds the total number of graduates of U.S. medical schools available to fill them. The excess amounted to over 21,000 positions last year. As a result over 33 percent of the residency positions in this country are filled with foreign medical graduates. Moreover, the balance among the positions is badly skewed away from primary care specialties toward the medical subspecialties, surgery and the nonpatient care specialties, despite a demonstrated need in this country for more primary care. Also, most residency training is located within large urban areas which demonstrate little if any need for more physicians.

The ability of our subcommittee to develop legislation designed to influence residency training has been greatly facilitated by the formation of the Coordinating Council on Medical Education. The CCME, which is comprised of representatives of the American Medical Association, the American Hospital Association, the Association of American Medical Colleges, the American Board of Medical Specialties, and the Council of Medical Specialty Societies, constitutes a recognition by the profession of its responsibility to influence graduate medical education in order to be responsive to the health needs of this country.

The legislation on which we are conducting hearings is intentionally designed to afford the profession, as represented by the CCME, to perform the difficult but necessary task of designating medical residency programs in the United States.

We are delighted that our first witnesses this morning are a panel representing the CCME.

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We welcome to the witness table Dr. William D. Holden, American Board of Medical Specialties; Dr. Leo Gehrig, vice president, American Hospital Association; Dr. Tom Nesbitt, Speaker, House of Delegates, American Medical Association; Dr. John Cooper, president, Association of American Medical Colleges; and Dr. C. Rollins Hanlon, president, Council of Medical Specialty Societies.

We welcome you gentlemen to the committee. Your statements will be made a part of the record in full if you wish to summarize and you may proceed as you desire.

STATEMENTS OF A PANEL REPRESENTING THE COORDINATING COUNCIL ON MEDICAL EDUCATION:

WILLIAM D. HOLDEN, M.D., IMMEDIATE PAST PRESIDENT, AMERICAN BOARD OF MEDICAL SPECIALTIES AND CHAIRMAN, COMMITTEE ON PHYSICIAN DISTRIBUTION, CCME;

LEO J. GEHRIG, M.D., VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION;

TOM E. NESBITT, M.D., SPEAKER, HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY C. H. WILLIAM RUHE, M.D., DIRECTOR, DIVISION OF MEDICAL EDUCATION, AMA AND SECRETARY, CCME; AND LEONARD D. FENNINGER, M.D., SECRETARY, ADVISORY COMMITTEE ON GRADUATE MEDICAL EDUCATION, COMMITTEE ON EDUCATION;

JOHN A. D. COOPER, M.D., PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; AND

C. ROLLINS HANLON, M.D., F.A.C.S., PRESIDENT, COUNCIL OF MEDICAL SPECIALTY SOCIETIES

Dr. HOLDEN. Mr. Rogers, with your permission, we would like to each make a statement and then respond to any questions that the committee would like to present to us.

Mr. ROGERS. That will be excellent.

For the reporter, it might be well if you would identify everyone in their positions at the table.

Dr. HOLDEN. At my far right is Dr. Hanlon; at my right is Dr. Cooper; to the far left Dr. Nesbitt, and to my immediate left, Dr. Gehrig.

Mr. Chairman and members of the committee, I am Dr. William D. Holden, immediate past president of the American Board of Medical Specialties, director of the Department of Surgery at Case Western Reserve University School of Medicine, member of the liaison committee on graduate medical education, and chairman of the committee on physician distribution of the coordinating council on medical education.

I am here today as a representative of the American Board of Medical Specialties. It is my understanding that the purpose of the committee's invitation to testify today is to elicit comments on proposed legislation affecting health manpower and that the proposals restate

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those contained in the Health Manpower Act of 1974, H.R. 17084, title XIV. I am pleased to have the opportunity to discuss the proposed legislation.

Section 1401 (a)1A of H.R. 17084 designates that after calendar year 1977, the number of first year positions in any accredited medical residency shall not exceed the number prescribed by an agency approved by the Secretary of Department of Health, Education, and Welfare and that the number of first year positions may not exceed 125 percent of the estimated number of graduates from accredited medical schools in the preceding year.

The intent of this proposal appears twofold, one, to identify a voluntary agency that will designate the number of residencies in each specialty in order to achieve a greater output of primary care or family oriented physicians and to reduce the number of specialists being educated where an existing or projected excess can be identified; Two, to introduce a mechanism to reduce stringently the number of foreign medical graduates entering approved graduate programs in this country.

The emphasis on first year positions in accredited residencies will not in any obligatory fashion increase the number of primary care physicians who are classified as general internists and general pediatricians since a progressively larger number of medical and pediatric residents who complete the requirements for the American Boards Internal Medicine and Pediatrics proceed to complete residencies or fellowships in the subspecialties of medicine and pediatrics. There are 12 such subspecialty categories that provide board certification. Examples of the 12 are cardiology, rheumatology, gastroenterology, and nephrology.

If the whole structure of graduate medical education is to be manipulated to produce more primary care physicians, attention should be directed to the numbers of physicians completing residencies and fellowships rather than the number entering general residencies.

The ceiling of 125 percent of the preceding year's U.S. medical graduates will indeed limit the number of foreign medical graduates who can compete successfully for residency positions in this country. With approximately 15,000 U.S. medical graduates in 1977, the maximum number of foreign medical graduates who could enter U.S. residencies would be 3,750. Presumably these would be well or reasonably qualified to accept positions in this country.

This will not solve the principal problem of permitting unqualified foreign medical graduates to enter into the patient care setting in this country. Unless attention is directed to both immigration policies and licensing procedures, there will continue to be a large influx of foreign medical graduates into the so-called underground, a complex and amorphous situation where the opportunity for monitoring the quality of care provided is essentially nonexistent.

It should also be noted that establishing national quotas for the annual production of specialists of all types will not in itself solve the problem of the adequate delivery of comprehensive medical services to all people.

House Report 93-1382, entitled National Health Policy, Planning and Resources Development Act of 1974, which is now law, established

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a complex system of planning for the effective utilization of health care resources on a regional basis—a geographic area with a defined population for which all required resources can be made available. Among those resources should be physicians of all specialty categories as well as all other health providers. The total number of physicians and the mix of specialists will vary significantly from one region to another depending upon the cultural and economic characteristics of the population as well as upon such indirectly related factors as concentration of people, industrial characteristics, adequacy of housing, education facilities, and many others.

The needs for the region's physician population will not only vary because of these factors but should be determined by the regional agency responsible for the planning and distribution of resources. Regulation of the number of specialists produced, whether by federal legislation or by the assumption of this responsibility by organized medicine, will have to be responsive to regional quotas and needs.

Section 1403(a)(2), referring to the designation of the number of first year positions in residencies by an agency, states: "in determining the number of such positions in any such accredited program the designated or established agency shall (a) take into consideration the report made with respect to the study conducted under section 15(c) of the act of December 31, 1973 (P.L. 93-233) and the report made with respect to the study conducted under section 801 of the Health Manpower Act of 1974."

There is an implication in the statement that the designated agency in making its decisions should attend only to these reports, whereas many excellent studies already completed provide a mass of information about the specialty and geographic distribution of physicians. An example is "The Study of Surgical Services for the United States" conducted by the American Surgical Association and the American College of Surgeons. It will be published this spring.

If the statement in 1403(a)1(A) contained an insert, the agency would have more freedom to examine all data and information relevant to physician manpower. The statement might read "the established agency shall take into consideration the reports made with respect to studies of medical services and manpower including the study conducted under 15(c), et cetera."

When the Committee on Physician Distribution of the CCME was established in March 1973, its members were aware of the need for a comprehensive analysis and solution of the physician manpower problem. The committee felt that its most compelling responsibility was to do its utmost to change the environment within medical schools, teaching hospitals, and specialty boards so that more graduating medical students would be attracted to careers of primary care in family medicine, general internal medicine, and general pediatrics.

This report has been accepted by the parent bodies of the CCME and is now being distributed to all persons and agencies concerned and is being published. Many of the convictions held by the Committee on Physician Distribution and the CCME expressed in this report became widely known while the report was being developed. They have already influenced significant changes in schools of medicine, university hospitals, and the specialty boards. Dr. Nesbitt will refer to these a little later.

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The committee in approaching the ultimate task of recommending policy for the specialty and geographic distribution of physicians appreciated that no valid projections of specialty needs could be made without addressing the question of the role of foreign medical graduates in the health care delivery system. Accordingly, the second effort of the committee was to produce a report on the foreign medical graduate. This report is the most comprehensive document on the subject and contains 44 recommendations addressed to multiple private agencies concerned with medical education and health care as well as several departments of the Federal Government and State legislatures.

The CCME has approved the report, as have two of the five parent bodies, including the American Board of Medical Specialties. All five have approved the establishment of an invitational conference in April 1975 sponsored by the CCME. Representatives from all private and governmental agencies are being invited and the agenda will consist principally of the CCME's report on the foreign medical graduate. It is the intent of the CCME's planning committee for this conference to arrive at a consensus about the implementation of the report's recommendations that are accepted or modified in order to permit the medical educational institutions in this country to assist only in the education of those FMG's who are unequivocally qualified to participate and benefit from such experience.

The third report that the Committee on Physician Distribution is preparing at the present concerns the actual distribution of physicians by specialty and geography. It is assisted in this task by the availability of all the information on physicians contained in the files of the American Medical Association. This is the most complete bank of information on physicians in the country.

The committee is also assisted by the availability of multiple reports of studies done by many specialty organizations. Some have already projected the production of excessive numbers of certain specialists and have recommended that a mechanism be created within organized medicine that will assure a better distribution of specialists in the future.

There are unequivocal changes taking place spontaneously in medical education that will lead to a more effective national distribution of physicians, and many feel that these changes will meet manpower needs in the foreseeable future. Others feel that a variety of policies devised and announciated with conviction by organized medicine can accelerate the spontaneous changes for improvement already occurring. Still others feel that some form of arbitarary regulation with or without the introduction of appropriate incentives is the only way in which the physician manpower problem will be resolved.

It is almost an axiom that young physicians will select and compete for desirable options but will not engage in the type of medical practice that conflicts with their personality requirements, or if they do, the practice is conducted without their full commitment.

The stipulation in the legislation that the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education be given the first opportunity for recognition by the Secretary for the specific purposes enumerated in the legislation is appropriate only if it is accepted that these voluntary agencies, established for specific purposes by organized medicine, become arms of the Fed-

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eral Government and subject to whatever requirements the Secretary may wish to impose upon them.

The many segments of organized medicine with their fragmented authorities have already disposed of many of their vested interests in uniting behind the LCCME as the single accrediting agency for graduate medical education and identifying the CCME as a body within which all major national policy affecting medical education will be approved.

The CCME is intentionally engaged in attempting to devise policies for the educational establishment that will bring the best of medical services to all people without creating an environment of adversity in the process. It recognizes the responsibility and indeed obligation of the Congress to see that the people's needs are met with an adequate supply and distribution of qualified physicians.

Legislation that identified the responsibility of appropriate medical organizations to accomplish stated goals and the required monitoring of the organizations' productivity by the Secretary without introducing specifications would provide additional incentive and challenge for the medical profession to establish such mechanisms, procedures, and agencies as are required to meet the needs of the people.

It is my personal belief that organized medicine is highly sensitive to the problem of physician manpower and the various aspects of maldistribution. It has already formally taken a firm stand on the need for more primary care physicians. It has stated that 50 percent of the graduates of American medical schools should be entering and graduating from primary care residencies.

There is also a realization that this change must be accomplished within the next 2 to 4 years, not in 1985. These premises inevitably lead to the adoption of whatever mechanisms are required to accomplish the goal.

The CCME's report and conference in April 1975 should resolve the problem of foreign medical graduates, if several departments of the Federal and State governments are responsive to the recommendations. There is no question about the several segments of organized medicine desiring immediate resolution of this problem.

The problems of specialty maldistribution are already in the process of being resolved voluntarily and require little more than the annunciation of a strong national policy by organized medicine and more deliberate direction and attention to the process of accreditation.

Geographic distribution will only be resolved on a regional basis within broad and permissive national policies directed to total numbers and the mix of specialists.

The resolution of these issues requires the attention of both the Federal Government and organized medicine. The actual manipulation of the educational process should, and in fact will have to be, accomplished by the medical profession. The assistance and challenge of the Federal Government can appropriately augment the efforts of medicine.

It has been a privilege for me to appear before this committee and I am grateful for the opportunity.

Mr. ROGERS. Thank you, Dr. Holden, for your statement.

The next panelist, Dr. Gehrig.

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STATEMENT OF LEO J. GEHRIG, M.D.

Dr. GEHRIG. I am Dr. Leo Gehrig, vice president of the American Hospital Association. Our association represents more than 7,000 member institutions—including most of the hospitals in the country, numerous extended and long-term care institutions, mental health facilities, hospital schools of nursing—and over 20,000 personal members. We welcome the opportunity to testify before this subcommittee on the important subject of health manpower.

I have a full statement that addresses H.R. 2957, the Nurse Training Act of 1975; H.R. 2956, the Health Manpower Act of 1975; and H.R. 2958, the National Health Service Corps program.

In the interest of time, I will summarize a few points of our testimony and request that you put the full statement in the record [see p. 491].

Our interest in health manpower relates not only to the utilization of personnel for the delivery of high-quality care in our institutions, but also to the critical role of many hospitals in training health workers.

At present, some 64,000 nursing students are enrolled in hospital schools of nursing, and most of the nursing students trained primarily in academic settings receive their clinical education in hospitals. Moreover, some 11,160 interns, 45,000 residents, and a large number of allied health trainees are receiving all or significant portions of their education in hospitals.

I would like with your permission, Mr. Chairman, now to draw attention to the Nurse Training Act.

The hospitals of this country, as of October 1974, operated approximately 462 diploma schools of nursing. Last year, approximately 32 percent of all nursing students graduated from these diploma schools.

I cite these statistics to point out that diploma schools of nursing continue to be a vital resource for the education of nurses in this country.

Mr. ROGERS. What was the percentage graduated?

Dr. GEHRIG. Thirty-two percent of those graduated came from diploma schools.

We want to emphasize to you our belief that we must utilize fully every available educational resource if we are to meet our nursing needs. We are firmly convinced that a program of adequate Federal support for all nursing education programs is essential.

The chairman is well aware of the difficulty of getting statistics about shortages, but in the interest of shedding some further light on it, the AHA during recent months surveyed the chief executives of each of the State hospital associations in order to determine the nursing situation in these States. Granted, this is a qualitative sort of analysis, but you may be interested to know 36, or 72 percent, of the States reported shortages of registered nurses that appeared relatively statewide. That left 14 who viewed no overall statewide shortages but these indicated that they had serious shortages in certain areas, especially in rural and low-income population areas.

This indicates to us the shortage of registered nurses is real, despite reports from some quarters to the contrary. Moreover, hospitals have made concerted efforts in the interest of patient care to broadly expand their recruitment programs, to provide increased pay and fringe bene-

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fits to their nursing staffs, to retrain nurses who have left the workforce, to expand the use of licensed practical nurses wherever possible, and have attempted to recruit trained nurses from foreign countries.

Yet, despite all of these efforts, the shortage of nurses for the health-delivery system remains a serious problem. It has necessitated, in shortage areas, a decrease in some needed hospital services, or in some instances their elimination; and it has inevitably lowered the quality of nursing care. These circumstances, we believe, underscore our contention that nursing education programs must be supported.

Mr. ROGERS. I want to commend the American Hospital Association for making this survey because, as you say, we get so many contrary reports and I think this is pretty up to date. This was done in the last month?

Dr. GEHRIG. Yes, sir.

Mr. ROGERS. Which indicates 36 States report an overall shortage throughout the State, and 14 say there is no overall statewide shortage but there are many areas where there would be shortages.

Dr. GEHRIG. A majority of those 14 said they had a location in which they had serious shortages.

Mr. ROGERS. Thank you.

Dr. GEHRIG. An important effort toward meeting the need for institutional support is recognized, Mr. Chairman, in your bill, H.R. 2957, in its section providing for extension of the capitation grant authority. Such capitation funds are important to diploma schools, since these institutions typically receive little or no financial support from State and local government.

H.R. 2957 provides for the continuation of annual capitation grants for schools of nursing. The dollar amount provided, however, represents but one-sixth of the net average annual expenditure for schools of nursing as determined in the IOM study. We believe that these levels are too low and we would recommend that capitation assistance be authorized at one-third of the net annual educational expenditures.

Another issue in the capitation grant program is the requirement, which would be continued under the terms of H.R. 2957, for enrollment increases as a condition of receiving such grants.

Many schools which have received capitation grants in the past and have expanded their enrollments accordingly, are now unable to expand further. They would therefore be ineligible for capitation grants because of the requirement for continued enrollment increases, despite the fact that they will carry previously added students until graduation and hopefully maintain this increased class size.

We energetically supported that in terms of the earlier legislation; but I must say, Mr. Chairman, this is a problem now. Many of the schools who have received capitation grants in the past have increased their enrollments accordingly and are now in the situation of being unable to expand further. The reasons are many—lack of facilities, the lack of faculty, a host of these things.

If you have a requirement for continued increase, it means that these schools which have increased their enrollment—and we hope will maintain this increase in the quality of education—will have very real difficulty in obtaining the capitation support that your bill provides.

We would certainly like to recommend, Mr. Chairman, the elimination of the enrollment increase requirement. We would urge, however,

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the continuation of the requirement that all schools maintain at least their present level of training.

I would like to move briefly to the loans and scholarships. Again, your bill extends authority for nursing student loans and scholarships. We do not agree with the administration's position that these programs should be transferred or phased out.

We are convinced that these loans and scholarships are essential in assisting many nursing students who cannot otherwise meet the financial requirements of enrollment in schools of nursing.

In summary, Mr. Chairman, the American Hospital Association commends the committee for its action and endorses the provisions of H.R. 2957, the Nurse Training Act of 1975. We believe that its enactment with the recommended modifications is basic to meeting present and future needs for this important segment of health manpower.

I might add, Mr. Chairman, I am sure Miss Connie Holleran would support that statement 100 percent.

Mr. ROGERS. I expect Connie might.

Dr. GEHRIG. I would now like to turn to the health professions training bill briefly. H.R. 2956 would include in the Public Health Service Act a new title XVII which would establish a program directed at the problem of physician-specialty maldistribution.

This new authority would establish (in section 1702) procedures for the Secretary of HEW to designate or establish an agency to accredit medical residency training programs in this country. If legislation is necessary in this area, we would support a provision that would permit the liaison committee on graduate medical education to be the agency designated for this task.

This new title XVII would also provide authority for the Secretary to designate or establish an agency to certify the number of first-year positions in accredited residency training programs which may be made available in any calendar year beginning after calendar year 1977.

The AHA, Mr. Chairman, testified before this committee with many of the same gentlemen at the table today, and in testifying indicated then, as we do now, that we do not believe that there should be Federal legislative intervention in this area, but that incentives and voluntary action such as has been carried out by CCME continue.

However, if a process for certifying medical residency programs is to be established in legislation—and we are really not proposing such to be done now—the AHA strongly recommends some specific changes in H.R. 2956 to imporve the development of the proposed certifying process, the details of which are spelled out in my longer statement.

Mr. ROGERS. In other words, you would have a phased-in program, more than at the end of 3 years?

Dr. GEHRIG. There are two basic elements in our statement. One is the timing of it. The second is the mechanics of its operation, and here we have tried to detail it in our statement.

If legislative action is taken in this area, we must be concerned with the immediate effect of such actions on the direct delivery of medical services in many teaching hospitals.

We are concerned that the direct delivery of medical services in teaching hospitals not be disrupted or reduced by enactment of this legislation.

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There is no doubt that a diminution of numbers of residents in medical specialties will have an impact on physician services to patients in many teaching hospitals. A considerable amount of patient care is provided by residents in specialties that cannot be provided by primary care physicians-in-training or by physician extenders.

This problem is particularly true in many major teaching hospitals located in urban centers and on which large segments of low-income residents of inner cities depend for their care.

Before such changes are introduced, careful analysis should be made of their impact on patient care. Further, when changes appear indicated, adequate time must be provided for necessary adjustments to meet the needs of service.

It must be recognized also that necessary adjustments for service delivery, where adjustments are possible, often will necessitate the addition of full-time professionals and that this will have an increased cost implication.

The need to recruit full-time professionals, moreover, will often pose serious problems because of the lack of available individuals willing to work full-time in such a capacity. And we do not know the answer to this problem. We are certainly looking into the situation but today this is the fact, and I would like to underline this need in the delivery system as we look to the matter of manpower, its distribution and other problems.

If I could touch on one other subject, that is, of the alien physicians. We are aware you introduced H.R. 3279, a proposal of the Association of American Medical Colleges. Section 602 of that bill provides for amendment of the Immigration and Nationality Act and also includes other requirements on alien physicians.

In this connection I would like to call your attention again to the fact that alien physicians are providing essential services to patients in some areas and institutions in our country and they are providing a service as individuals that is very difficult to replace in some localities by an American-trained physician.

Such needs for alien physicians are a fact. They exist now and they probably will exist for a period in the future. We believe there should be included, should legislation be enacted here—and we are not proposing it—an appropriate waiver provision which would work to meet the needs of areas in trouble, and we feel this would be justified in hardship situations.

If this committee adopts the AAMC recommendation, we strongly recommend this waiver.

Mr. CARTER. Mr. Chairman, I happen to be familiar with some of the alien physicians. Some of them are fine and well-educated people, some are not so good. I can refer specifically to one particular hospital in a town in Dr. Nesbitt's State, euphemistically called "Bloody Bucket." The hospital is staffed principally by alien physicians. Years ago I had a very fine old friend who had a stroke caused by periarterio infiltration around an artery. He had this stroke and he recovered. Not too long ago I regretfully heard that he had passed away after surgery, which I believe was not indicated.

In another case, a friend of mine called me and said they wanted to do a laparotomy—an exploratory operation—at the "Bloody Bucket."

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After I referred her to a specialist, I was told that she only had a mild case of hemorrhoids.

This has been some of my experience with some of our alien physicians.

Other alien physicians fill our State psychiatric institutions. In some States 100 percent of the medical staff are FMG's. The irony is that psychiatry is based in great part on communication between physician and patient; in most cases such communications is utterly impossible—I myself have had difficulty in communicating with them about patients.

The FMG problem is greater than we might realize, and I think that they should pass the same examination required of physicians in our country—and, also, that they should be required to pass an English test, too, because if they are functional illiterates we cannot expect them to function as physicians.

So I differ somewhat from what you say, Dr. Gehrig, although I respect your statement that there is need in some areas.

Dr. GEHRIG. I don't believe we are differing because I can agree with your comment, but I think there needs to be a real awareness, as you pointed out in your comments, that there are some that do an excellent job. And we do have some areas of extreme difficulty. We are not suggesting that we want second-rate medicine practiced.

Mr. Chairman, in conclusion, ours is a highly labor-intensive industry. Typically, in fact, more than half of a general hospital's budget, as you know, is allocated for labor costs. To provide needed health care to patients we must continue to work to develop the quantity and quality of health professionals to do the job and to face the increased demands for care in the future.

The efforts of this committee are very important to the task ahead. We believe the bills you have introduced, if they might be modified in some areas that we have highlighted, are essential and we support them.

I thank you for this opportunity.

[Testimony resumes on p. 499.]

[Dr. Gehrig's prepared statement follows:]

STATEMENT OF LEO J. GEHRIG, M.D.

Mr. Chairman, I am Leo J. Gehrig, M.D., Vice President of the American Hospital Association. Our Association represents more than 7,000 member institutions (including most of the hospitals in the country; numerous extended and long-term care institutions; mental health facilities; and hospital schools of nursing) and over 20,000 personal members. We welcome the opportunity to testify before this Subcommittee on the important subject of health manpower. I will address my remarks to H.R. 2957, the Nurse Training Act of 1975; H.R. 2956, the Health Manpower Act of 1975; and H.R. 2958, the National Health Service Corps Program.

The hospital field is greatly concerned about the health manpower shortages that exist in some areas and the maldistribution of health care personnel throughout the nation. The urgency and seriousness of these problems is evident when one considers the increasing complexity of many types of health services today, the need for increased accessibility and availability of services in urban and rural poverty areas, the demands for more comprehensive health care services for all, and the present efforts of Congress to develop a national health insuarnce program to meet these problems. On the other hand, when we look at our resources for the training of needed health manpower, we see programs that are facing

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tremendous financial difficulties—difficulties such as inadequate funds for institutional support and for student assistance.

Our interest in health manpower relates not only to the utilization of personnel for the delivery of high quality care in our institutions, but also to the critical role of many hospitals in training health workers. At present, some 64,000 nursing students are enrolled in hospital schools of nursing, and most of the nursing students trained primarily in academic settings receive their clinical education in hospitals. Moreover, some 11,160 interns, 45,000 residents, and a large number of allied health trainees are receiving all or significant portions of their education in hospitals.

NURSE TRAINING

The hospitals of this country as of October, 1974, operated approximately 462 diploma schools of nursing with an enrollment of some 64,000 nursing students. Last year, approximately 32 percent of all nursing students graduated from these diploma schools. I cite this statistic to point out that although there have been substantial increases in other types of nursing programs, diploma schools of nursing continue to be a vital resource for the education of nurses in this country. We want to emphasize to you our belief that we must utilize fully every available educational resource if we are to continue to meet our nursing needs. We are firmly convinced that a program of adequate federal support for all nursing education programs is essential.

In an effort to evalaute the extent of the shortage of registered nurses, the American Hospital Association surveyed the chief executive officers of all of the 50 state hospital associations in order to determine the situation in each of the states. As a result of this review, the following were indicated:

—There is a shortage of registered nurses today in health care facilities in 36, or 72 percent, of all of the states; and

—Of 14 states in which no overall statewide shortage was apparent, a majority indicated serious shortages of available registered nurses in certain areas, especially areas of rural and low-income populations.

This review certainly indicates that the shortage of registered nurses is real, despite reports from some quarters to the contrary. Moreover, hospitals have made concerted efforts to broadly expand their recruitment programs, to provide increased pay and fringe benefits to their nursing staffs, to expand the use of licensed practical nurses in the place of registered nurses, and have attempted to recruit trained nurses from foreign nations. Yet, despite all of these efforts, the shortage of nurses for the health delivery system remains a serious problem in many areas. It has necessitated in shortage areas a decrease in some needed hospital services, or in some instances their elimination; and it has inevitably lowered the quality of nursing care. These circumstances, we believe, underscore our contention that nursing education programs must be supported.

Construction Assistance

H.R. 2957 provides for the extension of the existing authority to assist in the construction of new nurse training facilities and the replacement or rehabilitation of existing facilities. The bill would assign a new priority under this program to projects which expand a school's capacity to provide graduate training.

AHA's recommendation.—That Title I of H.R. 2957, providing for extension of the construction grant program, be supported.

Capitation Assistance

An important effort toward meeting the need for institutional support is recognized, Mr. Chairman, in your bill, H.R. 2957, in its section providing for extension of the capitation grant authority. Such capitation funds are especially important to diploma schools, since these institutions typically receive little or no financial support from state and local government. As you know, the Institute of Medicine (IOM) of the National Academy of Sciences completed a major study of "Costs of Education in the Health Professions" which determined that the average annual net educational expenditures per student in baccalaureate degree programs in nursing was $2,450; in associate degree programs, $1,650; and in the diploma programs, $1,500. While the average annual educational cost per diploma program student was $3,300, there was a $1,800 offset for reimbursed service. The IOM study then further went on to make the following recommendations:

"(1) The study group endorses a capitation grant program as an appropriate federal undertaking to provide a stable source of financial support for health professional schools.

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"(2) The study group is of the opinion that capitation grants ranging between 25 and 40 percent of net educational expenditures would contribute to the financial stability of public and private health professional schools and would be an appropriate complement to income from tuition and gifts and support by state governments, all of which should be maintained as nearly as possible in their present proportions."

H.R. 2957 provides for the continuation of annual capitation grants for schools of nursing at the following levels: baccalaureate, $400 per student enrolled in the last two years of such schools; associate, $275 per student enrolled in the last year of the program; and diploma, $250 per full-time student. These figures represent just one-sixth of the net average annual expenditure for schools of nursing. We believe that these levels are too low, and we would recommend that capitation assistance be authorized at twice these levels, or one-third of the net annual education expenditures.

Another problem with the capitation grant program is the requirement, which would be continued under the terms of H.R. 2957, for enrollment increases as a condition of receiving capitation grants. This requirement has existed since the 1971 legislation became law and has worked a hardship for many schools. When, for reasons other than financial, a school is unable to expand its physical space, or the size of the clinical facilities available, or the number of its faculty members, that school is not eligible for capitation grants. Moreover, many schools which have received capitation grants in the past and have expanded their enrollments accordingly, are now unable to expand fourther. They are now ineligible for capitation grants because of the requirement for continued enrollment increases, despite the fact that they will carry previously added students until graduation and hopefully maintain this increased class size. We feel that the continued requirement for enrollment increases is a barrier to participation in the capitation program and will prevent many schools from continuing to produce nursing graduates in the numbers and of the quality that have been produced in the past. While H.R. 2957 does include waiver provisions, we would recommend, instead, the elimination of the enrollment increase requirement.

AHA's recommendation.—That the capitation grant program be continued, but at a substantially higher authorization level and without the requirement for enrollment increases.

Special Project And Financial Distress Grants

H.R. 2957 recommends the extension and modification of the existing authority for special project grants and contracts, and continuation of the authority for financial distress grants.

AHA's recommendation.—That the provisions in H.R. 2957 for continuation of the Special Project and Financial Distress Programs be supported.

Traineeships

The existing program of traineeships for graduate-level training of nurses is aimed at developing larger numbers of well-qualified teachers, clinical nurse specialists, administrators, and supervisors. In 1973, some 2,600 nurses received long-term traineeship aid, while another 900 benefited from short-term courses. Assistance of this type is acknowledged throughout the health industry to be one of the most beneficial and important programs funded by the federal government. Therefore, we enthusiastically support its proposed continuation under H.R. 2597.

AHA's recommendation.—That the nurse traineeship program be continued.

Loans And Scholarships.

The Administration has proposed to end the special program of nursing scholarships and to phase out the federal contribution to the nursing student direct loan program. It has maintained that the scholarship program can be replaced by making Basic Opportunity Grants available to undergraduate nursing students. The fact is, however, that the Office of Education-administered Basic Opportunity Grants averaged about $250 in 1973, while the typical nursing scholarship was closer to $600. Moreover, the BOGs were available only to freshmen and sophomores, while the nursing scholarships have no such limitation. Thus, if the limited BOG grants continue at or near the $250 level, the BOG program would by no means be an adequate replacement for the nurse scholarship program.

Similarly, the Administration has contended that the nursing direct loan program can be continued through reliance on federal capital contributions already made and on repaid loans. However, it is evident that if the proposed phase-out is completed, there will be insufficient funds in the institutions' loan programs to

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continue direct loans at a level even close to that of the present program, and either the number or amount of nursing student loans will have to be sharply reduced. We are therefore pleased to see that H.R. 2957 proposes the extension of the nursing student loan program.

A very large number of students are financially unable to pay for the full costs of their education, and a study of nursing students shows that over 50 percent come from families whose annual incomes are less than $10,000. Inasmuch as very real efforts are being made to recruit candidates into the nursing profession from the lower income groups, it is readily apparent that programs of assistance to nursing students through both loan and scholarship efforts are necessary to the success of the Nurse Training Program. In FY '74, the amounts requested under the Nursing Student Loan program totalled over $62 million, a figure significantly above that which was appropriated and obligated. The higher authorization levels contained in H.R. 2957 would permit more students to enter the program.

H.R. 2957 would also extend the present nurse scholarship program. While nursing students would also be eligible for National Health Service Corps scholarships under the provisions of H.R. 2956 and H.R. 2958, we agree that the existing program of scholarships just for needy nursing students should be retained.

AHA's recommendation.—That the provisions in H.R. 2957 calling for extension of the existing loan and scholarship programs for nurse training be supported.

In summary, Mr. Chairman, the American Hospital Association generally endorses the provisions of H.R. 2957, the Nurse Training Act of 1975, and believes that its enactment with the recommended modifications is basic to meeting present and future needs for this important segment of health manpower.

HEALTH PROFESSIONS TRAINING

Mr. Chairman, I would now like to turn to the non-nursing aspects of the health manpower issue.

National Health Service Corps

H.R. 2956 contains provisions (introduced separately as H.R. 2958) to revise and extend the authority for the National Health Service Corps and to assist individuals who express a desire to join the Corps to complete their educational requirements. The American Hospital Association supports these provisions.

Scholarship funds are important mechanisms in attracting physicians, dentists, nurse practitioners, and other health professionals to provide health care to medically underserved populations. We support the authorization of adequate educational subsidies for health professionals who participate in the Corps. Appropriation of such funds should be made sufficiently in advance of Corps service to allow prospective candidates a timely option for Corps participation and, thus, facilitate stable planning and recruitment for the program.

Salaries for Corps members should be established at an adequate level to allow the Corps to compete realistically in the recruitment process for health professionals. Successful recruitment requires that the monthly rate of pay available for Corps personnel be competitive with that provided health professionals with equivalent training in established practices.

The American Hospital Association supports deferment of periods of obligated Corps service following completion of basic academic training for doctors of medicine, osteopathy, or dentistry, as well as for nurses and other selected professional personnel when those professionals wish to pursue an additional educational program deemed to be of value to the Corps. In line with the goal of this program to assist areas which have shortages of health manpower to obtain such manpower, postgraduate training should be encouraged to further develop the skills required to meet community needs.

We note membership on the National Advisory Council on the National Health Service Corps of three persons representing the "medical, dental, and other health professions and health teaching professions." Due to the significant role played by institutional providers in supporting activities of the Corps, the Association recommends includsion of representation by institutional health care providers on the Council. Similarly, the important role of nurse practitioners in Corps service makes appropriate inclusion of the nursing profession on the Council.

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AHA's recommendation.—That the role of the National Health Service Corps and the scholarship assistance necessary to assist in obtaining health personnel to serve in the Corps be continued and expanded.

Area Health Education Centers

H.R. 2956 contains authority to establish "Area Health Education Centers." Such centers were first authorized in the 1971 legislation under the more general program of Health Manpower Education Initiative Awards.

The Association favors the continued support of area health education centers whose purpose is the improvement of quality and quantity of health personnel and of the health delivery system, as well as the encouragement of regionalization of educational responsibilities. Operating examples of area health education centers are just beginning to appear, with some preliminary evidence that they are having a positive impact on the training, placement, and effective utilization of health workers in underserved areas. This is being accomplished through the regionalization of medical schools, nursing, and allied health programs, and through the integration of curricula to permit people trained at one level to receive additional education to function at a higher level.

AHA's recommendation.—That funds continue to be provided to area health education centers and that more such centers be developed.

Grants For Health Professions Schools

Mr. Chairman, we are pleased to note the inclusion in your bill, H.R. 2956, of a capitation support program for schools of the health professions. We are convinced of the need for such capitation assistance if these schools are to continue to produce an adequate supply of well-trained health professionals to staff our nation's developing health care system.

We applaud your decision to include, for the first time, Schools of Public Health among the educational institutions eligible for capitation assistance. However, most programs of health care administration are not located at schools of Public Health. We believe that institutional grant support at comparable levels should be provided these accredited programs which are not located in Schools of Public Health.

There is a large and growing need in this country for well-trained health administrators and Public Health specialists. The changing patterns in the delivery of health services, including the anticipated growth of health maintenance organizations (HMOs) and the likelihood of a national health insurance program, will necessitate a larger number of health management specialists, both in and out of government. Moreover, the educational preparation of health administrators should be enhanced, thereby increasing the quality and the cost-effectiveness of programs increasingly funded by government.

H.R. 2956 would provide for specific kinds of special project grants, and we support this emphasis on projects aimed at expanding the use of computer technology in health care programs, increasing the numbers of students from disadvantaged backgrounds, and encouraging training in emergency medical services.

Similarly, we also support the provisions in H.R. 2956 calling for continuation of programs for direct loans to students of the health professions, including students of Public Health. As we have previously indicated concerning other areas, we urge that students in accredited programs in health care administration not located in Schools of Public Health also be included.

AHA's recommendation.—That programs of assistance to schools and students of the health professions be continued. In addition, all accredited programs in health care administration should be included in the institutional, special project, and student assistance support programs.

Allied Health Peresonnel

Mr. Chairman, I would like to comment on the proposed new Part H which would revise and extend the program of Allied Health Training. Ours is a labor-intensive industry in which the skills provided for through this program are important for efficient and effective delivery of health services, and, thus, are of substantial interest to hospitals.

We are pleased to note in H.R. 2956 the proposed continuation of a separate program for the support of allied health manpower training. The bill authorizes a program of project grants and contracts with respect to planning, developing, and coordinating activities in this field. We feel this is extremely important since many hospitals are active partners in the education of allied health personnel.

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At the present time, approximately 1,100 hospitals provide clinical facilities for 7,083 allied health programs in educational institutions. For most hospitals, the costs of training allied health personnel cannot be completely offset by payments for the health services rendered. In fact, third-party payors such as Blue Cross have placed limitations on hospital payments for education. It is important, then, that the awards of funds for grants and contracts under the allied health manpower legislation include provision for hospitals to receive financial reimbursement for costs related to special projects authorized by H.R. 2956.

The proposed continuation and revision of the Allied Health Traineeship program certainly receives our endorsement. The bill would continue to authorize advanced training of allied health educators and of administrative and supervisory personnel in the allied health field. We feel that this type of student assistance is greatly needed to enhance both the quality of allied health education and the effectiveness of health delivery systems utilizing allied health personnel. Such training of needed teachers and administrators in the allied health field seems to us a very appropriate federal function.

MEDICAL RESIDENCY TRAINING PROGRAMS

The American Hospital Association is concerned that many urban and rural areas lack physicians for the appropriate medical care of the population in these areas, and recognizes especially the need for physicians to provide primary care.

The AHA believes that there are potentials for corrective action through some of the current legislative proposals. However, redirection of choice of specialty by medical students and residents cannot be accomplished within a brief span of years, nor can the needed and desirable changes be wisely accomplished through a crash program for the designation of numbers of specialists to be trained and their location and relocation enforced through a punitive payment policy.

A look back on the legislative and financing programs which provided for the expansion of our medical manpower through creation of new medical schools and expansion of existing schools demonstrates that carefully designed incentives can produce dramatic results. So, as we approach the design for change to create better distribution of physicians and more adequate numbers of physicians providing primary care, creative legislation combined with adequate financial incentives must be used.

We support the approach taken by Section 781 of H.R. 2956 calling for a $40 million per year program of grants to hospitals to develop training programs in family medicine and to provide financial assistance to students and physicians who participate in such programs. We also support Section 788 providing for grants to medical and osteopathic schools to establish academic units for clinical instruction in family medicine.

And, as we have already indicated, we endorse the proposed expansion of the role of the National Health Service Corps in providing direct medical care to underserved populations; allowing full or partial payback of capitation assistance through service in the Corps or medically underserved areas; and authorizing support for Area Health Education Centers which will establish programs to improve the delivery of health services to medically underserved areas.

The American Hospital Association is engaged in the efforts of the Coordinating Council on Medical Education (CCME)[1] and its Committee on Physician Distribution which is currently studying physician geographic and specialty maldistribution. As you know, in mid-1974 the Committee produced a report on the primary care physician. We would also note that Public Law 93-223, an amendment to the Social Security Act passed by Congress last year, has authorized and supported extensive study under the Institute of Medicine, National Academy of Sciences, which in its various aspects bears on these same issues. The results of such studies should yield valuable information which will be useful in resolving the dual maldistribution problem.

Toward the same end, H.R. 2956 would include in the Public Health Service Act a new Title XVII which would establish a program directed at solving the critical problem of physician specialty maldistribution. This new authority

[1] The CCME consists of representatives of the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, the American Board of Medical Specialties, the Council of Specialty Societies, plus representatives of various levels of government.

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would establish (in section 1702) procedures for the Secretary of HEW to designate or establish an agency to accredit medical residency training programs in this country. We would support this provision that would permit the Liaison Committee on Graduate Medical Education of the Coordinating Council on Medical Education to be the agency designated for this task.

This new Title XVII would also provide authority for the Secretary to designate or establish an agency to certify the number of first year positions in accredited residency training programs which may be made available in any calendar year beginning after calendar year 1977. In establishing such training positions, the agency would be required to take into special consideration the geographical distribution of programs, their relationship to area health education centers, and the need for residency training in primary care specialties. Section 1701 limits the number of positions to a maximum of 125 percent of the estimated number of graduates from accredited schools of medicine in the preceding calendar year. Section 1703 provides procedures for application by entities for designation as the certifying agency, and names the CCME as a potential designee. The American Hospital Association recommends several changes in the proposed Title XVII of the Public Health Service Act, as included in H.R. 2956. If a process for certifying medical residency programs is to be established in legislation, and we are not proposing here that it should be, the AHA strongly recommends specific changes in H.R. 2956 to improve the development of the proposed certifying process.

AHA's recommendations.—(1) That the proposed deadline dates for implementation of new Title XVII be revised to allow a reasonable phase-in period for adjustment of training programs and compliance by teaching institutions, a revision that is necessary because the dates established in this bill were predicated on the assumption that the bill would have been enacted last year;

(2) That the Secretary of HEW, with the approval of an agency established by him, should be responsible for the certification of medical residency programs; and,

(3) That the Secretary should establish the agency for the certifying process to be composed of the following: the Assistant Secretary for Health and the Administrator of the Health Resources Administration of HEW, the chief medical director of the Veterans Administration, and the President of the Uniformed Services University of the Health Sciences, all ex officio, non-voting members, and 19 members appointed by the Secretary of whom (A) ten shall be appointed from lists of nominees submitted by the American Medical Association, the American Hospital Association, the Association of American Medical Colleges, the American Board of Medical Specialties, and the Council on Medical Specialty Societies, each such list to contain four or more nominees and two appointees to be appointed from each such list; (B) one each shall be appointed from lists of two or more nominees submitted by the American Osteopathic Association and the American Association of Colleges of Osteopathic Medicine; (C) six, none of whom may be providers of health care, shall be representatives of consumers of health care; and (D) one shall be in a full-time medical residency position.

We strongly recommend these changes in new Title XVII because they would establish appropriate governmental responsibility for the designation of residency training programs and provides effective nongovernmental, professional advice to the Secretary for this critical process.

It is essential that actions by the Secretary, with the approval of this agency, be concerned with the immediate effect which such determinations would have on the direct delivery of medical services in many teaching hospitals. We are concerned that the direct delivery of medical services in teaching hospitals not be disrupted or reduced by enactment of this legislation.

There is no doubt that a diminution of numbers of residents in medical specialties will have an impact on physician services to patients in teaching hospitals. A considerable amount of patient care is provided by residents in specialties that cannot be provided by primary care physicians-in-training or by physician extenders. This is particularly true in many major teaching hospitals located in urban centers and on which large segments of low-income residents of inner cities depend for their care.

Before such changes are introduced, careful analysis should be made of their impact on patient care. Further, when changes appear indicated, adequate time should be provided for necessary adjustments to meet the needs for service. It must be recognized also that necessary adjustments for service delivery, where

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adjustments are possible, often will necessitate the addition of full-time professionals, and that this will have an increased cost implication. The need to recruit full-time professionals will often pose serious problems because of the lack of available individuals willing to work full-time in such a capacity.

Alien Physicians

We are aware that the Association of American Medical Colleges has submitted a proposal to this committee which includes Section 602 that provides for amendment of the Immigration and Nationality Act. This amendment relates not only to the priority for admission of such alien physicians to this country, but also includes requirements for aliens passing Parts I and II of the National Board of Medical Examiners Examination; demonstrated capacity in oral and written English; and determination that the admission of the alien would not lead to the surplus of practitioners in a specialty or geographic area.

Alien physicians are providing services to patients in some areas and institutions in our country in which the service is essential and for whom there is little likelihood of finding an American physician as a replacement. Such needs for alien physicians will continue and we believe that there should be included in this section appropriate waiver provisions which would permit the entry of alien physicians to meet hardship situations. If this committee adopts the AAMC's recommendation, we strongly recommend that the waiver provision be included. The following legislative language would accomplish this:

SEC. —(a) Section 212(a) of the Immigration and Nationality Act (8 U.S.C. 1182) is amended by renumbering paragraphs (15) through (31) as (16) through (32), respectively, and by inserting after paragraph (14) the following:

"(15)(A) Aliens who are members of the medical profession, unless the Attorney General finds, after consultation with the Secretary of Health, Education, and Welfare that—

"(i) the alien has passed parts I and II of the National Board of Medical Examiners Examination or the Federal Licensing Examination; and

"(ii) the alien has demonstrated competency in oral and written English; and

"(iii) the admission of the alien will not lead to a surplus of practitioners in a speciality area or geographical area in which there is no present or projected need.

"(B) The Attorney General may grant a waiver of the provisions of paragraph (A) for a period of one year where he finds (after consultation with the Secretary of Health, Education, and Welfare) that a waiver—

"(i) is necessary to meet a critical need for which no reaonable alternative exists, and

"(ii) that the alien will be enrolled in a supervised training program designed to identify and correct the educational deficiencies of the alien so as to enable the alien to pass the required examinations within a one-year period.

"(C) The waiver provided for in subparagraph (B) may be extended for a period of one additional year.

"(D) The exclusion of aliens under this paragraph shall apply only to (i) special immigrants defined in section 101(a)(27)(A) (other than the parents, spouses, or children of United States citizens or of aliens lawfully admitted to the United States for permanent residence), (ii) to preference immigrant aliens described in section 203(a) (3) and (6), and (iii) to nonpreference immigrant aliens described in section 203(a)(8);".

(b) Section 212(a)(14) of the Immigration and Nationality Act is amended by inserting "(except aliens described in paragraph (15))".

(c) The amendments made by this section shall take effect July 1, 1976.

It is necessary that we be concerned with maintenance of service to patients and such a waiver should be no deterrent to the basic thrust of the provisions which have been included in the AAMC's recommended legislation.

CONCLUSION

Mr. Chairman, I mentioned earlier in my testimony that ours is a highly labor-intensive industry. Typically, in fact, more than half of a general hospital's budget is allocated for labor costs. While we obviously need adequate numbers of health workers, we must also be greatly concerned about the quality of the individuals trained if we are to fulfill our role in delivering high-quality health serv-

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ices to the public. For both these reasons, we look for leadership and assistance to the federal programs of health manpower training which are the subject of your current hearings.

I will be pleased to answer any questions you may have.

Mr. ROGERS. Thank you for your suggestions, which the committee will consider in its writing of the legislation.

Next, Dr. Nesbitt.

STATEMENT OF TOM E. NESBITT, M.D.

Dr. NESBITT. Mr. Chairman, members of the subcommittee, I am Tom Nesbitt, a physician in the practice of urology in Nashville, Tenn.

I would like to emphasize my remarks not only reflect the position of the American Medical Association but some personal views from the vantage point of a physician who is involved in the day-to-day practice of urology, of medicine, in an area of middle Tennessee and northern Alabama, and I do experience many of these things and the problems with which we are concerned in this testimony.

I also serve as speaker of the American Medical Association's House of Delegates, and until recently was the chairman of the Coordinating Council for Medical Education (CCME).

With me is Dr. C. R. William Ruhe, director of AMA's Division of Medical Education, who currently serves also as the secretary to the CCME.

Mr. ROGERS. We welcome the doctor here. We know him and he has helped this committee often.

Dr. NESBITT. We are pleased to present the views of the American Medical Association on legislation concerning the education and training of persons entering and pursuing careers in the health professions. The bills bfore the committee are aimed at improving the availability and the quality of health care. This legislation is indeed significant and would, if enacted, influence the future of medical and other health services to individuals, families, and communities in the United States.

Although the bills have only recently become available, it is our understanding H.R. 2956 is the same as H.R. 17084 passed in the last Congress, and our comments are based accordingly. We also direct your attention to our testimony on manpower legislation presented in the last Congress. We will comment upon principal sections of the bills in this statement.

First, the National Health Service Corps.

We support a continuation of the National Health Service Corps program. We will comment on certain amendments proposd in H.R. 2956 and H.R. 2958, and propose certain changes which we feel will make this bill more effective. It is our understanding that the provisions of H.R. 2956 and H.R. 2958 are the same as they relate to NHSC.

We hope you will read and consider our suggestions in detail which are contained in our prepared testimony.

Perhaps I should emphasize that we do oppose that section of H.R. 2956 and H.R. 2958 which would amend section 329(b)(2) of the present law to change present language requiring certification of the need for corps personnel by "the" State and local medical society,

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or other appropriate professional society, to certification by "any" State and local medical, dental, or other health society.

The present language clearly indicates that certification for a particular professional must be by whatever medical or other health society represents the majority of the appropriate profession practicing in the area.

In our 1972 testimony, prior to passage of Public Law 92-585, the association pointed out the importance of such approval if the program was to have long-term impact. For any physician considering permanent settlement in one of these shortage areas, it is an obvious "plus" if he start out with the encouragement and support of the local medical profession.

The proposed language changes the nature of medical society approval and could, conceivably, undermine some of the efforts of the association and the corps in this area. In addition, we do not feel it is necessary as a protection for the community. Under present law, the Secretary already has the authority to assign personnel without this certification if he finds it has been arbitrarily and capriciously withheld.

For the same reasons, we must oppose even more strongly the amendment made to section 329(b)(2)(A) by H.R. 2956 and H.R. 2958 which would allow the Secretary, in reviewing an application, the option, in obtaining area medical "input," of "recommendations from medical, dental, or other health societies or from medical personnel serving the population."

Under this language consultation with local medical societies could be bypassed. Such a change seems likely to place unnecessary difficulties in the way of encouraging corps members to remain in the community where they have served, which, in the long run, is the most valuable service the corps could provide to any underserved community.

We urge you to retain the present language of the law, and delete these amendments.

We do have additional testimony relative to this area which we hope you will consider in depth.

Second, Public Health and National Health Service Corps Scholarship Training program.

In regard to the Public Health and National Health Service corps Scholarship amendments, we are in support of a scholarship program. The association does, however, question the service provisions and the repayment penalty formula proposed under the bill. The specifics of this are also in our submitted printed testimony.

Mr. ROGERS. May I just ask, you do not believe service should be given for the amount of scholarship given?

Dr. NESBITT. Not for service. It is the double payback provision.

Mr. ROGERS. You oppose that?

Dr. NESBITT. Yes, sir.

Mr. ROGERS. But that is the main opposition?

Dr. NESBITT. That is the main opposition, the double payback provision.

Third, the support for medical schools.

Education that is sound and prepares people adequately for health care requires able teachers, good and eager students, places in which

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they can learn, and the necessary facilities and equipment for their learning. This requires the formation of stable teaching institutions.

Stability depends on the availability of continuing and assured resources derived from governmental, nongovernmental, public and private support and from the students, themselves.

As regards construction, we support a continuation of provisions for construction grants and for construction loan guarantees.

Relative to capitation, we believe that it is wise to provide for a continuation of Federal assistance to support teaching through direct assistance to the institutions. Thus, we support a continuation of capitation grants to medical schools.

As regards capitation assistance and payback provisions, we should like to make these observations.

In order for a school to receive capitation grants under H.R. 2956, it is necessary for the school to provide assurances that the school will enter into a "legally enforceable agreement" with each student.

Under the agreement, the student would be required to pay in equal installments to the U.S. Government a total amount equal to the amount which the school received as capitation assistance based on the enrollment of the student.

This required student payback would begin shortly after completion of the individual's internship, residency or other advanced clinical training. For each year of service in a medically underserved area or in some institutional or governmental agency service (similar to NHSC and PHS obligations), 1 year of the payback requirement would be waived.

These requirements—that the students, as a personal obligation, repay to the Federal Government those amounts which the Government has given to the schools—are without precedent and are discriminatory against health professions students. These conditions are not imposed on students in other fields, nor should they be.

This amounts in effect to a forced loan required of all health professions students under the bill. Through the service requirements and the loan forgiveness features, in our opinion the low-income or disadvantaged student would carry a disproportionate burden. This obligatory loan provision should be eliminated.

Mr. ROGERS. May I interrupt just a minute? I noticed on the remote site training, I presume from the statement you are giving—although I think you did not read that—you do not approve of remote site training?

Dr. NESBITT. We very strongly approve of remote site training.

Mr. ROGERS. That is what I thought, but I don't get that from reading this statement.

Dr. NESBITT. I will put it this way, Mr. Chairman. We approve of it within certain guidelines as long as it is closely supervised, and it will require careful planning and direction more than is required for training within an institution. It requires that much greater care be given by the individual who is supervising the medical education involved.

Mr. ROGERS. I presume the school as operated and as we would envision it, would arrangements so the practicing physicians of the clinic who go outside of the university setting would have affiliation and understanding with the university.

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Dr. NESBITT. That is true. Some of the attempts to carry out these activities by some institutions have been miserable failures. There is one in Indiana——

Mr. ROGERS. You say they are not having success in Indiana?

Dr. NESBITT. No; I say in Indiana it is highly successful.

Mr. ROGERS. And we have done well in the Northwest. They are doing well in North Carolina. Many areas.

I just want to make clear—because this would give the impression that AMA does not provide it—and we specifically put it in because the practicing physicians over the Nation, everywhere I go, say, "Get that student out for a while, out of the university setting"; and then we do it and then I am not sure whether you support us.

Dr. NESBITT. I will make that clear right now. I did not emphasize that in the essence of time involved but I will guarantee you, sir, we do support that very strongly.

Mr. ROGERS. I thought so.

Mr. CARTER. Mr. Chairman, on that very thing, the Indiana plan has some features but the basic part of any medical training involves clinical work that the intern or resident does, and it simply is not available in many outreach programs. If you want a well-trained physician, he must have training where sick people are, and you may not find them in outreach programs at all times.

You may learn to live in rural areas, but if the physician is not trained in what he is supposed to do little is accomplished. So I find myself somewhat in agreement with the doctor.

Mr. ROGERS. I don't think you do, if that is the position, because he is for it, but——

Mr. CARTER. If he is for it, I disagree.

Mr. ROGERS. I think we all agree you cannot have all your training away from the university. But there are periods of time where the exposures outside, which is what these envision in the legislation, would be beneficial—for example, undergraduates: I would like to see 6 or 8 weeks or the last 2 weeks of their training maybe in the AHEC's for some exposure at some of the outlying sites. But I agree, I think we understand each other, that the main thrust is given in the Corps Center, but with exposure outside.

Dr. NESBITT. And it is not universally applicable to all medical schools or all teaching centers. In some places it has greater applicability in view of existing facilities in some outreach areas, that some areas do not have available.

Mr. CARTER. Why has it been considered that charity hospitals have been outstanding teaching hospitals? Because of the wealth of clinical material, isn't that true?

Dr. NESBITT. Yes, sir.

Mr. CARTER. That is the way physicians learn, by seeing pathology. It is all nice to be out in the satellite area, but it is doubtful that you ever see sick people there. You need sick people to learn your basic medicine.

Could you have learned urology, for instance, down at Cookville, Tenn.? I believe you learned yours in the University of Iowa.

Dr. NESBITT. Michigan. No. But you know, Dr. Carter, Johns Hopkins' urology program has always had a plan where their residents

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have gone to Mason City, Iowa, for 6 months of their training and those men consider it productive.

Mr. CARTER. That is the center where your present program of transurethral intersection started, so that is not really an outreach program.

Dr. NESBITT. Mason City is a little different.

Mr. ROGERS. But I think the bill requires a rotation.

Dr. NESBITT. We are not basically in disagreement.

Mr. ROGERS. I think everyone understands.

Dr. NESBITT. Concerning the support for students, we would like to observe that while support of teaching, including the faculties and facilities required to teach, should go to institutions, there is also need for additional financial assistance to students. Scholarships should be available for students from disadvantaged backgrounds who are not in a position to borrow money.

Such assistance should not require these students to repay either in money or through a period of assigned service. It should be limited to giving able students who could not otherwise enter medicine or other health fields the opportunity to do so.

Provision is made for Federal financial support for students who agree to serve in the National Health Service Corps. Such a provision is a suitable means of assisting those students who wish to enter into such agreements, but should not be the sole Federal program for medical student financial assistance.

The Secretary is given discretion to determine when loan repayment would be a hardship. We believe such provisions are sound.

As discussed previously, we support service in shortage areas through the National Health Service Corps program.

We also support a program which continues to provide scholarship and loan assistance to medical students, without requirement of mandatory service, and with reasonable loan payback and loan forgiveness provisions. Such program should be in addition to assistance under the National Health Service Corps program.

Mr. ROGERS. You do know the bill actually provides that?

Dr. NESBITT. Yes, sir.

Mr. ROGERS. A student can, without joining the Health Service Corps, go to a critically short area and in return receive forgiveness of student loans. You support that provision, don't you?

Dr. NESBITT. We do support that, yes, sir.

Insofar as family practice and primary care is concerned, we support provisions for the development, maintenance, and expansion of programs in family medicine and primary care and would similarly endorse authority to expand, renovate, or construct ambulatory facilities in which much of family practice and primary care must be learned.

H.R. 2956 under discussion provides for Federal assistance in the establishment, development, and conduct of family practice programs in medical schools and during the period of graduate medical education.

The American Medical Association has been most active in fostering the development of family practice programs in medical schools and in graduate medical education. In fact, our House of Delegates

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urged in 1973 that approximately 50 percent of the graduates of medical schools enter one of the primary care specialties.

Provision of Federal assistance for the strengthening and growth of family practice and other primary care specialties can have a constructive, accelerating effect on the development of much-needed programs. We support continuation of Federal assistance for such training.

The fourth major item relates to allied health personnel training. We support a continuation of Federal assistance for the training of allied health personnel.

Fifth, public health training. We believe that a continuation of support for schools of public health and public health training, including capitation grants, is necessary to satisfy what would otherwise be an unmet training need for a wide spectrum of public health professionals in addition to physicians.

Accordingly, we support a continuation of assistance to schools of public health and their students.

The sixth relates to U.S. students in foreign medical schools. The section entitled "Education of Returning U.S. Students from Foreign Medical Schools" addresses itself to a problem that has been of great concern to the American Medical Association and to many groups in the United States.

It is a situation of great complexity, raises questions of international relations, of the use of educational resources in foreign countries, and of the problems of student adaptation to a different system of education and of medicine from that in the United States.

We believe, however, that this provision will not deal with the many problems of U.S. citizens studying abroad and that it is not realistic to expect a report on deficiencies, if any, of foreign medical education of U.S. citizens.

The foreign medical schools vary from one to another and deficiencies may be in the student's early education or in college. No judgment should be made of the schools themselves on the basis of such information. The questions and issues must be approached much more broadly with the several agencies of the Federal Government which are involved in immigration as well as the States and their functions in licensure.

The seventh major subject is concerned with control of medical residency training programs, and I should like now to comment on the provisions for residency training programs in this bill.

Again I direct your attention to our earlier testimony on this subject. There is, however, additional information available which should have strong bearing upon your deliberations.

During the years from 1968 to 1973, the latter being the most recent year for which there are complete data, substantial changes have occurred in the numbers and specialty activities of physicians. These changes are evident in the distribution of recent graduates among approvied residencies and in the percentage of first-year residency positions that are filled.

The most significant change is a 69 percent increase in the number of domestic and Canadian graduates entering residency programs in the "primary care" specialties.

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Mr. ROGERS. Could you put that in numbers for us rather than percentages?

Dr. NESBITT. The numbers are in the tables, Mr. Chairman, which are attached, and I will present these later in the testimony.

Mr. ROGERS. How many residencies are there in family practice?

Dr. NESBITT. This will be included as I continue with my statement, Mr. Chairman.

The significance of this, Mr. Chairman, is that now nearly 50 percent of the graduates entered primary care specialty programs. A further fact of significance is that distribution of physicians has generally paralleled changes in the population at large. The ratio of physicians in patient care has increased nationwide and regional variations in the ratio reflect general population trends.

If I may, I should like to leave with this committee copies of tables indicating data I have cited above, but I would like to elaborate on some of the changes which I have just mentioned.

Certain factors influence increases in residency positions. The 23 new medical schools, for example, which admitted their first entering class between the fall of 1967 and the fall of 1973, by their very existence substantially increased both the number of positions in the first year of residency programs and the number of approved specialty residency programs.

New schools have been established in every census region in the United States and have already created 1,255 new first-year places. If additional new schools are established in the future—and several are in development at this time—it may be anticipated that there will be additional residencies established as a part of the development of those schools.

Even more striking has been the change in the choice of specialty by students entering their first year of residency training. In 1968 a total of 4,604 1st-year residents were in the "primary care" specialties of family medicine, general practice, internal medicine, obstetrics and gynecology, and pediatrics.

Mr. CARTER. Mr. Chairman, I do not believe obstetrics and gynecology has always been considered a primary care specialty. I feel it should be, and I am glad the doctor brought that out.

Dr. NESBITT. The fact was given to me the other day—it was very interesting—the physicians practicing OB–GYN claim they are the first portal of entry into the health care system for 29 percent of the health care population. If that is a fact that can be corroborated, they are indeed primary care physicians. I am not certain that I can substantiate that.

Mr. ROGERS. How many of the 4,600 entered OB–GYN residencies?

Dr. NESBITT. It is in the table, Mr. Chairman. 1,003 residency positions.

By 1973, this number entering "primary care" specialties had reached 7,783; an increase of 69 percent. In 1968, 3,001 graduates of U.S. and Canadian schools entered residencies in the "primary care" specialties in the United States. By 1973 this number was 5,723. The total number of graduates from U.S. medical schools in 1973 was 11,613. This means that by 1973 the recommendation of the house of delegates of the American Medical Association—which has also been

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approved by the CCME and other organizations—that 50 percent of graduates of U.S. medical schools should enter "primary care" specialties had almost been achieved with the medical school classes which were graduated in 1973.

This shift to the "primary care" specialties, which projections suggest are continuing and possibly accelerating, has taken place because of student interest, actions of the American Medical Association and of the medical schools, as well as increases in the number of approved residencies and 1st year positions available to medical students.

The geographic distribution of physicians active in patient care shows no appreciable change in the nonmetropolitan counties with populations under 25,000 between 1968 and 1973. However, there has been an increase in the physician-population ratio in all nonmetropolitan counties with more than 50,000 people.

The highest physician-population ratios remain in counties in standard metropolitan statistical areas of more than 5 million people. Physician-to-population ratios for physicians in patient care have increased for the Nation as a whole from 120/100,000 in 1968 to 130/100,000 in 1973.

I have commented on these significant trends which have been underway for the past 5 years to indicate that the objectives of the control program before you are already well on their way to achievement with respect to redistribution among specialties and that geographic distribution of physicians appears to be a function of the changing geographic distribution of the entire population of the United States.

It is also important to note that the creation of new medical schools—particularly in areas where, prior to their establishment, there were relatively few approved residency programs and relatively few positions—is associated with substantial increases in the number of positions and in the variety of specialty training available to candidates for graduate medical education.

Furthermore, graduates of foreign medical schools represent a decreasing proportion of persons entering approved residency programs in the United States.

These changes have occurred for a variety of reasons, but all of them have taken place without Federal regulatory legislation.

Mr. Chairman, we believe that legislation to regulate either the number of residencies, their geographic location, or the numbers of programs or number of 1-year positions by specialty is not warranted and indeed could conceivably have an adverse effect on current trends which are moving in the direction sought by the public, by the Congress, and by the medical profession.

Let us again turn to the proposal in the legislation. The bill provides that in determining the number of positions in any accredited program the agency shall, among additional requirements, "insure that 1-year positions in medical residency training programs are distributed equitably throughout various geographical areas of the United States.

The emphasis here is clearly on geographic distribution. Is this a logical basis for distribution? And if so, what exactly does this mean? Will this, for example, be based on the 10 regions now designated by the Department of Health, Education, and Welfare or on some other regional basis?

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Will it be based on State boundaries? According to census regions? Will it be determined solely by concentration of population? Will the areas be determined regardless of where approved residency programs now exist? Any of these determinations will have profound effects upon medical training.

Additional questions need answers. What will be the effect of discontinuation of programs which affect care of patients and the future quality of care in the various areas, where programs might be discontinued—or initiated—solely to meet an arbitrary redistribution to meet some approved quota of programs and positions?

Will the distribution be required to equalize the total number of residency programs? The total number of positions in the area? The total number of positions in each of the various specialties? Is each area to have the same number of surgical residencies, et cetera? Will one State have to give up training programs and positions to accommodate another State's "equitable" allotment—irrespective of caliber of programs?

Will the study currently being conducted by the Institute of Medicine and the studies outlined in this bill enable the Secretary of Health, Education, and Welfare, or the body which he may designate to make allocations of positions by geography or by specialty, to make adequate projections of the numbers of physicians needed in each field and where the location of such program should be?

We know that physicians who embark on one field of medicine may find that their interests and abilities lie elsewhere and wish to change their field of practice. Will this legislation inhibit or limit the ability of the resident physician or the physician in practice to do so?

Because of the serious implications here, the time has come to talk in terms of actual application of the program and not in terms of generalities. We have not seen a practical example of how this new program would work.

Under the legislation it would seem that this program will ultimately require the establishment of fixed numbers of programs and positions in each of the 24 currently recognized specialties. While the proper mix is an unknown, if we take a hypothetical number, just for purposes of example, that the current figure for residency programs in a given field is presently at 1,000 and quota is then fixed at 600, many adjustments would be required.

First, the 600 would have to be distributed geographically. This could result in an increase in some areas, but would have to cause decrease in others. Established programs or positions would be terminated. One region because of excellence of programs might presently have a high percentage of positions. These programs could be eliminated under a wholesale countrywide distribution.

Further factors complicate the new proposal. Decisions relating to one specialty will have ramifications for another. The current concentrations of residency programs, particularly in specialties in which small numbers of persons undertake training each year, are related to the quality of graduate medical education provided in the institutions where the concentrations occur. Residency programs in the various specialties are interdependent and their quality is determined by the environment in which they are offered.

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Graduate medical education in family practice includes extensive experience in internal medicine, pediatrics, obstetrics and gynecology, psychiatry, and surgery. This experience is essential if the family practitioner is to be competent to deal with the variety of problems which patients will bring to him. He must also depend on other medical specialists to augment his own skills and to bring their special skills to bear when his patients need them.

Will such matters as these be taken into account and can they be appropriately provided for through the regulatory mechanisms proposed in the bill which we are discussing?

One further effect of this proposal requires careful analysis. At the present time medical schools receive funding from a variety of sources. Some States presently contribute a major share—a higher amount than the Federal share. Under the proposal being considered, where the Federal Government determines the training mix and residency program eligibility will the States be expected to maintain their support?

Mr. Chairman, we believe these are questions of the utmost importance, particularly in light of the trends which we have described that are already in progress. We have not been able to find answers to them as we have read this bill.

Until answers have been worked out, for at least the most crucial questions, we feel strongly that the proposed residency control program should not be enacted. In our view, current developments are providing a resolution of problems addressed by this legislation. We strongly urge this committee not to adopt this statutory program for control of residency training programs.

As to nurse training, we would, however, like to recommend some changes in the legislation before you, and these are in our prepared testimony.

Mr. Chairman and members of the committee, we thank you for the opportunity to appear before you. We will be pleased to answer questions and supply additional information if you so desire.

[Testimony resumes on p. 524.]

[Dr. Nesbitt's prepared statement and appendix follow:]

STATEMENT OF TOM E. NESBITT, M.D., SPEAKER, AMA HOUSE OF DELEGATES, AND C. H. WILLIAM RUHE, M.D., DIRECTOR, DIVISION OF MEDICAL EDUCATION, THE AMERICAN MEDICAL ASSOCIATION

Mr. chairman and members of the subcommittee:

I am Tom E. Nesbitt, a physician in the practice of urology in Nashville, Tenn. I serve as Speaker of the American Medical Association's House of Delegates, and until recently was the Chairman of the Coordinating Council for Medical Education (CCME). With me is Doctor C. H. William Ruhe, Director of AMA's Division of Medical Education, who currently serves also as the Secretary to the CCME.

We are pleased to present the views of the American Medical Association on legislation concerning the education and training of persons entering and pursuing careers in the health professions. The bills before the Committee are aimed at improving the availability and the quality of health care. This legislation is inded significant and would, if enacted, influence the future of medical and other health services to individuals, families and communities in the United States.

While the bills have not yet become available, it is our understanding H.R. 2956 is the same as H.R. 17084 passed in the last Congress and our comments are based accordingly. We also direct your attention to our testimony presented

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in the last Congress on manpower legislation. We will comment upon principal sections of the bills in this statement.

National Health Service Corps

We support a continuation of the National Health Service Corps program. We will comment on certain amendments proposed in H.R. 2956 and H.R. 2958, and propose certain changes which we feel will make this bill more effective. It is our understanding that the provisions of H.R. 2956 and H.R. 2958 are the same as they relate to NHSC.

The Association conducts a great number of programs, and has supported many legislative proposals to help make good health care available to all Americans. We have supported, and will soon offer, a revised national health insurance program to make adequate comprehensive health insurance available to all. Among other programs, in a more restricted area, we have urged improvements in the health facilities and staff of the Indian Health Service to make adequate care truly available to the first Americans. We are testifying before you today, as we have in the past, for assistance in the education of members of the health professions so that availability of care will not be limited by lack of personnel.

We are particularly concerned that the National Health Service Corps program be successful, since the Association has worked closely with the Corps to make the program a functioning reality. We have carried out information campaigns to the profession and state and local medical societies and, since 1972, have contracted with the Corps to recruit private physicians to replace the Corps physicians on a short-term basis. This program, which we have named PROJECT U.S.A., has been a valuable adjunct to the Corps in operating the program.

The large number of assignments of physician personnel made through the program to date have been possible because local and state medical societies have certified the need for such personnel. In short, the medical profession, through its professional organizations, share with the National Health Service Corps, and with you and your Committee, the common goal of getting needed health personnel into these shortage areas.

However, the Association recognized, when this program was first enacted, that it provides only temporary solutions to the problems of such shortage areas and that Congress did not contemplate permanently stationing federal health personnel in such shortage areas. The Association, therefore, urged that the Corps, in assigning personnel, so plan its programs that there would be at least a reasonable chance that some Corps members would remain in the areas where they were assigned after completing their tour of Federal duty.

We note with approval, as in H.R. 14721 and H.R. 14357 of the last Congress, the inclusion in H.R. 2956 and H.R. 2958 of Congressional directives aimed at utilizing the Corps to achieve just such a more lasting solution to the problem of a lack of health personnel. We particularly wish to commend those sections of the proposed legislation which limit assignments to four years, at which time a new application must be made detailing community efforts to obtain other health personnel, and other sections which require HEW to attempt matching the assignees with community characteristics in an effort to encourage permanent settlement.

We would also like to comment in particular support of the requirement that the Secretary conduct, or contract for, studies to identify characteristics of manpower more likely to stay in shortage areas, and the characteristics of areas able to retain health manpower. The Association has itself studied these questions, as have a number of local and state medical societies and some state governments, in an effort to develop programs which might be effective in meeting manpower needs. These inquiries have, indeed, provided some insights into the problem, but we would welcome additional well-structured scientific studies to increase our knowledge of this problem, and would welcome the opportunity to contribute to such studies.

All these efforts emphasize the program's purpose as a temporary solution to the manpower shortage and its efforts to encourage a more lasting solution through private efforts. In the same vein, we support the provision in H.R. 2956 and H.R. 2958 which provides technical assistance in recruiting health manpower to those communities where the Corps is unable to actually assign personnel.

For the same reason, however, we oppose that section of H.R. 2956 and H.R. 2958 which would amend section 329(b)(2) of the present law to change present language requiring certification of the need for Corps personnel by "the" state

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and local medical society, or other appropriate professional society, to certification by "any" state and local medical, dental, or other health society. The present language clearly indicates that certification for a particular professional, must be by whatever medical or other health society that represents the majority of the appropriate profession practicing in the area. In our 1972 testimony, prior to passage of P.L. 92–585, the Association pointed out the importance of such approval if the program was to have long-term impact. For any physician considering permanent settlement in one of these shortage areas, it is an obvious "plus" if he starts out with the encouragement and support of the local medical profession.

The proposed langauge changes the nature of medical society approval and could, conceivably, undermine some of the efforts of the Association and the Corps in this area. In addition, we do not feel it is necessary as a protection for the community. Under present law, the Secretary already has the authority to assign personnel without this certification if he finds it has been arbitrarily and capriciously withheld.

For the same reasons, we must oppose even more strongly the amendment made to Section 329(b)(2)(A) by H.R. 2956 and H.R. 2958, which would allow the Secretary, in reviewing an application, the option, in obtaining area medical "input", of "recommendations from medical, dental, or other health societies or from medical personnel serving the population." (Emphasis ours.) Under this language consultation with local medical societies could be by-passed. Such a change seems likely to place unnecessary difficulties in the way of encouraging Corps members to remain in the community where they have served, which, in the long run, is the most valuable service the Corps could provide to any underserved community.

We urge you to retain the present language of the law, and delete these amendments.

The proposed section of H.R. 2956 and H.R. 2958 which would authorize bonuses of up to $1,000 per month for the first thirty-six months of service in the Corps, also seems likely to create difficulties in operation .From the practical viewpoint, also seems likely to create difficulties in operation. From the practical viewpoint, the language of the bill does not provide guidance as to how, within the $1,000 limit, a monthly income competitive with income from an established practice would be defined. If the benchmark were established on a regional or community basis, the bonus amount might well vary from one Corps assignment to another, with the potential of competition for particular assignments.

As the Committee is aware, P.L. 93–274 does provide special pay for medical officers of the Public Health Service, varying with length of service. We believe any bonus provision in National Health Service Corps legislation should be coordinated with the legislation already enacted.

We also believe that the section providing for community repayment of NHSC costs based on the amount of scholarship funds expended for NHSC personnel would be difficult to administer and would require highly complex accounting procedures. We also believe that the requirement in H.R. 2956 that the community repay the sum of (1) NHSC personnel pay and allowances, (2) a percentage of the grants to the community, and (3) percentage of the scholarship funds expended may well prove to be onerous on those very communities which would most need NHSC personnel. Although H.R. 2956 would allow the Secretary to waive the repayment provisions, we would nevertheless favor the repayment language incorporated in H.R. 14721 of the last Congress while retaining the waiver provisions of H.R. 2956. We also favor the retention of the provision in H.R. 2956 which requires that funds retained in the community be spent on improved health care or in seeking health manpower.

With these recommendations, we support the amended sections, as set forth in H.R. 2956, dealing with the National Health Service Corps program itself.

Public Health and National Health Service Corps Scholarship Training Program

In regard to the Public Health and National Health Service Corps Scholarship amendments, we are in support of a scholarship program. The Association does, however, question the service provisions and the repayment penalty formula proposed under the bill.

The bill requires double payment to the United States of any educational contribution of the government not repaid by service under the program. We recognize the argument that a high repayment rate is perhaps more likely to result in the student's actually fulfilling their service requirements. On the other hand, we would recommend some modification of this formula, which is essentially punitive, so that the program will be implemented in a positive manner. We have

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supported efforts to place Corps personnel in communities where they may wish to remain after completing their tour of duty. This goal was the basic premise of the NHSC program. The double payback provision, where it serves to compel an individual to remain in the community under compulsion of penalty, detracts from the positive aspect of the program. It appears to be a negative approach to punish NHSC members for failing to serve in their assigned communities when the rationale of the program is to introduce young physicians to communities in which they may choose to remain.

We would also question the provision for special payment to schools which enlarge their enrollments specifically for the purpose of accepting NHSC students. We believe that any payment for expansion of the capacity of professional schools should come under the special projects section of general manpower legislation, rather than be tied to a single scholarship program.

The service payback provisions are too broad. The nature of clinical practice for which a program participant may receive service credit under H.R. 2956 is broadly stated and may become subject to abuse.

Under the National Health Service Corps and Public Health Service Scholarship Program each individual receiving assistance would obligate himself to one year of service for each year of assistance received, with a minimum of two years. The service would be in an area which is to be designated by the Secretary in one of the following (to be determined by the Secretary at the time the service obligation commences, in one of the following categories stated in order of priority):

(A) The National Health Service Corps or the Indian Health Service;

(B) As a member of the Service in the clinical practice of his profession relating to the delivery of health service in any institution, hospital or station of the Service (section 321 of the PHS Act); relating to care or treatment of seamen and others (section 322); relating to care and treatment of federal prisoners (section 323); relating to examination and treatment of certain federal employees (section 324); relating to examination of aliens (section 325); relating to services of certain federal employees (section 326); or relating to services to persons with Hansen's disease, (Part D, Title III–Leprosy);

(C) In a medical facility of a State correctional facility, State mental hospital, community mental health center, migrant health center, community health center, or other medical entity designated by the Secretary as having a priority need for health personnel; or

(D) As a member of the Public Health Service in such unit of the Department of HEW as the Secretary may prescribe.

Notwithstanding the provision which would permit an individual to enter practice in a shortage area apart from the foregoing service obligation, the above authority in the Secretary is entirely too broad and would permit him virtually unlimited discretion in making assignments for service, particularly since he is the sole arbiter with respect to determination of need. In our view this changes the character of the scholarship program and could seriously inhibit participation in the National Health Service Corps program.

The scholarship program also authorizes the Secretary to release participants from service obligations if they would agree, in lieu of any NHSC or PHS obligation, to serve in the practice of their professions in shortage areas. Grants would be available to such practitioners for the purpose of establishing their practices, that is, for such expenses as salaries, equipment acquisition and facility renovation. Such incentives seem to exceed the bounds of a scholarship and training program, particularly in view of the fact that the practitioner would be absolved of his service obligation in the NHSC or Public Health Service. It would appear to be more appropriate to place these programs within the general manpower and resource development system.

Another feature of this scholarship program is troublesome. While it provides for a postponement of service for those entering residencies in primary care, other physicians, without further training, would be assigned for immediate service in delivery of health care. Thus, physicians who desire residencies in other fields would have to postpone such training for a period up to 4 years. While this may create pressures toward primary care, other effects will also occur. Not only will individuals motivated toward a particular specialty be thwarted in their goals for desired medical practice—which could have pronounced effects on the number of specialists to meet future needs—it will result in graduates delivering care without the benefit of additional training.

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Moreover such persons evidently could be assigned to sites of specialized services, such as community mental health centers.

One significant result is almost inescapable. Is an individual who is assigned to "desk duty" at the FDA—or even to patient care in a field other than his desired specialty—likely to retain a stimulus and interest in returning, after four years, to the field of medical practice, where he might have made his strongest contribution to patient care? The bill in its present form can have adverse effects on future patient care delivery.

Support for Medical Schools.—Education that is sound and prepares people adequately for health care requires able teachers, good and eager students, places in which they can learn, and the necessary facilities and equipment for their learning. This requires the formation of stable teaching institutions. Stability depends on the availability of continuing and assured resources derived from governmental, nongovernmental, public and private support and from the students themselves.

Construction.—We believe that the Federal Government has a responsibility to share in providing stability to institutions. This can be accomplished, in part, through grants to schools which will provide for construction and renovation of facilities and equipment in locations where they are needed and where the communities themselves may not be able to generate the necessary capital.

We support a continuation of provisions for construction grants and for construction loan guarantees.

Capitation.—While construction of facilities will continue to be necessary for some time, support for the operations of existing and new schools is essential. We believe that the Federal Government should share in maintaining the continuity and stability of schools of the various health professions through annual capitation grants based on enrollment of full-time students in the health professions. However, such support for the primary professional group receiving their education should not be related to continuing enrollment increases, although requirements to retain enrollment levels are proper. Nor should it be related to training of other personnel in the educational institutions. The provision of any capitation grants based upon a program of training for physician assistants is unwise since this is a field where the duties of the people trained, the curriculum, and their functions in the provision of health care are still far from settled. Programs to train physician assistants are in many instances experimental and should be recognized as such. Federal assistance for such purpose should, therefore, be provided through project grants and contracts suitably reviewed by external expert advisors, rather than through capitation.

We believe that it is wise to provide for a continuation of federal assistance to support teaching through direct assistance to the institutions. Thus we support a continuation of capitation grants to medical schools.

Remote Site Training.—The bill would require that all medical students, as well as physician assistant students should receive training in remote site facilities. The school would have to allot 25% of its capitation assistance toward this function. Undergraduate medical education requires a well organized curriculum and close supervision of students by competent teachers. The use of remote site training facilities requires the development of closely supervised experiences in settings where a deficiency of health services rendered by physicians may already exist, thereby imposing further burdens on physicians and the public alike. This could result in situations where the experiences of these students are less effective than they would be in more closely supervised situations.

Capitation Assistance and Payback Provisions.—In order for a school to receive capitation grants under H.R. 2956 however, it is necessary for the school to provide assurances that the school will enter into a "legally enforceable agreement" with each student. Under the agreement the student would be required to pay in equal installments to the United States Government a total amount equal to the amount which the school received as capitation assistance based on the enrollment of the student. This required student payback would begin shortly after completion of the individual's internship, residency, or other advanced clinical training. For each year of service in a medically underserved area or in some institutional or governmental agency service (similar to NHSC and PHS obligations), one year of the payback requirement would be waived.

These requirements—that the students, as a personal obligation, repay to the federal government those amounts which the government has given to the schools—are without precedent and are discriminatory against health profes-

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sions students. These conditions are not imposed on students in other fields, nor should they be. This amounts in effect to a forced loan required of all health professions students under the bill. Though the service requirements and the loan forgiveness features, in our opinion the low income or disadvantaged student would carry a disproportionate burden. This obligatory loan provision should be eliminated.

Support for Students.—While support of teaching, including the faculties and facilities required to teach, should go to institutions, there is also need for additional financial assistance to students. Scholarships should be available for students from disadvantaged backgrounds who are not in a position to borrow money. Such assistance should not require these students to repay either in money or through a period of assigned service. It should be limited to giving able students who could not otherwise enter medicine, or other health fields, the opportunity to do so. Provision is made for federal financial support for students who agree to serve in the National Health Service Corps. Such a provision is a suitable means of assisting those students who wish to enter into such agreements but should not be the sole federal program for medical student financial assistance. Student loans bearing interest are also provided with a forgiveness provision based on service. The Secretary is given discretion to determine when loan repayment would be a hardship. We believe such provisions are sound.

As discussed previously, we support service in shortage areas through the National Health Service Corps program.

We also support a program continuing scholarship and loan assistance to medical students, without requirement of mandatory service, and with reasonable loan payback and loan forgiveness provisions. Such program should be in addition to assistance under the National Health Service Corps program.

Family Practice and Primary Care.—We support provisions for the development, maintenance and expansion of programs in family medicine and primary care and would similarly endorse authority to expand, renovate or construct ambulatory facilities in which much of family practice and primary care must be learned.

H.R. 2956 under discussion provides for federal assistance in the establishment, development and conduct of family practice programs in medical schools and during the period of graduate medical education. The American Medical Association has been most active in fostering the development of family practice programs in medical schools and in graduate medical education. In fact our House of Delegates urged in 1973 that approximately fifty percent of the graduates of medical schools enter one of the primary care specialties. Provision of federal assistance for the strengthening and growth of family practice and other primary care specialties can have a constructive, accelerating effect on the development of much needed programs.

We recommend support for a continuation of federal assistance for such training.

Allied Health Personnel Training

The provision of federal assistance for development of institutional arrangements and advanced training in the allied health disciplines is suitable for fields undergoing as rapid changes as these are and where local and state support has made possible rapid expansion of training programs. The proliferation of job categories and of training programs has resulted in uneven quality of training and performance. Good teachers and program directors are scarce. It is essential for the safety and well-being of patients, and in fairness to students who devote their time and energy in study, to have programs in allied health education meet appropriate standards of quality, an aspect of allied health education to which the AMA directs major attention and effort.

We support a continuation of federal assistance for the training of allied health personnel.

Public Health Training

We believe that a continuation of support for schools of public health and public health training, including capitation grants, is necessary to satisfy what would otherwise be an unmet training need for a wide spectrum of public health professionals in addition to physicians. Because of their nature, schools of public health should be considered, in actuality, regional educational institutions rather than state or local institutions, and it should be recognized that individual states cannot be depended upon to provide such schools with adequate

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financial support. We are of the opinion that these schools, in serving a national need, should be supported through a continuation of federal financial assistance.

Accordingly, we support a continuation of assistance to schools of public health and their students.

U.S. Students in Foregin Medical Schools

The section entitled "Education of Returning United States Students from Foreign Medical Schools", addresses itself to a problem that has been a great concern to the American Medical Association and to many groups in the U.S. It is a situation of great complexity, raises questions of international relations, of the use of educational resources in foreign countries, and of the problems of student adaptation to a different system of education and of medicine from that in the U.S. We believe, however, that this provision will not deal with the many problems of U.S. citizens studying abroad and that it is not realistic to expect a report on deficiencies, if any, of foreign medical education of U.S. citizens. The foreign medical schools vary from one to another and deficiencies may be in the student's early education or in college. No judgement should be made of the schools themselves on the basis of such information. The questions and issues must be approached much more broadly with the several agencies of the Federal Government which are involved in immigration as well as the States and their functions in licensure.

Control of Medical Residency Training Programs

I should like now to comment on the provisions for residency training programs in this bill.

The bill would recognize or establish two agencies: One would be responsible for accrediting medical residency training programs in the U.S., and the other for establishing the number of positions in each residency program which could be filled. The aggregate limit on the number of positions which could be available would be an amount equal to 125% of the estimated number of graduates from accredited U.S. schools of medicine in the preceding year. Priority for designation as these agencies would be assigned to the Liaison Committee for Graduate Medical Education of the Coordinating Council on Medical Education as the accrediting agency, and the Coordinating Council on Medical Education as the agency to establish the number of residency positions. In the absence of such designations the activities would be undertaken by another organization designated by the Secretary.

As a penalty provision the bill provides that no charge could be made by facilities for services of physicians in training programs when the charge is attributable to compensation paid to any physicians who are in either nonaccredited residency training programs or in programs with a number of positions which exceed that established for that program. In addition, each such charge which is made for the services of such an individual would be subject to a penalty of an amount up to $5,000. Also, if the Secretary determines that an entity is operating a nonaccredited residency program or has a number of positions within its residency programs which exceed the number established for it, the Secretary would not provide further assistance under any of the provisions of the Public Health Service Act.

Again I direct your attention to our earlier testimony on this subject. There is, however, additional information available, which should have strong bearing upon your deliberations.

During the years from 1968 to 1973, the latter being the most recent year for which there are complete data, substantial changes have occurred in the numbers and specialty activities of physicians. These changes are evident in the distribution of recent graduates among approved residencies and in the percentage of first year residency positions that are filled. The most significant change is a 69% increase in the number of domestic and Canadian graduates entering residency programs in the "primary care" specialties.

This now means that nearly 50% of the graduates entered primary care specialty programs. A further fact of significance is that distribution of physicians has generally paralleled changes in the population at large. The ratio of physicians in patient care has increased nationwide and regional variations in the ratio reflect general population trends.

If I may, I should like to leave with this Committee copies of tables indicating data I have cited above, but I would like to elaborate on some of the changes which I have just mentioned.

Certain factors influence increases in residency positions. The 23 new medical

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schools, for example, which admitted their first entering class between the fall of 1967 and the fall of 1973 by their very existence substantially increased both the number of positions in the first year of residency programs and the number of approved specialty residency programs. New schools have been established in every census region in the U.S. and have already created 1,255 new first year places. If additional new schools are established in the future—and several are in development at this time—it may be anticipated that there will be additional residencies established as a part of the development of those schools.

Even more striking has been the change in the choice of specialty by students entering their first year of residency training. In 1968 a total of 4,604 first year residents were in the "primary care" specialties of family medicine, general practice, internal medicine, obstetrics and gynecology and pediatrics. By 1973 this number had reached 7,783, an increase of 69%. In 1968, 3,001 graduates of U.S. and Canadian schools entered residencies in the "primary care" specialties in the United States. By 1973 this number was 5,723. The total number of graduates from U.S. medical schools in 1973 was 11,613. This means that by 1973 the recommendation of the House of Delegates of the American Medical Association that 50% of graduates of U.S. medical schools should enter "primary care" specialties had almost been achieved with the medical school classes which were graduated in 1973. This shift to the "primary care" specialties, which projections suggest are continuing and possibly accelerating, has taken place because of student interest, actions of the American Medical Association and of the medical schools, as well as increases in the number of approved residencies and first year positions available to medical students.

The geographic distribution of physicians active in patient care shows no appreciable change in the non-metropolitan counties with populations under 25,000 between 1968 and 1973. However, there has been an increase in the physician-population ratio in all non-metropolitan counties with more than 50,000 people. The highest physician-population ratios remain in counties in Standard Metropolitan Statistical Areas of more than 5,000,000 people. Physician to population ratios for physicians in patient care have increased for the nation as a whole from 120/100,000 in 1968 to 130/100,000 in 1973.

I have commented on these significant trends which have been underway for the past five years to indicate that the objectives of the control program before you are already well on their way to achievement with respect to redistribution among specialties and that geographic distribution of physicians appears to be a function of the changing geographic distribution of the entire population of the United States. It is also important to note that the creation of new medical schools, (particularly in areas where, prior to their establishment, there were relatively few approved residency programs and relatively few positions), is associated with substantial increases in the number of positions and in the variety of specialty training available to candidates for graduate medical education.

Furthermore, graduates of foreign medical schools represent a decreasing proportion of persons entering approved residency programs in the United States.

These changes have occurred for a variety of reasons, but all of them have taken place without federal regulatory legislation.

Mr. Chairman, we believe, that legislation to regulate either the number of residencies, their geographic location, or the numbers of programs or number of first year positions by specialty is not warranted and indeed could conceivably have an adverse effect on current trends which are moving in the direction sought by the public, by the Congress and by the medical profession.

Let us again turn to the proposal in the legislation. The bill provides that in determining the number of positions in any accredited program the agency shall, among additional requirements, "insure that first-year positions in medical residency training programs are distributed equitably throughout various geographical areas of the United States."

The emphasis here is clearly on geographic distribution. Is this a logical basis for distribution? And if so, what exactly does this mean? Will this, for example, be based on the 10 regions now designated by the Department of Health, Education and Welfare, or on some other regional basis? Will it be based on state boundaries? According to census regions? Will it be determined solely by concentration of population? Will the areas be determined regardless of where approved residency programs now exist? Any of these determinations will have profound effects upon medical training.

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Additional questions need answers. What will be the effect of discontinuation of programs which affect care of patients and the future quality of care in the various areas, where programs might be discontinued—or initiated—solely to meet an arbitrary redistribution to meet some approved quota of programs and positions? Will the distribution be required to equalize the total number of residency programs? The total number of programs in the area? The total number of positions in each of the various specialties? Is each area to have the same number of surgical residencies, etc. Will one state have to give up training programs, and positions to accommodate another state's "equitable" allotment-irrespective of caliber of programs? Will the study currently being conducted by the Institute of Medicine and the studies outlined in this bill enable the Secretary of HEW, or the body which he may designate to make allocations of positions by geography or by specialty, to make adequate projections of the numbers of physicians needed in each field and where the location of such programs should be? We know that physicians who embark on one field of medicine may find that their interests and abilities lie elsewhere and wish to change their field of practice. Will this legislation inhibit or limit the ability of the resdent physician or the physician in practice to do so?

Because of the serious implications here, the time has come to talk in terms of actual application of the program and not in terms of generalities. We have not seen a practical example of how this new program would work. Under the legislation it would seem that this program will ultimately require the establishment of fixed numbers of programs and positions in each of the 24 specialties. While the *proper* mix is an unknown, if we take an arbitrary number, just for purpose of example, that the current figure for general surgery is presently at 1000 and is then fixed at 600 many adjustments would be required. First, the 600 would have to be distributed geographically. This could result in an increase in some areas, but would have to cause decrease in others. Established programs or positions would be terminated. One region because of excellence of programs, might presently have a high percentage of positions. These programs could be eliminated under a wholesale countrywide distribution. Further factors complicate the new proposal. Decisions relating to one specialty will have ramifications for another. The current concentrations of residency programs, particularly in specialties in which small numbers of persons undertake training each year, are related to the quality of graduate medical education provided in the institutions where the concentations occur. Residency programs in the various specialties are interdependent and their quality is determined by the environment in which they are offered. Graduate medical education in family practice includes extensive experience in internal medicine, pediatrics, obstetrics and gynecology, psychiatry and surgery. This experience is essential if the family practitioner is to be competent to deal with the variety of problems which patients will bring to him. He must also depend on other medical specialists to augment his own skills and to bring their special skills to bear when his patients need them. Will such matters as these be taken into account and can they be appropriately provided for through the regulatory mechanisms proposed in the bill which we are discussing?

One further effect of this proposal requires careful analysis. At the present time medical schools receive funding from a variety of sources. Some states presently contribute a major share—a higher amount than the federal share. Under the proposal being considered, where the federal government determines the training mix and residency program eligibility will the States be expected to maintain their support?

Mr. Chairman, we believe these are questions of the utmost importance, particularly in light of the trends which we have described that are already in progress. We have not been able to find answers to them as we have read this bill. Until answers have been worked out, for at least the most crucial questions, we fell strongly that the proposed residency control program should not be enacted. In our view current developments are providing a resolution of problems addressed by this legislation. We strongly urge this Committee not to adopt this statutory program for control of residency training programs.

Nurse Training

Before concluding the Association's testimony today, I would like to briefly comment on another bill before this Subcommittee, H.R. 2957 the Nurse Training Act of 1975, which would amend and extend the present Nurse Training Act under Title VIII of the Public Health Service Act. This bill has not been available, but we understand it is identical to H.R. 17085 passed by the Congress last year.

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We would like to again state, as we have on previous occasions, our support for Federal assistance to nursing schools and to nursing students. We would, however, like to recommend some changes in the legislation before you.

In the 1972 Nurse Training Act, Section 805(a) Special Project Grants and Contracts, provision was made for assistance to special projects to develop cooperative interdisciplinary training. We would recommend reinstatement of the provisions because of the need for interdisciplinary education, especially for physicians and nurses. In 1972, funded by the Kellogg Foundation, the American Medical Association and the American Nurses' Association established a National Joint Practice Commission to review and make recommendations on the roles of physicians and nurses in providing quality health services. The NJPC is identifying interdisciplinary education projects where physicians and nurses learn together, at this should have a positive effect on the team approach to delivery of health services. The NJPC strongly supported the development of additional joint education opportunities. For this reason, we recommend that the provisions for financial aid to develop programs for cooperative interdisciplinary training be retained under Special Project Grants.

Under the bill we note that capitation amounts for students in diploma schools of nursing and students in associate degree schools of nursing are different. We recommend that the capitation amount for diploma students be equal to the provisions for students in associate degree programs. Diploma programs still account for almost 500 schools of the 1,373 schools of nursing in existence and over 70,000 students or just less than one-third of total students enrolled in all basic nursing education programs. Diploma programs are an important national asset and, therefore, we recommend that the amounts per student in a diploma program be equal with the amount per student for the associate degree program.

We would also like to comment favorably on the provision for financial assistance to nurse practitioner programs. Nurse practitioners, especially those trained as pediatric nurse practitioners and family nurse practitioners, are providing needed services to children and families. These individuals have been trained in short-term special education programs in collaboration and cooperation with physicians in a variety of settings. We are pleased to see the eligibility of a variety of sponsors to obtain funding to develop nurse practitioner training programs. The guidelines developed to determine eligibility for funding will be an important component in assuring that the programs offer excellent training to the students. We are then pleased to note the provisions concerning advisors to the Secretary of HEW to develop the guidelines have been broadened to include nursing and other organizations. Physicians, especially pediatricians, have been involved in these programs from the beginning and their knowledge based on experience will be invaluable to the development of guidelines. The AMA would also be pleased to participate.

In singling out the provisions for nurse practitioner training, we in no way mean to imply the other categories of educational assistance are not important. It is to give recognition to this newer category of training programs, and also to encourage diversification in sponsorship and participation during this developmental phase, that we have commented here.

With these changes, we believe that H.R. 2957 will provide the kind of Federal support which is required to fill our need for skilled nurses.

Mr. Chairman and members of the Committee we thank you for the opportunity to appear before you. We will be pleased to answer questions and supply additional information of you so desire.

APPENDIX

The public, the Congress, the Medical profession, and others who participate in providing medical and health care have been increasingly concerned with the timely availability of medical and other health services. Both the economic access to care (increasing the purchasing power for medical and health services and the geographic access have been approached in a variety of ways, including private, State and federal support to increase the number of persons entering the health and allied health professions particularly through financial support of educational institutions and students in the fields related to health. Particular concern has been expressed about services to both rural and urban populations who have limited access to all health services including those rendered by physicians.

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Data are inadequate with respect to where and how persons seek and obtain care and to the ways in which health professionals use their time and expend their efforts in providing services. The location of physicians, for example, is not directly related to the location of persons who use their services. The use of services provided by hospitals is also not solely a matter of their location as related to the locations of their patients. Nonetheless there are data which indicate changes in location of populations and of physicians in the period between 1968 and 1973 and which show the changes in choice of specialties by graduates of U.S. and Canadian medical schools and graduates of foreign medical schools who have come to the United States for further graduate medical education and in increasing numbers as permanent residents.

The tables which follow show recent trends in choice of specialty by U.S. and Canadian and foreign medical graduates and in geographic location and migration of physicians in relation to the U.S. population. They also show the association of the creation of new medical schools in various settings with numbers of residency positions and numbers of approved programs in the various recognized medical specialties. The tables are derived from data published by the American Medical Association in the 1968 and 1973 editions of Distribution of Physicians in the U.S. and the Directory of Approved Internships and Residencies.

Table I shows the distribution of physicians between those in federal service and in non-federal functions, by activity in 1968 and 1973.

The decline in federal physicians between 1968 and 1973 has been approximately 10%. This loss of federal physicians has been primarily in the areas of training (−20+%), administration (−30+%) and research (−50%). There has been a slight gain in the number of federal physicians providing patent care.

The number of non-federal physicians has increased substantially. The areas of substantial increase are in patient care and physicians in training. Although there has been a substantial increase in the number of students enrolled in medical schools and 23 schools have admitted their first classes since 1967, and in the number of residents in graduate medical education, there has been only a 25% increase in the number of physicians in full time teaching (4,477 in 1968 to 5,608 in 1973) and in administration (from 8,654 to 1968 to 9,848 in 1973). There has been a major decrease in the number of physicians who state that they are engaged in full time research (about 60%) from 12,993 in 1968 to 7,046 in 1973. This trend, if it continues, may be a cause for serious concern for the future of biomedical sciences.

Table II compares the number of approved residency programs by specialty, the number of first year positions filled and the percentage of graduates of foreign medical schools in each specialty in 1968 with 1973. The number of approved programs has risen slightly from 4.518 to 4.840.In some fields, general surgery, anesthesiology, orthopedic surgery, pathology and radiology, the number of approved programs has decreased. New programs in diagnostic radiology, therapeutic radiology, family practice, neuropathology, forensic pathology and nuclear medicine have been established.

The total number of filled first year residency positions has increased from 12,721 in 1968 to 18,076 in 1973. The percentage of positions filled has increased in all fields, the over-all percentage increasing from 83% to 92%. At the same time there has been a decrease in the percentage of graduates of foreign medical schools in first year residency positions from 33% in 1968 to 30% in 1973.

The field of family practice has increased rapidly in the number of approved programs and in the number of first year residency positions and continues to do so.

Tables III and IV compare the changes which have occurred in residency programs in "primary care" specialties with the surgical specialties between 1968 and 1973. The number of first year residency positions filled in 1968 was 4,604. In 1973 the number had risen to 7,783, an increase of 69%. Even more significant is the fact that the number of graduates of U.S. and Canadian medical schools had risen from 3,001 to 5,723. The number of graduates of U.S. medical schools was 11,613 in 1973. Therefore nearly 50% of the U.S. graduates were entering "primary care" specialties by 1973. This approaches closely the goal set by the House of Delegates of the AMA that 50% of graduates of U.S. medical schools should enter "primary care" specialties.

The decline in the percentage of graduates of foreign medical schools entering "primary care" specialties is significant, having gone from 36% in 1968 to 27% in 1973.

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Family practice, internal medicine, pediatrics and obstetrics and gynecology have all shown substantial gains. General practice residency programs and positions are declining. These are largely two year programs and do not lead to specialty certification. In general they are in smaller institutions. With the establishment of residency programs in family practice and with the recognition of family practice as a medical specialty, interest in general practice residencies has declined substantially. The number of positions in such programs has always been small.

The total number of approved surgical programs has declined slightly between 1968 and 1973 although the number of first year positions filled has risen from 4,005 to 4,843, a rise of 21% as compared with a rise of 69% in the "primary care" specialties. The percentage of foreign medical graduates filling first year positions in surgery and the surgical specialties has declined from 38 to 36%.

It is important to note that in the specialties of neurosurgery, plastic surgery, colon and rectal surgery, and thoracic surgery the total number of first year positions filled is small, representing 4% of the 1973 U.S. graduates and 2.6% of all first year positions filled in 1973.

Table V shows the distribution of physicians as compared with the U.S. population by demographic county classification. Between 1968 and 1973 there have been substantial shifts of the U.S. population from counties and regions with small populations to those with large populations. The migration of physicians has been similar. The physician in patient care to population ratio has risen from 120/100,000 to 130/100,000 over this period. The physician inpatient care to population ratio has remained essentially unchanged in the non-metropolitan counties with populations under 25,000 and is about one-third (40/100,000) that of the nation. In all county classifications over 25,000 the active physician to population ratio has increased, the highest ratios being in counties in standard metropolitan statistical areas of more than 5,000,000.

Table VI shows the new medical schools which admitted their first classes between 1967 and 1973. There are 23 in all, distributed through all census regions in the United States (Tables VII). In each of the schools which was developed in an area where there were few approved residency programs and few positions, the development of the new medical schools has been associated with substantial increases in the number of approved residency programs, the number of first year positions and the number of specialties in which residency programs are approved.

Hospitals with extensive residency training prior to the establishment of new schools which are affiliated with them have also had the increases in the number of first year residency positions filled and have increased the number of specialties in which approved programs are offered, although the change has not been so striking. If additional new schools are developed (and several are in various stages of planning) one can anticipate similar increases in the numbers of positions and the numbers of specialties which will be created in association with these schools.

Tables VII and VIII deal with the distribution of new schools and residency positions filled by census region of the United States. It should be noted that the ratio of residency positions to population is higher in the Northeast than in any other census region. This is related to the early creation and development of medical schools and hospitals in this region and to the fact that strong residency programs were developed in this region earlier than in other parts of the country. The high percentage of first year residency positions filled in the New England States is an indication of the degree of desirability of these residency programs from an educational point of view. The decreasing percentage of graduates of foreign medical schools indicates the attractiveness of residency programs in New England for graduates of U.S. and Canadian medical schools.

The significant increase in the number of first year residency positions filled and the percentage of the number filled in the South is of particular interest because of the major development of new medical schools in this region and the increasing improvement of graduate medical educational programs.

The quality of residency programs is not only important from the point of view of candidates for them; it is also important from the point of view of medical practice in the future. Since persons in residency training and physicians at the beginning of their careers in practice are relatively mobile, programs of high quality attract candidates nationally and serve as national resources for graduate medical education.

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TABLE I.—FEDERAL PHYSICIANS—UNITED STATES AND POSSESSIONS

Year	Patient care	In training (residency)	Teaching	Administration	Research	Other	Total
1968	17,674	5,677	574	3,061	2,448	444	29,768
1973	18,034	4,373	575	2,111	1,286	390	26,769
NON-FEDERAL PHYSICIANS—UNITED STATES AND POSSESSIONS							
1968	196,936	41,545	4,477	8,654	12,993	1,939	238,466
1973	218,971	53,879	5,608	9,848	7,046	2,246	333,961

TABLE II.—NUMBER OF 1ST-YR RESIDENCIES BY SPECIALTY

Specialty	Number of approved programs		Total positions filled		Percentage filled		Percentage foreign graduates in filled positions	
	1968	1973	September 1968	September 1973	1968	1973	1968	1973
Anesthesiology	193	170	677	797	78	93	56	52
Child psychiatry	117	138	118	288	64	76	16	25
Diagnostic radiology		175		587		91		13
Dermatology	79	92	166	234	92	98	12	6
Family practice		206		766		78		5
General practice	154	51	254	176	54	86	56	82
Surgery	570	482	2,394	2,698	88	94	33	35
Internal medicine	419	433	2,589	4,139	89	98	36	24
Neurological surgery	86	100	119	143	92	97	22	22
Neurology	94	107	249	357	85	91	25	30
Nuclear medicine		26		24		96		38
Obstetrics and gynecology	358	347	759	1,003	87	94	46	33
Ophthalmology	159	177	418	495	97	98	9	7
Orthopedic surgery	234	207	403	591	91	93	13	10
Otolaryngology	106	113	206	266	90	96	13	12
Pathology	639	502	661	898	60	82	56	54
Forensic pathology		30		27		62		15
Neuropathology		29		26		67		31
Pediatrics	260	274	1,002	1,699	85	96	42	33
Pediatric allergy	41	46	41	56	84	93	20	21
Pediatric cardiology	53	57	55	66	79	80	44	41
Physical medicine and rehabilitation	65	69	95	135	60	80	35	64
Plastic surgery	73	117	90	171	92	93	19	20
Do		1		3		100		33
Colon and rectal surgery	14	20	6	26	60	87	67	46
Psychiatry	260	270	1,209	1,472	70	86	36	35
Radiology	272	211	849	372	89	81	22	42
Therapeutic radiology		97		108		65		46
Thoracic surgery	93	96	137	130	88	89	45	42
Urology	179	188	222	320	88	94	26	24
Total	4,518	4,840	12,721	18,076	83	92	33	30

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TABLE III.—CHANGES IN "PRIMARY CARE" RESIDENCY PROGRAMS AND 1ST-YR POSITIONS 1968–73

Specialty	Number of approved programs		Percent change—	Number of 1st yr. positions filled		Percent change—	1st yr. positions filled, number of United States and Canadian graduates		Positions filled, number of FMG's		Percent FMG's	
	1968	1973	1968–73	1968	1973	1968–73	1968	1973	1968	1973	1968	1973
Family practice	0	206			766			720		46		6
General practice	154	51	−200	254	176	−98	116	33	143	143	56	81
Internal medicine	419	433	+6	2,589	4,139	+60	1,801	3,154	788	985	30	23
Obstetrics/gynecology	358	347	−3	759	1,003	+33	433	765	326	328	43	32
Pediatrics	260	274	+5	1,002	1,699	+69	651	1,141	406	588	41	33
Total	1,191	1,311	+9	4,604	7,783	+69	3,001	5,723	1,663	2,090	36	27

Note: U.S. Graduates—1968, 7,973; 1973, 11,613.

TABLE IV.—CHANGES IN SURGICAL RESIDENCY PROGRAMS AND FIRST-YEAR POSITIONS (INCLUDING SURGICAL SPECIALTIES) 1968–73

Specialty	Number of approved programs		Percent change—	Number of 1st yr. positions filled		Percent change—	Positions filled by, United States and Canadian graduates		Positions filled by FMG's		Percent FMG's	
	1968	1973	1968–73	1968	1973	1968–73	1968	1973	1968	1973	1968	1973
Surgery	570	482	−18	2,394	2,698	+12	1,580	1,759	814	939	34	35
Neurological surgery	86	100	+16	129	143	+10	93	111	36	32	28	22
Ophthalmology	159	177	+11	418	495	+18	386	458	32	37	7	7
Orthopedic surgery	234	207	−13	403	591	+22	356	531	47	60	12	10
Otolaryngology	106	113	+6	206	266	+29	178	233	28	33	14	12
Plastic surgery	73	118	+60	90	174	+93	73	136	17	36	19	20
Colon and rectal surgery	14	20	+43	6	26	+333	2	14	4	12	67	46
Thoracic surgery	93	96	+3	137	130	−5	74	75	63	55	46	42
Urology	179	188	+5	222	320	+44	160	242	62	78	16	24
Total	1,514	1,501	−1	4,005	4,843	+21	2,902	3,559	1,103	1,282	38	36

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TABLE V.—DISTRIBUTION OF NON-FEDERAL PHYSICIANS BY DEMOGRAPHIC COUNTRY CLASSIFICATION, 1968-73

Demographic county classification	Total physicians			Physicians in patient care			Physicians, other activities			Inactive			U.S. population			Physicians active in patient care per 100,000 population	
	1968	1973	Percent change	1968	1973	Percent change	1968	1973	Percent change	1968	1973	Percent change	1968	1973	Percent change	1968	1973
Total	285,175	333,966	+17	238,481	272,850	+14	28,063	24,748	−12	18,631	22,624	+21	199,223,600	209,448,200	+5.1	120	130
1	2,323	2,232	−4	2,021	1,852	−8	53	37	−30	249	276	+11	4,920,600	4,652,600	−5.4	41	40
2	9,477	8,718	−8	8,261	7,417	−10	243	178	−27	937	922	−.9	16,566,900	15,133,600	−10	50	49
3	12,897	13,229	+2.6	11,329	11,173	−1.4	495	407	−2.2	1,073	1,279	+19	17,297,900	15,997,900	−8	65	70
4	14,775	17,621	+19	12,550	14,595	+16	958	847	−13	1,267	1,613	+27	14,727,700	16,057,300	+9	85	91
5	11,979	4,501	−166	10,055	3,846	−161	978	190	−415	946	356	−166	9,917,400	4,209,700	−136	101	92
6	42,338	56,482	+33	36,040	46,651	+29	3,246	3,682	+13	3,052	4,187	+37	33,502,600	38,944,000	+16	108	120
7	40,372	45,212	+12	33,784	37,080	+9.8	4,037	3,450	−17	2,551	2,958	+16	25,994,800	27,691,000	+6.5	130	133
8	92,826	124,897	+34.5	75,888	100,759	+32.8	11,515	10,697	−7.6	5,423	7,961	+47	50,772,700	62,728,000	+23.5	149	161
9	55,842	58,178	+4.2	46,530	47,039	+11	6,302	5,025	−25	3,010	2,975	−.1	25,523,000	24,033,800	−6.2	182	196
Possessions	2,346	2,896	+23	2,023	2,438	+20.5	236	208	−13	87	97	+11	----------	(1)	--------	(1)	(1)

1—Nonmetropolitan counties with 0 to 9,999.
2—Nonmetropolitan counties with 10,000 to 24,999.
3—Nonmetropolitan counties with 25,000 to 49,999.
4—Nonmetropolitan counties with 50,000 or more.
5—Counties considered potential SMSA's.
6—Counties in SMSA's 50,000 to 499,999.
7—Counties in SMSA's with 500,000 to 999,999.
8—Counties in SMSA's with 1,000,000 to 4,999,999.
9—Counties in SMSA's with 5,000,000 or more.

1 Not available.

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TABLE VI.—RESIDENCY POSITIONS AND NUMBER OF APPROVED RESIDENCY PROGRAMS ASSOCIATED WITH THE DEVELOPMENT OF NEW SCHOOLS SINCE 1967

School	Year admitting 1st class	Total residency positions filled		Number of specialties approved	
		1968	1973	1968	1973
University of South Alabama, Mobile, Ala.	1973	32	51	7	8
University of Arizona, Tucson, Ariz. (Tucson Medical Center)	1967	0	154	1	15
		49	54	5	5
University of California, Davis (Sacramento, Calif.)	1968	56	208	11	19
University of California, Irvine, Calif. (Orange County Medical Center)	1967	33	134	13	21
		94	131	8	21
University of California, San Diego, Calif.	1968	97	321	11	18
University of South Florida, Tampa, Fla.[1]	1972	59	116	9	13
University of Hawaii, Honolulu, Hawaii	1967	203	236	10	10
Rush Presbyterian-Saint Lukes, Chicago, Ill.[1]	1971	170	197	19	20
Louisiana State University, Shreveport, La.[1]	1969	105	104	11	11
University of Massachusetts, Worcester, Mass.[2]	1971	111	160	4	7
Michigan State University, East Lansing, Mich.[1]	1971	54	111	5	6
University of Minnesota, Duluth, Minn.[2]	[3] 1972	14	1	1	1
Mayo Medical School, Rochester, Minn.[1]	1972	605	663	22	23
University of Missouri, Kansas City, Mo.[1]	1971	184	233	10	17
University of Nevada, Reno, Nev.[2]	[3] 1971	0	1	1	1
Mount Sinai Medical, School, CUNY, New York, N.Y.[1]	1968	345	430	20	2:
SUNY, Stony Brook, N.Y.[1]	1971	384	548	12	20
Medical College of Ohio, Toledo, Ohio[1]	1968	133	187	8	12
Pennsylvania State University, Milton S. Hershey Medical Center, Hershey, Pa	1967	48	92	6	14
University of Texas, Houston, Tex	1971	135	200	11	16
University of Texas, Lubbock, Tex.[1]	1971	15	27	2	4
University of Texas, San Antonio, Tex.	1968	111	265	11	17

[1] Schools using hospitals for clinical programs of the school that had major programs in graduate medical education prior to establishment of the medical school.
[2] Schools using hospitals for clinical programs of the school that had graduate medical education prior to establishment of the medical school. Currently planning or building university hospital.
[3] 2-year medical schools.

Note: Total positions filled, 1968, 2,940; 1973, 4,624; increase in positions 1968–73, 1,684.

TABLE VII.—NEW MEDICAL SCHOOLS ADMITTING 1ST-YR CLASSES FROM 1967–73 BY CENSUS REGION

Region	Number of schools	Number of 1st-yr places	Total enrollment
Northeast:			
New England	1	25	65
Middle Atlantic	3	156	525
North-central:			
East	4	254	634
West	3	94	130
South:			
South Atlantic	1	24	48
East south-central	1	25	25
West south-central	4	245	740
West:			
Mountain	2	124	341
Pacific	4	308	928
Total	23	1,255	3,436

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TABLE VIII.—NUMBER OF RESIDENCIES BY CENSUS REGION

Region	Positions filled		Percentage filled		Percentage filled by FMG's		Resident population	
	1968	1973	1968	1973	1968	1973	1968	1973
Northeast:								
New England	2,612	3,613	85	96	38	31	11,363,800	12,142,400
Middle Atlantic	9,193	12,777	84	94	47	49	36,982,100	37,755,200
North-Central:								
East	6,319	8,714	81	91	41	41	39,363,300	41,083,600
West	3,455	3,648	80	87	26	21	16,150,600	16,736,600
South:								
South Atlantic	4,437	6,872	81	90	30	23	29,647,600	32,063,300
East south-central	1,233	1,875	76	85	15	18	12,927,600	13,151,400
West south-central	2,282	3,301	82	86	17	15	19,107,900	20,125,600
West:								
Mountain	847	1,559	76	94	17	8	8,069,100	8,977,100
Pacific	4,205	6,055	87	92	7	7	25,611,600	27,386,000
Possessions	212	455	58	91	53	56	(1)	(1)
Total	34,795	48,869	83	91	32	31	199,223,600	209,448,200

[1] Not available.

Mr. ROGERS. Do you support the training of the nurse practitioners?

Dr. NESBITT. Yes, sir.

Mr. ROGERS. What are your main objections to the Nurse Training Act?

Dr. NESBITT. Mr. Chairman, if I might call on Dr. Ruhe.

Dr. William Ruhe, director, division of medical education, American Medical Association.

Dr. RUHE. Mr. Chairman, they are contained in the two terminal portions of the statement. The bill calls for different capitation amounts for students in diploma schools of nursing and associate degree programs. We recommend that the level of capitation for the diploma students be equal to the provision in the associate degree programs. This is the same position as that which Dr. Gehrig spoke of.

Mr. ROGERS. In other words, to continue the support of the diploma schools in the same proportions as baccalaureate and associate degree programs.

Dr. NESBITT. Yes, sir.

Dr. RUHE. There is a provision in the nurse training bill for nurse practitioner training. There is a special requirement on the number of students per year in programs as a condition of eligibility for Federal funds. We feel these are too restrictive.

Mr. ROGERS. In other words, you feel that the provision where we ask them to train at least 25 students per class is too high?

Dr. RUHE. The requirement that at least 25 students be in a class in order to be eligible—our feeling is that this kind of specific restriction is frequently inappropriate for some institutions and judgments can be made on other than exact numerical restrictions.

I think this is more a matter of philosophy than it is of serious objection to that provision. But it seems to be unduly restrictive as it is now written, in our opinion.

Mr. ROGERS. Thank you very much.

Dr. Cooper.

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STATEMENT OF JOHN A. D. COOPER, M.D.

Dr. COOPER. Mr. Chairman and members of the subcommittee, the association welcomes this opportunity to comment on one of the major issues being addressed this year in the consideration of Federal health manpower legislation: The distribution of health care personnel by specialty.

The association is the national organization of institutions engaged in the formal education of physicians at the undergraduate—medical school—and graduate—teaching hospital—levels. It is comprised of all of the 114 medical schools in operation in the United States, 400 of the major teaching hospitals, and 58 academic societies, which encompass the teaching and research faculties of academic medical centers.

There is general agreement that the United States faces a maldistribution of physicians by specialty and gographic location and that the situation will worsen if corrective action is not taken. We agree with the Congress that the focus of the past on simply expanding the aggregate supply of physicians will not in itself bring about a redistribution of physicians, either among specialties or in their practice locations.

In fact, we have seen that by increasing the number of physicians which our medical schools produce, we have also increased the disproportion of subspecialists and suburban physicians. Clearly the answer is not simply to turn out more doctors, but to influence their specialty training opportunities and ultimate career choices.

The trend toward specialization and the growth of subspecialties has developed in response to the rapid expansion of biomedical knowledge during the past 30 years. Through specialization, it has become possible to transform the discoveries of biomedical research into greatly improved preventive, diagnostic, therapeutic, and rehabilitative procedures. Although it would be undesirable to jeopardize these clear benefits of specialization, the apparent shortage of primary care physicians dictates some readjustment of the balance between specialists and generalists.

Primary care is defined by Alpert and Charney in their publication "The Education of Physicians for Primary Care" (DHEW Pub. No. (HRA) 74–3113) as first-contact medicine in which the physician assumes longitudinal responsibility for the patient regardless of the presence or absence of disease and serves as the "integrationist" for the total health care of the patient. Family medicine is a subset of primary care, which is more often provided by internists, pediatricians, and obstetrician-gynecologists. For example, a recent study by the University of Southern California shows that cardiologists devote about half of their time to providing primary care unrelated to their subspecialty. Similar studies being conducted on the activities of other internal medicine subspecialists will probably produce similar findings.

It must also be emphasized that general internal medicine, general pediatrics, and family medicine are considered specialties of medicine, requiring 3 years of post-M.D. training in internship and residency programs leading to certification. Four years of medical school and a

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single year of internship do not prepare a physician for the independent practice of medicine. Thus, graduate medical education, which encompasses both internship and residency training, is the point at which the student becomes committed to his ultimate career choice, whether it be general practice or subspecialization.

There can be basically two approaches to increasing the number of physicians entering the primary care specialties. The first is to attract young physicians to primary care by making it a more desirable career choice. The second approach is to force more students into primary care by limiting the opportunities for training or practice in other specialties. The association believes that both approaches can be successfully employed if thoughtfully administered and adequately supported.

The Association of American Medical Colleges believes that the long-range solution to specialty maldistribution lies in making primary care a more attractive career to young physicians. To accomplish this, the association has supported the development of new models of delivering primary care, utilizing teams of health professionals and in the HMO setting. At the urging of the AAMC, many of our medical schools have begun to train students in a setting in which they will gain exposure to these new models.

The association believes that the major issue which must be addressed in seeking to make primary care as attractive as specialization is the disparity in income. The differential in compensation is a major factor in attracting physicians to specialization and is a controversial issue in the medical community. We would like to point out that when the salaries of generalists and specialists were equalized by the British National Health Service, they found that they no longer had a shortage of generalists.

Mr. ROGERS. Would you make that statement again.

Dr. COOPER. When the British National Health Service equated the incomes of the consultants and the general practitioners, they found they had no further difficulty in recruiting graduates of the British medical schools into general practice.

This is in spite of the fact that except for the new school in Southampton there is no medical school in Great Britain that either has a department of primary care or a department of family medicine, and all of the education and training is given in the teaching hospitals by the consultants who are specialists.

I might also point out that almost 75 percent of all physicians in England are in general practice. This is obviously a long-range solution to be addressed when the Congress takes up the issues of national health insurance in the United States.

The immediate solution then becomes the second approach—limiting training opportunities outside the primary care specialties while increasing the training programs available in primary care.

The association supports the provisions of H.R. 3279, introduced by Congressman Rogers, which would attack the problems of specialty distribution in several ways.

First, H.R. 3279 requires that each medical school, in order to receive its full capitation grant, undertake at least two projects in areas which this subcommittee has identified as being of the highest priority. One of these areas is specialty distribution—schools would have a choice of

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carrying out on of the following three projects: (*a*) Increasing the number of primary care residency positions in affiliated general hospitals by at least 5 percent of all residencies, if the percentage of primary care positions is less than 50 percent; (*b*) maintaining primary care residency positions at 50 percent or more of all residencies; (*c*) establishing or expanding undergraduate programs devoted to primary care education in an outpatient or ambulatory care setting.

These provisions recognize both the need to increase the absolute number of primary care residency programs and the need to develop programs outside of the traditional inpatient hospital setting. The reason for this is that most primary care is given away from the hospital setting. Training programs in hospitals tend to reflect the patient service requirements of the hospitals and thus often emphasize specialty services. By receiving primary care training opportunities in an outpatient or ambulatory care setting, students would be given a better view of the challenges and rewards of a career in primary care medicine.

Second, H.R. 3279 would provide funds available on a competitive basis for special project grants to help offset the costs of responding to these initiatives. Special project grants would be authorized to support residency programs in primary care and undergraduate training in outpatient or ambulatory care facilities. This provision of H.R. 3279 recognizes that while many institutions will want to respond to the desire of Congress and the needs of the Nation, few can afford to pay for these programs out of their already inadequate basic operating budgets.

Third, H.R. 3279 would authorize the Secretary to designate the Liaison Committee on Graduate Medical Education as the Agency responsible for accrediting internship and residency programs. After designation of this accrediting agency, the Secretary would be authorized to designate, with the approval of a special advisory group, which accredited residency positions would be approved for the upcoming year. This designation of approved residencies would take into account the health care needs of the Nation by determining the specialty distribution of residency positions, the geographic distribution of residency positions and the total number of residency positions. Health care institutions operating unapproved residency programs would be ineligible for reimbursement under existing Federal health care programs.

The association believes that these provisions of H.R. 3279 recognize the need for an overall review of graduate medical education programs, looking both to the educational excellence of the programs and to their appropriateness in meeting the health care needs of the American people.

The record shows that the Nation's medical schools have always responded to major problems affecting the health of the country, when provided with the resources necessary to do the job. For example, the schools have nearly doubled their entering class size in the last 10 years because the Congress adopted this goal and provided the needed funds.

I have testified previously before this subcommittee on the nature and extent of activities voluntarily undertaken by the medical schools and teaching hospitals to deal with crucial problems before they have even been identified as high priority items by the Congress. But these

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types of activities can only be pursued when an institution has resources above and beyond those required for the operational chassis. In these troubled economic times, few of our institutions find themselves in this position.

The association believes that H.R. 3279 would provide the type of support which would allow the institutions to undertake with success these new and weighty responsibilities which you, as Members of Congress, have identified as the most serious obstacles to making good health care available to all Americans.

Thank you very much.

Mr. ROGERS. Thank you very much, Dr. Cooper.

Dr. Hanlon?

STATEMENT OF C. ROLLINS HANLON, M.D.

Dr. HANLON. Mr. Chairman, I am Dr. Rollins Hanlon, president of the Council of Medical Specialty Societies, an organization of 20 specialty societies representing a membership of 174,000 physicians. I am one of three CMSS representatives on the Coordinating Council on Medical Education (CCME) and also a member of the CCME's Committee on Physician Distribution under the chairmanship of Dr. William D. Holden. I hold membership on the CMSS as one representative of the American College of Surgeons (ACS), an educational organization of more than 36,000 surgeons in America and throughout the world. I am director of the ACS, but my remarks today do not constitute a statement by that organization.

The CMSS is pleased to respond to the subcommittee's invitation to express its views on H.R. 2956—the Health Manpower Act of 1975. As a preface to my remarks, let me say that the CMSS recognizes, by organizational definition, the CCME as the primary, overall supervisory body in American medical education.

The CMSS is aware of the problems in providing primary care in this country, and has joined in studies and recommendations designed to solve such problems. As we all know, proposed solutions must go beyond such simple facts as primary physician/population ratios. They must also recognize the specific proportions of various specialists best suited to provide care most efficiently in different geographic areas, with wide variations in population density and in other factors. There is, for example, no ideal mixture of primary care physicians to surgeons to anesthesiologists which could be applied as a national norm in estimating needs for each of these specialties. To determine this exactly one would need to secure data for each specialty on numbers of physicians being produced, the workloads being handled by individual practitioners in urban or rural settings, in solo or group practice, and in academic or nonacademic environments, and other information.

Such data on distribution and workloads have been gathered under their own initiative by various specialties, and most strikingly by the surgical specialties in the study on surgical services for the United States (SOSSUS). This study was a successful 5-year effort on the part of the American College of Surgeons, the American Surgical Association, and other important surgical specialty organizations to provide the most comprehensive data ever collected on surgical services and manpower.

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The SOSSUS effort is cited not only to highlight the responsible and effective performance by the surgical profession, on its own initiative, but also to stress the complexity of the cooperative effort required to gather the sophisticated data necessary for intelligent and reliable planning. Now that these data are on the verge of publication, we are in a position to plan, with sound foundation, for continuing studies and internal controls on the use and distribution of our total surgical manpower resources.

These surgical studies provide both a stimulus and pattern for similar studies underway or being planned for the other specialties. Coordination of a group of such studies for all specialties will provide, for the first time, the opportunity for rational matching of overall physician resources to population needs in various parts of the country. These studies were initiated with funds from the surgical community and other private sources, subsequently supplemented to a substantial degree by Federal funds, which we gratefully acknowledge.

Studies such as the SOSSUS project and others in progress constitute a careful, meticulously drawn blueprint for meeting effectively the health care needs of the American people, while providing reliable guidance to thousands of young people who aspire to a career in medicine. It is not my purpose to discuss details of the legislation before us, Mr. Chairman, since specific points have been fully addressed by previous speakers. Rather, I wished to indicate for all the specialties represented in the CMSS, our conviction that the private sector of medicine is now addressing these issues responsibly, has gathered reliable information as only the profession is capable of doing, and has fashioned out of these data plausible plans for solving the distributional problems among specialty programs. To supplement the documents I forwarded to you after our testimony 8 months ago, I am pleased to say that the surgical profession will make available in slightly over 2 months the final abbreviated version of the completed SOSSUS study to be followed promptly by a massive 3-volume supplement which gives evidence of the size of the task accomplished.

We recognize that these studies and recommendations, despite their extent and refinement, provide only a single analytical picture of a mosaic of health manpower. Moreover that mosaic is constantly changing as our American people change their location, their life pattern, and their expectations. These demographic changes call for continuing adjustments in the nature and extent of our response to the task of providing high quality medical care, and such adjustments can best be provided by internal control mechanisms within the profession, guided by the research capacities and unparalleled data base of the American Medical Association with its ongoing assessment of trends and activities.

We are not opposed to innovative approaches to old problems; indeed we have initiated them and are vigorously continuing our efforts. We are confident of our ability to manage effectively graduate medical education through new and rapidly evolving mechanisms in the private sector. We applaud the aims you are attempting to achieve through H.R. 2956, but would ask most urgently for a reasonable time to achieve those objectives without direct governmental intervention at a single point in the delicately balanced field of graduate medical education.

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I wish to express my appreciation for this opportunity to present the views of CMSS on H.R. 2956 to your committee. I will be pleased to try to answer questions which you and your committee members may have.

Mr. ROGERS. Thank you so much, Dr. Hanlon.

We are grateful to all of you for being here and for giving us your viewpoints.

Mr. Hefner.

Mr. HEFNER. I have no questions at this time.

Mr. ROGERS. Dr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

I appreciate your presentation here today. I would like a little more enlightenment about how you gentlemen would handle the foreign medical graduate.

Dr. HOLDEN. Dr. Carter, if I may respond to you, this is the Foreign Medical Graduate Report which perhaps you have not had available. This is a very detailed analysis of the entire problem and there are in here, as mentioned before, 43 or 44 specific recommendations.

The primary recommendations, if I can put this into a capsule, are, first of all, a recommendation that the schools of medicine take the responsibility for the education of qualified foreign medical graduates, perhaps through their affiliated hospitals and residency programs.

The second recommendation of importance in here is that there be a complete revision of the procedures required to qualify a foreign medical graduate to enter a graduate program in this country.

The third is that attention be directed to both the Exchange Visitors Act and immigration policies that require the same kind of qualifying procedure, not only with respect to the candidate's medical education, but also his mastery of the English language so that he can communicate.

The fourth is directed toward the licensing procedures which now are lax and loose and permit a great many immigrant physicians to participate in the direct care of patients without permanent licensure, without ever having qualified in any way either through ECFMG, through the State licensing boards, or through the perusal of a peer group of physicians.

Mr. CARTER. We have those practicing today.

Dr. HOLDEN. That is right. And there is another recommendation in here that those many physicians in this country today who apparently cannot qualify for the independent practice of medicine be looked at and be given what assistance the medical profession can possibly provide in order that they may be qualified.

We do not intend in any way to eliminate the ingress of all foreign medical graduates. The sole purpose of this is to establish qualifying procedures that will not only permit them to benefit from such education but it is also directed toward their benefiting within the Exchange Visitors Act so that they can be helpful in their own country upon return.

Dr. COOPER. The provisions in H.R. 3279 cover most of the recommendations made by the Committee on Foreign Medical Graduates. It would prevent special preference visas for physicians. It would return to the earlier restrictions on the ability to exchange student visas into permanent immigration visas and would carry out many

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of the recommendations that came out of our task force on foreign medical graduates and those that were made by the committee of the CCME.

Mr. CARTER. Do we have any taxicab drivers from the Philippines here now? How many would you estimate?

Dr. COOPER. I really would not know.

Dr. NESBITT. Dr. Carter, I think we should point out to you and the chairman and the members of your committee that the document to which Dr. Holden referred is being studied by all the component associations of the Coordinating Council. There has not been a unified position that has been adopted as yet.

An invitational conference will be held to consider this document and others that have been developed on the foreign medical graduate question in April of this year. We hope at that time to be able to arrive at some form of consensus about these various elements. And, Mr. Chairman, Dr. Carter, we would hope it would be possible at that time that representatives from your committee would join us in considering these questions.

We feel that this is of vital interest to all elements of society, Government, Congress, when this does occur.

Mr. CARTER. I was interested in your comments on the National Health Service Corps. I believe you stated that in effect they should first be approved by the medical association before they went into a community. Is that correct?

Dr. NESBITT. We feel there should be that proper segment of the profession to which they will relate and from which they should seek their approval rather than any health organization in the community.

Mr. CARTER. Yes. I will tell you why that came about.

We had a county in Mississippi with a population of 16,000. They had four physicians and they refused to admit another.

Dr. NESBITT. The Secretary—if that is a capricious act—the Secretary has the authority to overrule that.

Mr. CARTER. At one time it was impossible to do that. That was the law, but it has been changed somewhat. In fact, I helped change it, to be frank with you.

I think it would be advisable to have their comments. In all fairness, however, we should always have their vote of approval. I hope that our physicians realize the necessity of obtaining the service of others and would not hold them back when they are needed in a certain community.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you.

I think your testimony has been most helpful to us.

Mr. HEFNER. Mr. Chairman, could I ask a question for my own information.

Dr. Holden, in your statement here on page 3 you referred several times to mechanisms that could be set up to do different things, to accomplish things that need to be done, and you mention "some have already projected the production of excessive numbers of certain specialists and have recommended that a mechanism be created within organized medicine that will assure a better distribution of specialists in the future."

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And down in the next paragraph, the last sentence, still referring to mechanisms "* * * still others feel that some form of arbitrary regulation with or without the introduction of appropriate incentives is the only way in which the physician manpower problem will be resolved."

And we talked in several instances about mechanisms. What do you see as incentives to get our people in the places that they should be?

Dr. HOLDEN. Mr. Hefner, I think there are many, not the least of which is a strong statement by organized medicine as to what the problem is, what the deficiencies are.

Another is a mechanism whereby this kind of information where there are deficiencies in the mix of specialists in various parts of the country are made known. Spontaneously many things have occurred in the past within medicine, where the number of people going into a specialty has dropped very significantly for a variety of reasons, because of the attractiveness of the specailty, because of observed needs or lack of needs for people in those particular areas.

This is occurring now in the area of general surgery, for instance. Fewer and fewer young people who are interested in surgical careers are selecting general surgery. Instead, they are going into some of the specialties that appear more attractive and appear to be more open.

So there are many things such as this.

The whole problem of the accreditation of programs is done now solely on the basis of the quality of the educational program. The standards and the criteria used for evaluating quality of programs can be addressed, not with the objective of reshuffling residency programs but solely because this is something that we should be doing all the time.

It has not been done as thoroughly in the past as perhaps it should have been done. Within the last 2 or 3 years there has been a change on the part of the whole accreditation system to upgrade the criteria that are being used to evaluate the quality of graduate educational programs, and this is producing a startling effect around the country, with the discontinuance of many programs that are borderline.

Mr. HEFNER. Do you think you are making progress in getting people where they should be?

Dr. HOLDEN. Indeed. We are going in the right direction and I think it is a matter of solely the private sector developing statements, policies, convictions, and procedures that will accelerate the process that is already taking place spontaneously.

Dr. NESBITT. Might I respond, Mr. Hefner? I think a point that has not been alluded to, that is currently a big factor in this problem of necessary geographic distribution, is the fact that we have such a tremendous lagtime in the production of our medical students until the time they actually get into practice.

We have virtually doubled the output of physicians in the last decade, but most of this has been in the last 6 years and these men take their 4 years in medical school and a couple of years in training and usually go beyond that. So we are just now beginning to see these increasing numbers of physicians that will be dispersed out into the communities.

That factor alone will increase this output and it will help resolve

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the problem, plus the interest in the family-practice programs, in expansion of those programs, plus those other factors of the economy, the recession, inflationary problems, problems of professional liability which physicians in your State are experiencing or will be experiencing shortly.

All of these will be factors that will affect this mix by geography.

In my own area I can recall that 3 to 5 years ago physicians in the smaller communities—those communities of 25 to 30 to 50 thousand of which Dr. Carter and I both happen to be intimately aware—I would get a call two or three times a week from physicians, "Where can you find me another man to help me?" I can go around and name you 20 communities in that area—the smaller communities out and around our area now—all of which have new physicians that have come in in the last 12 to 18 months and are supplying their needs.

We are beginning to see that the physicians are responding to these areas on a voluntary basis. They are not being coerced, regulated, or anything else. This will occur spontaneously once we get the increasing numbers of physicians out actually into the field which they have not had, by virtue of the time lag, an opportunity to get to yet.

Mr. HEFNER. I don't know where the testimony is here, but I believe since 1968 you have almost doubled your——

Dr. NESBITT. Annual output of physicians.

Mr. HEFNER [continuing]. And you have statistics to show where these people are going.

Dr. NESBITT. That is hard to describe, because that output is not reflected in where they are located.

Mr. HEFNER. This refers just to physicians?

Dr. NESBITT. Yes.

Dr. COOPER. I think it would be more correct to say we have doubled the incoming class.

The major increase began in 1968—it takes roughly 7 years for a physician to complete his training for independent practice, so in 1975 and on we will be beginning to see a substantial increase in the number of physicians entering independent practice.

Mr. HEFNER. In some field.

Dr. COOPER. In some field.

Dr. HOLDEN. But a large number, with the tables that Dr. Nesbitt has, are turning to primary-care programs. This is the largest increment of specialty selection.

There is another feature that I think we ought to be very cognizant of and that is that medical schools all over the country are increasing the input of women into medical school classes. Many of them—up to 20 percent of their enrollment now in first-year classes are women.

And we know from studies that have been done that 70 percent of the women who go through medical school, go through residencies, enter the primary-care fields.

Mr. HEFNER. Maybe we should concentrate heavier on the women.

Dr. HOLDEN. I would just as soon.

Dr. COOPER. The national average is now 21 percent in the last year's entering class, and I think within the next 4 or 5 years we will see it at 35 percent.

Mr. ROGERS. Dr. Ruhe.

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Dr. RUHE. I wanted to call attention to the fact that these medical colleges are changing rapidly. One of the things which has not appreciated is the rapid growth in family-practice programs. Most of our statistics are retrospective and they are effective as of 1973 the last year for which full data are available.

Mr. ROGERS. How long have we had the family-practice specialty as such?

Dr. RUHE. The new American Board of Family Practice was approved in 1969 and the first full-scale programs came in in 1970.

Mr. ROGERS. So it is a relatively new residency program?

Dr. RUHE. It is quite new.

Mr. ROGERS. These are doctors that would otherwise have gone into internal medicine or one of the other primary specialties?

Dr. RUHE. They may have, or to other fields. We don't really know. But the significant thing here is that the figures which we have shown in these tables showing the comparison between 1968 and 1973 indicate a substantial growth. Those 1973 figures show, for example, in family-practice residencies, 766 students in the first year. But in July 1, 1974, that first-year figure jumped up to 1,250.

Mr. ROGERS. First-year residents?

Dr. RUHE. First-year residents in family practice jumped from 766 to 1,250, which shows the way this is accelerating. Those people are not going to come out, of course, for 3 more years, but the numbers are growing each year.

The number of family-practice residency programs is now over 220, starting with zero in 1969–70. So it is growing quite rapidly. But the effects of these are generally not manifest in the reports which appear because they are usually reporting figures of a year or two earlier.

Mr. ROGERS. Are we having any increase in surgery?

Dr. RUHE. The number of programs is actually reduced between 1968 and 1973.

Dr. HANLON. Might I speak to that? The number of approved programs, speaking to Mr. Hefner's question about regulatory mechanisms, by quality assurance on programs, dropped 18 percent in those 5 years, so the number of programs approved dropped 18 percent. These are general surgical programs.

Mr. ROGERS. What about the subspecialties of surgery?

Dr. HANLON. Some of them rose very rapidly and——

Mr. ROGERS. Which rose rapidly?

Dr. HANLON. Plastic surgery rose rapidly. Colon and rectal surgery rose to fantastic levels, 300-odd percent, but the specialty is so small the figures are hardly capable of being statistically analyzed.

I think there is one interesting thing about surgery with relation to women. Although 25 or 30 percent of the entering classes, entering into specialties, may be women, the number of women who will be going into surgical specialties constitute—and seem to continue to constitute—a very small percentage. Therefore, as you increase the number of women in the total pool of specialties you decrease the relative number going into surgery despite the rise in number of women.

I think there is another thing about the surgical residency programs, although they dropped 18 percent, the efficiency of utilization of the bad programs remaining was such that the total positions filled rose from about 2,400 to about 3,700, so that although the bad programs

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are being phased out, the number of empty spaces are being decreased so that you are progressing really in your education more effectively.

Mr. ROGERS. The family physician feels that at least 25 percent of the residency positions offered should be in family practice. Do you agree with that?

Dr. HOLDEN. Twenty-five percent of the total number would amount to roughly around 13,000 or 14,000 in family practice.

Mr. ROGERS. That is correct.

Dr. HOLDEN. This would mean roughly about 3,000, 4,000 or 5,000 first-year physicians. That is a very large number to contemplate in a practical way. I would think they would get up to 2,000–2,500 within the next 5 to 10 years, but 4,000 or 5,000 seems like an awfully large number and they will be competing with young men who want to go into internal medicine and pediatrics.

There is also an increase demonstrated in internal medicine and pediatrics both, so I think this will be a matter of competition within the primary-care environment.

Mr. ROGERS. So you do not agree with the family physicians?

Dr. HOLDEN. I would agree with their objective, but I think, practically, this is not the way the marketplace for residencies will attract young men and women. I think there will be a much more even distribution between family practice, internal medicine, and pediatrics than a marked accentuation of family practice to the detriment of internal medicine and pediatrics.

Mr. ROGERS. But there is not much of a balance between internal medicine and family practice.

Dr. HOLDEN. Balance how?

Mr. ROGERS. In numbers.

Dr. HOLDEN. That is right. At the present time.

Mr. ROGERS. Internal medicine, which has been established so long, offers 9,000 or 10,000 residencies.

Dr. HOLDEN. But there are roughly 4,000 entering internal medicine. There are 1,250 entering family practice. I would imagine that within 5 years this will get up to perhaps 5,000 in internal medicine and 2,500 or 3,000 in family practice.

Mr. ROGERS. But how many are entering internal medicine?

Dr. HOLDEN. About 4,000-some odd.

Mr. ROGERS. For your total of what, about 9,000?

Dr. HOLDEN. 11,000 at the present time and it will be 15,000 within 2 or 3 years.

Mr. ROGERS. Whereas family practice won't get to that level until——

Dr. NESBITT. It just started in 1969. It is 1,200 to 1,500 first-year residents now and it is being expanded rapidly, not on a totally predictable basis but the trend is much more rapid than internal medicine, certainly.

Mr. ROGERS. We have given funding to establish family-practice residencies and there has been other initiative and governmental action as well. We have given colleges funding to establish family-medicine departments, and to put emphasis on them. I would think that the rapid growth of family-practice residencies is in part due to Federal stimulus.

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Now what we are trying to decide is, if that does work—and it has in family practice and is beginning to move people away from heavy subspecialization—why wouldn't it be reasonable to have some incentives like we are offering you to get the profession to address itself to this issue, rather than just saying, "Gee, we all want you to go into primary care and family practice; that is where we really need you right now."

That is good, and I am sure it is helpful to have everybody feel that way. But I do not see that much action, and I do understand it takes some time. But do you really think, Dr. Holden, that the CCME will be able to do the task contemplated by this legislation without enacting this bill?

Dr. HOLDEN. I personally do.

Mr. ROGERS. You think you can?

Dr. HOLDEN. I think the incentives that the CCME have have been generated both within the medical profession and also by much of the discussion within your committee. There is no question about this. I do think that we can do this.

I think these five parent organizations are terribly sensitive to the problem today and a good example is in internal medicine. The American Board of Internal Medicine is now changing its requirements to place the general internist in a much greater position of stature than the multiple subspecialties within internal medicine.

These are the things that are attractive to young people and this is not the kind of thing that can be done except by exhortation within the medical profession, and I do believe these things can be done, perhaps not quite as quickly as by regulation but nevertheless it can be done much more atraumatically and in the long run, I think, effectively by the CCME addressing itself to this problem in a very convincing way.

Mr. ROGERS. Are we addressing the problem of too many surgeons?

Dr. HOLDEN. We are.

Mr. ROGERS. What have you done there?

Dr. HOLDEN. The SOSSUS report has come out with very specific recommendations about the number of surgeons that this country will need with in the next decade and this is something that, as soon as this is public, the CCME will look at. The multiple specialty societies that have the clout to come out with statements and convictions and premises that they have to live wtih will be very effective, I think, in changing the environment in terms of attracting young people into these surgical specialties.

Dr. HANLON. I would like to emphasize one thing, that it is absolutely essential that we define what a surgeon is, and unfortunately in many of the statistics that are being circulated, anyone who does one surgical procedure in a year, whether that be a circumcision or heart catheterization, is considered in the statistics as a surgeon. And we all know the number of surgeons represents only about 50,000 or a ratio of 18 per 100,000 of population, which is a reasonable ratio if you speak of board-certified surgeons.

Now if you include those other people doing operations, some of whom are competent, some who are not, and raise the number to 92,000, then you are talking about obviously an entirely different ratio, and if you include the occasional operator who should not be dignified

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by the term "surgeon," then you are talking about something which obviously needs to be reduced.

Mr. ROGERS. Could we recess for 10 minutes now, and then we will return and finish up before lunch.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please. Do we think of internal medicine as being entirely primary care?

Dr. HOLDEN. No, Mr. Rogers, in that they have altogether nine subspecialty areas. All of the people who enter those specialty areas, like cardiology and pulmonary disease, must be qualified as general internists first.

Mr. ROGERS. I understand that, but what I am trying to get at is this problem, are we really producing enough primary care people by increasing numbers of internists?

In other words, a cardiologist—I am not sure in my own mind that I would consider him a specialist and not a primary care man. Would you?

Dr. HOLDEN. This is true up to a point.

Mr. ROGERS. That is true of every doctor.

Dr. HOLDEN. That is true of every doctor, but with cardiologists especially. Studies have been done at the University of Southern California—they completed a study of cardiologists and about 50 percent of the patients who come to cardiologists do not have cardiovascular disease, so they become the entrance points for those patients into appropriate medical circles for the care that they require.

Now, it does not mean that they provide comprehensive primary or family care. But they do function in a part of this whole business of providing comprehensive care in that they provide an access to good care.

Mr. ROGERS. I understand that. That is not my question. I probably would not call a cardiologist unless I thought I needed a heart specialist.

Dr. HOLDEN. They differ enormously in that you cannot compare the cardiologist in a university hospital or big clinic to the cardiologist in the community of 50,000 people.

Dr. COOPER. Very few subspecialists can practice entirely their specialty except in an academic institution or a very large city. And many of them to spend a considerable fraction of their time in continuing competitive ongoing care of patients without a condition related to their subspecialty.

Mr. ROGERS. What is the difference between the cardiologist who is a specialist and the family practice specialist? Is there a difference or not?

Dr. HOLDEN. A marked difference in that, first of all, the family practitioner is trained differently. He is trained very broadly, not only in internal medicine and pediatrics but psychiatry as it is applied to family situations; some of them in obstetrics and gynecology; some of them in surgical diagnosis.

The general internist is trained only in internal medicine and this is the strongest difference, yet most of these people in internal medicine do become in essence family physicians for adults.

Dr. COOPER. I think there is another problem, Mr. Rogers. That is with the diminution in the number of rotating internships and intern-

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ships in other areas. Many of these first year general internal medicine residency slots are utilized by other specialists to broaden the experience and training of their students before they enter that particular specialty.

For example, very often a radiologist will spend a year in internal medicine or pathology, dermatology, or a matter of fact, psychiatry, so one cannot judge the output of the internalists by the number of first-year positions.

Mr. ROGERS. What about lung, the internal lung guy? Would he come treat me for any medical problem?

Dr. HOLDEN. No; most of these individuals who are in pulmonary disease are located in large centers. There are very few of them as a matter of fact and they deal almost exclusively with chronic and acute pulmonary conditions. They are not family physicians in any sense of the word.

Mr. ROGERS. So is that a subspecialty of internal medicine?

Dr. HOLDEN. Yes.

Mr. ROGERS. I just wonder if we were using too broad a term in calling internal medicine, a primary care specialty.

Dr. HOLDEN. It is not by any means. As I mentioned in my prepared text more and more young men have been, within these last 5 years, going into the subspecialty areas by taking these fellowships in rheumatology, nephrology, medical oncology, and hematology. This trend is being reversed now by the American Board of Internal Medicine because they realize that they have an obligation to provide general internists.

Mr. ROGERS. Are you reducing the number of residencies in rheumatology?

Dr. HOLDEN. This is will be done eventually.

Mr. ROGERS. How will it be done? Will the CCME—will your committee do it?

Dr. HOLDEN. It will be done through the CCME's terms of policies. These will have to evolve upon the liaison committee for graduate medical education which accredits these programs.

Mr. ROGERS. I did not think that you used the accrediting process as a limitation.

Dr. HOLDEN. We do not.

Mr. ROGERS. Then how can you limit, if you do not have the ability to do it?

Dr. HOLDEN. Because I think we have got to be cognizant of the number of people who are educated. Now, this is something that we are still in the process of getting information about. We do not know today whether there are too many pulmonary physicians or not enough pulmonary physicians.

Mr. ROGERS. Because we have not addressed ourselves to the problem, have we?

Dr. HOLDEN. Not in great detail. But we are in the process of doing this. We have this information for surgery, and many of these specialty organizations—dermatology, anesthesiology—have this information. It is going to be up to some group within private medicine to project needs, not only in terms of the number of physicians in a specialty but all of the ancillary personnel who can contribute to patient care. Anesthesia is a good example.

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Mr. ROGERS. But who is going to do it? Are you going to do it?

Dr. HOLDEN. We are going to do it by statements that will have an enormous effect.

Mr. ROGERS. I am sure they will have some effect.

Dr. HOLDEN. I don't think there is any question about this, Mr. Rogers.

Mr. ROGERS. In other words, if you say a specialty—for example, rheumatologists—are going to decrease their residencies——

Dr. HOLDEN. There are many other mechanisms that can be invoked. At the present time the number of residencies that are permitted through the various programs—this is being restricted.

Mr. ROGERS. Through what mechanisms?

Dr. HOLDEN. Various insurance programs that provide salaries for residents in teaching hospitals.

Mr. ROGERS. That is not from the profession, is it?

Dr. HOLDEN. It is.

Mr. RORERS. Is it medicare or medicaid?

Dr. HOLDEN. It is medicare, medicaid.

Mr. ROGERS. In other words, governmental?

Dr. HOLDEN. And the private insurance companies are taking cognizance of this.

Mr. ROGERS. They are following medicare and medicaid?

Dr. HOLDEN. But they are also following the fact that the medical profession is aware this cannot be an endless expansion.

Mr. ROGERS. I understand. What I am trying to do is help you accomplish your goal. But you still tell me that you are limited to making policy statements because you cannot limit them through your accrediting process and I would presume many of your specialists would oppose severe limitation.

Dr. HANLON. I would not say you cannot limit them through accreditation.

Mr. ROGERS. It is against your policy?

Dr. HANLON. It is our strong policy in surgery that the problem is not too many surgeons, it is too many operations, and we suffer the obloquy of being blamed as being in excess when the problem is that the properly credentialed surgeons in many areas are deficient in number, and the load is being carried inappropriately and not well by people who are not really surgeons.

Mr. ROGERS. How do you get to that problem?

Dr. HANLON. You get to that point by a stricter credential mechanism.

Mr. ROGERS. What do you mean credential?

Dr. HANLON. I mean if a person is permitted to operate in a hospital——

Mr. ROGERS. He must be board certified.

Dr. HANLON. That would be one credential.

Mr. ROGERS. What would be others—a certain amount of experience?

Dr. HANLON. Yes, sir; and peer evaluation.

Mr. ROGERS. PSRO?

Dr. HANLON. No. We have defined, after a great deal of thought in the American College of Surgeons, the character of a surgical specialist, and for many reasons—including the obvious charge we would be labeled as self-serving—we have not put the simple criterion of

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fellowship in the American College of Surgeons; but that is a criterion, as well as board certification or eligibility for board certification.

Mr. ROGERS. How can you get to that? Does that have to be done through AHA and their accrediting through the hospital?

Dr. HOLDEN. Through the Joint Commission on Accreditation of Hospitals.

Dr. NESBITT. The Joint Commission on Accreditation of Hospitals.

Dr. HOLDEN. They are beginning to require professional standards for permission for staff privileges now. This was the result of a small committee of the American College of Surgeons and the American Surgical Association that went to the joint commission.

They have upgraded standards already so that individuals who are not properly prepared to carry out certain patient care activities will not be provided staff privileges if the hospital expects to get accreditation by the joint commission.

Mr. ROGERS. When does that become effective?

Dr. HOLDEN. It is already in process.

Dr. HANLON. But it does not become immediately effective in changing the ratio, because every hospital is not accredited every year. The interval is 2 years, and the load of accreditation builds in a certain lag.

Mr. ROGERS. When would you expect that to be?

Dr. HANLON. I would think with perhaps between 2,000 and 2,500 hospitals on the standard pattern of accreditation to be inspected—I would think that if they are not in conformity I would think that then they would lose their accreditation; which obviously, as we all know, does not mean they immediately go out of business.

If you are unaccredited what you are unable to do is to get house staff that will come to the hospital because if you are working in an unaccredited hospital it is highly unattractive and you will simply dry up your supply of house officers.

Mr. ROGERS. Who makes the judgment as to whether the man that is operating in that hospital is competent to operate?

Dr. HANLON. He has to be judged on credentials which are done locally by his peers according to general standards which are laid down by the JCAH—Joint Commission on Accreditation of Hospitals.

Mr. ROGERS. In other words, you have set forth what should happen.

Dr. HANLON. Precisely.

Mr. ROGERS. Can you file those standards with the committee?

Dr. HANLON. Yes; we will give you the data.

[The information requested was not available to the committee at the time of printing.]

Mr. ROGERS. Could we get from the American Hospital Association how many hospitals are enforcing——

Dr. GEHRIG. Yes, sir.

Mr. ROGERS. How many have been refused the right to operate? Do you have any figures on that?

Dr. GEHRIG. I would expect we would have to go to the joint commission.

Dr. HANLON. At the last count there were 158 hospitals that the Joint Commission on Accreditation held out of conformity with their standards, not necessarily for this particular thing of credentials.

Mr. ROGERS. I want to particularize, if you could let us know.

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Dr. HOLDEN. There is a problem with this, Mr. Rogers. That is of all the hospitals in the country—and there are 7,100-odd—the joint commission has surveillance over some 5,000-odd number of them. There are 2,000 hospitals, of which something like 800 are general hospitals, that do not request the accreditation by the joint commission. And this is where a lot of the problem that Dr. Hanlon has addressed resides.

Mr. ROGERS. What about that, Dr. Gehrig, why don't the general hospitals have accreditation?

Dr. GEHRIG. Probably a variety of reasons. I think the majority of hospitals aspire to it. There are a host of reasons notwithstanding this in which——

Mr. ROGERS. Is the American Hospital Association going to do anything to make that a requirement for membership?

Dr. GEHRIG. As far as requirement, no.

Mr. ROGERS. Accreditation?

Dr. GEHRIG. We are attempting to encourage this anywhere, in any way and through the educational programs. As you can recognize, there are institutions in which there is need for surgery in which if that were an absolute requirement there is inability in that community to obtain a qualified surgeon at the present time.

Mr. ROGERS. Is there?

Dr. HANLON. Yes, sir.

Mr. ROGERS. How do we get one there?

Dr. HANLON. If you made a stipulation that every surgeon in America starting today had to be board-certified or he would be ruled out of the operating room you obviously would do great harm. And I think another thing that needs to be introduced is that the Joint Commission on Accreditation of Hospitals is a voluntary body, that is to say, no one is compelled to seek accreditation by the Joint Commission. It is, for just a brief historical note, an organization which was started by the American College of Surgeons and run for 35 years by the American College of Surgeons after which the job obviously became so massive it then became a joint effort of the American College of Physicians and the American College of Surgeons, AMA and AHA.

But nonetheless, as Dr. Gehrig points out, it would be very difficult if we insisted that as a condition of belonging to the American Hospital Association you would have to be inspected by the JCAH. I do not know what problems that would bring.

Mr. ROGERS. Why would that be such a problem?

Dr. HANLON. I would think——

Mr. ROGERS. It is the profession itself being upgraded. You all belong.

Dr. HANLON. One of the difficulties of that is that the Social Security Administration has considered acceptance by the Joint Commission on Accreditation of Hospitals as a so-called deemed status. They deemed them acceptable for Medicare and Medicaid programs and if you lost your deemed status by virtue of nonconformity with JCAH standards the presumption would be medicare would be cut off. Unfortunately, that has not occurred.

Dr. HOLDEN. No.

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Dr. GEHRIG. There is a provision in the Medicare Act which if the Joint Commission accredits a hospital this provides an inspection that is accepted under medicare.

On the other hand, if a hospital is not inspected and accepted by the Joint Commission it is inspected by a State agency for participation in medicare and there are a significant number of such institutions.

Dr. HOLDEN. And they still receive Federal funds through medicare and medicaid.

Mr. ROGERS. Should we look at that?

Dr. HANLON. I think that is an extremely turbulent statement at the moment because of the fact that the standards under which the re-examinations of the hospitals are being done by the Federal agency as contrasted to those being done by the JCAH are different sets of standards so that if you have a hospital which is in conformity with the JCAH it can be delivered out of conformity by an extremely searching inspection done by the Federal Government for such things as life safety codes which are according to a different Life Safety Code, 1967, as contrasted to the 1970 Life Safety Code under which JCAH operates.

Mr. ROGERS. If you had to be put in a hospital, what kind would you want to go to?

Dr. HANLON. I would like to see that plaque "Approved by JCAH" on the wall.

Dr. HOLDEN. Requirements of JCAH are much more stringent than any Federal requirements.

Mr. ROGERS. Would you let us have those requirements for the record? For comparison.

[The following information was received for the record:]

EXCERPTS FROM MEDICAL STAFF ACCREDITATION MANUAL FOR HOSPITALS

STANDARD I.—EACH MEMBER OF THE MEDICAL STAFF SHALL BE QUALIFIED FOR MEMBERSHIP, AND FOR THE EXERCISE OF THE CLINICAL PRIVILEGES GRANTED TO HIM

Interpretation

Medical staff membership shall be limited to individuals who are fully licensed to practice medicine and, in addition, to licensed dentists. These individuals, after having made formal application, may be granted membership on the staff, in accordance with its bylaws, rules and regulations and with the bylaws of the hospital. Members of the medical staff must be professionally and ethically qualified for the positions to which they are appointed. Appointment to the medical staff is a privilege granted to the applicant by the governing body after considering recommendations made by the medical staff through established mechanisms. The medical staff must define in its bylaws the requirements for admission to staff membership and for the delineation and retention of clinical privileges.

Each member of the medical staff shall assume responsibility for abiding by medical staff and hospital policies. A major responsibility in this context is that of appropriate documentation of his patients' illnesses and care. Beyond this requirement, a member of the medical staff should take an active role in the development of policies and standards of patient care through the mechanisms of medical staff organization. Within this organizational framework, he may advise and supervise the less experienced, and accept advice and supervision from those more experienced. He accepts medical staff controls as a protection to himself as well as to others.

Clinical privileges granted to dentists should be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform must be specifically defined

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and recommended in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the chief of surgery. All dental patients must receive the same basic medical appraisal as patients admitted for other services. A physician member of the medical staff must be responsible for the care of any medical problem that may be present, or that may arise, during the hospitalization of dental patients.

The governing body of the hospital, after considering the recommendations of the medical staff, may grant clinical privileges to qualified, licensed podiatrists in accordance with their training, experience and demonstrated competence and judgment. When this is done, podiatrists must comply with all applicable medical staff bylaws, rules and regulations, which must contain specific references governing podiatric services.

A podiatrist with clinical privileges may, with the concurrence of an appropriate member of the medical staff, initiate the procedure for admitting a patient. This concurring medical staff member shall assume responsibility for the overall aspects of the patient's care throughout the hospital stay, including the medical history and physical examination. Patients admitted to the hospital for podiatric care must be given the same basic medical appraisal as patients admitted for other services.

The scope and extent of surgical procedures that each podiatrist may perform must be specifically defined and recommended in the same manner as all other surgical privileges. Surgical procedures performed by podiatrists must be under the overall supervision of the chief of surgery. The nature and degree of supervision is a matter of determination, in each instance, within the medical staff policy that governs the relationship and dual responsibility existing between the medical staff and the podiatrist. A physician member of the medical staff must be responsible for the care of any medical problem that may be present or that may arise during the hospitalization of podiatric patients. The podiatrist is responsible for the podiatric care of the patient, including the podiatric history and physical examination and all appropriate elements of the patient's record. The podiatrist may write orders within the scope of his license, as limited by the applicable statutes and as consistent with the medical staff regulations.

STANDARD II.—THE MEDICAL STAFF SHALL BE ORGANIZED TO ACCOMPLISH ITS REQUIRED FUNCTIONS; IT SHALL PROVIDE FOR THE ELECTION OR APPOINTMENT OF ITS OFFICERS, EXECUTIVE COMMITTEE, DEPARTMENT HEADS AND/OR SERVICE CHIEFS

Interpretation

The medical staff organization must provide a framework in which the duties and functions of the medical staff can be carried out. The complexity of the organization will depend upon the size of the hospital and the scope of the activities of the medical staff.

Active Medical Staff. All hospitals must have an active medical staff that should deliver the preponderance of medical service within the hospital, and should perform all significant organizational and administrative duties pertaining to the medical staff. Members of the active staff shall be eligible to vote and to hold office. The existence of additional staff categories should in no way modify the privileges, duties and responsibilities of the members of the active medical staff. Members of the active medical staff must be conveniently available to the hospital.

Associate Medical Staff. There may be an associate medical staff, consisting of individuals who are being considered for advancement to the active medical staff. Members of the associate medical staff must be appointed and assigned to departments or services in the same manner as are members of the active medical staff. Although they may not hold office, they may serve on some medical staff and hospital committees. Voting privileges should be determined by the active medical staff.

Courtesy Medical Staff. There may be a courtesy medical staff, consisting of those medical practitioners eligible for staff membership, who are given privileges to admit an occasional patient to the hospital. Courtesy staff members may neither vote nor hold office. Because the admission of patients to the hospital is an exercise of a privilege and, therefore, is accompanied by responsibility, admission of more than an occasional patient should require the practitioner to seek membership on the active medical staff.

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STANDARD III.—THE MEDICAL STAFF ORGANIZATION SHALL STRIVE TO CREATE AND MAINTAIN AN OPTIMAL LEVEL OF PROFESSIONAL PERFORMANCE OF ITS MEMBERS THROUGH THE APPOINTMENT PROCEDURE, THE DELINEATION OF MEDICAL STAFF PRIVILEGES AND THE CONTINUAL REVIEW AND EVALUATION OF EACH MEMBER'S CLINICAL ACTIVITIES

Interpretation

The maintenance of high standards of medical care depends upon the professional capabilities of the individual medical staff members, as well as on the effectiveness of the staff organization. The effective discharge of medical staff responsibilities depends in great part on the clear assignment, and full acceptance, of responsibility by the entire medical staff, its individual members, its officers and its committees. The form and complexity of the medical staff organization will vary substantially depending upon the size and composition of each staff. Although the establishment of committees is a common organizational device, other methods also are acceptable, provided that effective discharge of the following responsibilities can be demonstrated by the documentation of activities.

Medical Staff Selection. The medical staff must establish a procedure to ensure a fair evaluation of the qualifications and the competence of each applicant for appointment, and for periodic reappointment, to the medical staff. Whatever the procedure, it should be objective, impartial and fair, broad enough to recognize professional excellence and strict enough to safeguard patients. The selection of persons to be recommended for appointment shall depend upon a thorough study of the qualifications of each applicant. No applicant shall be denied medical staff membership on the basis of sex, race, creed, color or national origin, or on the basis of any other criterion lacking professional justification. In nondepartmentalized hospitals, the credentials of the applicant may be reviewed by the executive committee of the medical staff before recommendations are made by the medical staff, whereas in larger or departmentalized hospitals, the preliminary review of the applicant may be done through a credentials committee after recommendations are received from the department/service in which the candidate requests privileges. The report of this committee then is usually forwarded to the executive committee for medical staff recommendation to the governing body.

All recommendations to the governing body for staff appointment must include a clear delineation of clinical privileges. Privileges granted shall be commensurate with the training, experience, competence, judgment, character and current capability of the candidate. When a hospital uses a system involving classification of privileges, the scope of the classifications must be well defined, and the standards that must be met by the applicant should be clearly stated for each category. Reappointment policies should provide for a periodic appraisal of each member of the staff, including consideration of his physical and mental capabilities.

In connection with medical staff recommendations for denial of staff appointments and reappointments, as well as for the denial, curtailment, suspension or revocation of privileges, there shall be a mechanism provided in the medical staff bylaws, rules and regulations for review of decisions, including the right to be heard, at each step of the process, when requested by the practitioner. The final decision must be rendered by the governing body, within a fixed period of time. Medical staff membership must be extended to qualified physicians who have been given clinical privileges in the emergency department or service, the outpatient department or service and, where one exists, the home care program.

Medical Care Evaluation. The medical staff must take all reasonable steps to ensure clinical practice of the highest quality. In order for the medical staff to carry out this responsibility properly, each member of the staff must:

Provide his patients with the best possible quality of care;

Conduct his professional activities according to the bylaws, rules and regulations of the medical staff; and

Assist in the promotion and maintenance of high quality care, through the analysis, review and evaluation of the clinical practice that exists within the hospital.

Because the overall responsibility for the quality of medical practice rests with the medical staff, the individual staff member must be held accountable for the appropriateness of care rendered to his patients. Medical care evaluation should be a fact-finding and educational function. To accomplish such analysis effectively, criteria for evaluating medical care must be established by the medical staff. Findings relative to medical care evaluation should be compared with the

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criteria established by the medical staff and may, when pertinent, be compared with criteria reported from hospitals in other areas of the country. Assistance in performing these comparisons may be obtained through the use of outside facilities for processing medical record data for hospitals. Although the content of the medical record is indispensable to the evaluation of medical care, the medical record should be measured independently for adequacy of the form as a source document, and compared with established standards for completeness and accuracy.

The formal means established to accomplish medical care evaluation is dependent upon, and varies with, the size and organizational structure of the hospital. The medical staff may decide to do the clinical review as a unit, or it may delegate the responsibilty to a medical care evaluation committee or to a similar committee within each department. In the interest of unbiased medical care evaluation, some hospital medical staffs may wish to include on such committees physicians from the community, who are not members of the medical staff. In some specialty hospitals, physicians representative of other clinical specialties, which are not ordinarily represented within the active attending medical staff structure may be included on such committees. The performance of physicians having clinical privileges in the emergency department or service, the outpatient department or service, special care units, and, where one exists, the home care program, must be included in the hospital's regular medical care evaluation program.

Whatever the organizational pattern selected, the medical staff must provide an appropriate peer group method by which the required basic functions of medical, surgical and obstetrical audit are thoroughly performed at least monthly. Included in this audit must be a tissue review and the analysis of necropsy reports. The tissue review should include an evaluation of preoperative and postoperative diagnosis, the indications for surgery and actual diagnosis of tissue removed at operation. Similar review should be performed with respect to those situations in which no tissue was removed at the time of surgery. Necropsies should be performed to identify the contributing factors and processes involved in the patient's terminal illness, and to provide educational experiences.

Medical care evaluation shall include periodic review of the utilization of the bed facilities, and of the diagnostic, nursing and therapeutic resources of the hospital, with respect to both the availabilty of these resources to all patients in accordance with their medical needs and the recognition of the medical practitioner's responsibility for the costs of health care. This review should cover, on a sample, or other basis, admissions, lengths of stay, professional services furnished and the availability and alternate use of out-of-hospital facilities and services. In addition, the services of out-of-hospital facilities for diagnosis and therapy should be reviewed.

The use of consultations, and the qualifications of the consultant, should be reviewed as part of medical care evaluation.

There shall be analysis of those hospital services that directly affect patient care, including the emergency department or service, the outpatient department or service, special care units, and, where one exists, the home care program.

Minutes that adequately reflect the transactions of medical care evaluation shall be kept and regularly reported to the medical staff through its executive committee.

QUALITY OF PROFESSIONAL SERVICES

Standard

The hospital shall demonstrate that the quality of care provided to all patients is consistently optimal by continuously evaluating it through reliable and valid measures. Where the quality of patient care is shown to be less than optimal, improvement in quality shall be demonstrated.

Interpretation

The quality of patient care shall be evaluated by members of the medical and other professional staffs directly responsible for patient care. Evidence of the quality of patient care provided in the hospital shall be demonstrated by measurement of actual care against specific criteria. These criteria must be established or adapted by the medical staff for evaluation of all physician-directed care, and by nonphysician health care professionals for evaluation of these aspects of patient care which they provide. Criteria must be explicit and measurable, and

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must reflect the optimal level of care that can be achieved through current medical and related health-science knowledge.

Because of the probable relationship between the quality of patient care and the outcome which the patient experiences as a result of intervention by physicians and other health care professionals, criteria shall include expected patient outcomes, such as health status at discharge, complications, mortality, morbidity, and demonstrated knowledge of the patient concerning his health status, level of functioning, and self-care after discharge. Criteria reflecting desirable processes of care should be used when it has been demonstrated that observed patient outcomes fail expectations; when the critical patient outcomes are long delayed; when medical intervention cannot, or can only marginally, affect patient outcomes; when specific diagnostic or therapeutic processes are known to affect patient outcomes; or when it is known that certain processes may result in the early detection or prevention of potential complications or chronic disabilities. Criteria also shall include validation of the diagnosis and, where appropriate, justification for hospital admission, surgery, and/or the use of specialized hazardous drugs or procedures. Criteria may take into account specific patient variables such as health status prior to hospitalization, but these must be explicitly stated.

The measurement of the quality of patient care shall contribute to the reliability of the evaluation process. Since the patient medical record is the primary source of actual practice information, it must be accurate and complete. It must describe the patient's status at the time of admission, the care provided to the patient, his progress, and his health status at the time of discharge. To provide an unbiased measure of patient care, the number of medical records used in the evaluation study must be representative of the patient care being provided by all physicians and other health care professionals. The method used for retrieving, abstracting, and reporting data from patient medical records shall assure the reliability of the data.

Variations from the established criteria shall be identified and justified. In actual practice, variations from criteria are often fully justified, but evidence for such justification must appear in the patient medical record and the reason for justification must be explicitly stated by the professionals evaluating care. Such justification may include patient variables such as health status prior to the time of medical intervention. Variations that are not justified to peer satisfaction must be analyzed. If analysis indicates inappropriate patterns of patient care, action must be taken to correct problems. Such action should be specific to the problem and may include educational or traning programs, amended policies or procedures, increased or realigned staffing, provision of new equipment or facilities, or adjustments in staff privileges.

To demonstrate that corrective action has been effective, follow-up studies must be completed. If a problem poses a threat to patient health or safety, the follow-up must be immediate and should continue until it is clearly demonstrated that the problem has been corrected. If identified problems represent less than optimal patient care but are not immediately threatening to patients, follow-up must be completed within a reasonable period of time.

The entire patient care evaluation activity must be documented and its results reported. The general findings of and specific recommendations from evaluation studies conducted by the medical staff must be reported to the executive committee, the chief of the medical staff, the chief executive officer, and the governing body. The findings and recommendations from evaluation studies conducted by nonphysician health care professionals must be reported to the chief executive officer, the governing body, and the chief of the medical staff.

The evaluation activity shall be continuous and shall be comprehensive of the conditions and problems treated and the procedure performed. Evaluation studies shall be either ongoing or repeated periodically, according to the criticality of the evaluation study topic and of the problems previously disclosed. Evaluation criteria shall be revised or updated to reflect the findings of previous studies, new medical and health care knowledge, improvements in techniques, and scientific advances.

The results of the quality-of-care evaluation shall be specifically reflected in other quality-protective functions of the medical staff, including reappointment and reprivileging of medical staff members, control of the utilization of the hospital and its resources, the continual monitoring of practice within the professional staffs, and provision of continuing professional education.

Dr. GEHRIG. I think it is important to look though, at the hospitals

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across the country where you have in many rural areas small facilities. I think in terms of governmental participation in hospitals, they are inspected by one or the other body. If they are accepted, I do not believe that the inspections are necessarily lax in their inspection.

Mr. ROGERS. I understand. You are saying that there may not be properly certified surgeons in many areas, which we call maldistribution. Could the CCME begin to get at that through the residency programs?

Dr. HOLDEN. In some of these hospitals they do not have the capability of conducting an educational program. In some they probably do. Especially as an affiliate of a large program.

Mr. ROGERS. What can you do? How are you going to get on top of the problem. Are we just going to issue statements?

Dr. HOLDEN. I think there are multiple ways of doing this and I think it is going to take some action on the part of the Coordinating Council and its accrediting bodies.

Mr. ROGERS. What? What do you suggest? Are you going to suggest a reduction of any or an increase in others?

Dr. HOLDEN. This is already being proposed by many of these organizations. As I mentioned earlier the SOSSUS study is proposing there be a total reduction in the number of surgeons.

Now, I do not know whether their proposal is realistic or not because the increase in the number of surgeons in this country being produced in residency programs is only 21 percent compared to a 70 percent increment in primary care, just family medicine alone.

Mr. ROGERS. But, of course, it is already a large, established specialty program, isn't it?

Dr. HOLDEN. That is quite true but in terms of the curve of growth it is very rapid as a matter of fact in family practice.

Mr. ROGERS. I guess surgical residency programs from 1968–1973 have grown 21 percent according to the table you gave us.

Dr. NESBITT. Number of first year positions.

Dr. RUHE. The programs have actually been reduced in number.

Dr. HANLON. The programs have gone down.

Mr. ROGERS. But we are producing more surgeons.

Dr. HANLON. That is a combination of not only general surgeons but all the specialists we referred to as the aggregate number.

Mr. ROGERS. But there is an increase in numbers of surgeons.

Dr. HANLON. Yes, sir.

Dr. HOLDEN. But we are dealing with very small numbers turned out each year, 50, 100, 120. Getting 120 down to 100 is going to be meaningless. It is only in the larger specialties where there is a problem and it seems to me within the private sector that when we are convinced that the projected increment of surgeons in any specialty is going to be excessive that we will have to first, through exhortation, try to reduce numbers.

Mr. ROGERS. How do you do that? How do you expect to get any reduction by way of exhortations?

Dr. HOLDEN. By pointing out——

Mr. ROGERS. Because if you could do it this Congress would like to try it. No laws, just exhortation.

Dr. HOLDEN. Right. It does seem to me if we are convinced——

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Mr. ROGERS. I know you are trying.

Dr. HOLDEN. That surgeons are going to be coming out of the woodwork by 1980. We will do something about it no matter what it takes.

Mr. HEFNER. Dr. Nesbitt, as I recall you mentioned your statistics are not going to show where these people are going until when?

Dr. NESBITT. The next 2 to 3 years.

Mr. HEFNER. The next 2 to 3 years.

Dr. NESBITT. The increase in numbers of graduates, and number of persons completing residency programs and where they will end up in practice.

Mr. HEFNER. Do we not know what these people are studying now in college?

Dr. NESBITT. In the residency programs?

Mr. HEFNER. When they enroll in medical school do we not know what direction they are taking now?

Dr. NESBITT. In medical school?

Mr. HEFNER. Yes, sir.

Dr. NESBITT. No.

Mr. HEFNER. If it is going to show up in 2 years——

Dr. NESBITT. These are the young physicians residency programs now but what they are studying in medical schools bears no relationship to what they may end up doing when they get in medical practice.

Dr. HOLDEN. Is when they select their residency.

Mr. ROGERS. Although we have many who say they intend to go into family practice when they begin medical school, by the time the professors who are surgeons are finished with them they end up surgical residency programs; isn't this true.

Dr. HOLDEN. This is becoming less all the time.

Mr. ROGERS. You have 21-percent increase.

Dr. HOLDEN. I know, but there is a 70-percent increase in family practice.

Mr. ROGERS. Because they did not have any at the beginning. Now, we are getting a few.

Dr. HOLDEN. Many of those young people would have gone into surgery if there were no family practice residencies.

Mr. ROGERS. I am sure but at least the profession has begun to move in that area. The point I am making is I do not see any real mechanism that you have to bring about results that you say you really want.

Dr. HOLDEN. We do not have a mechanism that we can put on paper and say that is what we are going to do.

Mr. ROGERS. Why don't we get one. What is wrong with it? The goal is there. You want to do it. Why not have it so that the profession does it?

Dr. HOLDEN. One of the reasons—through this committee of the CCME, we are still accumulating all the information we can get and it will probably take us another 3 or 4 months.

Mr. ROGERS. You will never get it all, never.

Dr. HOLDEN. We will get all we possibly can assimilate.

Mr. ROGERS. It will never happen.

Dr. HOLDEN. We will get all we can assimilate in order to develop a policy.

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Mr. ROGERS. I know you are going to try, but what I am saying is this. You want to do this. We want you to do it. But we cannot get you to agree to use any mechanism other than exhortation in the future.

If we are going to get something as vital to health care as the proper ratio of doctors to treat people, and it takes 8 years or more hadn't we better get on with it now?

Dr. HOLDEN. I think so and I think if there were Federal legislation to the effect that the Coordinating Council representing national policy on behalf of medical education must accept a responsibility for mechanisms that will devise an adequate distribution of physicians in this country within such a period of time, that it will be done.

Mr. ROGERS. In other words, if we asked you to come up with a specific program in 2 years, could you present it to us.

Dr. HOLDEN. Right, absolutely.

Mr. ROGERS. It would work?

Dr. HOLDEN. Within 2 years; absolutely we will do it.

Mr. ROGERS. Yes; Could you propose it within 1 year?

Dr. HOLDEN. Yes; we could not in 6 months, but within 1 year one can make a proposal that will identify the problems and identify the solutions, the procedures, processes, mechanisms, agencies that are necessary to do it.

Mr. ROGERS. That sounds good.

Dr. NESBITT. I think it needs to be emphasized again, supported by the material that I presented, that the trends in the last 5 years, which we really were not aware of until we had researched these resulting in this new information with which you have been provided today, are showing that these elements are occurring despite our getting into any fixed specific investment of any precise mechanisms to accomplish it.

Elements are at work that are causing these changes and, I must hasten to add, the interests and concerns of you and your committee, I think, have served to stimulate our profession to begin to see that these things are occuring without any legislation required to accomplish it.

The fact that you and your committee have concerned yourselves with these problems and they have been ventilated and that they are in the public interest has served a fine purpose to provide us mechanism wherein those bodies that are responsible for setting up programs have much more latitude in defining what can be done and what should not be done. This in itself has been a great stimulus. One that is hard to pinpoint as a mechanism now.

Mr. ROGERS. Now, what is wrong with going ahead—say, we give you 1 year to come with a program that you would be prepared to implement as an advisory group to the Secretary.

Dr. NESBITT. It depends upon the precise manner in which the statutory requirement is placed or whether this is a recommendation, whether it is an edict or whether it is something that is addressed in a voluntary manner recognizing that this is being accomplished.

I think it hinges on that element of it and the responsibility as relates to the relationship of this voluntary body with the Government agency, Mr. Rogers.

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Mr. ROGERS. Let me ask you this. Do you accredit residencies that are not filled?

Dr. NESBITT. Yes, sir.

Mr. ROGERS. Why?

Dr. HANLON. The indication in those figures is that if you decrease unattractive and unsatisfactory residencies by 18 percent you can then get into those that remain a more reasonable percentage of filled spaces and, therefore, the efficiency of your system is improved so that I think the mere fact of deficiency of a given number of places—or to say it another way—if you have three or four or five empty spots in your program, a most rigid view would be to immediately cut that program off. I think what you would suggest rather than that would be that if you do not fill to a certain degree by a certain time you reduce the number of those that are available.

Mr. ROGERS. But suppose it is in a specialty that you feel you have a surplus, and not in one that you have a deficiency. Why shouldn't you reduce the number of those residencies by not accrediting them.

Dr. HANLON. Actually, the profession itself, without any Federal stimulation, has already begun to do that. In neurological surgery they have addressed this problem. In thoracic surgery they have reduced the residencies 4 percent in the past 3 years.

Dr. HOLDEN. One other comment about this. It is true at the present time we could discontinue programs that consistently are not filled or poorly filled. This has always been a practice of the residency review committees.

Mr. ROGERS. It seems to me in areas where you have surpluses and there are unfilled residency positions in these specialties you would be justified shifting proportions so that those young men and women then would look to primary specialties and maybe go into them.

For instance, in general surgery you have 6 percent that are not filled. You have 485. Why would you accredit these residency programs if there is surplus and surgeons tell you there are too many surgeons.

Dr. HANLON. I think it is unfeasible to match precisely to the last percentage point the number of available spots with the people that are available to fill them.

Mr. ROGERS. You could cut out 4 percent. Take 300 out, or 350 out. Why shouldn't that be done? Is anybody else going to do it?

Dr. HOLDEN. A lot of that 6 percent, Mr. Rogers, is not that several programs are 90 percent deficient. It is that several programs—I am responsible for 140 surgical residents. If I get 138 or 139 that is no big problem. On the other hand, a program that is responsible, let's say, for 10 surgical residents and gets 1, that is a very different matter.

Mr. ROGERS. But you could retain the 140 slots in the one program and cut out the second program altogether, I presume.

Dr. HOLDEN. If that were consistent over a period of 2, 3, 4, or 5 years, we would discontinue that program at the present time because it is not serving any purpose.

Mr. ROGERS. But when is it going to be done?

Dr. HOLDEN. It is being done all the time.

Mr. ROGERS. I certainly don't see it here. In fact, I see on the tables that from the number of residency positions, 54,137; total positions

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filled, 49,000; positions vacant, 5,000; the number of residents on duty, 34,159; Canadian and United States foreign graduates on duty, 14,923; and the total residency positions to be offered, 1975–76, are 65,000.

Now, have you thought of not accrediting residency programs which are 100 percent FMG's?

Dr. HOLDEN. This has been considered.

Mr. ROGERS. Has any action been taken?

Dr. RUHE. It is discriminatory.

Mr. ROGERS. Why is it discriminatory if the position is such that it is not filled by a man who could speak English or it is not filled by one who has had proper training. How do you judge it? Or do we just accept all FMG's?

Dr. RUHE. We do not accept all FMG's.

Mr. ROGERS. I am talking about 14,000 of them.

Dr. RUHE. That is correct, but the way the immigration laws are currently written——

Mr. ROGERS. I am not talking about the immigration laws. I am talking about what the profession sets as a standard and whether you are going to act on standards that you set.

Dr. RUHE. There are standards that the foreign medical graduates who come into approved graduate programs must meet.

Mr. ROGERS. 10,000 of them are not licensed.

Dr. RUHE. Not the ones that are in the approved residency programs.

Mr. ROGERS. They are practicing in hospitals, doing some of the same work residents do.

Dr. RUHE. That is a matter of the State licensing board. If they are willing to accept it.

Mr. ROGERS. It is a matter of accrediting hospitals that allow an unlicensed individual to do the work of a resident.

Dr. RUHE. No, it is not.

Mr. ROGERS. What is he doing in the hospital then? The hospital is using him. Although he is not licensed they give him the position and the doctor asked him to be there to take his place when he wants to go out and wants to go home for dinner or something. You know, "You stay in the emergency room." I understand that. It is not easy.

Dr. HOLDEN. But this is a matter of State licensing provisions.

Mr. ROGERS. It is beyond that. I am saying they are not licensed but they are still practicing medicine in our hospitals.

Dr. HOLDEN. That is right.

Mr. ROGERS. Who lets them? The accrediting process ought to stop that, and the profession should see to it that the hospitals stop the practice, or they do not get accredited.

Dr. HOLDEN. But the State licensing boards——

Mr. ROGERS. We can always bring it back to Government. I am talking about trying to get the private sector to do something before Government has to do everything.

It also goes to the whole policy of whether or not you are going to enforce standards.

Dr. HOLDEN. The trouble with the whole business is our standards for the whole foreign medical graduate problem have not been high enough.

Mr. ROGERS. I agree.

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Dr. HOLDEN. That is our trouble, and that is what this document is all about.

Mr. ROGERS. I agree; but not only that, even if it is high I do not know what you are going to do on all of these positions, where you have more than you need in some areas. As long as you have so many residency slots, how are we ever going to get on top of it. If all the FMG's qualify and want to come in and can do all the surgery they want.

Dr. HOLDEN. We are going to cut it down.

Mr. ROGERS. How and when?

Dr. HOLDEN. Much of that increment is the investment of new medical schools and affiliated hospitals. This is where many of those new positions have gone. They are not in hospitals that can not conduct effective and satisfactory graduate programs.

Mr. ROGERS. How much training is done in hospitals? Don't we do a good bit of the training in the hospitals? And the trend is to go out and do even more in the hospitals?

Dr. HOLDEN. There are only something like 1,500 hospitals in this country have accredited residencies, out of 7,100. We are only talking about roughly 20 percent of the total hospital population in this country when we are talking about residencies.

Mr. ROGERS. What was that percentage?

Dr. HOLDEN. Roughly 20 percent.

Mr. ROGERS. Where are the rest of the FMG's, then?

Dr. HOLDEN. Many of them are in these other hospitals and many are in hospitals that are not even accredited by the Joint Commission on Accreditation. They have no residency programs.

Mr. ROGERS. How many of the 14,000 FMG's would you say are in accredited positions?

Dr. HOLDEN. They all are. Those figures that you are reading, they are all in accredited residency programs.

Mr. ROGERS. And there are many more that are not accredited programs?

Dr. HOLDEN. Many.

Mr. ROGERS. How many?

Mr. HOLDEN. Tens of thousands.

Dr. HANLON. 69,000 FMG's practicing in this country today as an estimate.

Mr. ROGERS. What has the profession done on that problem?

Dr. HANLON. I think one thing needs to be said; that is, the original reason why FMG's came here under educational auspices was they would be trained, and it was not easy until the immigration laws were changed for them to immediately sign themselves over from a student visa to another characteristic. As soon as that dike was opened they flooded in and did not leave the system. I think that has happened in the beginning unbeknownst and certainly not with our by-your-leave. I think this is a thing which we deplore but which is a fact of life that has occurred. We are talking about trying to manage a tremendous group who are either in unaccredited hospitals or indeed are not even visible, because they are practicing in this so-called underground.

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Mr. ROGERS. Can the profession do anything about it? Or should they?

Dr. HANLON. In cooperation with labor.

Mr. ROGERS. What do we need to do to get to that problem?

Dr. HOLDEN. Tighten up the Exchange Visitors Act.

Mr. ROGERS. You want the immigration law changed?

Dr. HOLDEN. Yes, sir.

Mr. ROGERS. Will you give us specific language?

Dr. HOLDEN. Yes, sir.

Mr. ROGERS. What should we do? Say no more FMG's can stay in the U.S.? Or what?

Dr. HOLDEN. Not no more. We feel there are many foreign medical graduates that should be here.

Mr. ROGERS. What percentage?

Dr. HOLDEN. I would guess of the total percentage of our physician population, let's say of our graduates, 15,000, that we could very easily assimilate 1,000 to 1,500 foreign medical graduates that would benefit this country; they would be benefited by it, and their own countries would be benefited.

Mr. ROGERS. Would every one agree to that?

Dr. NESBITT. Not entirely.

Mr. ROGERS. Do you think it should be higher?

Dr. NESBITT. It is a variable factor. This can come and go from time to time.

Mr. ROGERS. As a general rule.

Dr. NESBITT. I don't consider myself an authority. This is a sort of off the top of our head, free-wheeling discussion.

Dr. HOLDEN. The 1,500 is off the top of my head too.

Dr. NESBITT. It could be considerably more.

Mr. ROGERS. Could it be as high as 5,000?

Dr. NESBITT. On a temporary basis, from time to time, that figure might vary from 5,000 to 6,000 down to 1,000, according to the circumstances as they develop in the residency training facilities that we have available to us and as to how the number of positions in approved programs do become regulated.

Mr. ROGERS. Should it be 10,000? Should it be 14,000 or 15,000?

Dr. NESBITT. It is getting too high.

Mr. ROGERS. Would you say 5,000 is a pretty good figure?

Dr. HOLDEN. That would be a maximum figure.

Dr. NESBITT. I would agree that is the upper limits.

Mr. ROGERS. What do you think, Dr. Gehrig?

Dr. GEHRIG. I would not differ with that.

Dr. HANLON. No. I think one of the things we have to recognize if we started phasing out the programs now to avoid the dislocations Dr. Gehrig spoke of and to avoid the inequities of depriving areas of service by excellent FMG's, of which there are many, and many of course——

Mr. ROGERS. We are talking about new residences.

Dr. HANLON. Many of the ones who come in perform in a superior manner.

Mr. ROGERS. Say we let 5,000 in——

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Dr. HANLON. I think if you let 5,000 in, depending on where they come from and what their previous background is, many of them will be inadequate.

Mr. ROGERS. So you think that may be too high a figure?

Dr. HANLON. No; I think if our entering qualifications are high and we let 5,000 in and have a narrow gate for them to come through, I think they will be adequate practitioners in the system.

Dr. COOPER. The bill H.R. 3279 addresses this problem by preventing the issuance of special preferences to physicians, so that they stand in line with everyone else from these countries in order to enter. In our testimony we suggested some additional legislation which would prevent the conversion of exchange students' visas into permanent immigration visas; that would limit the education and training of all foreign medical graduates to medical schools or approved large hospitals; that would make it necessary for student exchange visas to leave the country for 2 years and to have the whole program related between institutions in the donor country and institutions in the receiving country, with some assurance that the people coming here for education and training will benefit themselves and the country from which they come and in which they will provide care.

The problem is with the casuals that come to this country. We have had great experience over the years with Kellog Foundation Fellows who have come to this country as designated by their institutions, who are trained in this country and return to those countries and do provide the kinds of improvement in their teaching and education and health services that the country feels is appropriate.

The language comes substantially out of the FMG report of the task force and the language is in the testimony.

Mr. ROGERS. The point I was making is whether there should be some consideration of restricting the number of FMG's as to residencies.

Dr. NESBITT. Correct. Mr. Rogers, we are reluctant to define this because there has been no total agreement, but all of these are the elements that Dr. Cooper described.

Mr. ROGERS. You feel that 5,000 would be the upper limit, and it may be too high.

Dr. HOLDEN. It is.

Mr. ROGERS. What about 3,400?

Dr. HOLDEN. If the provisions in this report are accepted as a result of that April meeting that the CCME is considering the standards will be such that nowhere near 5,000 FMG's can qualify for admission to this country.

Mr. ROGERS. I'm happy to hear that. This is in line with the thinking of the committee because in our bill we say residencies ought to be about 125 percent of the U.S. graduating class which would be—25 percent of 15,000——

Dr. HOLDEN. 3,750.

Mr. ROGERS. So that 125 figure is not too much out of line; wouldn't you agree?

Dr. HOLDEN. If that is the purpose, yes.

Mr. ROGERS. Then we are pretty well agreed on our goal of 125 percent which would take care of all of our graduates plus this foreign medical contingent.

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Now, if we can just determine a mechanism.

Dr. NESBITT. But the issue is so complex we are fearful of getting tied to a specific percentage.

Mr. ROGERS. We can give a little bit. What about 135 percent as a beginning number?

Dr. NESBITT. That is not necessarily the problem, defining the percentage. It is mentioning in all the others factors that must figure into how we do this, and to getting uniform licensing laws or uniform acceptance.

Mr. ROGERS. Should we have Federal licensure?

Dr. NESBITT. That is the wrong word. I did not mean that. That is the wrong reference entirely, Mr. Chairman.

Mr. ROGERS. We just fought that in a conference, you know.

Dr. NESBITT. Please strike that from the record. That is entirely the wrong term. That was a slip of the tongue.

Dr. HOLDEN. But there should be uniformity among State requirements.

Mr. ROGERS. How could that be accomplished?

Dr. HOLDEN. Through the Federation or State Medical Boards.

Mr. ROGERS. Could the profession do it through its accrediting and approval mechanism?

Dr. HOLDEN. No.

When it gets to licensure it is the Federation or State Medical Boards.

Mr. ROGERS. Have you made recommendations to them as to what the model should be?

Dr. HOLDEN. We have talked to them.

Mr. ROGERS. Have you outlined it? Have you given specifics?

Dr. HOLDEN. They have already, you see, a uniform examination except for two States. They are now in the process of—at their last meeting 3 weeks ago—urging the States to accept the same scoring procedures. If they do that then it will be uniform.

Mr. ROGERS. Will you let us have them, and we will ask each State if they are going to adopt those recommendations. Maybe we could help speed it along.

Dr. HOLDEN. I think if this is done through the Federation, coming from this committee, it will be additional incentive for those few States who do not adhere to standard scoring procedures.

Mr. ROGERS. How many do not?

Dr. HOLDEN. I cannot tell you.

Mr. ROGERS. Should we have a minimum requirement nationwide?

Dr. HOLDEN. Yes, I think so.

Mr. ROGERS. Do you see any problem with a minimum Federal requirement? A State could have stiffer provisions but it at least should assure the public a minimum. Do you see any real problem on that?

Dr. NESBITT. If we talk about the FLEX examination I see no problem.

Mr. ROGERS. Suppose we required that in the law. This minimum should be met. Would you let us have specifics?

Dr. NESBITT. Individual States have individual requirements.

Mr. ROGERS. That go above?

Dr. NESBITT. And some go below.

Mr. ROGERS. That is what we should try to prevent.

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Dr. NESBITT. Not much below.

Mr. ROGERS. I know, but we have to draw a line. And we are willing for those of you who are competent to do it.

Dr. NESBITT. There are problems in supervising the States laws and advisory boards, Mr. Rogers.

Mr. ROGERS. I understand that. We have done it in numerous provisions when we say "If you will meet a minimum requirement you do whatever you want above that". If you are going to increase the protection for the public go ahead, but at least all of the public because when you move to Tennessee or Florida, you should have confidence in basic protection.

Dr. HOLDEN. There is great leverage that the Federal Government has through reimbursement through medicare and medicaid.

Mr. ROGERS. This committee now has jurisdiction over medicaid. Why don't you give us specific recommendations on that. That would be helpful.

Dr. HOLDEN. It is not a terrible problem right now, Mr. Rogers. There is one State—for instance, the scoring for practically all States is 75 on the FLEC examination. There is one State that goes to 60.

Mr. ROGERS. What States are those?

Dr. HOLDEN. I cannot tell you.

Mr. ROGERS. Could you provide it for the record?

Dr. HOLDEN. The Federation can give you this information. But there are some that have 70 as a scoring. But there is no reason why—if this is a qualifying procedure—this is desirable.

Mr. ROGERS. It should be nationwide.

Dr. HOLDEN. It should be in every State the same.

Dr. NESBITT. But they need language requirements in addition to this. And there are other things we need to look at also.

Mr. ROGERS. I want counsel to check that.

You say the examination will be given in English. Will that do it?

Dr. COOPER. Written English they can read. The problem is understanding spoken English.

Mr. ROGERS. So it must go beyond the written.

Now let me get back to the points where we have agreed on what our goals should be. Can we get to some mechanism—you say you can recommend within a year what should be done.

Dr. HOLDEN. Yes.

Mr. ROGERS. Do you agree with that, Dr. Nesbitt?

Dr. NESBITT. I would have some reservation about that.

Mr. ROGERS. I see you cueing him back there, Doctor.

I want to know why it cannot be done now.

Dr. NESBITT. You want to know why it can't be done?

Dr. FENNINGER. I am not sure what you have in mind, Mr. Chairman.

Mr. ROGERS. I am going to let you tell me.

Dr. FENNINGER. And I don't know what will be acceptable to this committee.

Mr. ROGERS. Anything that will work.

Dr. FENNINGER. I think the evidence shows that, without any legislative intervention, current trends are moving in the very direction that the legislation proposes.

Mr. ROGERS. That is certaintly not indicated by the facts; all these

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unfilled residencies, 14,000 FMG's, too many surgeons. I don't see it working.

Dr. FENNINGER. I believe that the entrance into primary-care specialties is working as far as first-year figures are concerned. We cannot change the fields of all the people who have already entered a particular specialty and one cannot change the field of the practitioner. Secondly, as I understand the foreign medical graduate problem, few of the questions raised here this morning, I think, have considered fundamental questions. The first is that the United States has traditionally welcomed people to its shores if they wished to come.

Mr. ROGERS. We are getting information from the Department of Labor?

Dr. FENNINGER. The changes in the immigration statutes or the immigration amendments—in a sense—prior to the amendment of 1970 we said to a person coming to these shores that you can come to these shores but we will not guarantee you can remain in your same profession. The recent amendments seemed to assure a person that he could pursue his profession automatically. This was a profound change in U.S. policy and many of the dilemmas we face now stem from that change in immigration more so than the change that allowed people to go from exchange visitor visas to permanent immigrant status without leaving the United States.

It was the change that gave preferential admission to the United States for people on the basis of a profession that changed much of the relationship.

Mr. ROGERS. Supposedly on a national need, not on the basis of a profession.

Dr. FENNINGER. The national need was related to specific professions.

Dr. COOPER. The Department of Labor uses as their argument for opening up and giving special preference to the number of unfilled residency positions.

Dr. FENNINGER. That was the next thing I was coming to, the question of unfilled positions.

You will notice that there is a substantial increase in the projected number of positions to be offered in 1976. Our experience has been the actual number of positions that end up by being offered is substantially less than those projected. The estimates in the tables are based on a questionnaire which is distributed more than a year in advance.

They are returned at a time when hospitals have not developed their budgets. They do not know about their patient loads. They do not know what other programs may be carried out in association with another institution. These are essentially guesses and one cannot determine in any way whether or not any of these positions, the estimated number of positions will end up as budgeted positions offered to applicants for residency positions.

We know there has been a steady rise in the percentage of positions filled, in part related to the increase in the U.S. graduates. And when you look at the aggregate tables which you have just quoted, you are in fact looking at aggregate tables of positions in all years. The future is reflected the first-year tables, which is why the data were prepared in that way, since we cannot change what exists without changing the

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whole nature of the United States and the rights of people to choose their careers and choose where they live.

Mr. ROGERS. Do you know how many young people you don't even let get into medical college? I don't know what you mean by you are letting them choose. I get letters constantly: "I want to be a doctor. I cannot get in. I cannot choose my career."

Why? Because there are only so many slots. All of us would like to believe that Americans have the freedom to choose their profession. But as a matter of practice, every young person who wants to can't become a doctor.

Dr. FENNINGER. That is quite right. It is one of the slogans we use.

Mr. ROGERS. And I applaud it.

Dr. FENNINGER. I applaud the opportunity to try to choose and to aspire to a particular choice of field which is a better way of phrasing it. We have had a tradition of giving people the chance to aspire to a career and then to find out in the reality of the competition in life or in their own ability and interest that careers are cut off from them.

Mr. ROGERS. But we do not create a position for everybody that wants one.

Dr. FENNINGER. No, we do not create a position for everyone who wants one.

Mr. ROGERS. And that is what we are trying to say. Now, let's gear this—if we have 15,000 U.S. graduates and 4,000 foreign graduates—that may be a little high for foreign medical graduates.

Dr. HOLDEN. With 15,000 graduates we are talking roughly about 60,000 positions.

Mr. ROGERS. Of course, because we are using an increased population. So even there you begin to cut some and begin to direct where you really need it—but you, as I understand, are willing to do this but without our establishing the mechanism.

Dr. HOLDEN. We would prefer to devise our own mechanisms.

Mr. ROGERS. If you will present it, this committee will work with you. In fact, H.R. 2956 would allow you to devise your own mechanism. You can develop your own mechanism as long as you reach our goal which is 125 percent. We might even give on that percentage.

Dr. Nesbitt, if you could let us have your thinking—and I think we can do this just between ourselves. Now, the committee wants to be helpful but we need to have some movement.

Now, should it start with 135 percent in 3 years, then go down to 125 percent, or whatever you may recommend. In other words, can't you give us something specific to put in so we can be assured of some movement.

This House is asking the profession to do it before the pressures create such an atmosphere that we have to begin taking some of the Senate recommendations.

Now, we want you to help the committee and we are asking for some specific suggestions before we write a bill. I am convinced you can come up with something that can be reasonable in this legislation, and we ask you to do that.

I think a responsible profession must respond when there is a national need. We know the goal. Now, help us fashion the legislative response; and I think we can do it.

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We are very grateful to you for being here. I think this discussion has been helpful to the committee. We want to write this legislation quickly. So it would be helpful if you could look at the legislation and see what you could suggest to us. We are going to try to write this next week. I know that is putting an awful burden on you, but I think we have thought about this problem for 2 or 3 years now.

Look at the legislation and see how we could best work it out and give us some specific language which would be helpful.

I think we can make significant progress within the private sector framework, which we want to try to do.

I apologize for keeping you so long and to the reporter and my colleagues as well. I think it is well for us to conclude for now.

Are there any other statements?

Thank you so much. You are very kind and the committee will stand in recess until 2 o'clock, at which time we have other panels.

[The following statement and letters were subsequently received for the record.]

SUPPLEMENTARY STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

In testimony presented before the Committee on Friday, February 21, 1975, representatives of the American Medical Association, the American Board of Medical Specialties, the American Hospital Association, and the Council of Medical Specialty Societies opposed the provisions of H.R. 2956 which would mandate control of residency training programs by establishing a quota of positions not to exceed 125% of the number of graduates of schools of medicine for the year in which residency quotas were set, would require geographic distribution of programs and positions and would require quotas of positions by specialty as well. These were to be established in accordance with the Institute of Medicine study now underway and the study proposed in H.R. 2956.

The American Medical Association believes that the evidence presented in testimony, as well as the questions raised in testimony which are not answered by H.R. 2956 and were not answered in the hearing, clearly indicates that federal legislation to control the geographic and specialty distribution of residency programs is not warranted.

It was brought out that new data about all residency programs and "primary care" programs and positions are currently being gathered. The questionnaires have been sent to all residency programs to be returned in March, 1975 and that analyses of the 1974 data can begin at that time. We strongly urge that your Committee take no action with respect to federal legislation to control residency programs by geography and by specialty at this time and that it wait until the 1974 data are available.

If at that time the Committee still believes that the Congress must take action to provide federal control of the number, geographic location and specialty field of residency positions, an action which we oppose, then the following alternative mechanism might be considered to provide the least untoward interference with current trends.

No limit should be set on the total number of positions, for reasons given in the testimony presented on February 21, 1975, since choice of students, actions of third party payors and economic factors, as well as actions of professional bodies and hospitals, are already adjusting the total number of positions and their location and type of specialty. Any provisions of the bill relative to residency control should not take effect prior to July 1, 1978 at the earliest, and later if legislation is delayed. All evidence should be used in determining the need to implement the provisions at that time, and, if they are unnecessary on the basis of evidence, provisions should be made not to require the legislation to be activated.

Any responsibility and authority to determine by means established in the statute and regulations, the number of approved residency positions by region and by institutions and the number of approved positions in each of the specialties should reside in the Secretary of DHEW. In making his determination

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he should be advised by a National Advisory Council on Residency Training which would consist of the Assistant Secretary for Health, DHEW, the Assistant Secretary for Health and Environment, DOD, and the Administrator of the Veterans Administration—all to serve ex-officio without vote. In addition the Secretary is to appoint 16 members, 10 of whom shall be physicians involved in and knowledgeable of medical education, graduate medical education and provision of medical care, with at least two being doctors of medicine actively engaged in the private practice of medicine. The Secretary should appoint one member who is a physician in a residency program. The remaining 5 members should represent the public at large and persons knowledgeable in methods of payment for medical and other health services. The terms of the National Advisory Council members should be three years. In making these appointments the Secretary should be required to seek the advice of national organizations prominent in the health field.

The National Advisory Council is to advise the Secretary on broad policy matters relating to the needs and demands for health care, the resources required to meet these needs, the criteria on which such determinations are made, current resources available to meet needs for health care, means of expanding the resources and the priorities for such expansion, and standards of quality of graduate medical education and residency training as established by the recognized bodies currently approving such programs. The National Advisory Council, in developing its advice and recommendations to the Secretary, shall take into account such studies as have been done on graduate medical education, needs for health services, population distribution, availability of health services and methods of financing graduate medical education and shall seek the advice and counsel of the Coordinating Council on Medical Education.

In closing, we again stress that we believe legislation to be unwise and unnecessary and should not be adopted. If, however, the Committee decides to enact legislation, the allocation of positions should be based on the alternative method outlined above.

CASE WESTERN RESERVE UNIVERSITY,
SCHOOL OF MEDICINE,
Cleveland, Ohio, February 25, 1975.

Hon. PAUL G. ROGERS,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: The representatives of the five parent bodies of the Coordinating Council on Medical Education appreciated the opportunity to testify before your Committee on Friday, February 21, 1975. You indicated at the close of the meeting that the bill would be reported out of committee to the House next week and that you would welcome any constructive suggestions from the panel members.

There quite obviously is insufficient time to devise a formal statement that would represent a consensus of the five parent organizations. It therefore seemed reasonable for the individual members of the hearing panel to submit as they wish their thoughts to you with the complete understanding that they do not represent the official posture of either the Coordinating Council or any of the five parent organizations.

My own perspective of the situation is based upon a voluminous amount of information about the problem of the specialty and geographic distribution of physicians, a sensitivity to the realities of American medicine and medical education, a degree of pragmatism concerning what can be accomplished, and how quickly and effectively procedures for change can be implemented without creating an environment of intractable adversity.

As pointed out during the hearing on Friday, many of the changes that both you and organized medicine wish to see are already taking place; e.g., more and more graduating medical students entering residencies leading to careers in primary care, the percentage of foreign medical graduates in residencies in this country is becoming smaller, a relatively satisfactory distribution of the overall number of physicians in communities of 50,000 people and more, changing requirements of some of the specialty boards to attract more physicians into primary care, the rapid growth of residencies in family medicine, and many others.

By 1977, more than 60,000 residency positions will be required for only U.S. and Canadian graduates. I would always prefer to have a slight excess of

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residency positions than an inadequate number in order to preserve a competitive buyer's market which does a great deal in preserving and extending the standards of the graduate medical educational programs.

With the present trends evident and the already apparent commitment of organized medicine to resolve these problems I would suggest for your consideration that legislation relevant to physician manpower direct the Secretary of the Department of Health, Education, and Welfare to request from the Coordinating Council on Medical Education by one year from the enactment of legislation a report that contains the following information:

(*a*) The distribution of specialists and the physician population ratio by specialty in the regions established in the Health Planning and Resource Development Act of 1974.

(*b*) The relationship of U.S. medical graduates and foreign medical graduates in each specialty in the same regions identified in (a).

(*c*) The number of specialists graduating from residencies in each specialty and subspecialty in June, 1975, compared to June, 1972.

(*d*) The number of first year residency positions in each of the specialties in July, 1975, compared to July, 1972.

(*e*) The number of foreign medical graduates entering residencies in all specialties in July, 1975, compared to July, 1973.

(*f*) The effect of the CCME's report on The Primary Care Physician published in February, 1975.

(*g*) The action resulting from a discussion of the CCME's report on The Foreign Medical Graduate at the invitational conference to be held in April, 1975.

(*h*) Specific proposals for undertaking the correction of any deficiencies identified after accumulating the information required in items (a) through (g).

The proposal in effect gives organized medicine a year further to document the voluntary and spontaneous changes that are occurring and to devise whatever policy and/or action that may be required to achieve a reasonable resolution of the problems.

I am indeed grateful for your kind invitation to submit this statement and assure you if the responsibility for this matter remains with the medical profession, I will do my utmost to see that an effective program is generated.

With respect and best wishes,

WILLIAM D. HOLDEN, M.D.

COUNCIL OF MEDICAL SPECIALTY SOCIETIES
Chicago, Ill., February 27, 1975.

Hon. PAUL G. ROGERS,
House of Representatives, Chairman, Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce, Washington, D.C.

Dear Mr. ROGERS: On February 21, 1975, I presented before your Subcommittee on behalf of the Council of Medical Specialty Societies (CMSS) a statement in opposition to the advisability of direct governmental intervention in the numbers and distribution of residencies for graduate education in the United States under provisions of H.R. 2956. We opposed a quota formula not exceeding 125% of the graduates of schools of medicine in relation to the residency positions offered, because we believe that the market mechanism for achieving a striking reorientation of emphasis in graduate education has already begun to act and indeed has achieved, to a significant degree, the goals all of us are seeking. These goals embrace the ready availability of first-contact physicians in contrast to a previous state characterized by a relative excess of individuals exclusively engaged in secondary or tertiary specialist activity.

You are aware of the large numbers of candidates entering specialties providing primary care as well as the striking, recent increase in the number of residency programs in family practice which in 1975 provided 1271 first-year positions as contrasted to 766 the preceding year, an increase of 66%. These figures show a trend which is still moving upward at a time when the total number of residency positions in so-called primary care specialties has already reached nearly 50% of the aggregate number of residency positions.

During our discussion, after testimony on February 21, you indicated your willingness to consider a figure for first-year residency positions higher than the 125% mentioned in the current version of the bill. If we grant that such a

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quota system is necessary, let us apply it as a test to the figures for 1972, at which time there were 9551 U.S. medical graduates. 125% of this number would provide 11,939 positions. In contrast to this theoretical figure for 1973, there were in that year actually 18,076 filled first-year positions which represent 189% of the number of 1972 U.S. medical school graduates. Of the 18,076 filled residency positions in 1973, 7905 (44%) were in primary care specialties (general practice, family practice, internal medicine, pediatrics and obstetrics and gynecology).

Again, considering United States medical school graduates alone by 1980 there should be 15,000 graduates per year which, if the 125% figure were applied, would allow for 18,750 first-year residents. Allocating 50% of these residencies to primary care specialties, this would mean an increase of only 1400 first-year residency positions in primary care specialties by 1980. 15,000 graduates would represent a 57% increase over the number of graduates in 1972, but the increase in first-year primary care residencies would be only 19%.

To refine the figures for 1972 residency positions in primary care specialties, only 942 (12%) of the 7905 first-year positions were family or general practice residents, and 20% of these were foreign medical graduates. The other 88% of positions in the so-called primary care specialties offered substantial opportunities for further subspecialization in secondary specialties of internal medicine, such as gastroenterology, and the same opportunity and likelihood also exists in pediatrics. For these reasons and because of the inadequacy of predictions concerning such factors as career choice, it would appear that 175% of the number of graduates of U.S. schools of medicine would not be an unrealistic estimate of the total first-year residency positions necessary to avoid sudden, drastic disruption of available medical training and care. It would seem that a period of at least three years following passage of the legislation would be necessary before calling for its implementation. Provisions could be made to avoid its implementation if agreed upon goals should be reached by way of market mechanisms which are directed appropriately by organized medicine.

Assuming that the Secretary of HEW will be given statutory responsibility for determining the number and distribution of residencies, he would require the advice of a national advisory council on residency education. The national advisory council would provide the Secretary with policy recommendations concerning manpower needs, the criteria by which these needs were determined and the manner in which the needs might be met including standards of quality and patterns of education, as established under current regulatory auspices within the private sector. Undoubtedly, the residency review committees, in their cooperative relationship with the Liaison Committee on Graduate Medical Education, would play an important role in the individual determinations of both quality and performance by the residency educational programs.

The advisory council should seek the advice of those organizations which have long been engaged in the provision and the review of graduate educational programs, such as the American Board of Medical Specialties, the American Medical Association and the Council of Medical Specialty Societies. These bodies currently operate in direct relationship to residency programs, not only individually but in conjunction with the specialty boards and in cooperation with the overall supervisory body of the Coordinating Council on Medical Education.

Our testimony on February 21 emphasized our awareness of the need to provide primary care in the United States as well as appropriately refined total care which can only be carried out in an appropriate mixture of various specialties, both primary, secondary and tertiary. Both primary access specialties and other specialties are well represented in the Council of Medical Specialty Societies which provides a unique forum for studies, decisions and direction of total medical manpower resources.

In summary, while we feel that intervention by legislation to regulate the specialty numbers and distribution is not required, if it should be passed we feel that it should be realistically planned, with a substantial period of adjustment for at least several years before implementation to avoid chaotic dislocation of services and of careers in medical practice.

Sincerely yours,

C. ROLLINS HANLON, M.D., F.A.C.S.
President.

[Whereupon, at 1:30 p.m. the committee was recessed, to reconvene at 2:00 p.m. the same day.]

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After Recess

[The subcommittee reconvened at 2 p.m., Hon. Paul G. Rogers, presiding.]

Mr. Rogers. The subcommittee will come to order, please. We are continuing work on proposed legislation on health manpower and and nurse training.

This afternoon we start with a distinguished panel on remote-site training. For medicine the WAMI program is represented here by Dr. Robert L. Van Citters, who is dean of the School of Medicine, University of Washington, Seattle, Wash.

Dr. Roy Schwarz, associate dean, academic affairs, director of WAMI, University of Washington.

Mr. Glenn Wilson, associate dean, School of Medicine, director of AHEC program, University of North Carolina.

From osteopathic medicine, Dr. A. Archie Feinstein who is assistant dean for clinical training, Pennsylvania College of Osteopathic Medicine.

For dentistry, Dr. Dale F. Redig, dean, College of Dentistry, University of the Pacific, San Francisco.

We welcome each of you to the committee. Your statements will be made a part of the record in full if you would care to summarize and you may proceed as you wish.

STATEMENTS OF A PANEL ON REMOTE SIGHT TRAINING:

M. ROY SCHWARZ, M.D., ASSOCIATE DEAN, ACADEMIC AFFAIRS AND DIRECTOR OF WAMI, UNIVERSITY OF WASHINGTON; ACCOMPANIED BY ROBERT L. VAN CITTERS, M.D., DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF WASHINGTON;

GLENN WILSON, ASSOCIATE DEAN, SCHOOL OF MEDICINE AND DIRECTOR, AHEC PROGRAM, UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL;

A. ARCHIE FEINSTEIN, M.D., ASSISTANT DEAN FOR CLINICAL TRAINING, PENNSYLVANIA COLLEGE OF OSTEOPATHIC MEDICINE, IN BEHALF OF THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE; AND

DALE F. REDIG, D.D.S., DEAN, SCHOOL OF DENTISTRY, UNIVERSITY OF THE PACIFIC

Dr. Van Citters. Mr. Chairman, I am Robert Van Citters, dean of the School of Medicine, University of Washington. In previous testimony before your committee we described the principles and general operation of WAMI.

Mr. Rogers. I might say this committee has been most impressed with the WAMI program. I understand your purpose in being here today is to discuss quotas, results and your evaluation of the program.

Dr. Schwarz?

Dr. Schwarz. Would you prefer I not give you general background?

Mr. Rogers. You might just sum it up.

THE WAMI TERRITORY

Dr. Schwarz. WAMI stands for four States which are included in the WAMI territory, including the States of Washington, Alaska,

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Montana and Idaho. The territory contains 22 percent of the land mass of the United States. Covering five time zones, this large geographic area possesses slightly over 6 million people. By definition, therefore, it is a predominantly rural area of the United States and, as a consequence, its health care needs are predominantly rural in nature.

HEALTH NEEDS

Of the many health needs which the WAMI territory has, five stand out as being unusually significant. First, since the States of Alaska, Montana and Idaho do not have medical schools and cannot afford to build medical schools, there is a need for training opportunities in medical education for residents of these States.

Second, there is at this moment in time a shortage of primary care physicians in the WAMI territory.

Third, the primary care physicians in the WAMI territory are not generally located in the areas of greatest need, that is in the rural areas. In other words, the WAMI territory has a maldistribution of primary care physicians as is common to other sections of the United States.

Fourth, while there are sophisticated health education and health care resources available in the Medical Center in Seattle, there is a paucity of these resources in various communities in the WAMI territory. In an attempt to address the needs, the WAMI program was undertaken.

BASIC PREMISES

The basic premises on which the WAMI program was built are as follows:

(1) Since it is impossible to create a new medical school in the four Pacific Northwest and Alaska States, it is necessary to use existing faculty and facility resources if there is to be an increased number of training positions available for undergraduate medical students.

(2) By using facility and faculty resources in sites other than Seattle, the impact of an increased student load will be reduced in Seattle, and, as a consequence, an increased number of students can be trained with the existing faculty and facilities.

(3) In order to fully meet the need for primary care physicians in the WAMI territory, a curriculum in family medicine must be established which must include a pathway for training primary care physicians.

(4) In order to redress the maldistribution of primary care physicians, a number of steps must be undertaken. Included among these are:

A greater number of students in rural backgrounds must be admitted since greater numbers of students with rural backgrounds return to rural areas to practice than do students with nonrural backgrounds.

Exposure of students at various stages in their training to rural practice will result in greater numbers choosing rural sites for practice. This exposure should include experiences during the beginning of undergraduate medical education, late in the undergraduate training and during the residency or graduate training.

Once a physician is located in rural America and begins practicing,

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it is imperative that continuing education opportunities as well as consultative services be available if the physican is to be retained in these practice settings.

For a physician to be satisfied with a rural lifestyle, his or her spouse must also be satisfied with a rural existence.

FAMILY MEDICINE

Based on the above premises, the University of Washington School of Medicine in 1968 established a department of family medicine and staffed it with physicians who had delivered primary care in community-settings. In addition, the school of medicine revised its curriculum and established a pathway of study entitled "The Family Physician Pathway". The curriculum for this pathway was and is determined by the faculty members of the department of family medicine.

THE WAMI PROGRAM

The 1971 the University of Washington embarked upon a decentralized medical education experiment known as the WAMI Experiment in Medical Education. The objectives of the program were as follows:

1. Increase the numbers of residents from the WAMI States admitted to the University of Washington School of Medicine.
2. Increase the number of primary care physicians trained at the University of Washington.
3. Bring the resources of the medical center to communities throughout the WAMI States.
4. Accomplish the preceding goals without building new teaching facilities.
5. Redress the maldistribution of physicians in the WAMI territory.

It was anticipated that the WAMI experiment would be conducted with private and Federal support and if the experiment proved to be economically feasible, logistically possible, and educationally sound, that the participating States would assume the ongoing support of the program.

The WAMI experiment consists of two phases, the university phase and the community phase. In the university phase, students spend up to the first year of their medical school curriculum at four universities without medical schools including Washington State University in Pullman, Wash., the University of Alaska in Fairbanks, Alaska, Montana State University in Bozeman, Mont. and the University of Idaho, in Moscow, Idaho. Upon completing the first year of undergraduate medical education, the students then come to the University of Washington School of Medicine in Seattle for their second and third years of their undergraduate training.

During the fourth year, or during the "clinical phase" of the curriculum, students spend time in the community phase. This phase consists of 6-week clerkship experiences in various subdisciplines of medicine and at various sites in the WAMI States. During these 6-week experiences students are exposed to role models in the form of groups of physicians who are delivering high-quality medical care to the people in that area.

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In addition, students gain first-hand medical experience in diagnosing and treating disease, and in addition, gain knowledge of the structure and function of the community and the various roles which a physician and his family are required to assume in the community.

Mr. ROGERS. Is that in residency?

Dr. SCHWARZ. During residency and during undergraduate training.

Mr. Chairman, the thesis being that if you want to recruit more people for remote sites, for practice, you will enhance your chances by taking people from these remote sites, exposing them to remote sites early in their medical education, late in their undergraduate medical education, during their residency training, and then provide sustenance to them once they are out there in the form of continuing educational opportunities and in terms of consultative backup.

There is, I think, one other vital element in this which I had not heard mentioned this morning, and that is if you want a physician to go to a remote site and stay there, then his or her spouse must also want to go to a remote site and stay there. Hence, when the students and the resident goes out to practice the family unit goes with them so that they can experience what it is that they will encounter if they eventually set up practice there. I think that is a very important aspect of it.

Mr. ROGERS. There is no way you can use prescreening on that I presume.

Dr. SCHWARZ. No; I suggested to the Dean that we hold special social events that are limited to males and females with rural backgrounds to try to facilitate this but he has not acceded to this suggestion.

The performance of students who participated in WAMI program cannot be distinguished from other students on "common examinations" of course work taken separately, on performance in courses taken together or on external and on objective measures such as the National Board Examinations. It has been concluded, therefore, that the quality of the educational experience at these remote sites does not differ in a quantitative way from the experience received in the medical center.

Mr. ROGERS. How much time is actually spent away from the medical center? I think Dr. Carter is somewhat concerned about that and I wanted to get that clear.

Dr. SCHWARZ. Undergraduate medical education of a 4-year variety, the entire first year may be spent away.

Mr. ROGERS. In another university setting where he takes what basic courses?

Dr. SCHWARZ. Basic sciences, yes, sir. He returns to Seattle and spends the second and majority of his third year of training in the medical center in Seattle taking sophisticated integrated courses, basic clerkships in medicine, pediatrics, et cetera.

At that point then he may choose to spend 1, 2, 3 or 4, 5 or 6 weeks in clerkship experiences in the community.

Each of the clerkships is designed for 6 weeks. A student can take a multiple of these.

Mr. ROGERS. Clerkships in what?

Dr. SCHWARZ. Family medicine.

Mr. ROGERS. They can spend maybe a week——

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Dr. SCHWARZ. Up to 6 weeks.

I will give you an example. We have 14 of these community operations going at the present time. Six of them are in family medicine located in places such as Kodiak, Alaska; Kalispell, Mont.; Omak, and Grandview, Wash. All of these sites are places with 4,000 or 5,000 people. Students move to these sites and spend 6 weeks using as faculty, physicians who are in practice in these sites.

We have three more of these sites in internal medicine, three in pediatrics, one in obstetrics and one in psychiatry.

In each case they are spending at least 6 weeks in that community with our faculty on site there in a defined set of experiences.

Mr. ROGERS. So it would be a one or more basis.

Dr. SCHWARZ. More than that, two physicians to one student.

As a consequence, a student could spend up to between 30 and, say, 35 percent of his time maybe even 40, away from the medical center, but at least 60 percent of it would be spent at the medical school in Seattle.

We think the combination of these two experiences has the greatest impact on the student.

A second parameter in which they are usually interested is how many studies have you enrolled and has there been an increase from the rural States.

For the State of Washington, if you compare the 4 years before WAMI with the 4 years after WAMI, in the State of Washington we have admitted the 4 years before, 239 students and 396 after, which is an increase of 36 percent.

In the State of Alaska we had two students admitted in a 4-year period before WAMI. We admitted 20 since WAMI, or a tenfold increase.

In Montana it was 7 before and 24 after, which was a 300 percent increase.

In Idaho it was 7 before and 27 after or a threefold increase in the number of students.

This has all been done during experimental phase of the program and I think it gives us great confidence that as we go from experimental into on line programs that we can even make these numbers more impressive without compromising the quality of what the students are receiving.

We have had 120 students away from the University of Washington for the university phase or the first part of training. This year we have 12 students at the University of Alaska for the entire first year.

The students who started at a university without a medical school, are choosing, by a two to one margin, the family medicine pathway over the other pathways in our curriculum. This suggests that we are having an impact on the choice of ones career. The specific percentages are 62 percent of those students who started in the university phase are choosing family medicine as compared to 35 percent of their colleagues who started in Seattle.

In the community phase of WAMI, 242 students have spent at least one 6-week clerkship in each of our community's clinical units (CCU).

In addition we have had 47 residents in the various disciplines which I have described receive instruction at these sites.

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Since the initiation of the WAMI program, we have had three classes graduate and we have done studies to determine whether they have gone or where they anticipate establishing practices.

It is striking to us that three times as many students who have participated in the community phase of WAMI are now practicing or anticipate practicing institutions with populations of less than 5,000 than equivalent numbers of students who have not participated in the community phase of WAMI.

Again we think this bespeaks of the impact that we are having on students by exposing them to communities.

Mr. ROGERS. Are you finding they go back to their communities from which they came, or are they moving to different States, or what?

Dr. SCHWARZ. A little of both, sir.

The first six students that we had in the community clerican units and family medicine—of the first six, we have two of that are back to the universities in which they had part of their training. Four have set up practice, have been attracted back. So we have some going back to home communities, some going back to communities in the State of Washington, and some who are going back to communities in States other than their home State.

If you look at just those who chose the family medicine pathway, the ratio of choosing practices in small towns becomes four to one instead of three to one. So if they are in the family medicine pathway, the impact appears to be greater.

We have concluded therefore that a far greater percentage of students who participate in the community phase of WAMI anticipate setting up practices or have established practices in small towns than do their counterparts who have not participated in this program.

The final piece of data available concerns what happens to graduates of our family residency program which is conducted in part in Seattle and part in remote WAMI sites.

To date, 17 residents have graduated from the family medicine residency program. Of these, nine are practicing in rural towns of 5,000 or less in Washington, Montana, Alaska, or Idaho. Two more are in the military. Two have assumed teaching positions and four are practicing in metropolitan settings.

In June of 1975, 19 additional graduates will complete this residency program. At the present time, 7 of these 19 are scheduled to practice in rural areas. 2 more will join the military, one of which will be assigned to a rural military installation in the State of Washington. Three anticipate setting up practices in metropolitan areas, and 7 at this moment in time remain undecided as to where they will locate.

Thus, of the 29 residents who have completed the family residence program and have made practice plans, sixteen, or 55 percent are practicing in rural America, as defined by towns of 50,000 or less. Four or 13 percent are in military programs. Two, or 7 percent are on academic faculties and 7 or 24 percent are practicing in metropolitan settings. In short, the residents who have been exposed to the university medical centers as well as rural communities in their training are choosing to practice in small rural communities in the Pacific Northwest by a ratio of 2 to 1.

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In summary, then, based on the data which is presently available, it can reasonably be concluded, we think, that decentralized medical education can be conducted in sites remove from major medical centers without compromising the quality of the educational product. In addition, by capitalizing on the faculty and facility resources in these sites it is possible to increase the total enrollment of the medical school without requiring new "bricks and mortar" and as a consequence, provide additional expense for students with rural backgrounds.

By exposing these students to rural medicine early and late in their undergraduate training and as a resident, it can be expected that a significant percentage will choose to set up in practice in the rural settings or in the areas of need. Such a program, we believe, cannot be conducted without the resources of a major medical center to provide backup and assistance. As such, all five goals of the WAMI program have been or are at the present time being met.

[Dr. Schwarz' prepared statement follows:]

STATEMENT OF M. ROY SCHWARZ, M.D., ASSOCIATE DEAN FOR ACADEMIC AFFAIRS AND DIRECTOR OF WAMI, UNIVERSITY OF WASHINGTON

It is a pleasure to once again be able to testify on the general subject of the production of health manpower and its relationship to health care delivery. More specifically today, I wish to provide you with a brief review of a decentralized experiment in medical education which has been conducted in the Pacific Northwest and Alaska and is known as the WAMI Program.

THE WAMI TERRITORY

The WAMI Territory, which includes the states of Washington, Alaska, Montana and Idaho, contains 22 percent of the land mass of the United States. Covering five time zones, this large geographic area possesses slightly over 6 million people. By definition, therefore, it is a predominantly rural area of the United States and, as a consequence, its health care needs are predominantly rural in nature.

HEALTH NEEDS

Of the many health needs which the WAMI territory has, five stand out as being unusually significant. First, since the states of Alaska, Montana and Idaho do not have medical schools and cannot afford to build medical schools, there is a need for training opportunities in medical education for residents of these states. Second, there is at this moment in time a shortage of primary care physicians in the WAMI territory. Third, the primary care physicians which are present in the WAMI territory are not generally located in the areas of greatest need, that is in the rural areas. In other words, the WAMI territory has a maldistributoin of primary care physicians as is common to other sections of the United States. Fourth, while there are sophisticated health education and health care resources available in the Medical Center in Seattle, there are a paucity of these resources in various communities in the WAMI territory. In an attempt to address these needs, the WAMI Program was undertaken.

The basic premises on which the WAMI Program was built are as follows:

1. Since it is impossible to create a new medical school in the four Pacific Northwest and Alaska states, it is necessary to use existing faculty and facility resources if there is to be an increased number of training positions available for undergraduate medical students.

2. By using facility and faculty resources in sites other than Seattle, the impact of an increased student load will be reduced in Seattle and, as a consequence, an increased number of students can be trained with the existing faculty and facilities.

3. In order to fully meet the need for primary care physicians in the WAMI territory, a curriculum in Family Medicine must be established which must include a pathway for training primary care physicians.

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4. In order to redress the maldistribution of primary care physicians, a number of steps must be undertaken. Included among these are:

(*a*) Greater numbers of students with rural backgrounds must be admitted since greater numbers of students with rural backgrounds return to rural areas to practice than do students with normal backgrounds.

(*b*) The exposure of students at various stages in their training to rural practice will result in greater numbers choosing rural sites for practice. This exposure should include experiences during the beginning of undergraduate medical education, late in the undergraduate training and during the residency or graduate training.

(*c*) Once a physician is located in rural America and begins practicing, it is imperative that continuing education opportunities as well as consultative services be available if the physician is to be retained in these practice settings.

(*d*) For a physician to be satisfied with a rural life style, his(her) spouse must also be satisfied with a rural existence.

FAMILY MEDICINE

Based on the above premises, the University of Washington School of Medicine in 1968 established a Department of Family Medicine and staffed it with physicians who had delivered primary care in community settings. In addition, the School of Medicine revised its curriculum and established a pathway of study entitled "The Family Physician Pathway". The curriculum for this pathway was and is determined by the faculty members of the Department of Family Medicine.

THE WAMI PROGRAM

In 1971, the University of Washington embarked upon a decentralized medical education experiment known as the "WAMI Experiment in Medical Education". The objectives of the Program were as follows:

1. Increase the number of residents from the WAMI states admitted to the University of Washington School of Medicine.
2. Increase the number of primary care physicians trained at the University of Washington.
3. Bring the resources of the medical center to communities throughout the WAMI states.
4. Accomplish the preceding goals without building new teaching facilities.
5. Redress the maldistribution of physicians in the WAMI territory.

It was anticipated that the WAMI experiment would be conducted with private and federal support and if the experiment proved to be economically feasible, logistically possible and educationally sound, that the participating states would assume the ongoing support of the Program.

The WAMI Experiment consists of two phases, the University Phase and the Community Phase. In the *University Phase*, students spend up to the first year of their medical school curriculum at four universities without medical schools including Washington State University in Pullman, Washington, the University of Alaska in Fairbanks, Alaska, Montana State University in Bozeman, Montana and the University of Idaho in Moscow, Idaho. Upon completing the first year of undergraduate medical education, the students then come to the University of Washington School of Medicine in Seattle for their second and third years of their undergraduate training.

During the fourth year; or during the "clinical phase" of the curriculum, students spend time in the *Community Phase*. This Phase consists of six week clerkship experiences in various subdisciplines of medicine and at various sites in the WAMI states. During these six week experiences, students are exposed to role models in the form of groups of physicians who are delivering high quality medical care to the people of that area. In addition, students gain first hand medical experience in diagnosing and treating disease, and in addition, gain knowledge of the structure and function of the community and the various roles which a physician and his family are required to assume in the community.

In addition to the undergraduate medical students, graduate physicians, or "residents", who are in residency training programs, spend from six weeks to two months in the remote sites. The objectives of the residence experience are essentially the same as those of the students. Because of the important role that is played by the spouse of a physician in reaching the decision as to where to practice, the spouses of both undergraduate medical students and residents are

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also sent to the community and university sites. To date, fourteen Community Clinical Units exist in the following disciplines:

1. Family Medicine—Kodiak, Alaska, Whitefish-Kalispell, Mont., Anacortes, Grandview, Omak, and Whidbey, Wash.
2. Internal Medicine—Billings, Mont., Missoula, Mont., and Wenatchee, Wash.
3. Obstetrics and Gynecology—Boise, Idaho.
4. Pediatrics—Pocatello, Idaho, Great Falls, Mont., and Spokane, Wash.
5. Psychiatry—Anchorage, Alaska.

Finally, the WAMI Program envisions a continuing medical education program in which faculties from the medical center make periodic visits to the community where they review the progress of the students and the residents, serve as consultants to the physicians of the Unit and provide continuing medical education opportunities for the health professionals in the area. In a reciprocal fashion, the community based physicians will come to Seattle at least four times during the year for educational and administrative purposes.

In short, students with rural backgrounds are admitted to medical school and are assigned to universities in the rural parts of the States. Through "preceptorships" in these Universities, they are exposed immediately after they enter medical school to the delivery of primary care in rural areas. Returning to Medical School, they become part of a major, scientific medical environment. During their fourth year they again return to rural communities where they are once again exposed to the delivery of primary care. Finally, during their residency or graduate training, they once again participate in educational experiences in rural communities.

RESULTS TO DATE

1. *Quality of Education*

Students who have participated in the WAMI Program cannot be distinguished from other students by "common" examinations on course work taken separately, on performance in courses taken together or on external objective measures of performance such as the National Board Examinations. It has been concluded, therefore, that the "quality" of the educational experience at these remote sites does not differ in a quantitative way from the experience received in the medical center.

2. *Numbers of Students Admitted*

When the number of students enrolled in Medical School in the four years prior to the advent of the WAMI Program is compared to the number enrolled in the four years since the Program began, the following emerges:

(*a*) *Washington.*—293 before, 396 after—from an average of 73 students the year before to an average of 99 after; an increase of 36%).

(*b*) *Alaska.*—2 before, 20 after—(from an average of ½ student a year before to an average of 5 students per year after; an increase of 900%).

(*c*) *Montana.*—7 before, 24 after—(from an average of 1.8 students the year before to an average of 6 students per year after; or an increase of 193%).

(*d*) *Idaho.*—7 before, 27 after—(from an average of 1.8 students per year before to an average of 6.8 after; an increase of 286%).

In short, even during the experimental phase of the Program, an increased number of students have been admitted from all states and especially from those states which are predominantly rural in nature.

3. *University Phase Training*

Since the advent of the WAMI Program, 120 students have received instruction in the University Phase. Included were 9 students in the 1971–72 school year, 29 students in the 1972–73 school year, 40 students in the 1973–74 school year and 42 students in the 1974–75 school year. Of these, 30 students have been trained at Washington State University, 41 at the University of Alaska, 20 at Montana State University and 29 at the University of Idaho.

4. *Choice of Pathways*

The students who have participated in the University Phase of the WAMI Program have chosen the Family Physician Pathway of the undergraduate medical school curriculum by nearly a two to one margin over students who begun medical school at the University of Washington in Seattle. This is reflected in the 62% of the WAMI students who have chosen the Family Physician Pathway as compared to 35% of the students who began their medical education in Seattle.

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5. Community Phase

Since the advent of the Community Phase of the WAMI Program in 1971, a total of 242 students have received instruction in the Community Clinical Units. An additional 47 residents have also received instruction in these sites. Included among this total are 158 students and 18 residents in Family Medicine, 8 students and 12 residents in Internal Medicine, 36 students in Obstetrics and Gynecology, 32 students and 15 residents in Pediatrics, and 8 students and 2 residents in Psychiatry. Of the students who have participated in the Community Phase of the WAMI Program and graduated in 1972, 1973 and 1974, three times as many students anticipate practicing or are now practicing in towns with populations of less than 5,000 as compared to students who have not participated in the Community Phase of WAMI. Focusing only on those students who have chosen the Family Physician Pathway, one finds that 24.6% of the students anticipate practicing or are practicing in towns of less than 5,000 as compared to 6.1% who are not in the Family Physician Pathway and who plan on practicing in towns of this size. It can be concluded, therefore, that a far greater percentage of students who participate in the Community Phase of the WAMI Program anticipate setting up practices or have established practices in small towns than do their counterparts who have not participated in the Program.

6. Products of the family medicine residency program

To date, 17 residents have graduated from the University of Washington Family Medicine Residency Training Program. Of these, nine are practicing in rural towns of less than 5,000 people in Washington, Alaska, Montana or Idaho. In addition, two are in the military, two have assumed teaching positions and four are practicing in the metropolitan settings.

In June, 1975, 19 additional graduates will complete the Program. At the present time, seven of these 19 will practice in rural areas, two will join the military (one will be assigned to a rural military installation in the State of Washington) and three anticipate setting up practices in metropolitan Seattle. Seven remain undecided as to where they will locate.

In summary, of the 29 residents who have either completed the Program or who have made practice plans, 16, or 55%, are practicing in rural America, four, or 13%, are in military programs, two, or 7%, are on academic faculties and seven, or 24%, are practicing in metropolitan settings. In short, these residents who have been exposed to University Medical Centers as well as rural communities in their training are choosing to practice in small rural communities in the Pacific Northwest by a ratio of two to one.

SUMMARY

Based on the data which is presently available, it can be reasonably concluded that decentralized medical education can be conducted in sites remote from major medical centers without compromising the quality of the educational product. In addition, by capitalizing on faculty and facility resources in these remote sites, it is possible to increase the total enrollment of the Medical School and, as a consequence, provide additional access for students with rural backgrounds. By exposing these students to rural medicine early and late in their undergraduate medical education and as residents, it can be expected that a significant percentage of the products will choose to set up and practice medicine in these rural settings. Such a Program, however, cannot be conducted without the resources of a major medical center to provide back-up and assistance to this decentralized effort. As such, all five of the goals of the WAMI Program have been or are being met.

Mr. ROGERS. Thank you very much. That is a very impressive report, and we are delighted to have these current statistics.

Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman. I am very much interested in the program. After 4 years of training in your combination of schools, then the student has an internship; is that correct?

Dr. SCHWARZ. That is correct, right.

Mr. CARTER. Is that entirely in one of the hospitals in Seattle or Anchorage?

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Dr. SCHWARZ. Yes. At this point in time it is, "Yes."

Mr. CARTER. What hospitals, particularly?

Dr. VAN CITTERS. We have an affiliated residency and internship program that involves, I believe, a total of 31 institutions throughout the four States.

Mr. CARTER. Yes.

Dr. VAN CITTERS. The bulk of them are in the specialty areas, I mean the bulk of the specialty training takes place in Seattle, but we have residents in, for instance, Spokane, Washington and Anchorage, Alaska, and as I also said, we also send the residents for a short time to the 13 community clinical units we have mentioned.

Mr. CARTER. During those 3 years, they have continual exposure in the satellite areas; is that correct?

Dr. VAN CITTERS. Yes.

Dr. SCHWARZ. Right.

Mr. CARTER. About their continuing education in the senior year, when they are with two physicians say on Kodiak.

Dr. SCHWARZ. Right.

Mr. CARTER. They have examinations on their clinical work there?

Dr. SCHWARZ. The students?

Mr. CARTER. Yes.

Dr. SCHWARZ. Yes.

Mr. CARTER. How do you accomplish that?

Dr. SCHWARZ. Once every 6 weeks, which is a period of time the student is there for, one of our faculty members will go up to review the progress of the student, present oral evaluations, and so forth. As a consequence, we have a continuous monitoring of the students by our own faculty based in Seattle.

Secondly, we take on as our clinical faculty those practitioners in Kodiak that are delivering this educational care. At the end of every 6 weeks they provide us with a more extensive evaluation of the students than our own faculty do at home base.

So that is two ways that we have this aspect monitored. I would also add that when our faculty go to Kodiak, not only do they review the progress of the students and the residents, but they also serve as consultants to the physicians there and may also give a public lecture for all the people, or anyone who is interested in venereal disease or tuberculosis or what have you.

That is one way we are bringing continuing education, medical education from the medical center to the community.

Mr. CARTER. How many physicians do you have at Kodiak?

Dr. SCHWARZ. Four at the present time.

Mr. CARTER. Four?

Dr. SCHWARZ. Right.

Mr. CARTER. Yes. And what is the population of Kodiak Island?

Dr. SCHWARZ. Kodiak Island, surrounding area that it serves is about 8,000 people.

Mr. CARTER. 8,000 people?

Dr. SCHWARZ. Right.

Mr. CARTER. About the internship and residency program, what portion of that is spent in the field?

Dr. SCHWARZ. Three years; a half, one-sixth.

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Mr. CARTER. One-sixth of the internship and residency?
Dr. SCHWARZ. Right.
Mr. CARTER. Of the 3 years?
Dr. SCHWARZ. Right.
Mr. CARTER. Thank you, Mr. Chairman.
Mr. ROGERS. Do you have any questions, Mr. Hefner?
Mr. HEFNER. No; I don't, Mr. Chairman.
Mr. ROGERS. Thank you very much.

Now we have Mr. Glenn Wilson, who is associate dean, School of Medicine, director AHEC program, University of North Carolina. We are pleased to have three members from the State of North Carolina on our committee now, so things will be heavily weighted for North Carolina, I can see that.

Congressman Hefner is already turning out to be a very effective member who is attending all of the sessions. We look forward to great accomplishments on his part. Mr. Hefner?

Mr. HEFNER. Well, I would just like to thank Professor Wilson for being here because I think he represents one of the greatest medical schools in the country. Of course, I may be a bit prejudiced, but I don't think so. I am sure his statement is going to be very enlightening, and I just want to thank you, sir, for all the great work that you are doing at the University of North Carolina and for turning out well prepared medical personnel. They mean so much not only to the State of North Carolina, but to the whole country. We want to thank you for coming today.

STATEMENT OF GLENN WILSON

Mr. WILSON. I guess for the record, Mr. Chairman, I should give my name and after your nice words and those of Mr. Hefner I think I should quit.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Did you say he was from Duke or the University of North Carolina?

Mr. ROGERS. You really know how to hurt a man.

Mr. WILSON. I will say that Duke is participating in the program, however, Congressman. I want to take a moment to make a couple comments other than directed to the AHEC program, because there seems to be agreement that health care is the right of every citizen, but we are finding that it is more difficult to do than it is to declare it. We have no objective evidence to measure what is needed.

There was a rather obscure French economist, J. B. Say, who said that "supply creates its own demand," and I would suggest to the committee there is enough evidence of that in the health field to raise a few flags of caution.

In looking at the data, by 1990, we will have 593,000 active physicians. We have now 1,329,000 active health professionals, and about 2.7 million nonprofessional personnel.

If we continue to produce people in the rate we are at the moment, my estimate is that we will have 7½ percent of the American labor force in 1990 in the provision of personal health services.

Mr. ROGERS. What was that percentage again?

Mr. WILSON. About 7½ percent, Congressman.

Now, we can make these projections, but I would suggest that if the

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financial support to the institutions is reduced, that we are not likely to meet the projection, so I think that when we get into that arena, as I gather the Secretary did yesterday, I am not sure our projections will hold if we cut the support.

Mr. CARTER. Mr. Chairman, may I ask a question?

Mr. ROGERS. Certainly.

Mr. CARTER. You say there will be 593,000 physicians, if we continue to produce them as we are today, in 1990? Is that correct?

Mr. WILSON. That is correct.

Mr. CARTER. And what will the population of our country be at that time?

Mr. WILSON. About 250 million.

Mr. CARTER. 250 million, yes.

Mr. WILSON. About one physician for every 450 persons, or thereabouts. It is a very complicated arena, though, Congressman, as you well know, because active physicians are not patient care physicians, and we have some problems of definition.

But to look at it another way, if all are active in patient care, we will have capacity to produce about 3 billion doctor office visits per year. That would be about 12 visits per person per year, not quite three times what we are currently doing.

I am not suggesting that is too many. I would suggest to the Congress, however, that action in producing personnel makes short- and long-term commitments, action in financing make other kinds of commitments. There seems to us at least an urgent need for somebody to be bringing these two areas together.

National health insurance or other financing mechanisms will generate demand for services which may not be realized if there aren't adequate personnel.

Personnel may put stress on the financing machinery. It is our conclusion that there needs to be some kind of unified national health policy group to look at these projections, to look at the financing implications and economic consequences of it.

Mr. ROGERS. Who should be on that group? Maybe you would like to submit that for the record. Would you like to do that?

Mr. WILSON. Yes. I think that I have no difficulty with the responsibility and the authority of the Congress to address those questions, Mr. Chairman.

Mr. ROGERS. All right.

Mr. WILSON. I think the public policy will have to be set by the Congress, and that the private and public institutions would then respond to the policy declarations and the goals set by the Congress.

Mr. ROGERS. Thank you.

Mr. WILSON. The Nation is focused on the distribution of physicians. If you look at physicians and their distribution, they are not distributed much differently than other professionals in our society. In the context that rural people, inner city people lack a number of services, they also lack physician's services.

The point that we think is observable in our rural State is that we are not simply talking about physicians; but you are talking about nurses, dentists, public health workers, allied health personnel pharmacists, and the whole gamut of personnel.

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It is unlikely, in our judgment, to have physicians in an area where there is an inadequate supply of other kinds of personnel. And I think that if we do this directed only at physicians and don't have a coordinated effort that we are not likely to find very happy physicians in those areas, or those that will stay because the professional environment will be particularly sterile.

I would like to turn to one proposal that is currently before the Congress, fortunately not before this committee, and that is the compulsory National Health Services Corps.

I would say at the outset that we don't find that a very attractive alternative. Particularly under the current regulations and under the Senate proposal at the end of 1 year postgraduate training the obligated service would begin. No one would seriously argue today that 1 year of postgraduate training is satisfactory, therefore, it is reasonable to predict after they finish obligated service they will return to health science center to complete their residency.

We think people of North Carolina deserve better than itinerate and indentured servants. I would like to make the observation that other countries in the world have tried to conscript physicians and we are not aware of evidence that produced quantity or quality people.

Mr. ROGERS. Do you have any objection to joining the National Health Services Corps voluntarily?

Mr. WILSON. Absolutely not.

Mr. ROGERS. You are just saying not to conscript, not to draft?

Mr. WILSON. Yes.

Mr. ROGERS. Thank you.

Mr. CARTER. Mr. Chairman, on that very thing I do not know of anyone who has proposed that on this side.

Mr. ROGERS. No, I think he was referring to the Senate bill from last year.

Mr. CARTER. This is a Senate provision, of course?

Mr. WILSON. Yes. I recognize that I am addressing the other body's issue.

Mr. CARTER. Yes.

Mr. WILSON. But if the committee will indulge us.

Mr. ROGERS. But you want us to stand firm against that?

Mr. CARTER. We like what you are saying; go right ahead.

Mr. ROGERS. I agree.

Mr. WILSON. Well, I think there are certain additional questions to the National Health Services Corps' proposal, on a compulsory basis. It places the responsibility for solving the national problem on the back of the student. The administration and faculty of an institution can essentially continue in its existing pattern and have no authority, or no obligation for that matter, which has been declared a high national priority. And we believe the Health National Service Corps if they have 3 years to finish their primary care residency can play an important part. And voluntarily we think the numbers who enroll will be substantial.

We can tell you from our student body that a number have not enrolled because they were going to be obligated for their service after 1 year of resident training.

If it is the ultimate decision to require compulsory service for

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physicians, which we oppose, but if that is the final solution, at a minimum it should include all health personnel.

If you are going to require physicians to serve in the underserved areas, then we should take the nurses and the dentists and the pharmacists and all the rest of them out there, and that might have a better return.

I want to repeat, we are opposed to the proposal, but if you do it, we hope it will be for everyone, not just physicians.

Mr. CARTER. Mr. Chairman, let's include lawyers, too.

Mr. WILSON. I would be happy, Dr. Carter, to support the Student Medical Association proposal that if the Congress wants to draft all young people for public service they would be happy to join; but they don't feel that just tackling the problem of physicians.

So I would be happy to support their position on that, which would include lawyers.

Mr. ROGERS. Well, now, I think I understand what you are saying, but I want to make inquiry. You have no objection to the present setup of a National Health Service Corps, do you?

Mr. WILSON. One problem, Mr. Chairman.

Mr. ROGERS. That would be active duty after a year's residency?

Mr. WILSON. Yes.

Mr. ROGERS. In other words, you think they should finish residency before they begin service?

Mr. WILSON. And your bill last year very nicely encompassed cleaning that position up.

Mr. ROGERS. Yes. So you have no objection to operating a National Health Service Corps, except you would have it activated as far as service after the complete term of residency?

Mr. WILSON. If they go into a primary care residency.

Mr. ROGERS. If they go into primary care residency?

Mr. WILSON. Yes.

Mr. ROGERS. What if they don't go into primary care residency?

Mr. WILSON. I would have no position on that. But if they would have to do their obligated service after the first year, I wouldn't worry too much about it.

Mr. ROGERS. I see what you mean.

Mr. WILSON. I would put an additional carrot on that if I were writing legislation.

Mr. ROGERS. I see. Thank you.

Mr. WILSON. Now, the Comprehensive Manpower Training Act of 1971 had another approach to the distribution program, and that is the AHEC program. There were 11 funded programs in the country, and I think the experience of these 11 programs has been salutary in their accomplishments.

I don't think necessarily my remarks will represent all 11 programs, but I would certainly like to make clear to the committee that they have worked very well and have been one of the most successful programs.

The primary objective of the program is to improve the quantity, quality, and distribution of all health personnel by geography and by specialty.

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There are some unique features why this has worked. The responsibility and authority for carrying out the program was clearly placed on the medical schools.

During the debate of writing the regulations under that act there was some discussion as to which Federal agency would supervise the program. And one agency proposed that we set up new free-standing organizations which would have the authority, and they would then contract with medical schools and other health science institutions for specific programs and specific activities.

It was our position at that time, and history has reinforced our position, that to place the responsibility in one institution, that is, the medical school or health science school, and give the authority to get another, has significant problems.

Responsible educational institutions can pick and choose those activities for which they will apply for funds. They can pick and choose which counties they want to work in; they have no total responsibility if the authority is placed with a newly formed organization. The program never becomes an integral part of the institutional activity priority lists since it lacks the authority and has no obligation except for what it elects to do.

So that we think the formulation which was in the House bill last year is highly desirable and terribly important if the AHEC program is to succeed.

After we were awarded the contract by the National Institutes of Health, the board of governors of the University of North Carolina and the North Carolina General Assembly appropriated $28.5 billion. $23.5 million of that was to build educational facilities at community hospitals across North Carolina and to build nine area health education centers in the State.

The balance was to support residency positions and to strengthen and expand the program. We have provided by contract with these clinical resources a great measure of regional autonomy. We expect the clinical resources—the AHEC—to develop a variety of training programs and not only train them in their institution. They must assume by virtue of being designated as a AHEC responsibility for graduate, undergraduate, and continuing education for all health personnel for several counties.

We think that it will very nicely serve the entire State. Given the clear lines of authority and responsibility, to the university and then to the regional hospitals, and they in turn to educational institutions in their region, we have a substantial amount of promise that the program can have some impact.

We, first of all, demonstrated with these clear lines of authority and performance contracts that the academic medical centers, regional hospitals, educational institutions in the region, practicing physicians and other health personnel can work together and get a job done.

Last year 10 percent of all of our third and fourth year teaching for medical students was done off the campus. In each AHEC we anticipate that there will be 6 to 10 full-time faculty members appointed by our faculty in Chapel Hill and approved by the local hospital who will provide the core of this teaching.

Certainly the local physicians play a very important role, but they do have practices to attend to. And we have full-time people in nursing

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to organize the resources at the region for nurses education and the same in dentistry, each region has its own staff.

Our students are going out for about 1 month rotations in medicine, pediatrics, obstetrics, psychiatry, and family medicine. Our faculty is convinced, and our AHEC's are convinced that there must be a balance between medical centers and the activity in the educational experience in the community.

All of our dental students and pharmacy students will receive about 6 weeks of their senior year off the campus at this point.

Public health and nursing are doing the same kinds of things with their students, not in hospitals but with agencies in the regions.

Now, some have prejudged this situation, and assert that this training will be inferior, and our evidence is the same as WAMI. Our students when matched by admitting scores to medical school class standing before they take their program off the campus, those who take all their training off the campus score equally well as those who take all their training on the campus.

But we do believe that it is terribly important in our arrangement to have full-time faculty to provide the educational experience, monitoring, and interaction between our faculty in Chapel Hill, our faculty in the AHEC, and practicing general physicians.

The North Carolina General Assembly authorized and appropriated funds to support 300 new residencies. We are actually paying the residency stipend. All of these will be in primary care, and by 1979 half of our residencies in each will be primary care, if the definition is medicine, pediatrics, obstretrics, and the rest.

Mr. ROGERS. How many in family medicine?

Mr. WILSON. Twenty-five percent, Mr. Chairman. We anticipate affiliated but reasonably independent family residencies in all nine of our AHEC's in this decade.

We will also have internal medicine and perhaps pediatrics. And we will be rotating medicine, obstretrics, and psychiatry from the family medical series.

In addition to what we are doing it certainly is not just Chapel Hill, the Bowman Gray School of Medicine has assumed total responsibility for 17 northwestern counties in North Carolina and the Duke Medical School is currently looking at one or two AHEC's for which they will assume responsibility.

In three of our more developed regional centers we have created a professional environment to indicate pretty clearly that the program does work, and that we are able to retain people. And we have some limited evidence of new recruiting.

We have been involved in a variety of programs like training laboratory technicians, nursing personnel, inhalation therapists. We are deeply involved in training of dietary personnel for nursing homes and small hospitals.

We have a number of small hospitals in North Carolina of less than a hundred beds. There is a single school of public health in North Carolina and they have an off-campus program in Asheville to serve that area.

For 3 years they will train students in Asheville. We will discontinue the program at the end of 3 years on the assumption that we

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have met that regional need. We will then move it to one of the other AHEC's, and move it around the State to offer full-fledged MPH programs without building new schools.

Nurses refresher courses for active nurses have been held in three regions, and out of 40 nurses who attended those courses 20 are back at work after 6 months.

We have certainly a number of inactive nurses in the State and in the country, which we think will be very helpful in getting the nurses into the working pool. We have had at Chapel Hill for sometime a family nurse practitioner program. We have set up one family nurse practitioners program in one AHEC, and we plan this year to have two additional family nurse practitioner training programs in the State. We think three will serve the entire State in terms of its needs.

Mr. ROGERS. Well now, does the school of nursing direct those programs, or is that done by the medical college?

Mr. WILSON. It is a joint venture in Chapel Hill between nursing medicine and the school of public health. But because we believe very strongly in regional responsibility, our program is being given to a nursing school in a region and the faculty to run that program will be given to them, and we will simply be available to provide technical assistance as called upon.

Mr. ROGERS. We got the impression during our hearings before that the nurses felt the responsibility for competency should lie at the door of the nursing school, rather than the medical school.

Mr. WILSON. We have a very harmonious, happy relationship among the three schools, Mr. Chairman.

Mr. ROGERS. That is good to know.

Mr. WILSON. And I don't believe that anybody has felt intimidated by working jointly together on this activity. And the medical faculty will work together with these programs with no problems.

Mr. ROGERS. That is fine.

Thank you.

Mr. WILSON. We do not have definition data that shows the impact in personnel. We could give you tons of information about the impact on other personnel, but on physicians it is very difficult for us as we try to monitor the program on the impact. We have a lovely community of Wilmington, N.C., with a marvelous hospital. They have recruited in 18 months 27 new physicians. Twenty-two of those physicians asked if they would be able to participate in educational programs.

Now, did AHEC bring them there? I would not say that. We had some impact. They have a good hospital. The ocean is right handy, so we find it difficult to factor out whether or not we made the difference.

We clearly have been able to recruit faculty, physicians who are not on our faculty who have come to this region because they want to participate in medical education programs. We have recently recruited five physicians for Fayetteville and all of those came there primarily because of the AHEC program.

By 1980 we anticipate that we will have 180 medical students off the campus all the time from the three medical schools in North Carolina. We have 300 new primary care residency positions who will be there. We will be training a thousand allied health personnel, 80 dental stu-

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dents and 60 students in pharmacy and public health, and 200 or 300 nursing students at all times.

And I would point out that because the authority and responsibilities were placed squarely on the university, the curriculum of the schools has changed with the advice and consent of the faculty.

We now have a required rotation for students and family medicine in the AHECs, we have required rotation in internal medicine, keeping in mind, as Dr. Carter pointed out earlier, that our faculty wants a balance between the academic center and the community setting.

We have a number of—several hundred—people working on this with enthusiasm in North Carolina. We are somewhat nervous as we see changes in the Congress and their attitude. We are convinced that it will take several years to document that this has worked.

But we believe that as long as we educate the numbers of students and produce the measurable activity set forth in the contract year-by-year, that is the best way to monitor.

My colleagues and I have spent a great deal of time on studying the supply of physicians and the question of distribution. The data are imprecise, and there is no perfect solution to it. We certainly wouldn't argue that the AHEC program is necessarily for every academic health science center or every medical school. But de do believe that we can by exclusion look at the more promising alternatives.

We would conclude that there is an urgent need for a unified national health policy group to deal with the interrelated problems. The enactment of a compulsory National Health Service Corps legislation is discriminatory and punitive for the student. Capitation support is absolutely essential, if you are going to have institutional change and ask the institutions to try to have some impact on the problem by geography and by specialty.

We think the AHEC program has demonstrated promise in this, as the other programs have, and that the legislation drafted by this committee and passed by the House with perhaps some very minor modifications deserves careful reconsideration.

We can find no great quarrel with the legislation passed by the House at the last session.

If the chairman will indulge me, I want to discuss a topic that came up this morning which caused me some anxiety. I join the chair in the position on foreign medical graduates. But if we increase standards of acceptance, and reduce the numbers, I have great difficulty with the question of taking the very best physicians from other countries and bringing them to this country. And as you reduce the numbers and raise the standards as was proposed this morning, I have some difficulty with the morality of that for this country. I will be glad to answer any questions. Mr. Chairman.

[Testimony resumes on p. 601.]

[Mr. Wilson's prepared statement and attachment follows:]

STATEMENT OF GLENN WILSON, PROFESSOR, MEDICAL ECONOMICS; ASSOCIATE DEAN AND AHEC PROGRAM DIRECTOR, SCHOOL OF MEDICINE, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

There is broad agreement that health care is the right of every citizen. It is, however, increasingly clear that it is easier to make the declaration than it is to provide access to quality services at a socially acceptable cost.

Several complex and interrelated issues are essential components. These include financing, physical resources, organization and manpower resources. The

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country's attention is currently focused on the debate about national financing. The financing may be the easiest question to resolve. Money, however, will not assure reasonable access to quality health services to every citizen.

Actions by the Congress have set in motion efforts for resource development, especially physical resources; quality under the PSRO framework; and organization through the HMO and new Health Service Agency legislation.

AGGREGATE SUPPLY

The current national debate is heavily focused on the supply of physicians. Although it is clear that the aggregate supply of physicians is a vital component of the total, the number of nurses, dentists, pharmacists, public health workers and allied health personnel is an equally important question.

There is little objective evidence to project with certainly the total number of personnel required. An unheralded French economist, J. B. Say, once wrote a brilliant essay on the central hypothesis that "supply creates its own demand." The evidence that this is true in the health field is sufficiently compelling to at least introduce a strong note of caution.

In the absence of any clearly measurable yardstick of need mixed with a healthy suspicion that supply creates its own demand, the determination of appropriate public policy is extremely difficult. There is an additional compounding problem. The time delay between initiating training programs or expanding existing programs is substantial. Increased medical school enrollment does not have any impact upon the supply of patient care physicians for at least seven years. Results of any action appears unresponsive in a society attuned to more immediate resolution of its problems. Patrick Monihan once observed, "A tremendous amount has been incurred, but nothing has occurred."

The aggregate supply of physicians will enormously increase in the next decade. United States medical schools were enrolling less than 9000 students in 1960 and the number is expected to be nearly 16,000 in 1976. The numbers have been rising significantly since the enactment of the Comprehensive Health Manpower Act of 1971. It is now expected that by 1990, there will be 593,800 active physicians in the United States. This will be one active physician for every 455 persons in the country at that time.

At the end of 1970, there were 1,329,130 active health professionals in the United States. This number is expected to rise to nearly 2,000,000 by 1980 and to 2.5 million by 1990. The number of allied health professionals at the end of 1970 was 2,743,000 and, based upon the current enrollment figures, this number may well double by 1990.

The number of registered nurses is expected to double in the course of the next 15 years. In the 20 years from 1970 through 1990, the number of trained x-ray technicians will quadruple from 41,000 to 161,000. The number of occupational therapy assistants will go from 600 to 8000. The number of licensed practical nurses will increase from 400,000 to more than 800,000. The number of respiratory therapists will increase five-fold as will the number of dental hygienists. In that period of time, the number of speech pathologists and audiologists will increase from 13,000 to more than 70,000. The number of laboratory assistants will increase from 6700 to 41,000 and the number of trained medical technologists will increase from 45,000 to 123,000.

At the current rate of output, approximately 7½% of the labor force in the United States in 1990 will be directly involved in the provision of health services. This would not include those engaged in the drug industry, and those who supply goods and supplies necessary to maintain health services. Public policy implications and the economic consequences of decisions that have been made and will be made in the immediate future are enormous.

It is impossible to state with certainty that one doctor for every 455 persons is adequate, too many or too few—or that one registered nurse for every 150 persons will meet the demand.

Stated another way and assuming no increase in individual productivity, the supply of doctors in 1990 would be capable of producing nearly 3 billion office visits per year. This would be 12 office visits per person per year which is nearly 3 times the current demand for office visits in the United States.

In examining these data, however, one must carefully take into account changing science and technology which may or may not increase productivity. One must also observe the changing disease patterns in the country, and the more com-

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plicated treatments now available and likely to be available in the future. In the past two decades, there has been an enormous change in our capabilities to treat more complicated disease patterns.

National financing will almost certainly increase demand—probably at the level of 20%. Further expansion of health personnel training will probably also increase demand. It would indeed be unfortunate public policy if further increases in personnel or national financing requires a greater percentage of our gross national product than is acceptable. Stated another way, at what percentage point does personal health services begin to consume an inappropriate share of our national resources? This would appear to be a question that only the Congress can begin to answer.

Existing data is imprecise. Measuring productivity in a highly personal service, the question of predicting disease patterns and our advances in dealing with these new patterns is complex. This is compounded by the absence of objective measurable need. It may well be, that after careful examination of the existing data and scrutiny of future trends, the only way to make a judgment on health manpower is to examine the total capacity of the country and to establish, in terms of all our priorities, that portion of the human and economic resources that can appropriately be allocated to health services.

The action of this Committee and the Congress in the months ahead will have more impact on the reality of health care as a right than any of the actions previously taken or national health insurance. Health care is a highly personal service and the quantity, quality and distribution of the personnel will ultimately determine whether or not every citizen has the access to necessary service as a right.

It seems imperative, at this point, to enter a plea for a coordinated, measurable national health policy. It is altogether clear that public action on financing that is not carefully orchestrated with the resource capacity can bring about not only disappointment but increasing inflation. Physical and human resource development in the absence of a coordinated policy with financing will bring about other problems.

It is my firm conviction that the Congress should establish a unified national health policy group with the authority and responsibility for developing short and long-term priorities for health care, taking into account financing, organization, quality and resource development. Projections of the impact of past and current decisions on the future in a unified manner appear essential to the establishment of sound policy. Such a policy body should not overlook the important contribution that research has made in the past and can make in the future. There is clear and present danger that as we attempt to address the question of health care delivery we will undermine the role of research in the field.

And now to the questions of immediate concern to the Committee on the quality, quantity and distribution of personnel.

DISTRIBUTION OF HEALTH PERSONNEL

The nation is focused on the distribution of physicians. There is ample evidence to document the fact that health professionals are distributed in a manner very similar to other professionals in our society. Indeed, if other professionals were distributed more widely in our society, it is quite likely that health professionals would also be more evenly distributed. There is, therefore, a much broader question of providing services to rural people and to those in the inner cities of the country. There is a fundamental public policy question as to whether or not a society has the right to expect a substantially different behavior pattern from physicians than from other professional groups.

In the context that rural people and the inner city do not have reasonable access to a whole range of services that are more generally available to others, it is reasonable to state that there is maldistribution of health personnel including physicians. The trend of recent years would clearly indicate that counties of 10,000 or less in population and the inner city are not only behind in physician and other health personnel, but are failing to keep up with the increased output of personnel. Communities of 50,000 or more are rapidly improving. Communities from 10,000 to 25,000 are essentially holding their own with some improvement. It is reasonable to predict that if the physicians of the future locate in a manner similar to that of those physicians trained in the past 10 years, communities of 50,000 to 500,000 will have a doctor-patient ratio of about 1 physician for every 20 persons. Urban areas in excess of 500,000, except for the inner city, will also

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improve and the rural citizenry doctor-patient ratio, especially in counties of 10,000 or less, will almost certainly decline.

Unless there is a public policy to bring a broad range of services to rural America, it is unlikely that the villages, small towns and crossroad communities can expect physician personnel except as indentured servants.

Set aside for the moment non-health services. Even physicians as indentured servants are unlikely to meet the rural expectations unless the rural communities have available quality and quantity nursing, dental, public health, pharmacy and allied health personnel. We are persuaded that the question is broader than health and if it is only possible to deal with the question of health at this time, then the total spectrum of health care personnel is an essential requirement. We cannot support compulsory National Health Services Corps duty for physicians. If this is the decision of Congress, however, such obligation should be placed on all health personnel.

There is much criticism of medical education in the United States about the training of specialists and the general orientation to research. I would remind the Congress that in the early 1950's there was an extended debate about the role of the federal government in the health care arena. That debate was concluded by the Congress in the direction that there was to be no public policy concerning health care delivery. The decision was made that the federal government would support research. I am not aware that the medical schools played on overriding role in this decision. I would further assert that the medical schools responded in full measure to the public policy and to the establishment of N.I.H.

The medical schools responded again, in full measure, to the Comprehensive Health Manpower Training Act of 1971 and three years later the current enrollment projections attest to their response. The criticism that the medical schools will not once again respond to public policy, is, I believe, based upon the record, at variance with the facts.

At this point in history, there is too little known to be able to state with certainty what course of action will produce primary care physicians and what will produce physicians and other health personnel who will practice their profession in the rural and inner city sections of the country.

There is an alternative proposal currently under serious consideration which is, in effect, to conscript physicians for a period of time in the underserved areas. This debate is further refined as to whether all or a percentage of the physicians would have such a public service obligation. This proposal is that all or a part of the medical school student body, in order for the school to retain its capitation, would be obligated to join the National Health Service Corps. At the end of one year of postgraduate training, the physician would be required to provide a period of public service in an underserved area. This requirement is an especially unfortunate provision of this proposal. No one would seriously advance the argument today that one year of postgraduate training is adequate; family physicians are required to take three years. Thereafter, one can reasonably predict that just as soon as the public service is completed, the physicians under this program will return to an academic medical center for the completion of their residency. This is certain to produce itinerate, indentured servants for the underserved parts of the country. We believe that the rural people of North Carolina deserve better.

There are other countries of the world that have introduced this requirement for physicians. We are not aware of any evidence that this system has produced either the quantity or quality of personnel that the American people have come to expect. It could indeed, in a few years, produce a high degree of visibility of physicians in the underserved areas, but there is a very substantial question as to whether or not it will produce a viable solution to the problem.

There is yet another fundamental flaw in this proposition. It is the responsibility of the Congress to establish national priorities and public policy to carry out those priorities. It is the responsibility of the private and public institutions in this country, working within the policy, to deal effectively with social questions. The National Health Service Corps proposal clearly places the responsibility for solving a national problem on the students. The health professional schools in the United States can enroll all or part of their students who have joined the National Health Service Corps and remain essentially unchanged as institutions, leaving it to the students to bear the burden. The administration and faculty of the institutions can essentially continue in the existing patterns with no authority and no obligation for that matter which has been declared a high national priority.

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We believe the National Health Service Corps can play an important role and that its continuation on a voluntary basis should be an essential part of any manpower legislation. We would urge that the current regulations be altered by legislation so that the student will have, after graduation from medical school, 36 months to complete a primary care residency before being obligated to provide public service. This would not disrupt the training program and it is our judgment that a physician who had completed this postgraduate training would be more likely to stay in the community. We are convinced that if this is part of the health manpower bill, a significant number of medical students will enroll in the National Health Service Corps.

The Comprehensive Health Manpower Training Act of 1971 provided yet another alternative to the problem of distribution of health personnel. In addition to its other features, this legislation established the concept of Area Health Education Centers. There are eleven such programs now in existence in the country and based upon the past three years of performance, we believe they show great promise in having an impact on the questions before this Committee. We believe that the 11 funded programs have constructively and responsibly met the challenge placed on them by the Congress. I would point out that these contracts were provided to academic medical centers and once again 11 institutions responded in full measure to the policy declaration of the Congress.

I would like to address my remarks specifically to the program in North Carolina, but it is important to note that there are programs in 10 other institutions working extremely well. The presentation today does not necessarily represent the view of the other 10 institutions, but we are in agreement on the basic principles of the AHEC program as it has evolved over the past three years. There are several distinctive reasons why, in our judgment, this program has worked.

The primary objective of the program is: "To improve the quantity, quality and distribution of all health personnel by geography and specialty."

The relationship between the academic medical center and the federal government is a five year performance contract. The authority and the responsibility for the conduct of the program is placed squarely on the institution. Quantifiable, objective measurements were established in the initial contract. To meet those objectives, the academic medical center was obligated to bring about fundamental changes in the educational institution.

There was a debate at the time the regulations were being written for the Comprehensive Manpower Act of 1971 as to whether or not these contracts should be written with the academic institutions or with newly organized free-standing community corporations. It was our position at that time, and history has re-enforced our position, that to place the responsibility on an institution and give the authority to yet another institution has significant problems. The responsible educational institution can pick and choose those activities for which they will apply for funds. If the authority is placed with a newly organized institution, the program never becomes an integral part of the institutional priority list since it lacks the authority for the program and has no responsibility except what it chooses.

The academic medical center under the AHEC program was mandated to subcontract with regional centers for the training at the undergraduate, graduate and continuing education level of all health personnel. A basic part of these subcontracts in North Carolina is that the regional center further assumes responsibility for this basic charge for all health professionals in several adjoining counties.

This formulation has proven to be extraordinarily successful. The basic objectives of the program are clear. The authority and responsibility based upon measurable results is also clear. This mechanism has made it possible to introduce a high level of accountability that it is not characteristic of federal contracts and grants. Our relationship with the National Institutes of Health and now the Bureau of Health Resources Development has been unusually salutory.

After we were awarded a contract to establish three such centers in North Carolina, the Board of Governors of the University of North Carolina and the North Carolina General Assembly adopted a proposal to develop this plan into a statewide system. The General Assembly appropriated 28.5 million dollars in 1974 to build educational facilities in the regional centers and to strengthen and expand the operating program. In addition to state and federal funds, the communities have made significant financial commitments to this effort.

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All five health science schools at the University of North Carolina at Chapel Hill—dentistry, medicine, nursing, public health and pharmacy, the Bowman Gray School of Medicine, Duke University School of Medicine, 16 campuses of the University of North Carolina, 10 technical institutes and 20 community hospitals are intellectually and contractually committed to carrying out measurable objectives in this program through the rest of this decade.

We expect the region to set its priorities in carrying out the program and to make determinations about the most urgent personnel training needs for their region. By contract, the program has increased and will continue to increase the capabilities of regional institutions to train health personnel, especially in the nursing and allied health fields. In the past three years, the program has exceeded its measurable educational objectives. We anticipate that an operating budget from state and local resources in excess of $14 million annually will be required to carry on the program by 1980. It is still too early to measure with certainty the short and long-term impact on the distribution of health personnel, but for a moment let's review some of the accomplishments.

1. Given the authority and responsibility, the academic medical centers, community hospitals, educational institutions at the technical institute and university level and practicing health professionals have demonstrated that they can work together cooperatively as partners.

2. The academic medical centers and the regional community hospitals have demonstrated beyond any question that they will make their resources available to underserved communities.

3. Slightly more than 10% of all of our third and fourth-year clinical education in the medical school was accomplished off campus last year. We anticipate that it will rise to one-third of all our clinical training by 1980. All of our dental students and pharmacy students and much of our public health and nursing clinical training will be done off the campus. We are persuaded that health professional students who receive a balance of their training at the academic medical center and in the community will be different from students who receive all of their training in an academic medical center. Some have prejudged the situation and assert the quality of training will be inferior. We can report, based upon our constant review of the program, students who receive a significant portion of their training off the campus perform as well on the usual test as those who do not go off the campus. It is clear, however, that in order to meet the objectives of the program and maintain quality education, it is essentiall to bring about institutional change and have fulltime faculty in the regional setting.

4. The North Carolina General Assembly authorized and appropriated funds to support over the next few years, 300 new additional residency positions. We filled 75 of those new positions in the communities last year—all of them in the primary care field with particular emphasis in family medicine. We anticipate 180 of those 300 positions being in family medicine in the regional centers and have already recruited the faculty to establish these residencies, several of which will open in 1976.

5. In three of the most developed regional centers, we have already created an exciting regional professional environment that is conducive to recruiting and retaining health personnel. In one region, every single person employed in the health field had at least one extended educational experience through the AHEC program in one year.

6. We have expanded regional capabilities to train quality laboratory technicians, nursing personnel, inhalation therapists and other personnel in quality programs based in regional institutions.

7. There is a single school of Public Health in North Carolina and it has developed an off-campus masters program to extend the capabilities of the agencies in that region to have more personnel trained locally. We anticipate this program will be extended to other regions in the state and discontinued in the region once the need has been met.

8. Nurse refresher courses for inactive nurses have been held in three regions of the state and of those who took the course, approximately half of the 40 inactive nurses are now back helping serve the regional need.

9. The Schools of Nursing, Medicine and Public Health have had an outstanding Family Nurse Practitioner Training program for the past four years. This program has now been taken to one regional center and based in a regional institution in order to train the regional people who were not able to come to Chapel Hill for training. We expect, in the course of the next 18 months, to have two additional training programs in two new regions for the same purpose.

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10. Although the evidence at this early stage is not overwhelming, we can identify a significant number of new personnel in the state in some measure attributable to the program. This includes individuals recruited to the region who are attracted by the prospect of participating in the educational program. We can even identify some students who selected a region in which to practice because of their undergraduate or graduate training in that region. We are, of course, carefully monitoring this and expect in the course of the years ahead to be able to document our hypothesis that the program will contribute to the redistribution of personnel.

As early as 1978, 40% of all the residency training in North Carolina will be in the primary care field and we anticipate that in this decade, half of the residency training in North Carolina will be in the primary care field.

11. We have projected to state and national authorities that by 1980, in the nine regional centers, there will be 300 new residency positions in primary care. We will be training over 1000 allied health personnel, 80 dental students per year, 180 medical students, several hundred nursing students, 60 pharmacy students and 60 students in public health. This will require a fulltime faculty of nearly 90 individuals in the regional centers.

12. The medical school curriculum has been changed in response to this program which again reflects an institutional change.

There are hundreds of intelligent, devoted individuals working on this program in North Carolina. The lines of authority, responsibility and communication are clear. The nature of the performance contract is set forth and the objectives of the program are well understood. It is our firm conviction that the other 10 AHEC programs are also working well.

We would not conclude, however, that every medical school or every health science center should undertake an Area Health Education Center program. It shows great promise in North Carolina and we believe it has demonstrated that it can make a contribution. Medical schools and academic health science centers are sufficiently different, however, and there is still sufficient variation across the country that indicates there is no single answer to the national question.

Individuals and institutions in North Carolina have made a substantial and irreversible commitment based upon federal policy. I must confess that we are uneasy that having made these commitments, that Congress will not support our commitment through the life of the contract which expires in 1977. In a similar manner, the medical schools made a substantial commitment with the capitation formulation in the 1971 legislation. They have not yet graduated the first class under that initiative. It is extremely difficult to get institutional commitment if public policy is going to start in a new direction with every session of the Congress. We are impotent to respond to national need with regularly changing priorities and guidelines.

Public policy may dictate that additional requirements are necessary in order to carry out the public purpose. Capitation support to maintain strong academic medical centers is essential to any program, however.

My colleagues and I have spent the last several years intensely engaged in the questions of aggregate supply of health professionals and other health personnel, need versus demand and the distribution by specialty and by geography. The more we review what has been written, what is known and unknown, and are instant communication with those delivering the services, the more overwhelmed we are with the imprecise nature of our facts and the difficulty of projecting the future. One can exclude unacceptable and unworkable alternatives, but it is clear that it's not possible to predict with certainty a single answer or combination of alternatives that will necessarily succeed across the country.

It is our conclusion:

I. There is an urgent need for a unified national health policy group.

II. The enactment of compulsory National Health Service Corps legislation is discriminatory and punitive for the individual student. Although it has immediate political appeal, it shows no long term potential for a solution. In the absence of conscripting all health personnel it indeed shows little promise.

III. Capitation support is vital to any effort of the medical centers to support any public policy.

IV. The AHEC program has demonstrated great promise in answering the public need.

V. The legislation drafted by this Committee and approved by the House of Representatives in the last session of Congress squarely addressed the major issues in a responsible manner. There are undoubtedly questions that can be

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raised about the House Bill, but with modest modification it is worthy of careful reconsideration.

A quotation from Stephen Vicent Benet's poem, "John Brown's Body" seems appropriate as we consider these difficult questions.

If you take a flat map
And move wooden blocks upon it strategically,
The thing looks well, the blocks behave as they should.
The science of war is moving live men like blocks.
And getting the blocks into place at a fixed moment.
But it takes time to mold your men into blocks
And flat maps turn into country where creeks and gullies
Hamper your wooden squares. They stick in the brush,
They are tired and rest, they straggle after ripe blackberries,
And you cannot lift them up in your hand and move them.

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In Carolina, Teaching Centers Link Atlantic to Appalachians

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Hospital Practice

Reorienting Medical Education: A Reappraisal

Editorial

Even in the case of views that are more generally agreed upon, it is of value to re-examine the evidence, for it is an old story that opinions supported by little more than the weight of early authority have often remained embedded for years in the corpus of science through the failure to enquire carefully into the validity of the observations upon which the opinions rest.
Arnold R. Rich, M.D.

In December 1970, I commented editorially in HOSPITAL PRACTICE on the Carnegie Commission Report on Education in Medicine and Dentistry, expressing a high degree of skepticism about the reality of its basic recommendations. I noted that the Commission had not developed new ideas but had presented essentially a synthesis of information and programs previously described. The Commission Report included proposals for innovation in the education and training of health professionals and suggested that there would have to be significant changes in the kinds of health manpower and in the structure of the health delivery system to accomplish the nation's goal of access to comprehensive personal preventative medical care.

My skepticism was stimulated by the Commission's recommendation that existing university medical centers would have to do the job. In my view they were failing to take into account that, as Robert H. Ebert recently pointed out (in "Biomedical Research Policy: A Re-evaluation," *The New England Journal of Medicine*, August 16, 1973), "Universities and medical schools have had remarkably little institutional impact on public policy relating to biomedical research and research training," and that among faculty "loyalty to the university was secondary to loyalty to the NIH." It is my strong feeling that the cumulative impact of 20 years of this distortion of the educational mission of medical schools accomplished what William Osler forecast over 50 years ago – a professional professorial body remote from its profession, if not completely alienated from it.

The Carnegie Commission's contention that the establishment of Area Health Education Centers in strategic locations throughout the country would lead to a reorientation of educational philosophy and curriculum policies, I believe, *cannot be implemented unless these same administrations and faculties can reorient themselves* toward working with the practicing profession and the community hospitals – without attempting to dominate or interfere with their functions of service to the public.

In order to effect this profound reorganization of education in the health sciences through the mechanism of Area Health Education Centers, it seems fundamental to me that each responsible university would have to guarantee relative autonomy for the development of educational programs to meet local needs, as well as to provide a broadened learning experience for undergraduate and graduate students from the university medical center and health science school. Equally important in this new approach, the individual university administration would have to recruit persons to direct the program who would understand and know how to work with the local "power structure" in the community hospital, the board of trustees, the administration, and the medical staff. The community hospital would have to be responsive to the university and to have the capability of developing the resources for high quality learning experience.

In short, what would have to be done has been analytically and succinctly described by Swanson (*Journal of Medical Education*, May 1972). He wrote: "Area Health Education System connotes an entirely different approach to planning, development, and execution. It implies that an area (a region) with common interests and common needs will work out a coordinated plan to evolve an educational system for health which takes maximum advantage of existing resources and talents and utilizes these resources to educate the

This editorial is by Dr. Henry S. M. Uhl, Director, Area Health Education Center, Asheville, and Clinical Professor of Medicine, University of North Carolina, Chapel Hill.

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Editorial

needed manpower in the most appropriate settings within the region. Such a system would protect against duplication of effort and would allow the coordinated development of a brand new type of university of the health sciences."

The Area Health Education Center system in the state of North Carolina, described in detail on page 4 of this article, has evolved over three years of planning and implementation to the threshold of success in all six activities recommended by the Carnegie Commission. The community hospitals have been receptive because of their pressing needs for various kinds of health manpower and because the state and the federal monies have relieved the hospitals of an increasingly difficult burden, providing operational and capital dollars for education programs. The Area Health Education Center system has a strong central administration, but one that encourages a high degree of local autonomy. Step by step, it has gained the support of the key members of its campus faculties in medicine and dentistry, and those of the other health science schools. The timetable is realistic, and the recruitment of able individuals is assured by the commitment of the state legislature and the university system's Board of Governors in making the program a permanent part of the structure of higher education.

The Carnegie Commission Report devoted most of its content to the consideration of questions and proposals related to all aspects of providing "undergraduate" education for medical and dental students (who are, in fact, students in graduate schools offering only a doctoral degree!). While continuing education is included in the list of six appropriate activities for an Area Health Education Center, the lack of specific comments or detailed discussion by the Commission is perhaps indicative of the educational establishment's acceptance of existing traditional methods, and their realization that it is simpler to deal with the "captive population" of enrolled graduate students.

The participants in the recent Anglo-American Conference on Continuing Medical Education held at the University of North Carolina School of Medicine (see "'Keeping Up': A Concern on Both Sides of the Atlantic," HP, July 1973) had great difficulty in coming to grips with the basic concept that the purpose of learning is to change behavior; and in the field of the health professions, educators and teachers should first identify the deficiencies in performance of the professionals. The Area Health Education Center system in North Carolina will provide the core of educational administration and faculty in nine regions, with each having the resources to develop and maintain ongoing education for all health professionals according to *documented local needs*. The students learning in these centers will clearly see that, as practicing health professionals, continuing education can and must be an integral part of their daily work. It is likely, too, that faculty members, through increasing contact with community health care and education, will benefit and the isolation and alienation from professional colleagues will be eliminated.

Achievements within these first three years have not come easily, but what has been accomplished reflects the philosophy once expressed by David Lilienthal: "The short and sure road to despair and surrender is this: to believe that there is somewhere, a scheme of things that will eliminate conflicts, struggles, stupidity, cupidity, personal jealousy. The idea of Utopia is mischievous, as well as unrealistic. And dull, to boot. Man is born pushing and shoving as the sparks fly upward."

Should this massive statewide effort succeed in its long-term goals, it will make it possible to resolve the hectic haggling over curriculum reform because, as William Osler perceived early in the century, medical students try to learn too much and teachers try to teach too much. Osler wrote, "The knowledge a man can use is the only real knowledge, the only knowledge which has life and growth in it and converts itself into practical power. The rest . . . dries like raindrops off the stones." By 1980 every health professional in the state of North Carolina, and indeed all the citizens of the state, may well have available to them an established comprehensive program of professional and personal health education. This resourceful program could provide a bold national blueprint by which the promise of access to health care for all could be kept.

HENRY S. M. UHL, M.D.

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Clinic and Classroom

In Carolina, Teaching Centers Link Atlantic to Appalachians

They are bringing the mountain to Mohammed in North Carolina.

The mountain is the educational resources of the University of North Carolina Health Science Center, comprising the schools of medicine, dentistry, nursing, pharmacy, and public health. Mohammed is, collectively, hundreds of health professionals and trainees in five Area Health Education Centers (AHEC's) covering 31 of the state's 100 counties.

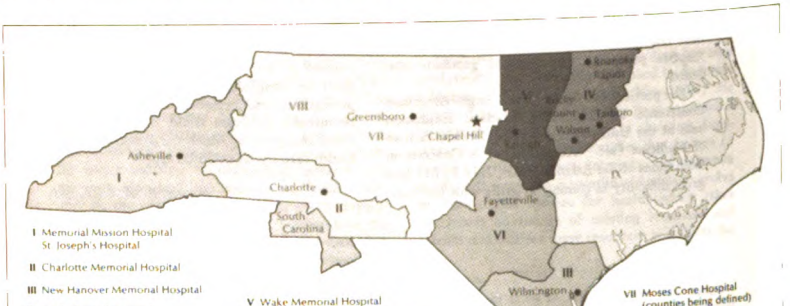
The aim is not only to provide education but to make a concerted attack on the problems of health manpower distribution – to give training in the community to local health professionals of the types and numbers needed, to give community experience to health students and teachers from the university in Chapel Hill, and to use university and local resources to provide continuing education of high quality so as to attract and hold competent professionals in rural areas.

The AHEC concept was set forth in 1970 in a report by the Carnegie Commission on Higher Education, and the following year it was incorporated into the Comprehensive Health Manpower Training Act. The University of North Carolina was one of 11 universities around the country to win an AHEC contract with the Bureau of Health Manpower Education, for $8.5 million over a five-year period to 1977.

The North Carolina AHEC program might be compared to a highway system, with the university at the hub of a cloverleaf that sends two-way roads off to five AHEC's comprising nine affiliated regional hospitals at major intersections, where branch roads go off to some 22 smaller community hospitals and 23 colleges, community colleges, and technical institutes. Each of the affiliated hospitals was already serving a regional responsibility for handling patient referrals, says UNC's Deputy Director for AHEC, Dr. Eugene S. Mayer, and the aim is to have them serve the same function in education. As each hospital provides the specific kinds of health care needed in the region, so it provides needed health education. So many and diverse are the educational programs now under way that this article can mention only some highlights.

Long before the Carnegie report, North Carolina had jumped the gun on the AHEC concept. In 1946, a commission headed by Dr. William T. Sanger, then President of the Medical College of Virginia, had recommended expansion of the two-year medical school at Chapel Hill into a medical center offering the full four-year course, as well as education for allied personnel throughout the state, clinical consultations and other services to community hospitals, and integration of the medical school's services "effectively and continuously with a statewide network of hospitals and health centers in so far as these volunteer to cooperate."

Clinical clerkships in community hospitals that had teaching residents, said the Sanger report, might show students they could keep contact with the medical school if they chose rural practice. But, the report warned, simply getting more doctors was not the total answer; many sorts of health



The boundaries and regional centers of North Carolina Area Health Education Centers, in operation or planned, are shown. The headquarters of the program are at the University of North Carolina, Chapel Hill, where the directors are making plans to have every county in the state served by an AHEC by January 1, 1975. See text, page 5, for further explanation of the map.

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professionals must be trained and employed throughout the state, which was and is largely rural.

By 1967, UNC's medical school – now offering the four-year course – began to pick up the Sanger recommendation on community hospital affiliations for student and resident rotations, and the other health science schools started community outreach programs. These activities, plus a Regional Medical Program, paved the way for the start of AHEC in October 1972.

The federal grant now covers about 40% of the cost of the program, with 30% each from state and local sources. But the state's General Assembly has just raised its ante by appropriating $4.7 million for a year's operating costs and $23.5 million to build or remodel space in the regional hospitals for faculty offices, conference and teaching rooms, library expansion, and model family practice units.

By 1980, UNC planners foresee a need for $14 million a year in operating costs from the state – a more stable source than the federal government, whose contract will have ended by then. The hospitals' share will probably be reduced to something less than 30%. Some of the AHEC's have formed tax-exempt educational foundations to raise money locally and apply for federal grants and loans.

The map on page 4 indicates the outlines of five existing AHEC's and the locations of the regional centers of four more AHEC's being developed or planned. Most are designated by the name of the city where the affiliated hospital is. In the far west, Area I is in Asheville, between the Blue Ridge Mountains and the Great Smokies. Area II, Charlotte, serves not only a large Piedmont area but two counties in South Carolina. At the extreme southern tip of the state is Area III, Wilmington. Area IV, so-called Area L, has a consortium of four hospitals, each in a different county. Some 30 miles east of Chapel Hill, Raleigh is the center of Area V. (Area VI, at Fayetteville, is about to start operations.)

Each regional hospital has a number of full-time faculty members. For fiscal year 1975 there are 82 authorized positions, including 44 medical faculty. The plan for 1980 is 83 medical faculty and 47 in other disciplines. One reason for such expansion is that UNC (as well as Duke and Bowman Gray, which may join the AHEC program) is more than doubling its entering medical class, from 75 in 1968 to 160 by 1978. Another reason is the state-supported plan to create, by 1978, 300 new residency positions, 85% of them in primary care including 150 in family medicine.

It is important that community hospital teaching activities be built up slowly, says Glenn Wilson, AHEC Director and Associate Dean of Community Health Services. "First came continuing education through faculty consultations in the hospitals and development of plans for special training programs. Then only after about a year have any medical students gone in, a few in one field. We made the mistake once of putting too many in without adequate build-up time, and everyone was unhappy. We won't duplicate that error again. Students are an intrusion into a community hospital and change its style."

Maintaining the delicate balance between the educational and research skills of the university and the service skills of the community hospital demands a partnership arrangement, Mr. Wilson continues. "This presupposes that one does not force programs into the community, that we do indeed recognize their integrity and help them build what they think is important to them. The people responsible for delivering care should have the power of choosing whom they will train first. We may insist that they take on the whole spectrum over the long range, but they decide within that spectrum what they will emphasize from year to year.

"They represent the people who are going to employ health personnel. There's very little point in our developing training programs if the hospitals and doctors in that area won't employ them. It's probably impossible to overemphasize that their positive response has resulted from our trusting them and recognizing their integrity and letting them set their own goals."

Goals come first, budgets later. Each AHEC has submitted a detailed statement of its goals for the five years of the federal contract. It reports quarterly to Chapel Hill on its progress in meeting the goals and is paid according to performance. Everyone knows how everyone else is performing.

"This is the most extended and complicated partnership I have ever observed or participated in," says Mr. Wilson. "Whenever we need to do something, we must discuss it in detail with a great number of people. But one of the most exciting things that has developed as a by-product has been the greater respect and understanding the faculty has for the physician in the community and the community physician for the faculty. They're learning to work together on real problems, not only theory, because several faculty members every day make trips into communities to consult on problem patients."

Not only clinical consultants but educators, administrators, students, and trainees fly from and to Chapel Hill in the medical school's fleet of four small planes. A retired Air Force colonel, Earl D. Provancha, coordinates the seven-day-a-week schedule and the rotation of six pilots. Last year, faculty members conducted 8,000 direct consultations with private practitioners, and from January to December, faculty and staff logged about one million passenger miles.

Despite increased understanding and cooperation, there is still some die-hard suspicion, particularly among some surgical specialists, that the Chapel Hill experts would like to peer over their shoulders at the operating table or snatch away their patients. But it diminishes as time goes on.

Another sensitive area, says Mr. Wilson, is the relationship between practicing physicians and the full-time faculty members in the regional hospital. "The practicing physicians make an invaluable contribution to our teaching programs. And they are coming to understand that the faculty people must be there to answer students' questions when the physicians are off fulfilling their primary responsibility of patient service."

The hospital faculty members are recruited mainly from practice. But sometimes one who thinks he wants to teach finds he doesn't like it or doesn't know how. So UNC has obtained $250,000 annually from the state for community medicine fellow-

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In Charlotte, Dr. David Citron (center) directs graduate and undergraduate teaching in family practice. The state will create 150 more FP residency slots soon.

ships. Clinically skilled practitioners will go to Chapel Hill one or two days a week, or as suits their practice, to get reinvolved in academia, find out whether they really want to teach, and learn how.

As the number of AHEC programs and personnel grows, the partnership gets ever more complex. Helping keep the two-way traffic moving are three associate directors – Vincent Kaval, John Payne, and George Stiles – each assigned as coordinator between Chapel Hill and one or two AHEC areas.

Mr. Kaval explains the role this way: "Say the School of Dentistry wants to know something in Raleigh. They would ask me who are the right people there to contact. And if somebody in Raleigh had an idea to put across in Chapel Hill, I would make sure he saw the right people and would handle the project until it got operational. Without this continuing responsibility, some programs could fall between the cracks."

Says Mr. Payne, "I see ours as a trouble-shooting job. First, we've got to keep the communities from being overburdened with a lot of programs they're not concerned about. Then we have to make sure development programs actually get done. The General Assembly is the third partner in this now, and it has given us a specific mandate to develop more health professionals. We're into it on the line with how many new residency slots we will produce, how many more students the hospitals have agreed to take. There's a commitment from both sides, and we are in between to make sure nothing is forgotten.

"If a medical staff doesn't want to accept a certain program, it might be up to us to find the particular person here to explain why it's desirable. We may have to find out the reason for their nonacceptance – with a family practice residency it might be the fear that it would disrupt the outpatient department or further overload the hospital beds – and find ways to make it more acceptable."

Another job, Mr. Stiles says, has been to try to bring the various schools' previously established programs throughout the state into the AHEC framework. "For example, one project director was upset to find out the first year that 23 dental students had rotated through his AHEC and he hadn't even known about it. Dentistry had long since set up this program. If you don't bring these things under a single organizational structure, on the one hand things don't get done that need doing, and on the other hand you have duplication and competition for scarce resources."

Mr. Payne calls the cooperation that has evolved "unbelievable. Representatives of the five health professions schools here are actually sitting down together regularly and discussing joint programs. To my knowledge it's never happened here before on a continuing basis."

An example of cooperative effort came this spring when the AHEC program almost ran out of travel funds. Each of the representatives dug some money out of his school's budget to keep the planes flying.

Perhaps inevitably, the medical school overshadows the other schools. But, says Audrey Booth, AHEC representative of the nursing school, "We now have an opportunity to make an interdisciplinary effort in a way we have not done before. If we are not yet quite as unified as we will be, we are much more aware of our parallel activities."

Describing her role in AHEC, Miss Booth says, "I can relate to the nursing faculty members out there as a consultant and broker, interpreting what we have in terms of their needs. They in turn may identify needs for new programs that we haven't addressed."

Asheville recently asked for someone to conduct a workshop on orthopedics for nurses. Chapel Hill had no suitable person available. But Miss Booth found an orthopedic nursing specialist in Wilmington and put the two AHEC's in touch to make their own arrangements.

"Singly I don't have a great deal of clout," says Miss Booth, "but with my colleagues in the other schools, all of whom feel as tremendously involved as I do, I feel greatly strengthened in what we're trying to do. I can pick up the phone and say, 'Hey, Glenn Wilson, I need you right now,' and I get him right now. But each of the disciplines has its own set of goals and I don't know whether we're really communicating that fully yet. I think we're getting there."

In varying degrees, other AHEC representatives feel the same way. Says Dr. Marvin Block, dentistry representative, "If I sound enthusiastic about AHEC, it's because I am. Some in my school still think it's an impractical, newfangled idea. It will take time. But we are all working together for the benefit of the health professions and of patients."

Pharmacy representative Claude Paoloni says, "There is definitely a camaraderie that has developed between the various schools. They're getting to know more about our aspirations and goals, and we get to know theirs. If there is some opportunity

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for me to help them, I do it, and they do the same for me."

Dr. Cecil Slome, public health representative, reports, "A few months ago I went to a meeting of all the AHEC people at which each representative was asked to speak to what the role of our school is in AHEC. A professor of obstetrics, a friend of mine, said afterward, 'I've never heard this before in my life. I didn't know what you public health people were all about.' And a doctor from Charlotte said. 'It's the first time I've understood what you guys could do for us.' So it's a process of educating them, because generally public health is thought of as vaccination, period.

"A hospital director doesn't know how an epidemiologist could help him in really scientific health planning. We could predict the caseload for the next year or next 10 years, so many cases of such and such diseases. The director could then say, for example, how many cardiac beds and cardiac nurses he will need. But no health planning in the nation is rational like this. None.

"Still, with the coming of AHEC, others are starting to learn what we can offer. I've been here 12 years, across the street from the medical school. And for 10 of those 12 years, that street might as well have been a thousand miles wide. In fact, through collaborative projects, our association with other medical schools was closer than with this one. Now, with this opportunity to participate with the other Chapel Hill schools, I want to fight and scream and shout for it."

"Our small staff are a bunch of eager beavers who really believe in this thing. We though it would be difficult to sell, but the people here bought it like a piece of cake," says Dr. Bryant Galusha, AHEC Director at Charlotte Memorial Hospital. "This is the first sensible thing I've seen in medical education, not those Punch and Judy shows of the professor hitting a little town. It has brought people out of th ir departmental cocoons. But it isn't just doctors. Health care is a team thing, and that's the message people have to get. The idea is absolutely workable if everyone does his part."

Charlotte Memorial's 11-year history of residency training gives some confirmation of the validity of the AHEC concept that local training brings in local practitioners. Consistently matching all its openings through NIRMP, the hospital now has 84 house officers in internship and nine specialties. Some 60 of its graduates have remained in the state, half of them near Charlotte. "When they come and stay, these people attract more," says Dr. Galusha. "Good draws good."

With its 811 beds, Charlotte Memorial is the largest in the AHEC complex. And, in a county relatively rich both in per capita income and supply of doctors, its problems may be less than those of smaller, poorer AHEC hospitals with not much educational tradition. Dr. Galusha reports that about 300 of the 435 doctors on the staff are willing to teach in the hospital's myriad programs for health professionals. "We have enough depth of talent so that we don't have to put a big load on a few. Sometimes it's difficult to use them all."

The Charlotte AHEC contract was supposed to cover only three counties instead of the actual nine, reports Associate Director John Allen. "But everybody wanted in, and you just can't tell people no. We were worried people wouldn't ask us to help them. Now we are worried how to keep up with the need."

A full-time faculty member at Charlotte is Dr. David Citron, Chairman of the Department of Family Practice, who says, "We are trying to bring the family physicians back into the hospital fold. They need the identification with the hospital for their own continuing education."

Customarily, local FP's have admitted their patients to the other two hospitals in town, which have shorter waiting lists. Dr. Citron wants to encourage them not only to bring their patients to Charlotte Memorial but to teach and participate in journal clubs and conferences. One FP or another attends every session of the family practice clinic both to act as consultant and to listen to case presentations. Dr. Citron says, "Many have said they're here less to teach than to learn."

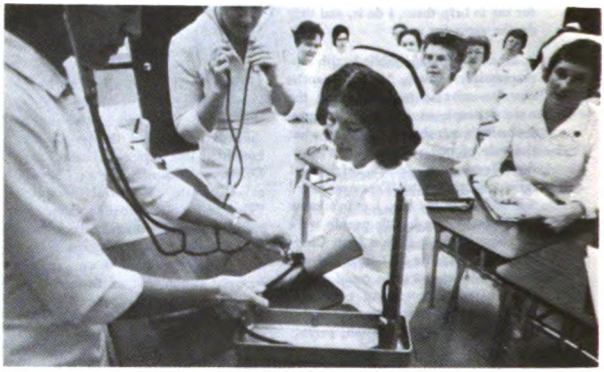
Wake Memorial in Raleigh has no residency programs of its own but provides rotations for residents from Chapel Hill in obstetrics, medicine, surgery, urology, ENT, and orthopedics, according to AHEC Director John Key. In addition, medical students do rotations there in medicine, pediatrics, and OB-GYN, three specialties in which Wake has full-time faculty members.

Dr. Archie T. Johnson Jr., directs Wake's pediatric teaching program, which at any given time has three residents and three third-year medical students. A specialist in neonatology, Dr. Johnson has had a family practice residency. So AHEC has assigned him statewide responsibility

Wilmington is one of the centers where videotapes and other instructional aids for health professionals are developed and circulated to other AHEC hospitals.



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Charlotte personnel helped develop a refresher course for nurses who had been inactive, on average, 21 years. All but two of the graduates are back in practice.

for developing FP training programs. "The key of all this has to be the physicians in the community hospitals," he says. "They are a very important element because they know the community and the hospital, so I'm going to lean very heavily on them for support and guidance in setting up the programs."

The Chapel Hill connection, he says, is valuable because of the resources it makes available. "If you need some information regarding almost any hing, there's someone over there who can usually get it for you. You don't have to dig it out yourself."

From July 1973 through the middle of March 1974, the medicine teaching service had 69 third- and fourth-year medical students and 20 residents, who saw 123 consultations, says the service's Director, Dr. Evin H. Sides III. These rotations may be extended to several hospitals in smaller communities in the area.

A questionnaire asking UNC graduates of the past four years to compare their educational experience at the university hospital with that at various affiliated hospitals showed that 70% preferred the community experience. "The one thing that concerns me," says Dr. Sides, "is that we've never been able to correlate popularity with effectiveness, so we don't know that we're doing any better job. But at least the students appreciate what is being done."

Another questionnaire asked Wake attendings what they thought of the teaching program. Among the 142 responding, 131 favored the program, and 103 actually participated to some degree. Of those commenting on possible expansion of teaching activities, 64 favored it, 51 thought the present level was about right, and 10 said such activities should be dropped.

Nonetheless, Dr. Sides' proposal last fall to expand the medicine teaching service was approved without a single dissenting vote. "When I first came," he says, "there were some of the classic fears and reservations. I think people are now getting comfortable with the program, don't feel threatened by the university, and are more receptive of further growth."

Wake's teaching service in OB-GYN is directed by Dr. Frederick G. Wiegand, who says, "We provide the training beds for the Chapel Hill residents, and they supply the manpower to take care of our indigent service. At all times we have two first-year men, one second-year man, and one third-year man. Basically there is just the one faculty member and that's me – looking desperately for a second one."

Though this rotation was established some years back, Dr. Wiegand cites the AHEC benefits that "we have more money available, and the entire hospital staff, not just this department as formerly, has liaison with Chapel Hill."

Another benefit has been that all four AHEC directors of OB-GYN teaching services (Asheville has none) get together at least twice a year to discuss mutual problems and their diverse methods of teaching.

They also exchange information and opinions on the use of such teaching aids as carrel units and videotapes. Every regional hospital has a library and learning center with facilities for viewing, listening, and taping instructional aids. When someone at one hospital develops a teaching package or program, Dr. Wiegand reports, it can be made available to other hospitals through Chapel Hill, which also has experts who produce slides and other such materials on request. UNC also circulates Audio-Digest and other programs.

Dr. Wiegand describes an educational program for indigent OB patients, aimed at eventually reducing the high perinatal mortality rate. "We don't have any great hopes of doing an awful lot for the immediate patients; we see them so late in their pregnancies there's almost nothing we can do except try to pick up the pieces. But we do hope through educating them that their daughters or their younger sisters will learn a little more about nutrition and hygiene and baby care.

"We have a series of lectures on such topics that we hope to get down on tape eventually. When the patients come in, their weight and blood pressure are checked. Then there's an hour when there isn't anything for them to do, because we're making hospital rounds. During that time, the patients sit in on a lecture.

"Formerly, when we made the lectures optional, the attendance would average something like two or three. With the new system, the attendance has gone up to about 35 to 40. I guess it's sort of a dirty trick, but we feel the lectures are the most important part of the prenatal visits. The effects won't show up for another 10 or 15 years, but already we're getting indications that patients with their second pregnancy remember a little bit of what we taught during their first pregnancy."

Sister Mary James, Administrator of St. Joseph's in Asheville, plans a different approach to patient educa-

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tion: programs prepared by local physicians and put on video cassettes played regularly at announced times to patients hospitalized with the conditions discussed.

Dr. Key, in Raleigh, is particularly interested in patient education and has asked Dr. Slome and the School of Public Health to help devise ways to accomplish this. "A lot of health education for patients has focused on just providing information and knowledge rather than dealing with attitudes and motivation," Dr. Key says. "Both aspects need to be covered, and you've got to have somebody in the hospital to organize and manage the program, drawing on the skills of nurses and dieticians and pharmacists and physicians to deal with specific topic areas. Last year we had 42,000 individuals visit our outpatient areas. What a tremendous potential for education!"

From fierce local autonomy, Area L's four AHEC-affiliated hospitals are progressing to cooperative planning to fill needs without duplicating services unnecessarily. For instance, says Dr. Lawrence Cutchin, AHEC Director at Edgecombe General in Tarboro, "We initiated an ENT clinic to which the university sends a specialist twice a month and an audiologist once a month. Nash General in Rocky Mount has similar monthly clinics in orthopedics and neurology. We see some needs, the others see some, and we try to put it together. But it's difficult to get the four hospitals, each funded by its own county, to give up any authority."

The hospitals have formed an educational foundation whose board decides policy. Then the AHEC staff has to go to each hospital to get permission from the hospital board, medical staff, head nurse, and others concerned. Says Dr. Cutchin, "Unlike Charlotte, where one hospital is the lead horse, we have to negotiate on each step. It's slower than when our hospital could move on its own."

In medicine, Area L's first priority is to develop an active continuing education program in each hospital. Edgecombe General approaches this through performance audits, says Dr. Cutchin, and he hopes to work out a relationship with the education committee at Wilson Memorial in Wilson to do similar audits there.

"I know we are doing a better job in utilization and record review than 90% of the hospitals in the country," he says. "Most hospitals go through the motions to meet their obligations to the Joint Commission. But for about a year we have begun to put a few teeth in it, identifying where the individual and staff need to improve. There have been a few complaints but no real difficulty, because the staff are very progressively minded. They have many new pressures on them now, to teach medical students and nurse practitioners, to accept innovations in medical record-keeping to make auditing easier, to use multiphasic screening. They are accepting most of these, but it is a painful process."

At Wilmington's New Hanover Memorial Hospital, Dr. Lockert B. Mason directs surgical education. Small groups of second- and third-year students fly in for a day, and fourth-year students may elect a month or more there.

"It's surprising how much the students think of it," Dr. Mason says. "Up there in Chapel Hill they don't get but so much of the faculty's time. Here, four of them have a faculty member all morning and the chief resident all afternoon. They can see a variety of conditions and get close to well-trained practitioners on the firing line."

The plane that brings the students early in the morning immediately turns around to fly Wilmington practitioners to Chapel Hill. On rotation, one day a week, eight surgeons participate at UNC in teaching and attending conferences. "I would have predicted one or more dropouts a year, but there have been none," says Dr. Mason. "There is no financial gain for them, no way to get patients out of it."

The shuttle was started in 1968, Dr. Mason explains, because "we wanted each staff to see the other, and the Chapel Hill people to find out we weren't all a bunch of boobs. We would always have been the UMD's if we hadn't gotten involved in teaching. Our people speak up in conferences, and their views are respected. What we see and hear influences our practice, and we have become aware of facilities up there that we don't have, such as chemotherapy for cancer. Because of this relationship, we feel more free to call someone in the university. You get to know the individual's strengths and real in-depth knowledge."

Nursing Refresher

Turning from medical education to nursing, a prime example of the AHEC approach is a Charlotte Memorial refresher course for nurses who are licensed but not in practice. Marcia Brooks, coordinator of nursing education, asked the help of Miss Booth in getting a mailing list of nurses in the Charlotte area, which was compiled from information supplied by the state nursing association and the state board.

About 100 inactive nurses responded to a postcard survey and expressed interest in a refresher course. These received a second questionnaire asking how long they had been inactive, what kind of education they had had, and in what areas they felt the need for education. This brought about 50 replies, and eventually 22 enrolled in the six-week course, although two did not complete it.

Mrs. Brooks had recruited Jane Fox, a faculty member of Central Piedmont Community College, to design the course. To be sure they were on the right track, they called in Robert Koewing, an instructional evaluation specialist at the UNC Office of Medical Studies.

He describes his role: "I asked my usual bag of questions. Who's the curriculum for? How do you know that the people you've designed it for really need what you've put in? And what if you discover they're up on this, but know nothing of this other thing you've assumed? I convinced them to construct a pre-test and a post-test and to define the instructional objectives. The tests had 80 items, which we matched to the objectives."

The mean age of the enrolled students was 44, and the mean number of inactive years was 21. Because they had been trained so long ago, says Mr. Koewing, they had learned "very little of the underlying scientific principles. They were taught to do

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Chapel Hill faculty members regularly fly to Halifax Memorial (above) and other hospitals to give continuing education lectures, consultations, and other aid.

well what they were told to do. But now nurses are expected to know why, to check with the doctor if his orders look wrong, to know what's likely to be prescribed for a certain condition, to recognize complications. The refresher nurses demonstrated on the pre-test that they hadn't been taught such things. The course had to be redesigned, as well as the post-test, again relating it to the objectives."

The mean pre-test score of the students was 36.36, and the mean post-test score was 50.85. Nine active nurses in a large teaching hospital scored 61.11 on the same post-test, while nine others in a community hospital scored 45.85. Eighteen of the 20 graduates of the course are now back in active nursing.

Says Mr. Koewing: "We quickly realized that this had statewide implications. We had a course curriculum oriented to the needs of community hospitals. We had some demonstration of performance. We had some experience with what they learned easily, what with difficulty."

Miss Booth concurs: "We will constantly refine it until we have a refresher course that is generalizable to the state, and in which minor amendments can be made to suit the needs in a particular region. But, in order to get nurses back in practice, we also need to tackle some of the other variables, such as poor pay, dull jobs, and family responsibilities."

Better pay is a theme of Dr. Henry S. M. Uhl, Director of the Asheville AHEC, which was recently visited by Miss Booth, Mrs. Brooks, and Mr. Koewing for discussions of setting up a refresher course there. Pointing out that some 60% of area nursing graduates quit within three years, Dr. Uhl says, "I keep telling the hospital administrators that if we upgrade salaries, benefits, and career opportunities to make the field attractive to men as well as to women, a lot might stay in the field permanently. It would mean great savings in the long run if we did not have to keep training so many new people. The aim of the course, however, is continuing education, not a recruiting device. It will help keep up their self-confidence so that when and if they are ready to go back into nursing it will not be such a difficult decision."

Wilmington's nursing education coordinator, Carol Moore, also plans a course patterned on the Charlotte model. Among other things, she says, inactive nurses need instruction in using disposables and prepackaged supplies. And she is working with a pharmacist to compile for the course a list of the most commonly used drugs, by categories such as antipyretics, including indications, contraindications, and side effects. Another of her projects is videotaped continuing education programs on such topics as coronary care that can be circulated for the use of nursing staffs in the smaller surrounding hospitals.

Wilmington AHEC Director Dewey Lovelace signals another continuing education course, 16 sessions on child-screening procedures for public health nurses. And he expects that a great deal about continuing education needs will be learned from the hospital's new nursing audit program.

The Wilmington, Asheville, and Area L AHEC's are also getting into a state program to train family nurse practitioners to staff satellite clinics in remote areas. The need is particularly acute in the Asheville area. Dr. John McLeod, Chairman of its Board of Directors, tells why:

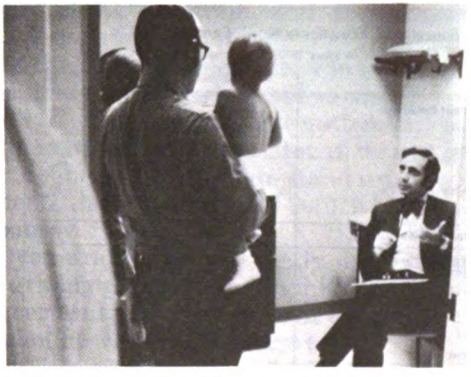
"Asheville is the only town of any size in the 17 western counties. Even if towns are only five miles apart, there may be two mountain ranges in between, so transportation and communication are difficult. Many people don't have electricity or telephones. A house call takes two or three hours, and the people can't pay more than $5. When I practiced out there before becoming a pathologist, girls who went into labor would catch the bus to my office, have the baby there, and rest in bed until the return bus came. They might have to walk two or three hours after they got off. As an alternative, a lot had their babies at home. The public health nurses watch the the people out there as best they can, and try to spot the sick and get something done for them."

Convinced that such remote regions will not be able to attract and support enough doctors, Dr. McLeod and Dr. Uhl see the solution in rural health clinics staffed by FNP's and linked to Asheville by telemetry. Presumably, as with other such clinics already staffed elsewhere in the state by graduates of a UNC course for nurse practitioners, a supervising physician would stop by regularly.

Area L, says Dr. John Hartman, AHEC Associate Director, is discussing a teaching program to give licensed practical nurses upward career mobility even to earning a baccalaureate degree in nursing. So far, however, arrangements have not been worked out to reconcile the views of the four area hospitals plus the technical institutes that would be involved.

At Charlotte Memorial, Jeanne Palmer, coordinator of allied health education, is helping nursing homes

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Dr. Stewart Schall, a Chapel Hill pediatric cardiologist, conducts a clinic in Area II. Faculty members provided 8,000 consultations with practitioners in 1973.

arrange for consultants and for shared services of technicians and other personnel they cannot afford full time. She also plans a career training course for coordinators of volunteers. And she works with the public schools to foster better science preparation for health careers.

The need for such preparation is stressed by Dr. William Highsmith, Chancellor of the University of North Carolina, Asheville, and a member of the local AHEC Board of Directors. "The whole country," he says, "is in the early stages of an enormous transformation of medical care and health services. Nothing of any consequence is going to occur, however, without significant change and enlargement of the system of health education. By the time students have graduated from high school they should know how the body is constructed and functions, the influences of nutrition and the environment, and something of emotional and mental health."

Dr. Highsmith's long-range plan is to develop a UNC division of health sciences tied in with the school of education. The result, Dr. Uhl suggests, would be that "we might be able to train health educators and put them right into the school system."

The Asheville AHEC got a later start than the others in the state. But Dr. Uhl is proud of a masters' degree program in public health now being conducted on the UNC campus there, patterned after a course developed in Raleigh. Since the students are all employed, teaching sessions are held only one day a week and completion of the course takes three years.

Every Friday the 21 students drive in from surrounding areas as far away as the vicinity of Charlotte, and two faculty members fly in from Chapel Hill, each taking the class for three hours. One week this April, tornadoes and violent rainstorms caused flooding and a great deal of damage in the western part of the state. But that Friday every student showed up, even a sanitarian whose town had been severely stricken.

Speaking of this AHEC's continuing education programs, Dr. McLeod says, "We have been amazed that not only physicians but nurses, technicians, hospital administrative personnel, college professors and students, and even occasionally lay people have shown up at our workshops."

As in Asheville, much of the other AHEC educational effort in public health takes place away from participating hospitals. Thus, Dr. Slome's message about the contribution public health can make has still not struck home to most other health professionals. The exception may be in Charlotte, where in interdisciplinary seminars all students from the various UNC schools learn something of the others' roles.

The School of Public Health is working on a survey of nursing homes with members of the staff of Charlotte Memorial. And a hospital administrator in Area L has asked Dr. Slome's help in solving the problem of migrant workers, who have no health insurance, earn too much to qualify for Medicaid, but are too poor to pay for hospital care. Dr. Slome will propose state health insurance legislation to cover these people.

Local public health personnel in Tarboro, as well as social service and mental health workers and members of the hospital staff, are participating in a pilot project to screen elementary school children for illnesses and to guide teachers in observing physical and behavioral signs that suggest referral for treatment. In Raleigh, some sixth-graders are getting intensive instruction in dental care, which they in turn will teach to younger students.

Dental students, says Dr. Block, get a view of medicine and other health professions through clinical clerkships and summer externships, fellowships, and preceptorships. The course description of one summer clerkship in a home for mentally handicapped children proposes that students "will discuss with the dental director the community relationship with the disciplines of medicine, nursing, pharmacy and how they relate to dental care of this segment of the population." Some of the other clerkships are in correctional institutions and geriatric facilities.

Charlotte Memorial, surrounded by more dental specialists than most other AHEC hospitals, and with three dental residents, is particularly active in dental education. Students rotating here observe operating room procedures, go on medical and surgical rounds, attend house staff meetings, and learn about hospital administration and medical staff organization.

The high spot of their experience, though, says the dental education coordinator, Dr. Barry Miller, is their time in the family practice clinic: "This gives them an overview of the patient with his total complex of health and family problems." Special conferences in the unit are geared for the benefit of both dental and medical trainees; for instance, a presentation by a dietetics student and a professor of biochemistry from a nearby college took up nutrition in relation to dental health and to such medical problems as hypercholesterolemia.

For practicing dentists, Dr. Miller sets up one-day continuing education

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Educational Activities in North Carolina AHEC's

Year 1 October 1972 – September 1973

	Planned	Actual
UNC Student Rotations		
Medical	197	301
Nursing	71	139
Dental	128	196
Pharmacy	1	84
Public health	5	18
UNC House Staff Rotations	19	61
Continuing Education Hours by Staff or Visiting Lecturers		
Medical	919	2,256
Nursing	466	1,084
Dental	26	102
Pharmacy	12	60
Public health	0	120
Allied health	59	392

courses on topics chosen by an advisory council of representatives of each county and each dental specialty in the area. "Some of our communities had never had dental groups meeting before AHEC," he says. "Now they have not only formed study groups and started talking to each other, they are coming to meetings at our hospital and talking to the hospital administrator, nurses, and physicians."

Dr. Block works with the other AHEC's to provide faculty and set up continuing education courses based on practitioners' interests and needs. A two-year schedule will cover medical emergencies in dental practice, differential diagnosis, and new concepts and techniques in periodontics, prosthodontics, oral surgery, orthodontics, and endodontics.

In pharmacy, the UNC school last year put on 24 continuing education programs in seven cities around the state, to a total attendance of 400. The school also distributed more than 1,100 audio cassettes. This fall it will put on a 14-week course on basic biopharmaceutics and pharmacokinetics aimed particularly at the pharmacist who graduated more than 10 years ago.

Pharmacists in the Charlotte area have another means of keeping up to date, an AHEC drug information bulletin put out bimonthly by Wayne Rinehart, Director of Pharmacy at the hospital. These bulletins consist mainly of abstracts of recent medical journal articles with a bearing on pharmacy.

Mr. Rinehart also sets up local seminars with physicians as speakers. "I've been amazed," he said, "at how enthusiastic doctors are when asked to talk to our group." A recent three-month program comprised talks on the pharmacist's responsibility to the health care team, computers in medicine, and antibiotics in pediatrics.

Another aspect of continuing education that Mr. Paoloni is working on in Chapel Hill is the development of systems for small hospitals to monitor drug therapy.

At the undergraduate level, the pharmacy curriculum is being changed to allow fifth-year students to spend about six weeks in AHEC communities. They may work under practitioner-preceptors, in hospital pharmacies, or in patient care areas. Already, during clinical clerkships in community hospitals, pharmacy faculty members and students go on rounds with medical and nursing personnel.

After graduation, the pharmacist must spend a year's internship with a preceptor. As in any field, some preceptors are good, some not so good. Now, under AHEC, says Mr. Paoloni, "These experiences can be put into a structured program, with guidance from the faculty to the preceptor as well as to his students."

The pharmacy student's and practitioner's increased liaison with other health professionals may help advance a concept of the pharmacist as more than pill-dispenser that Mr. Paoloni describes this way: "Why not teach the pharmacist to take a blood pressure, to check the hypertensive patient who comes in for a refill of his medications, and to ask a few questions about headaches and other symptoms? He could draw a conclusion as to whether the patient needs to see his physician earlier than scheduled. The same thing would go for a lot of chronic illnesses and for geriatric patients.

"We already have such practice in the mental health area. Pharmacists keep a tickler file showing when the patient is due for a refill. If he doesn't show up, the pharmacist telephones him as a reminder and also reports to the doctor if the patient is getting refills too often or not often enough."

The pharmacist can help educate the patient, Mr. Paoloni continues, by discussing his drug therapy with him and giving instructions on proper timing of medication. Physician education can be aided if the pharmacist points out the possible harmful interaction between a new medication and others the patient is taking.

"I feel AHEC lends itself beautifully to interprofessional relationships, to the physician's recognition of the role and potential of the pharmacist," Mr. Paoloni says. "His patient becomes the pharmacist's patient as well."

Is all the massive and diverse activity showing any concrete results? Dr. Galusha, who is on the state board of medical examiners, answers, "We are seeing more doctors coming into the state. Something is happening, and AHEC is helping."

Hopeful as this may be, Mr. Wilson says cautiously, "It will be some time before we can really tell whether the program has made a difference in the distribution of personnel. We think it has great promise, but I'm not prepared to say categorically it's going to work. I'll talk to you about that in 1980. As near as I can tell, there are no easy panaceas for the delivery of health care in the United States. The simpler the answer, the wronger it's likely to be."

As this article proves, AHEC is far from simple.

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Mr. ROGERS. Thank you. I think your statement has been good.

I have visited your AHEC program, and I was most impressed with it. I think you have done a great job.

Now, with regard to the FMG problem, are you telling me we should not allow any, or we should allow all who want to come?

Mr. WILSON. I think the problems we have gotten ourselves into will have to be faced to some orderly manner. But if we are going to take students from other countries with high standards and take their very best students, then I think they should return home to serve their countries, not this country.

Mr. ROGERS. Well, you are saying you really don't think we should have foreign medical graduates practicing in this country?

Mr. WILSON. Well, certainly not the cream of the crop.

Mr. ROGERS. Well, should we take the worst?

Mr. WILSON. No, sir.

Mr. ROGERS. Well, then you would just take mediocre ones?

Mr. WILSON. The numbers this morning I would have reduced by 10 times or more, Mr. Chairman.

Mr. ROGERS. In other words, you would not take very many FMG's; you think it is better not to have a policy of being dependent upon foreign medical graduates for medical care in this country?

Mr. WILSON. I do not think we should be dependent. I think we have an obligation to the world to provide residency training for well-qualified students, but I think they should then return to their country and serve their people, not our people.

Mr. ROGERS. Yes.

Now then, would you limit the number you train in residencies, since residency training is rather heavily oriented to the problem of delivery of care as well?

Mr. WILSON. I would want to accept, within our capacity, all the well-trained foreign medical students we can, with the clear understanding they are going to return home.

Mr. HEFNER. All of them?

Mr. WILSON. All of them.

"All?" Excuse me, Mr. Chairman, "all" is too all-encompassing, but the overwhelming majority.

Mr. HEFNER. Well, I mean you would have to set a percentage who would have to understand that once they finished they would be returning to their own country.

Mr. WILSON. Yes.

Mr. HEFNER. But it would be a voluntary thing?

Mr. WILSON. No, I think this country has an obligation to set that policy and not make it voluntary.

Mr. CARTER. Mr. Chairman, if the gentleman will yield. I think he is giving the moral aspect of it, that we shouldn't create a "brain drain," in other words.

Mr. WILSON. Thank you.

Mr. ROGERS. Should the taxpayers of this country also be obliged to train students that are not American citizens?

Mr. WILSON. Nobody has with certainty identified how much a resident with a good medical education costs, and I would guess that at some point in that process we get about as much, assuming they

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can speak English and can perform service, we probably get pretty close with some crude accounting to breaking even on that, Mr. Chairman.

Mr. ROGERS. Well, the only thing is, should we gear up our whole health mechanism to train foreign students, or to train what we need here to serve our own needs? Should we go through the added cost to the patient? You know, the patient has to pay some, too, when you have a resident in your clinical center. And the taxpayer has to pay something, too.

Now, should we inflict that burden on this country? I realize we should assume some obligation to train a moderate amount, which I think this committee would be willing to consider. But I am not sure how far we should go.

Mr. WILSON. I would assume that the Congress would have the capabilities of deciding what our international interests are and they should come from Federal funds, not local funds, if they are going to recruit the physicians at the other end.

Mr. ROGERS. And, of course, now with our big deficit we would cut them all out if it was on that basis, because we have a $52 billion projected deficit in the budget now, which will probably go even higher.

Mr. CARTER. Mr. Chairman, on that, other countries are having deficits, too, at least most of them are, and I think we have got to have this interchange between our medical schools throughout the world. I believe it is vital. I don't mean that we should take upon ourselves to educate such a large percentage of physicians in other countries; quite the contrary. But to continue the interchange between our countries, is very healthy.

Now, just this morning I was talking to an eminent hemotologist and oncologist who was going down to Brazil to teach and to visit various institutions down there. This interchange is very necessary. We should accept some graduates with the idea of helping them, letting them learn our methods of training, and then expect them to return to their home, as you said.

Mr. ROGERS. Well, I think the committee in its proposed legislation assumes that 25 percent would be foreign medical graduates.

Mr. WILSON. Mr. Chairman, if 25 percent, under the new standards, from what I have seen from the data, will mean that from those countries we may be getting all of the best students around the world, with that 25 percent——

Mr. ROGERS. Well, we may be giving them the best training, and then they will go back.

Mr. WILSON. But they don't, Mr. Chairman.

Mr. ROGERS. Well, that may have to be an immigration policy.

Mr. CARTER. Mr. Chairman, I disagree that we are getting the best students.

Mr. WILSON. Congressman, I said if we raise the standards, not at the moment I do not.

Mr. CARTER. Yes, sir, if we raise the standards. At the present time I think probably the majority is on the low level, not the higher type. I think they stay at home, by and large.

Mr. ROGERS. Would you want to comment on that, Dean?

Dr. SCHWARZ. I am trying to refrain from entering, but if you will

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allow me, for a moment. I think you must remember that a large number of foreign medical graduates are U.S. citizens.

Mr. ROGERS. About 10 percent of those training outside the country are American citizens.

Dr. SCHWARZ. Right. But we don't know, at least I don't know, how many that is. That numbers in the thousands. They have no country to return to except this one.

Mr. ROGERS. Well, it is probably no more than 1,000 or 2,000.

Mr. CARTER. Mr. Chairman, I believe that was the reason you included in the last bill an arrangement by which they could receive continuing education here.

Mr. WILSON. Could I clarify the record? I was not addressing the question that has been raised of U.S. citizens.

Mr. ROGERS. Oh, you are thinking only of the foreign nationals?

Mr. WILSON. That is right.

Mr. CARTER. But from Guadalajara 400 graduate students returning last year, I don't know what the total number is.

Mr. ROGERS. I think the number is something close to a thousand who go overseas for training.

Dr. SCHWARZ. That will increase.

Mr. ROGERS. Out of the 9,000 or 10,000.

Dr. SCHWARZ. But that will increase, because of the large number of Americans who are now somewhere in that training pipeline.

Mr. ROGERS. Yes, it will, some.

Dr. SCHWARZ. I agree that it is a conservative estimate, that you will see expand over the next 4 or 5 years.

Mr. ROGERS. Well, many of the schools are now refusing to take American students, as you know, except in Mexico where they have very large schools, and the Philippines; many of the European schools now are no longer taking American students.

Thank you.

Any questions?

Mr. Hefner?

Mr. HEFNER. No, I don't think so. No.

Mr. ROGERS. All right, sir.

Dr. Feinstein.

STATEMENT OF A. ARCHIE FEINSTEIN, M.D.

Dr. FEINSTEIN. Mr. Chairman, for the record, my name is A. Archie Feinstein. I am the assistant dean for clinical training of the Philadelphia College of Osteopathic Medicine.

I am here this afternoon as a representative of the American Association of Colleges of Osteopathic Medicine. I am also a member of the board of trustees of the American Osteopathic Association and secretary-treasurer of the Pennsylvania Osteopathic Medical Association.

It is indeed a pleasure to appear before this distinguished subcommittee whose chairman and members have over the years perceived the importance and needs of health professional education. H.R. 2956, a product of this subcommittee's collective thinking, will in my opinion, and in that of my colleagues, go far in resolving some of the fundamental health manpower needs of this Nation.

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I have been invited here to address the issue of remote site training of osteopathic physicians. I welcome this opportunity, for as an osteopathic physician educator, I perceive such training as a fundamental dimension of osteopathic medical education. Although my testimony will address only the experiences of the Philadelphia College of Osteopathic Medicine, I would be remiss if I did not say that such training is an integral part of the curriculum of other colleges of osteopathic medicine and to a large extent has been the reason for the profession's success in producing high numbers of primary care physicians.

Prior to the inception of our rural training programs, the only clinical exposure available to our students was that of urban clinical and hospital facilities. Consistent with the basic philosophy of the Philadelphia College of Osteopathic Medicine, which was and continues to be the education of general practitioners, the administration and faculty perceived that the student deserved to experience "front line action," so to speak. In addition, it was judged that this exposure would engender, on the part of the student, the desire to establish his practice in areas of the country which are currently underserved with health manpower.

To achieve our goal, the Philadelphia College of Osteopathic Medicine established the Laport Health Care Center. The health care center, formerly a hotel, is in Sullivan County in north-central Pennsylvania, approximately 150 miles from Philadelphia. The population of Sullivan County is 5,800 and prior to the opening of the health care center, there was one active physician and one physician with a restricted practice because of ill health.

The health care center is staffed with one full-time physician and two part-time physicians, who together with a complement of nurses provide 24-hour-a-day medical service. In 1974, slightly over 6,000 patient visits were recorded at the health care center.

Four students are assigned on a 6-week rotating basis during the last year of their predoctoral education program. During the previous years of their training students have been assigned to practicing physicians who act as their preceptor in private practice settings. The Laport assignment provides a unique experience for the student.

We also have a general practitioner on a one-to-one basis, similar to what was discussed before in that other program from Washington University.

We sent our students out to a general practitioner's office, and try to get those young fellows who come in from rural areas and from the small towns to return to their towns at that time we contact the physician in their towns, make all the arrangements for them, this is education on a one-to-one basis.

Now, you also asked those fellows from the other institutions, how do they grade these people? (Their students.) Well, we have grading sheets on which they have to fill in the entire grade.

But we also have an evaluation by the student of what he picked up from his instructor, so this is sort of a two-way information system for evaluation of training process.

Mr. ROGERS. Very good.

Dr. FEINSTEIN. And then with that information we adjust our program. I thought that would be interesting, Mr. Chairman.

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Mr. ROGERS. Yes, it is.

Thank you.

Dr. FEINSTEIN. As a part of his clinical training in the health care center, each student will be the first contact point for the patient's introduction to the health care system. The student will take the patient's history; perform a complete physical and make a tentative diagnosis. The student will then discuss his diagnosis and prescribed treatment with his supervising physician. The student will participate in the patient's treatment and will maintain his relationship with the patient throughout subsequent patient visits.

Aware of the major role a wife will play in the eventual selection of a site where her husband will practice, the college permits, and indeed urges, that the student be accompanied by his wife and children on the Laport rotation. Through this arrangement, the whole family can become acquainted with rural life and the professional and family opportunities in rural areas.

Despite major financial losses, the Philadelphia College of Osteopathic Medicine continues to maintain the Laport rotation, due to the perceived benefits such training holds for each student. Through this and similar experiences the student very quickly develops a sense of self-confidence and perceives the need and necessity for making mature and independent decisions very often without the backup of sophisticated technology.

We have also found that as a result of the Laport experience, the student has become motivated to accept the challenge of medical practice in a rural area. Finally, as the director of this program, I have seen our students grow in their appreciation for the role of the primary care physician.

Because of the success of the Laport Health Care Center as a training and service center, the Philadelphia College of Osteopathic Medicine has employed a full-time health administrator to plan and supervise the expansion of the health care centers in both rural and urban areas. Other sites are now being investigated and a model building is being studied.

By virtue of Federal capitation support, the Philadelphia College of Osteopathic Medicine is able to maintain its current programs for the education of general practice/family practice physicians. In order to expand its educational programs, and specifically programs in rural and urban areas, the college is forced to look to outside sources of support. I trust that in your wisdom, Mr. Chairman and members of the subcommittee, that you can extend such support to schools like mine which are eager to respond to the Nation's needs for well-trained family physicians. However, Mr. Chairman, I fear that if a college like the Philadelphia College of Osteopathic Medicine is forced to divert 25 percent of its capitation support for remote site training, its basic educational efforts will be seriously impaired.

Over 60 percent of all doctors of osteopathic medicine practice in communities of less than 100,000. Mine is a profession totally engaged in the provision of health care services. Our dedication to meet the health care needs of the many remote and rural areas of our country has been demonstrated. We look to you, gentlemen, to reinforce our dedication.

Mr. ROGERS. Thank you very much.

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Again, I think what you are doing is impressive, and this committee is very much aware of the fact that most of the osteopathic physicians are in primary care.

Dr. FEINSTEIN. Yes, over 60 percent of all the DO's in the United States are in primary practice care.

Mr. ROGERS. Yes.

Dr. FEINSTEIN. And they are in areas of under 100,000 population.

Mr. ROGERS. It is a welcome fact.

Dr. FEINSTEIN. And the graduates from most of our colleges, 75 percent of them are general practitioners.

Mr. ROGERS. Yes, we are well aware of that.

Thank you for being there.

Next, on behalf of the dentistry, Dr. Dale F. Redig, dean, School of Dentistry, University of the Pacific.

STATEMENT OF DALE F. REDIG, D.D.S.

Dr. REDIG. Mr. Chairman and members of the subcommittee, my name is Dr. Dale Redig. I am dean of the University of the Pacific, School of Dentistry, and a member of the Commission on Accreditation of the American Dental Association. It is a pleasure to once again appear before this subcommittee. Last year I had the opportunity to present the views of dentistry on health manpower legislation.

This morning I am appearing in a private capacity, as a dentist and a dental educator, to offer some personal observations on one important aspect of that legislation—remote site training of dental students.

My principal remarks will be limited to the extramural learning experiences that are provided by the University of the Pacific. If time permits, I would also like to briefly comment on several programs that are conducted at other dental schools.

It is important, I believe, to initially outline the importance that dentistry places on these training programs. The requirements and guidelines of the American Dental Association Commission on accreditation states, and this is a partial quote:

> **Extramural Programs: The Commission expects schools to include extramural programs as part of the basic educational program. The Commission believes that such experiences assure an appropriate educational experience that may not be attainable or meaningful if the entire educational experience of students is limited to the physical confines of the dental school. Further, changing trends in dental practice indicate that practitioners of dentistry are, in fact, becoming more involved in providing dental care in hospitals and, in some cases, community clinics. The dental profession has shown interest and has, by its actions, undertaken positive steps to provide dental health care for institutionalized patients and certain patients in community clinics. Positive steps by the profession in these ever-changing areas do much to indicate to the public the concern and interest of the profession in providing dental health care to all segments of our population.**
>
> **In this context, extramural experiences under strict faculty supervision should orient the students towards various health care delivery systems; e.g., hospitals, community health centers and public health departments. The Commission is also aware of the advantages of observation in private practice settings in urban and rural areas. Such programs should be designed to expose the students to different population groups and give them experience in providing dental health care service in other than the dental clinic environment. All such activities should be under the strict supervision of faculty members who have been thoroughly indoctrinated in the objectives of the extramural program.**

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I think that it is equally important, however, that we do not overemphasize the impact that "remote site" training will have on solving the problems of geographic maldistribution. A number of the off-campus programs that were described in the 1974 House Report on Health Manpower have only been in operation for a limited time. While it is generally accurate to say that these training programs have been successfully integrated into the overall curricula of those schools, it would be, in my opinion, premature to suggest that they have had a demonstrated influence on the practice locations of their graduates.

It is my personal opinion that extramural learning experiences will ultimately prove to be an important factor in motivating and preparing students for later practice in underserved areas. Dentistry, however, is just beginning to develop a data base that can be utilized to justify these assumptions.

I share the concern of this committee that geographic maldistribution is a major obstacle to the delivery of health care. At this juncture, however, I am not certain that sufficient evidence exists to warrant the proposed requirement in H.R. 2956 that all dental schools allocate 25 percent of their capitation grant funds to students in a geographically remote site. As a practical matter, those institutions that presently do not have such a program may have to expand considerably more than this amount to establish extramural facilities. This could, in turn, result in the lowering of the quality of other programs at the school.

In that context I am saying that we may have to rob Peter to pay Paul in order to get some of these programs started.

At UOP, because of a revised curriculum and a substantially increased enrollment per class—33 percent—we developed extramural remote site programs beginning in 1970 and we now have 11 different sites.

One is in a Mexican-American community; two are in black ghetto areas; one is in a commune area on the upper northern coast of California; one is in a jail; one is in a valley hospital about 80 miles from San Francisco; one is in a dental foundation clinic in Sacramento operated by a dental group. We operate two facilities which are geriatric in nature, one mental health clinic, one emergency clinic in a hospital, and one in a home for unwed mothers.

Thus we have a really broad based extramural effort in remote sites, some within a mile of our dental school, and one about 180 miles away. However, these programs were not really quickly developed. We developed them over a period of 5 years, and it took 3 years to get most of them operational.

It cost us about $500,000 of dental school money to develop them, and we only put substantial money into about four of these programs. The others were paid for by San Francisco County, San Joaquin Hospital, and so forth.

Our concern, really, related to 25 percent of capitation money going into these programs is that, No. 1, it may not really be enough, and, No. 2, especially for schools in the private sector, and I think for a good many public schools as well, the capitation funds are already totally committed for existing teaching programs. If 25 percent of capitation money, the total of which, in our opinion, at this point, will not provide us with more funds than we are presently receiving

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under capitation, is required to be used for remote site training some of us are going to be in trouble.

We are going to have to find other sources, or cut programing in some instances, perhaps. Especially for the private schools, which do not receive State-related support, and I represent one of those, this could pose a really significant problem. I would like you to consider it not just from the aspect of my school, but from that of a good many other schools in the United States also.

There are 29 schools out of 58 total, which have substantial extramural programs. I could describe some of these in detail, but I think it is not really necessary to do that.

Mr. ROGERS. You might give that to us for the record.

Dr. REDIG. Yes. We will do that by the end of next week.

Mr. ROGERS. How many now have remote site training?

Dr. REDIG. Twenty-nine that I am certain of.

Mr. ROGERS. And the total number of schools?

Dr. REDIG. Fifty-eight. And we will verify it, the number may be higher than 29. I could only verify 29 this morning. We will verify it, though, by next Friday for the record.

[The following information was received for the record:]

DENTAL SCHOOLS CONDUCTING EXTRAMURAL CLINICAL PROGRAMS

Extramural site field experiences differ significantly among the 59 schools of dentistry. Some schools provide students with multiple and varied field experiences. The experiences include mobile clinics, field experiences with migrant farmers, private offices in under-served urban and/or rural areas, nursing and old age home experiences, centers for treating exceptional children, prisons, hospital clinics in underserved areas, and satellite clinics treating drug addicts. The following dental schools conduct extramural clinical programs:

University of Aabama
University of the Pacific
University of California, San Francisco
Loma Linda University
University of Connecticut
Howard University
Medical College of Georgia
Northwestern University
University of Illinois
University of Iowa
University of Kentucky
University of Louisville
University of Maryland
Harvard University
Tufts University
University of Michigan
University of Minnesota
University of Missouri
University of Nebraska
New Jersey University
New York University
University of North Carolina
University of Pennsylvania
University of Pittsburgh
Medical University of South Carolina
Meharry University
Virginia Commonwealth
University of Washington
University of Puerto Rico

Mr. ROGERS. Thank you very much.

Mr. Hefner.

Mr. HEFNER. No.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I just want to compliment the gentlemen on what they have said. I am very much interested in WAMI and AHEC's, and personally I would like to participate in an on-site visit, if we have the opportunity. I feel like they certainly are doing a good job.

Mr. ROGERS. Thank you.

Dean Redig, how are we going to get these other schools to consider a little off-site training? Just ask them to? It would be nice if they do it.

Dr. REDIG. No. No, I think there are some either/ors in the legisla-

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tion as written right now, and one of my suggestions would be that you could put remote site training in as an either/or condition.

Since the Commission on Dental Education and Dental Auxiliary Education which was activated in January is now strong, the guidelines in accreditation procedures have been strengthened.

Off-site training is strongly emphasized since it is stated in the guidelines in a very strong way. I believe that we are seeing schools move to implementation of off-site training programs very rapidly.

Mr. ROGERS. Well, suppose we were to say that you must spend the equivalent of 25 percent of capitation?

Dr. REDIG. You mean in kind?

Mr. ROGERS. So that you could——

Dr. REDIG. Yes.

Mr. ROGERS. Get it from other sources, as you have described.

Dr. REDIG. That would be much easier to take.

Mr. ROGERS. But perhaps it would have to be 25 percent in new funds.

Dr. REDIG. That would be easier to manage.

Mr. ROGERS. In other words, give the alternative of either using the new requirement of capitation or else new funding to carry those programs to the same extent, or at least an equivalent amount of the capitation moneys of 25 percent.

Dr. REDIG. Yes, looking at it very quickly——

Mr. ROGERS. Why don't you write us some language like that, if you think it would help.

Dr. REDIG. OK.

Mr. ROGERS. Could we have it so we can write the bill next week?

Dr. REDIG. Yes, you can.

Mr. ROGERS. Thank you.

[The following letter was received for the record:]

UNIVERSITY OF THE PACIFIC,
San Francisco, Calif., February 28, 1975.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Environment,
2407 Rayburn House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: Pursuant to our discussion at your recent health manpower hearings, I am forwarding to you a suggested amendment to the provisions of H.R. 2956 relating to the method of financing remote site training programs conducted by schools of medicine, osteopathy and dentistry.

As proposed, H.R. 2956 mandates these health professions schools to provide remote site training as a condition for receipt of capitation support. At the same time these schools would be required to obligate at least 25% of their total capitation payments to these remote site training programs. My concern is that these schools, which are already in difficult financial straits, will find it fiscally impossible to meet these requirements without severe effects on the quality of education provided.

The attached amendment would make remote site training programs optional with the schools while providing special funding for those schools which implement such programs.

Unfortunately, the transcript of my appearance before your Committee is not yet available. I am hopeful that this amendment responds to your request at that time.

I thank you for your consideration of this suggested change. If I can provide any further information, please do not hesitate to call on me.

Sincerely yours,

DALE F. REDIG,
Dean, School of Dentistry.

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SUGGESTED AMENDMENTS TO H.R. 2956

On page 66, line 21, substitute a semicolon for the period and add the word "or" following the semicolon.

On page 67, strike line 16–23 and renumber the following paragraphs.

On page 69, after line 16, insert the following: (2) For the purpose of assisting those schools of medicine, osteopathy, and dentistry which choose to train students in remote site facilities as provided in clause (1), the Secretary shall make grants to each such school which has a project approved by the Secretary under such section in an amount equal to not less than 25% of the amount received by such school as a grant under section 770.

(3) There are authorized to be appropriated $43,500,000 for fiscal year 1976 and $42,900,000 for fiscal year 1977 for payments under the grants authorized by section 771(b)(2) to schools of medicine, osteopathy, and dentistry.

Renumber the paragraph beginning on page 69, line 17 as (4).

Dr. REDIG. We are running into one more interesting problem which I believe other institutions are going to face very shortly. The malpractice insurance program is becoming a very serious problem for us in remote training sites.

Mr. ROGERS. For schools or in your clinics?

Dr. REDIG. In remote training sites and in the school because if faculty hold adjunct appointments, in our school, they must cover their teaching experience with their private malpractice insurance. It is just cropping up as a significant problem in our school, but I dare say that it will crop up in other institutions as well soon.

Mr. ROGERS. Now, those are people not associated with the school.

Dr. REDIG. No, they are associated with the school, they hold adjunct faculty appointments.

Mr. ROGERS. Oh, I see.

Dr. REDIG. And they do receive faculty indoctrination.

Mr. ROGERS. But no salary.

Dr. REDIG. And because they are not salaried, they are not under our insurance coverage and I believe this is probably true in other off-site programs as well, isn't it?

Mr. ROGERS. How are malpractice suits against the school handled?

Dr. REDIG. It is tangential to this testimony, you understand, but I don't know, it at some point may have a bearing.

Pardon?

Mr. ROGERS. Are there very many malpractice suits against the schools?

Dr. REDIG. Not very many in dentistry to date.

Mr. ROGERS. Against the school?

Dr. REDIG. I suppose in our school we get one suit a year. But it is the problem of going through it.

Mr. ROGERS. I would hope never guilty.

Dr. REDIG. So would I.

Mr. ROGERS. Thank you.

The malpractice problem is a very serious one, nationwide. And I think the problem is beginning to be addressed. The Secretary of HEW talked about it the other day. He has had companies together, and some of the State insurance commissioners, and they are agreed on a "cooling" for the moment to carry us through some critical problems until remedies can be taken.

Dr. REDIG. And since in our institution about 15 percent of the final year is spent in remote site training, it is a significant part of our curriculum.

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Mr. ROGERS. Dr. Carter.

Mr. CARTER. What does malpractice insurance cost for your initial level of protection, in your case?

Dr. REDIG. I am not able to tell you what the university pays. I can only tell you that it went up $19,000 recently for the dental school. I don't know what it is.

Mr. CARTER. You don't know what the average dentist has to pay for malpractice insurance?

Dr. REDIG. There is a representative here from the ADA who could answer that better than I. I do not practice, and haven't for 5 years, so I do not carry malpractice insurance any more.

Mr. CARTER. You weren't driven out, were you?

Dr. REDIG. No.

[The following letter was subsequently received for the record:]

AMERICAN DENTAL ASSOCIATION,
Washington, D.C., March 11, 1975.

Hon. PAUL G. ROGERS,
House of Representatives, Rayburn House Office Building, Washington, D.C.

DEAR MR. ROGERS: The American Dental Association is pleased to submit the following information for the 1975 hearing record on health manpower legislation: The annual premium for dental malpractice insurance coverage currently ranges between $125 and $350. Although the dental profession has not, at this juncture, experienced the same difficulty as other health professions in obtaining malpractice insurance coverage, a critical problem would occur if the insurance carriers elected to withdraw from the field. It should also be noted that while the annual premium rates for dental malpratice insurance are at present relatively low compared to certain other health care providers, the annual premium charges have increased steadily over the past several years.

Sincerely yours,

HAL M. CHRISTENSEN,
Director.

Mr. CARTER. Mr. Wilson, in your area, what is the average cost of malpractice insurance?

Mr. WILSON. I am afraid I don't know. It has been going up, but North Carolina has been reasonably free of the larger suits, and we have solved that problem by every place our students go they have blanket coverage for full-time and part-time students.

Dr. REDIG. Under the university policy?

Mr. WILSON. No, the institution has it; we are probably double covered.

Mr. Chairman, if I might speak for the dental school at the moment.

Mr. ROGERS. Yes.

Mr. WILSON. If the language is accommodated to the question of the capitation, at least the University of North Carolina School of Dentistry would like to have the committee consider that they have already gone out and gotten their 25 percent from State resources, so I would hope the language isn't restricted to new money, as you suggested to the School of the Pacific.

Mr. ROGERS. Well, could we not include ongoing programs?

Dr. REDIG. Yes.

Mr. ROGERS. Then certain amounts would have to be applied.

Mr. CARTER. I notice you stated the State of North Carolina in one instance had spent $28.3 million; is that right?

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Mr. WILSON. $23 million of that for physical facilities but $5 million is for operating money, and they are looking at doubling that in this session of the general assembly, from State resources.

Mr. ROGERS. Well, you might get some language for us to look at.

Dr. REDIG. I am sorry, sir, I thought I had also probably—using my interpretation—thought that you were speaking also of maintenance of effort.

Mr. ROGERS. Yes. I thought it would be a maintenance of effort. But with new moneys you could really move, if it is necessary.

Dr. REDIG. At UOP, our teaching program would not really allow us to put more students out at a given time to remote sites.

Mr. ROGERS. I see. Well, you better let us have some language.

Dr. REDIG. We will work on it [see p. 609].

Mr. ROGERS. Thank you very much. Your testimony has been most helpful, and the committee hopes to write legislation next week.

Dr. REDIG. Thank you.

Mr. ROGERS. Thank you.

The last panel today will represent the physician assistant and nurse practitioner segment of the physician assistants programs.

And I see Mr. Bill Wilson—we will be glad to have you join the table—who has been most helpful to the committee in bringing to our attention some of the problems and programs.

I understand someone did want to get a picture, and it is permitted, if you would like.

We welcome you to the committee, and we will be pleased to receive your testimony.

Your statements will be made a part of the record without objection.

You may proceed.

STATEMENTS OF A PANEL ON PHYSICIAN ASSISTANT AND NURSE PRACTITIONER PROGRAMS:

SUSAN DAGGETT, R.N.P., IN BEHALF OF THE AMERICAN NURSES ASSOCIATION, ACCOMPANIED BY CONNIE HOLLERAN, R.N.

C. HILMON CASTLE, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE, AND PRINCIPAL INVESTIGATOR, UTAH MEDEX PROGRAM, COLLEGE OF MEDICINE, UNIVERSITY OF UTAH;

THOMAS PIEMME, M.D., CHAIRMAN, DEPARTMENT OF HEALTH CARE SCIENCE, GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE;

DONALD FISHER, M.D., EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF PHYSICIAN ASSISTANTS PROGRAMS; AND

WILLIAM M. WILSON, DEPUTY DIRECTOR, UTAH MEDEX PROJECT.

Mr. ROGERS. Do the nurses want to be heard first, or do you want to?

Dr. CASTLE. Ladies first.

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STATEMENT OF SUSAN DAGGETT, R.N., M.S.

Ms. DAGGETT. OK.

My name is Susan Daggett. I am a graduate of Columbia University, and have been practicing as a nurse for the past 10 years.

The nurses potential role in the furtherance of health care delivery has been a major interest of mine for the past 5 years. I have been involved with neighborhood clinics in urban depressed areas, first as an R.N., later as an educator, and most recently as a nurse practitioner.

In 1972 as a masters degree candidate, my field study was investigating the perceptions of the expanded role of the nurse at the University of Oregon Medical Center. My nurse practitioner training program was through this masters program, and was financed by a Federal grant.

Presently I am chief of nursing at the Cambridge branch of the Harvard community health plan which is a health maintenance organization prepaid group. I practice half-time giving primary care as a nurse practitioner.

Historically nursing has been an expanding profession, taking on responsibilities originally done by physicians. A nurse has traditionally been involved with the patient as a person with physical, psychological, and social needs. Her education is comprised of a conglomerate of expertise in everything from anatomy and physiology to nutrition and community resources.

Nursing education has been for the most part hospital-based. The contacts for nursing in ambulatory settings has been either as a clinic nurse who is manly viewed as a technician, or as a public health nurse who has taken on expanded responsibilities without the necessary assessment skills or affiliation with a physician.

Many nurses have felt that they have not been able to practice to their fullest because of the constraints placed on them by institutions. This loss of professional utilization at a time when health care is inadequate in many communities is a sad commentary. One solution to this problem is the development of the role of a nurse practitioner.

The special interest group of the Massachusetts Nurses Association describes a nurse practitioner as:

> A licensed professional nurse who provides direct care to individuals, families, and other groups in a variety of settings including homes, institutions, offices, industries, schools, and other community agencies. The service provided by the nurse practitioner is aimed at the delivery of primary care which has two dimensions:
>
> 1. A person's first contact in any given episode of illness with the health care system that leads to a discussion of what must be done to help solve his problems, and
> 2. The responsibility for the continuum of care; i.e. maintenance of health evaluation and management of symptoms and appropriate referrals.
>
> The nurse practitioner collaborates with other health professionals and engages in independent decision-making. Nurse practitioners have been shown in the literature to perform comparable to physicians in the areas of well-patient examinations; the management of selected acute and chronic conditions; as well as to the more traditional nursing functions.

Now, I would like to refer to the Burlington study, which I have submitted.

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Mr. Rogers. Thank you. We will make that a part of the record as well [see p. 618].

Ms. Daggett. Thank you.

Virtually, patient satisfaction has been verified, also.

As nurses fulfill these responsibilities, they decrease the number of routine problems with which the physician must deal and enrich the quality of patient care and help bring nurses back to nursing.

At this point I would like to briefly describe three of the roles for the nurse practitioner who is functioning in the Boston area.

One is the neighborhood satellite clinics, which I was a part of for 2 years, whereby five neighborhood clinics were established in urban depressed areas.

As a nurse assigned to the Portuguese area which had a population of between 10,000 and 20,000 people, we opened a store-front clinic, and had closed circuit TV with the local city hospital for consultation.

We started with one full-time nurse practitioner who had M.D. back up, and then hired a Portuguese aide and a Portuguese receptionist. We gave care to a particular cultural group in their own language and in terms of their own perceived needs.

At the end of 1 year we were following 800 patients. At this point we needed to expand our staff to include another nurse practitioner, bring in a social worker, nutritionist, and several other ancillary people from the community to look at the consumer needs.

Another major way in which nurse practitioners are being used is the telemedicine program, through Boston City Hospital, and I would like to refer to the site article handed in.

In essence, the telemedicine program is based with a physician in a hospital and four nurse practitioners who cover the care in 11 nursing homes.

This group of five assume the responsibility for the care of these people when they are discharged from the hospital. Within 24 hours after discharge, the nurse practitioner does a complete physical examination and review of systems, meets with the patient and the family, and then provides the care that follows.

Telemedicine has found through their studies, which again is in process of being collected, that their program has cut down the number of hospitalizations from the nursing homes by at least 25 percent.

Do you also have the nursing pamphlet? It gives some of the statistical data on the preliminary findings.

In that setting nurse practitioners see an average of nine patients per day. Fifty-seven percent of the average nurse practitioner's work is still associated with paperwork. Eighty percent of the nurse practitioner's visits do not require a physician consult.

The setting in which I am now working is the Harvard community health plan, which is a health maintenance organization.

Because this is in the record, I won't take the time to go through and describe it, but more describe the role of a nurse practitioner.

Mr. Rogers. I might tell you that we have visited the center and have been very impressed with it.

Ms. Daggett. The one in Kenmore or the Cambridge?

Mr. Rogers. Cambridge.

Ms. Daggett. The new one? We opened it 2, 3 weeks ago.

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Mr. ROGERS. No, I guess it was Kenmore.

Ms. DAGGETT. We just opened the second facility in Cambridge.

Mr. ROGERS. I see. Very good.

Ms. DAGGETT. OK. The physicians and the nurses at HCHP are committed to the concept of primary health care. The nurse's role is defined as a registered nurse who works collaboratively with a physician in providing the health care. Her responsibilities are spelled out in the paper, so I will repeat that.

The emphasis is on optimal patient care, prevention of illness and health mantenance.

I'll briefly describe what is done when a patient comes to the building for the first time. The person chooses what primary care team he would like. The primary care team is made up of a nurse practitioner and physician. This team follows the same panel of patients on a continued basis.

Each physician-nurse practitioner has a specific time when they are by the phone to answer any questions that any of their patients have. They have synchronized schedules, so that the physician and the nurse can meet all of the patients that come in that day, if that is desired.

On the average we have between 18 and 25 patients seen in a morning or an afternoon by a team.

Because our training grant was turned down for an in-house practitioner program, we are in the process of coordinating with the Harvard Medical School in providing one in-house, so that all of our primary care through Harvard community health plan, including both centers, can be on this level.

The recent survey done in November looking at the preliminary nurse practitioner training and acceptance of patients in the Harvard community health plan was an overwhelming positive. There really were no negatives in the study, which will be completed, I think, in another month.

Mr. ROGERS. Is that so.

Thank you.

Ms. DAGGETT. Thank you.

[Testimony resumes on p. 629.]

[Ms. Daggett's prepared statement and attachments follow:]

STATEMENT OF SUSAN DAGGETT, R.N.P., IN BEHALF OF THE AMERICAN NURSES ASSOCIATION

THE ROLE OF A NURSE PRACTITIONER

The nurses' potential role in the furtherance of health care delivery has been a major interest of mine for the past five years. I have been involved with Neighborhood Clinics, first as an R.N., later as an Educator, and most recently as a Nurse Practitioner. In 1972 as a Masters Degree candidate, my field study was investigating the perceptions of the expanded role of the nurse at the University of Oregon Medical Center. Presently I am Chief of Nursing at the Cambridge Branch of the Harvard Community Health Plan which is a Health Maintenance Organization prepaid group. I also practice half-time giving primary care as a Nurse Practitioner.

NURSING TRENDS

A nurse has traditionally been involved with the patient as a person with physical, psychological, and social needs. Her education is comprised of a conglomerate of expertise in everything from anatomy and physiology to nutrition

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and community resources. Nursing education has been for the most part hospital-based. The contacts for nursing in ambulatory settings has been either as a clinic nurse who is mainly viewed as a technician, or as a public health nurse who has taken on expanded responsibilities without the necessary assessment skills or affiliation with a physician.[1] Many nurses have felt that they have not been able to practice to their fullest because of the constraints placed on them by institutions. This loss of professional utilization at a time when health care is inadequate in many communities is a sad commentary. One solution to this problem is the development of the role of a nurse practitioner.

DEFINITION OF A NURSE PRACTITIONER

The special interest group of the Massachusetts Nurses Association describes a Nurse Practitioners as: "a licensed professional nurse who provides direct care to individuals, families and other groups in a variety of settings including homes, institutions, offices, industries, schools and other community agencies. The service provided by the Nurse Practitioner is aimed at the delivery of primary care which has two dimensions:

(a) A person's first contact in any given episode of illiess with the Health Care system that leads to a discussion of what must be done to help solve his problems, and

(b) The responsibility for the continuum of care; i.e., maintenance of health evaluation and management of symptoms and appropriate referrals."

The Nurse Practitioner collaborates with other health professionals and engages in independent decision making about the needs of clients.

The Practitioner plans and institutes health care programs as a member of the Health Care Team.

Nurse Practitioners have been shown in the literature to:

1. Perform comparable to physicians in the areas of well-patient examinations, the management of selected acute and chronic conditions, as well as the more traditional nursing functions;[2]
2. Virtually, completely satisfy patients for whom they carry out those nursing and medical functions;[3]
3. Be available and a reasonably stable manpower pool.[4]

As nurses fulfill these responsibilities they decrease the number of routine problems with which the physician must deal and enrich the quality of patient care and bring nurses back to nursing.[5] These are some of the factors that have led the Harvard Community Health Plan to its commitment to the development of the role of the Nurse Practitioner.

IMPLEMENTATION OF THE ROLE OF THE NURSE PRACTITIONER

I would like to focus on how the role of the Nurse Practitioner was developed at the Harvard Community Health Plan in Boston. First, let me give you some background information about the Plan. HCHP was established as a prepaid group practice in 1969 and currently qualifies as a Health Maintenance Organization according to the HMO Act passed by Congress in 1973. Over the 5½ years since its inception, it has grown to a current membership of 47,000 subscribers. The Plan currently consists of two Health Centers one at Kenmore Square in Boston and a newly developed Center in Cambridge. In addition to the major Centers there is a smaller satellite health facility located predominantly in the low income Mission Hill-Parker Hill area of the City. This facility serves a Medicaid population enrolled in the Kenmore Center. The service component of the Harvard Plan is organized as a multi-specialty group practice with a full range of primary medical care and specialty services. There are currently

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[1] Baker, A.S. "Primary Care By the Nurse." The New England Journal of Medicine—January 31, 1974.

[2] Spitzer, W. et al. "The Burlington Randomized Trial of the Nurse Practioner." New England Journal of Medicine 290: 251–256.

[3] Lewis, C., Resnik, B.A. "Nurse Clinics and Progressive Ambulatory Patient Care." New England Journal of Medicine 277: 1236–1241 (1967).

[4] Spitzer, W. et al. "The Burlington Randomized Trial of the Nurse Practitioner." New Journal of Medicine 290: 251–256.

[5] Pickard, C. G. Jr. "Family Nurse Practitioners; Preliminary Answer and New Issues." Annals of Internal Medicine 80:267–270.

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90 full or part-time physicians and approximately 50 full or part-time professional nurses working at the Plan.[8]

The physicians and nurses at HCHP are committed to the concept of primary health care. Primary care is defined as the point of entry for people into the medical care system. This is the source of most basic health services, including preventive checkups, management of chronic-acute illnesses and specialist referral. In our Cambridge Center the internal medicine staff is made up of primary care teams in which a nurse and physician share the responsibility for a specific panel of patients.

The nurses' role is defined as a registered nurse who works collaboratively with a physician in providing primary health care. The practitioner possesses increased training and skills in assessing patient problems, in determining priorities of care, in planning treatment programs, and in seeking consultation or referral. The practitioner is capable of assessing and providing care for the well adult, the patient in need of chronic management, and the patient with minor acute illnesses in accordance with established guidelines.

The nurses' responsibilities are:

1. *Performs routine health exams* by obtaining baseline histories, review of symptoms and doing physical exams which include: otologic, ophthalmologic, chest, abdominal, pelvic and rectal evaluations. (Differentiates normal findings from abnormal).
2. *Screens and refers patient to supervising physician or to appropriate health care specialists.* Orders and interprets appropriate laboratory work.
3. *Shares responsibilities and collaborates* in the care of a selected panel of patients with a physician who supervises medical management.
4. *Develops and implements a comprehensive health plan* for patients and families. This includes assessment of patients' social and emotional needs as well as medical management.
5. *Communicates relevant patient data* verbally or in the record using a problem-oriented approach.
6. Identifies and manages specified acute illnesses such as URI, UTI, vaginitis, VD according to agreed-upon protocol.
7. *Monitors and manages stabilized patients with chronic diseases* such as hypertension, diabetes, obesity, and COPD according to agreed-upon protocols.
8. *Provides family planning counseling* and assesses patients for diaphragm use, IUD consideration, and pill risks. Performs diaphragm fittings.
9. *Teaches and counsels* individuals and groups with regard to health needs such as: basic nutrition, specialized diets, obesity, smoking, sexuality, hypertension and diabetes.
10. *Helps to achieve continuity of patient care* by exchanging information with other health or social agencies, and by coordinating management of patients requiring home care.
11. *Participates in review of quality of care* and works toward appropriate productivity.
12. *Participates in on-going educational programs* and protocol development for nurse practitioners.

Both the nurse and the physician have specific times when they are by the phone to answer any questions that their patients might have. They have synchronized patient schedules which allow the NP and MD to collaborate and consult on all patients seen each day. They investigate the overall needs of their practice and set up teaching group sessions as indicated. The emphasis is on optimal patient care, prevention of illness and health maintenance.

The implementation of this role is an ongoing process. Besides the development of the primary care teams, other major plans needed to be instituted to allow for understanding and utilization of the Nurse Practitioner by all health care deliverers and recipients. We are presently at the point of developing a system of monitoring the activities of the MD–NP team to assure that her skills are being utilized in practice and that the productivity and quality of her practice is acceptable.

Our present statistical data is raw, but seems to indicate that nurses are seeing from 30 to 40% of the patient population without the need of direct physician input. The results of a recent Health Center Survey of Patients indicate a greater than 87% acceptance of this kind of health care delivery.

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[8] Bates, B. "Doctor and Nurse: Changing Roles and Relations." New England Journal of Medicine 283:129–134 (1970).

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The Burlington Randomized Trial of the Nurse Practitioner

(By Walter O. Spitzer, M.D., M.H.A., M.P.H., David L. Sackett, M.D., M.Sc. Epid., John C. Sibley, M.D., F.R.C.P. (C), M.R.C.P., Robin S. Roberts, M. Tech., Michael Gent, M.Sc., Dorothy J Kergin, R.N., Ph.D., Brenda C. Hackett, B.A., and Anthony Olynich, C.A.—In Collaboration with W. I. Hay, M.B., B.S., G. Lefroy, R.N., G. Sweeny, M.D., C.M., I. Vandervlist, R.N., H. S. Nielsen, M.D., E.V. MacKrell, M.B., N. Prowse, R.N., A. Brame, R.N., E. Fedor, R.N., B.A., and K. Wright, B.N.)

Abstract From July, 1971, to July, 1972, in a large suburban Ontario practice of two family physicians, a randomized controlled trial was conducted to assess the effects of substituting nurse practitioners for physicians in primary-care practice.

Before and after the trial, the health status of patients who received conventional care from family physicians was compared with the status of those who received care mainly from nurse practitioners. Both groups of patients had a similar mortality experience, and no differences were found in physical functional capacity, social function or emotional function. The quality of care rendered to the two groups seemed similar, as assessed by a quantitative "indicator-condition" approach. Satisfaction was high among both patients and professional personnel. Although cost effective from society's point of view, the new method of primary care was not financially profitable to doctors because of current restrictions on reimbursement for the nurse-practitioner services. (N Engl J Med 290:251–256, 1974).

The concept of using nonphysicians to provide primary health service has seldom been accompanied by quantitative clinical evidence that this new form of patient care is both safe and effective. Our interest in testing the primary-care performance of nurse practitioners was stimulated by three distinctive features of the medical situation in Ontario: the delivery of primary health care is still oriented toward family physicians, who constitute 48 per cent of all registered physicians in the Province; the total number of family physicians is adequate (with an average ratio of 1:1723 per total population), but they are unevenly distributed so that many rural and small-town family physicians are overburdened[1]; and a surplus of well trained, experienced nurses has existed in the Province for several years.[2,3]

An opportunity to perform the desired test was presented in 1970, when two family physicians in Burlington, a middle-class suburban town of 85,000 just east of Hamilton, approached the Faculty of Medicine of McMaster University for possible help in introducing this innovation into their practice. For at least two years, their practice had been "saturated"—accepting no new patients or families because of inability to manage an increased case load. The physicians believed that their office nurses, with appropriate additional training, could assume a substantial portion of the responsibilities for primary care.

With this opportunity and with the offered co-operation of these and other participants, a collaborative group was formed, and two complementary randomized trials were designed. In one of these trials, reported elsewhere,[4,5] the major emphasis was on the way in which physicians and nurses were affected by the new form of practice. In the second trial, which is reported here, the principal concerns were with the effects on patients and on the practice itself.

PARTICIPATING PERSONNEL AND BACKGROUND

The two family practices under study had previously had no affiliation with a university or other institution. Patients in each practice were free to seek any

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[1] Spaulding WB, Spitzer WO: Implications of medical manpower trends in Ontario 1961–1971. Ont Med Rev 39:527–533, 1972.

[2] Ontario Ministry of Health, Research and Planning Branch: Mobility, Service and Attitudes of Active and Inactive Nurses. Toronto, Ontario Ministry of Health, 1968, p. 13.

[3] Canadian Nurses' Association. Report of a Preliminary Survey to Explore the Nursing Employment Situation in Canada in Terms of the Number of 1971 Graduates of Canadian Schools of Nursing Registered/Licensed for the First Time in 1971 Who Were Able or Unable to Obtain Permanent Employment in Nursing as of September 30, 1971. Ottawa, Canadian Nurses' Association, 1972, p. 18.

[4] Spitzer WO, Kergin DJ, Yoshida MA, et al: Nurse practitioners in primary care. III. The Southern Ontario randomized trial. Can Med Assoc J 108:1006–1016, 1973.

[5] Spitzer WO, Russell WAM, Hackett BC: Financial consequences of employing a nurse practitioner. Ont Med Rev 40: 96–100, 1973.

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desired source of primary care, and the costs of care, regardless of source, were completely covered by universal health insurance in Ontario.

One of the family physicians had received his medical degree in 1953 from the University of Durham and had practiced in Burlington for nine years; the other physician had graduated from McGill University in 1954 and had been practicing in Burlington for 14 years. One nurse had received her R.N. diploma in 1959, and the other nurse in 1948.

Before the study began, the nurses attended a special training program[*] conducted by the schools of nursing and medicine at McMaster University. The emphasis of this program is in decision making and clinical judgment, rather than on procedural skills. The graduating nurse practitioners are qualified to become not physicians' assistants, but *co-practitioners*, sharing the family physician's responsibility for continuing care of patients. The nurse practitioner learns to evaluate each patient's presenting problems, and to choose from three possible courses of action: providing specific treatment; providing reassurance alone, without specific treatment; or referring the patient to the associated family physician, to another clinician or to an appropriate service agency.

METHODS

The research contained at least three major methodologic challenges: the development of appropriate technics for assessing the outcome as direct effects on the patients' state of health; the development of quantitative methods for evaluating the process of medical care and the dynamics of an experimental practice; and the complex administrative logistics of preparing the patients, training interviewers and other data gatherers, maintaining the protocol and coordinating data reduction and analysis.

In this paper, we report the general design, logistics, and data of the trial together with a summary of the results obtained for patients' health status and quality of care.

The Investigated Patients

Because many clinical problems in primary care involve an entire family, families where chosen as the unit for randomization. A "family," which was defined as a person or group sharing a common provincial health-insurance number, typically encompasses a breadwinner, the spouse, and the dependent children. From the business records or clinical records of all families using the two practices, 1801 families, representing approximately 4850 people, were enumerated.

To be eligible for the trial, a family had to be established as having an ongoing medical relation with the practices. This relation was demonstrated if one of the family members had either made contact with one of the practices in the prior 18-month period or (during later interviews) identified the doctor as the family physician. The eligible people comprised 1598 families, containing 4325 members.

Randomization

Because a case load half that of a family physician's was considered manageable for a nurse practitioner, the eligible families were stratified by practice of origin, and randomly allocated in a ratio of 2:1. They formed a randomized conventional group, assigned to continuing primary clinical services from a family physician and a conventional nurse, and a randomized nurse-practitioner group, whose first-contact primary clinical services were to be provided by a nurse practitioner. The resulting conventional group contained 1058 families (2796 members) equally divided between the two doctors, and the nurse-practitioner group comprised 540 families (1529 members), equally divided between the two nurse practitioners.

After these assignments were completed, adult patients were sent a letter explaining their clinical allocation and the plans of the study. For subsequent medical care, after July 1, 1971, patients in the nurse-practitioner group were asked to make appointments with the named nurse, instead of with their customary doctor. All the families were given the opportunity to refuse their assignment and opt out of the trial.

Figure 1 shows the timing of these procedures and of subsequent events in the performance of the study.

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[*] Spitzer, W. O., Kergin, D. J. Nurse practitioners in primary care. I. The McMaster University educational program. Can. Med. Assoc. J. 108:991–995. 1973.

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Selection of Patients for Surveis Before and at the End of the Experimental Period

After the letters were distributed, a household survey was performed in a sample of the enumerated families, *the interview cohort*. This cohort received interviews to acquire the data needed for "paired comparisons" of change in health status and medical utilization. The patients for the interview cohort were chosen randomly as a single member from eligible families participating in the trial and living within 32 km of the doctor's office. To ensure sufficient numbers of children in the surveys, one third of the families were randomly designated as "child priority." The member for the interview cohort was then randomly chosen from any children contained in these families or otherwise, from the adults.

The resulting cohort that was successfully interviewed in both years included 817 patients, with 296 in the experimental group and 521 in the conventional control group. The refusal rates in the surveys were 11 per cent in 1971 and 5 per cent in 1972.

Data Obtained before the Experimental Period

Measurements on patients. Trained household interviewers administered pretested standardized questionnaires to the interview cohort to obtain demographic information, information on prior use of clinical services and data satisfaction with health care. Special questionnaire instruments, described elsewhere, were used for assessing health status in physical function.

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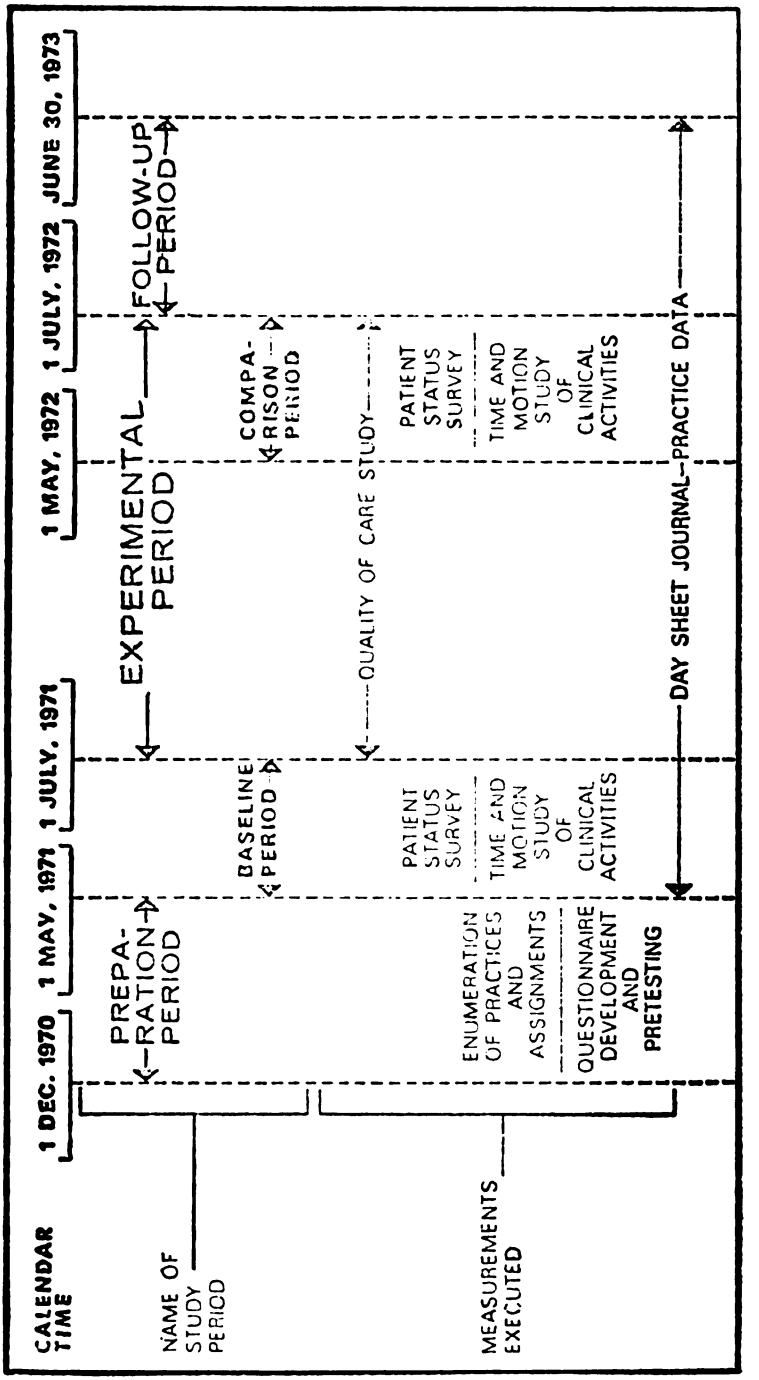


FIGURE 1.—Schedule of Time and Events during Implementation of the Trial.

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Clinician activities.—Time-and-motion studies of the physicians and conventional nurses were used to indicate the mixture of clinical and nonclinical activities in a representative week of family practice.

Activities of the practice.—A "day-sheet journal" was maintained for all clinical activities in the practices. For each visit or encounter with any medical or nursing practitioner, a separate entry was made in the journal, and included the following information: the patient's identification number; the date; the type of service; whether the patient was new to the practice; the presenting complaint (or complaints) or problems; diagnosis (or diagnoses); procedures (if any); the principal professional person who provided service at the particular visit; whether the doctor was involved in the visit or whether the nurse practitioner had provided the service alone without consultation; whether the patient was referred outside the practice; whether a prescription has been given to the patient; and the dollar value of service according to the provincial medical association's schedule of fees.

In the eight-week base-line period, there were 2,991 encounters for the groups who became the conventional and nurse-practitioner combined trial practice.

Data Obtained during the Experimental Period

Measurement on patients.—In addition to the cited data on health status, "dropouts" were identified, and all deaths were recorded.

Clinician activities.—The quality of care in "clinical judgment" used by the co-practitioners was assessed with two quantitative methods. One of these was based on identifying and assessing the manner in which the practitioner managed a series of 10 indicator conditions. As suggested in Kessner's concept of "tracers,"[7,8] an indicator condition is a district clinical entity (such as a disease, symptom, state or injury) occurring frequently in primary care, with an outcome that can be affected favorably or adversely by the choice of treatment. The second method for assessing the quality of medical care was to evaluate the manner in which 13 common drugs were prescribed. Explicit criteria for adequacy in the management of indicator conditions and prescriptions of drugs were established before the trial by a peer group of nonuniversity family physicians practicing in the same area. The selected conditions and drugs were not known to the Burlington co-practitioners during the trial. These approaches received a preliminary report, with details presented elsewhere.[9]

Practice activities.—All clinical activities were monitored throughout the entire experimental period and recorded in the day-sheet journal. During the exprimental year, data were obtained for 21,085 encounters.

Data Obtained at the End of the Experimental Period

Measurements on patients.—The household surveys of health status were repeated, with added questions on social and emotional function.

Clinician activities.—The previous studies of clinical activities were repeated during the eight-week comparison period, one year after base line. Quality-of-care measurements were continued to the end of the trial.

Practice activities.—The day-sheet journal surveillance was continued for a year after the trial to ascertain longer-term effects of this method of practice on profitability and cost effectiveness.

RESULTS

Base-line Survey and Encounter Data

Measurements on patients (Fig. 2).—As determined in the 1971 household survey, the patients in the conventional and nurse-practitioner groups had highly similar values for physical function, ability to carry out usual daily activities and freedom from bed disability. The base-line health status of the two groups of patients showed only minor differences that were not statistically significant (at an α level of 0.05).

Clinical activities.—Physicians had been involved in 86 per cent of all visits to the practices, and the conventional nurses along had dealt with the remaining 14 per cent of encounters.

Results during the Experimental Period

Of the 1598 families eligible for the trial, only seven families (two from the conventional group and five from the nurse-practitioner group) refused their

[7] Kessner, D. M., Kalk, C. E., Singer, J.: Assessing health quality—the case for tracers. N. Eng. J. Med. 288:189–194. 1973.

[8] Kessner, D. M., Kalk, C. E.: A Strategy for Evaluating Health Services. Washington, D.C. Institute of Medicine, National Academy of Sciences. 1973, p. 219.

[9] Sibley, J. C., Rudnick, K. V., Bell, J. D., et al.: A quantitative approach to quality of primary care. Clin. Research 21:726. 1973.

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assignments. Two families in the conventional group preferred care by nurse practitioners; two families in the nurse-practitioner group opposed the new concept, and three others had had a member under care by a doctor for a long-term problem.

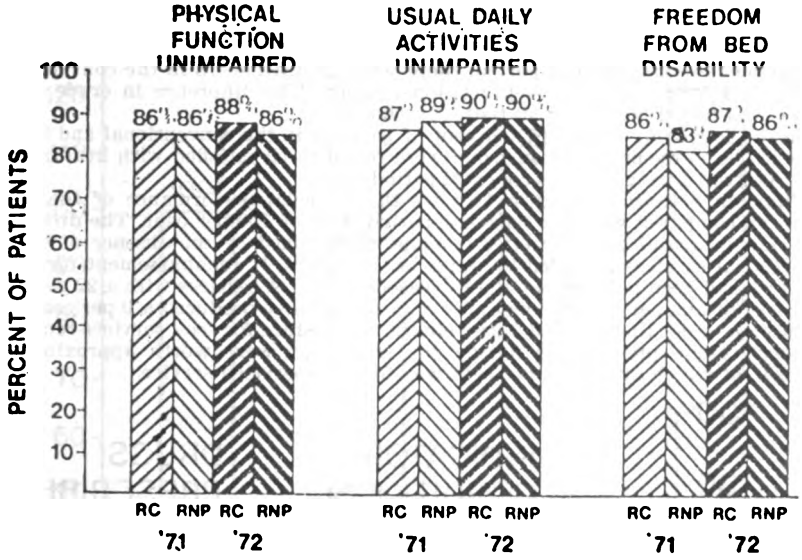


FIGURE 2.—Physical Status of Patients in Surveys during Base-line ('71) and Comparison ('72) Periods. These results are based on 521 subjects in the conventional (RC) group and 296 in the nurse-practitioner (RNP) group who were assessed in both 1971 and 1972.

Measurements on patients.—During the year 0.9 per cent of families in the conventional and 0.7 per cent in the nurse-practitioner group left the practice because of dissatisfaction.

Clinical activities (*Fig. 3*).—In 392 episodes of care for the 10 indicator conditions, the management was rated as adequate for 66 per cent of episodes in the conventional and for 69 per cent in the nurse-practitioner group. In 510 prescriptions similarly analyzed, an adequate rating was given to 75 per cent in the conventional group, and to 71 per cent in the nurse-practitioner group.[9a]

Practice activities.—The doctors in the conventional group continued to be involved in about 86 per cent of all patient visits throughout the trial. For visits of patients in the nurse-practitioner group, the doctors were involved in 45 per cent of visits during the first eight weeks. This proportion fell to 28 per cent by the 20th week, and rose from the 21st to the 44th week, when many new families were being seen for the first time. Starting with the final eight weeks of the trial the proportion of patient nurse-practitioner visits involving the doctor stabilized at 33 per cent. Subsequent follow-up study confirms that nurse practitioners handle two thirds of episodes without consulting a physician.

As noted from our enumerations and household interviews before the trial, the two original practices had provided care for an active roster of 1598 families who had an ongoing relation to the practitioners. Within eight weeks after the new form of practice was introduced, the physicians found that the demands on their own services had been reduced enough to allow new families to be accepted in the previously "saturated" practices. After one year, the practices had grown to 1952 active families, a net increase of 22 per cent.

[9a] The differences are not statistically significant at an α level of 0.05. Since demonstration of "no difference" or "no deterioration" is of greater concern in an experiment where we have compared a new form of practice with a standard practice, we also calculated β levels. Given the results, the probabilities of real deterioration of at least 5 per cent in physical function went from 0.02 to 0.01. The probabilities of real deterioration of at least 10 per cent were 0.004 for indicator conditions and 0.08 for drugs.

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Results at the End of the Experimental Period

Clinical outcomes.—As shown in Figure 2, the levels of physical status remained closely similar in the patients in the two groups. In measurements performed at the end of the trial in the 1972 survey, the index of emotional function was 58.3 per cent in 521 patients in the conventional and 57.9 per cent in 296 in the nurse-practitioner group. Corresponding values for the index of social function were 83.2 per cent and 83.9 per cent.[9b]

During the experimental period, there were 22 deaths—18 in the conventional group and four in the nurse-practitioner group. The difference in crude death rates was not clinically or statistically significant.

In the follow-up survey, 97 per cent of patients in the conventional and 96 per cent in the nurse-practitioner group were found to be satisfied with health services received during the experimental period.

Clinician activities.—Figure 4 shows the financial performance of the practices, as compared with the base-line-period level of 100 per cent. The drop of 5 per cent in actual gross practice revenue is explained by the absence of billing for clinical services provided by nurse practitioners. If reimbursement for these services had been permissible, the increased volume of services with a 22 per cent increase in number of families under care would have produced a 9 per cent rise in income. According to the dollar-weighting procedure for fees, services rendered by each nurse practitioner during the trial year were worth approximately $16,000, of which almost 50 per cent was for unsupervised service.

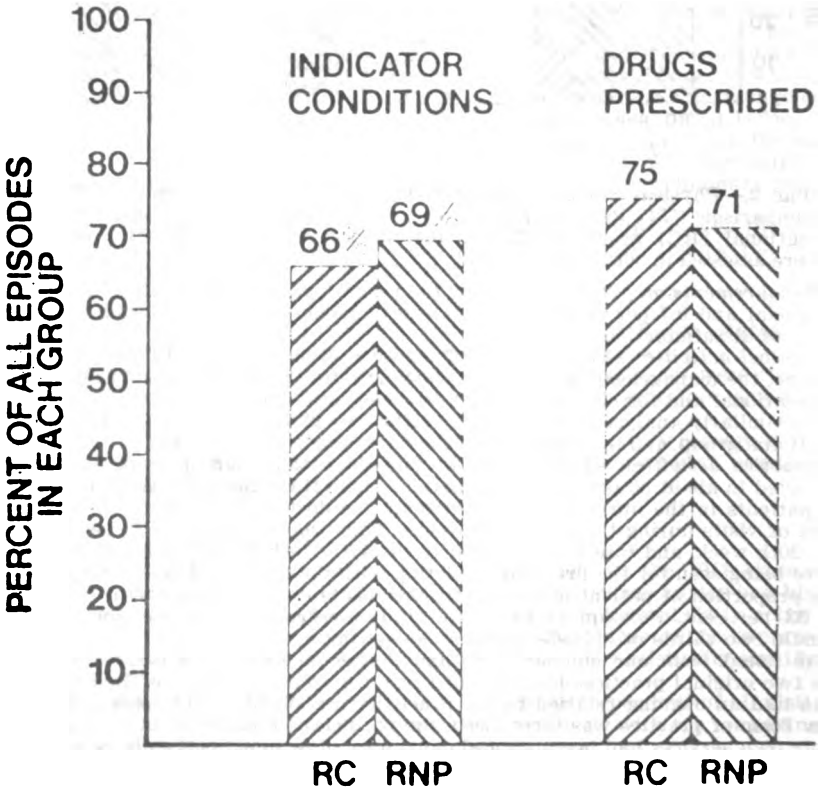


FIGURE 3.—Percentage of Episodes of Care Rated as Adequate. The denominators for these percentages were a total of 392 episodes for indicator conditions—225 in the conventional (RC) and 167 in the nurse-practitioner (RNP) group—and 510 episodes for drugs (284 in the RC and 226 in the RNP group).

[9b] Sackett, D. L., Spitzer, W. C., Gent, M., et al.: The Burlington randomized trial of the nurse practitioner: health outcomes outpatients. Ann. Intern. Med. (In press).

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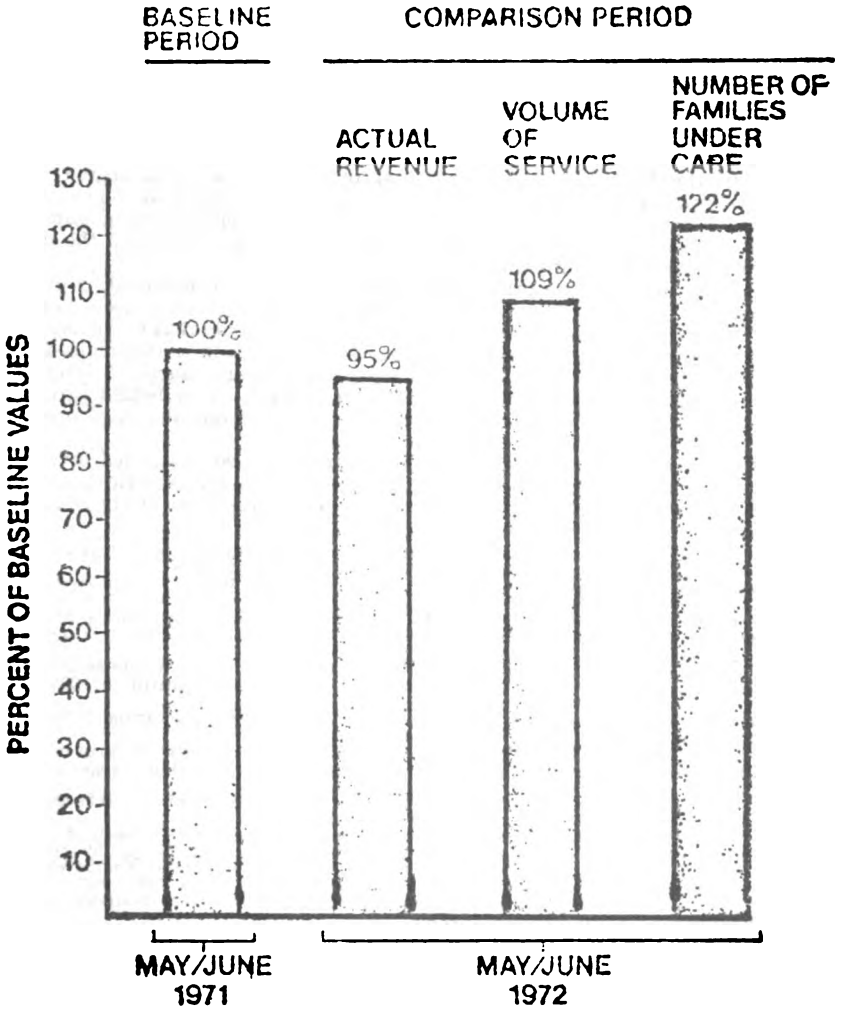


FIGURE 4.—Performance of Practice: The activities during the base-line period were given a value of 100 per cent for each of the three categories of performance assessed

Together with other financial studies, these data indicate that the economic advantage that society attains from the primary-care nurse practitioner is accompanied, under current Ontario regulations that prohibit billing for unsupervised nurse-practitioner services, by the psysician's loss in net income of nearly $12,000 per year.

Practice activities (follow-up observations).—One year after the experimental period had ended, the practitioners reported that they were at a new plateau of "saturation." As of June 30, 1973, 2256 registered families were under ongoing care, a 41 per cent increase from the 1598 families two years earlier.

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Discussion

In recent years, a few health-care trials, some with an element of randomization, have been reported.[10–16] The current research adds further evidence that innovations in health care can be assessed with randomized controlled trials.

Neither the concept of the nurse practitioner nor the evaluation of this new concept is new. "Outpost nurses" have established an enviable record of clinical accomplishment in isolated areas in the Canadian North and Maritime provinces.[17] In the United States, Silver and his colleagues[18,19] pioneered many current concepts of the nurse practitioner's role in pediatrics. Yankauer et al.[20,21] dealt with other issues of education and the efficient deployment of nurses in pediatric ambulatory settings. Other investigators[22,23] have described the use of nurse practitioners in adult primary care.

Introduction of the nurse practitioner has often been accompanied by evaluative research, including descriptive studies,[18,24] surveys[25,26] and assessment of process.[23,27] Lewis and his colleagues[28] made a major contribution to the methods of assessing the effect of nurse practitioners by executing a randomized controlled study conducted in a hospital outpatient setting. Charney[29] later performed a similarly controlled trial of the nurse's work in well-child care, and Schlesinger et al.[30] used a matched design to test registered nurses in prenatal care.

The work reported here differs from earlier randomized controlled investigations of nurse practitioners, because of the following characteristics: to allow detection of small differences in the variables of interest, our study contained

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[16] Hutter, A. M., Jr., Sidel, V. W., Shine, K. I., et al.: Early hospital discharge after myocardial infarction. N. Engl. J. Med. 288:1141–1144. 1973.

[17] Robertson, H. R.: Health Care in Canada: A commentary (Science Council of Canada Background Study Series No. 29). Ottawa. Information Canada. 1973. pp. 99–100.

[18] Silver, H. K., Ford, L. C., Stearly, S. G.: A program to increase health care for children: the pediatric nurse practitioner program. Pediatrics 39:756–760. 1967.

[19] Silver, H. K.: The school nurse practioner program: a new and expanded role for the school nurse. JAMA 216:1332–1334. 1971.

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much larger numbers of patients than had previously been admitted to such trials; the role of "experimental subject," assumed by the collaborating physicians and nurses, was almost entirely divorced from the specially trained interviewers, abstractors and observers who acted as "data gatherers"; all the data, including base-line data, were gathered purposefully and prospectively; both traditional and new health-care measurements were incorporated into an experiment patterned after a clinical trial, with the attention directed primarily at changes in health status; the study was carried out in previously saturated practices that were non-university and non-institutional; and, finally, a unique characteristic of the setting was that patients, if dissatisfied, had complete freedom to seek care from another source. Not only were several family physicians in the community accepting new families, but Canadian universal insurance covers costs completely regardless of the chosen source of care.

The results demonstrate that a nurse practitioner can provide first-contact primary clinical care as safely and effectively, with as much satisfaction to patients, as a family physician. The successful ability of the nurse practitioners to function alone in 67 per cent of all patient visits and without demonstrable detriment to the patients has particularly important implications in planning of health-care delivery for regions where family physicians are in short supply.

The increased number of patients who could be added to the previously saturated practices is probably due mainly to the case load carried by the nurse practitioners, but cannot be attributed to their activities alone. The physicians involved in this trial believe that their own work became more efficient since they were forced to develop the rigor and clarity of thought needed to communicate with their co-practitioners.

The decreased gross revenue of the practices is attributable to current regulations that do not permit the governmental health-insurance plan to pay for services rendered by an unsupervised nurse. Since nurse practitioners can provide a major increase in total quantity of clinical service, without a reduction in quality, a suitable adjustment of these financial regulations would make the innovation more attractive to physicians, while allowing society to obtain the additional benefits in care at a net cost that is still less than that of conventional approaches. Several medical practitioners and officials of the provincial health-insurance plan are now collaborating in an effort to develop appropriate new formulas for these financial arrangements.

(We are indebted to Dr. John R. Evans, formerly dean of the Faculty of Medicine of McMaster University (now president of the University of Toronto), for encouragement and support during the preliminary phase of this study (his leadership made possible the environment and the resources required for large-scale health-care trials in the Hamilton region) and to Dr. Alvan R. Feinstein, of Yale University, for counsel and critical review during preparation of the manuscript.)

The Role of the Nurse Practitioner in the Nursing Home Setting

NURSING HOME TELEMEDICINE PROGRAM, BOSTON CITY HOSPITAL

Roger Mark, M.D., Project Director.
Robert Master, M.D., Medical Director.
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Today there are approximately 1 million Americans in 23,000 nursing homes in the United States and the numbers are growing. Medical care to this population, which has in the past been considered of secondary priority to busy private practitioners, is overdue for major improvement. The appropriate use of nurse practitioner-physician teams may well provide the infusion of quality care which is so obviously needed.

The Nursing Home Telemedicine Program was established in 1972 at Boston City Hospital to study a method of improving the quality and accessibility of primary medical care to nursing home patients. It is presently funded by the RANN Program of the National Science Foundation. The health care team comprises one hospital-based internist and four nurse practitioners who provide pri-

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mary care in 11 Boston nursing homes. There are currently 320 patients in the system which has a planned capacity of 500. The Nursing Home Telemedicine (NHTM) team is responsible for the on-going medical management of these patients and provides 24-hour-day, 7-day-week coverage. Our focus today will be on the crucial role of the nurse practitioner in this system.

The NHTM program assumes clinical responsibility for the patient when he is discharged from the hospital to the nursing home. Within 24 hours the patient is seen by the nurse practitioner (NP). S/he performs a complete new patient work-up (history, family interview, physical examination, hospital chart review, etc.), and reviews the hospital orders with the nursing home staff. Within a few days the team physician examines the patient and reviews the NP work-up.

The NP has considerable responsibility for the medical management of her patients. S/he is responsible for performing all scheduled follow-up visits which generally include interval history, limited physical examination, and the ordering of necessary laboratory work, and also creates individualized flow-charts to facilitate record keeping and chart review.

S/he is also responsible for the initial evaluation of a new problem or emergency. A series of loosely structured guidelines has been developed to provide direction in the management of certain common acute problems such as fever, urinary tract infection, pneumonitis, etc. In some cases, the NP may deal with the problems without direct physician consultation. In other cases, a physician consultation is requested either via telephone or in person. (The decision as to the urgency of MD consultation is made by the NP. Discussion of problems may well be postponed until the weekly team conference.)

In the event of transfer from the nursing home, the team will act as patient advocates with the in-patient staff (in the event of hospitalization), with the consultant (in the case of specialty clinic visits), and with the community agencies (in the event of transfer home).

The role of the NP is modified to some extent by the special characteristics and problems of the geriatric nursing home patient in a skilled nursing facility. These patients typically have multiple medical problems, usually of a chronic, degenerative nature. Seldom does a patient have a single disease which limits his potential. More often a combination of diseases act synergistically to increase the debility of the aged person. Sensitivity to certain commonly used drugs may be increased in the elderly. Optimum patient management therefore demands rather careful and constant monitoring of clinical status.

Nursing home patients characteristically have many rather involved psychosocial needs relating to their chronic disease, their institutionalization, and in some cases, their impending death. The nurse's previous education and experience is particularly important in dealing with these problems. It is essential that there be an appreciation of the fact that total health care goes beyond the basic treatment of the physical pathophysiology, and encompasses the patient's psycho-social needs. The effective coordination of all available professionals and family members to support the patient is an important role of the geriatric NP.

The NP must always be aware of the rehabilitation potential of her patients. S/he must have an appreciation of the benefits of expert nursing techniques in optimizing each patient's potential for independent living. S/he must coordinate the services of such professionals as the occupational therapist, dentist, dietician, podiatrist, etc.

Another unique challenge to the NP in the NHTM program is to relate effectively with the nursing home staff—from nursing directors to nurse's aides. The NP must become an accepted member of the nursing home team in order to be maximally effective. The provision of inservice education to nursing home staff members is one contribution which the NP makes. Often this education is done informally, on a one-to-one basis in the context of a particular patient problem. In other cases the NP's have initiated more formal group teaching sessions in cooperation with the directors of nursing. Such sessions have served not only to impart factual knowledge, but have also improved the morale of the nursing home staffs.

The issue of dignity in death is an important concept to the NHTM staff. For many patients with or without family nearby, the NH has been "home" for a number of months or even years. When death is inevitable, the patient should not automatically be sent to the hospital to die. Rather, it is often more appropriate and humane to permit the patient to end his days in familiar surroundings, cared for by people he knows, and being kept as comfortable as

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possible. In such situations the NP must provide considerable support not only to the patient, but also the patient's family and the nursing home staff, who often have difficulty dealing with death. This process requires frequent NP attendance in the NH to assure that the patient is as comfortable as possible and to reinforce the staff and assure them that they are not being left to deal with the situation alone. It is clear that the special problems of the nursing home patient require a professional with considerably more skill than just an ability to acquire and interpret *medical* data. The NP in the NHTM program is constantly challenged to exercise not only the expanded skills of physical assessment, but also the professional skills of nursing.

The data collected and compiled since July, 1973 by the research component of the NHTM program is expected to be complete by September, 1975. Some quantitative data is now available relating to the activities of the NP in this system.

There are 4 NP's who are each assigned to 4–6 nursing homes, generally working in teams of 2 in each home. The average patient load is 90, with the ideal estimated to be 125.

The preliminary findings based on a fraction of the patient population (200 study/200 control) suggest the following:

The NP sees an average of 9 patients per day.
The average length of visit is 36 minutes.
The initial work-ups last 83 minutes.
The follow-up visits last 27 minutes.
80% of visits do *not* require MD consult.
57% of the average day is spent in patient visits and related paperwork.
The average number of days between visits is 16 days (compared to 30 days interval for patients receiving traditional care).
Hospital rate per 100 patient-months is 3, compared to 4 for nursing home patients receiving traditional care.
Mortality rate per 1,000 patient-months is 9, compared to 14 for nursing home patients receiving traditional care.

Costs are the final and crucial item. The only way that nurse practitioners will survive is if they can provide accessible, quality care at a reasonable cost. Based on preliminary estimates, the anticipated cost of an NP–MD visit is comparable to the existing fee schedules of the Visiting Nurse Association or a neighborhood health center visit.

Mr. ROGERS. We will go now to Dr. Castle.

STATEMENT OF C. HILMON CASTLE, M.D.

Dr. CASTLE. I am Hilmon Castle. I am chairman of the Department of Family and Community Medicine of the College of Medicine and principal investigator at the Utah Medical College program at the University of Utah.

I am aware of the kind of experiences that Miss Daggett has just described, and I would like to speak as a very strong advocate of the new health practitioner, both the nurse practitioner as well as the physician assistant, physician associate, and people who are given various names but who carry out what I consider some of the same functions.

Within our department we employ two nurse practitioners and three MEDEX, a type of physician assistant to provide primary care in some special remote projects that we are involved in, so I have had some direct experience.

Any of my comments come out of the experience, however, in the training of MEDEX, which is a particular type physician assistant, and I think you should know that. In our department we teach medical students, residents in family practice, physicians who are already in practice, physicians' assistants, social workers, and a num-

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ber of people who provide primary care and our focus is on primary care.

My original training as a physician was as an internist, then as a cardiologist, going in somewhat an opposite direction, finally as a family physician. And I work now as a family physician.

Mr. ROGERS. That is rather an unusual pattern, isn't it?

Dr. CASTLE. It is, but I think we are seeing a trend.

Mr. ROGERS. More of it?

Dr. CASTLE. Not only with young physicians becoming quite interested in addressing the problem we have in primary care, but some of us old guys are also changing directions.

Mr. ROGERS. That is encouraging.

Dr. CASTLE. It is. You probably know in 1970, the first year that there were as many general physicians in practice at the end of the year as there were in the beginning of the year.

Mr. ROGERS. Yes.

Dr. CASTLE. And I think that is a trend.

Mr. ROGERS. Yes.

Dr. CASTLE. I would not want to suggest that the problem in anyway has been solved, and I would not want in anyway to suggest that the physician assistant is a full solution to the problem of maldistribution of medical services, but I personally think it is having significant and measurable impact already and I think will have a considerably greater impact.

The program we have in Utah is a MEDEX program, as I mentioned. We have been funded by the Bureau of Health Manpower and Development program since 1971 and still have funding at the present time to continue to train. You probably know that there are 62 physicians assistant programs working now. I think there is a comparable number of nurse practitioner programs. And physicians assistants number about 1,800 who have graduated from accredited programs and are in practice, and about 1,500 who are still in training at the present time.

There are a number of different patterns that have been used in training, the nurse practitioner, the child health associate, the MEDEX, which is the type that we are involved in, the 2-year type training program, the characteristic one being at Duke. But I think there are more similarities among these than there are differences.

There are differences in regard to what kind of training the individual had before that individual was selected into training. I think there are some differences in how they are developed and how they are engaged in practice after they are trained, but I think there are no great dissimilarities as to what they do.

Those at least who are trained to assist in the delivery of primary care, and that is the area in which we have had our experience in working with MEDEX, we have been extraordinarily impressed that 95 percent of the graduates are still in the field for which they were trained, working as assistants in primary care. Ninety percent of those are actually engaged in delivering care directly; 70 percent of the graduates in MEDEX are in rural communities of smaller than 20,000 population.

Interestingly, in Utah 83 percent of those we have trained have remained in small communities, communities of less than 10,000 in size.

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But, as you probably know, we have a large number of small rural communities and have enormous problems similar to what you heard about in the State of Washington, in the sparsely distributed population and community, and also a deficit of people to deliver care in those communities.

I submitted some written testimony that described the experience.

Mr. ROGERS. Yes.

Dr. CASTLE. And I will not say more about that, except, having read the bill I would like to make some specific recommendations and if you have questions certainly I will be happy to respond to those.

Mr. ROGERS. Certainly.

Dr. CASTLE. But not try to support each of these recommendations as I go through it.

Mr. ROGERS. All right.

Dr. CASTLE. No. 1, I think the legislation should encourage and actually provide some incentives for the following:

1. To strengthen the existing accredited programs that train physicians assistants and nurse practitioners, particularly those in primary care.

I don't believe the capitation support that has been recommended in the current bill will be sufficient to sustain even the well-established programs, much less those that have just begun or those that are on the brink of starting.

I believe the contract mechanism directed to programs that will produce graduates who can become certified and who can be placed in areas of demonstrated need is the best mechanism to follow.

No. 2, training of the new health practitioner should be done in concert with training of other health professionals who are going to deliver care. I think this is especially true in the context of training family physicians, something that we are doing in our department, and I think we are begining to see some results from that.

I believe that there should be at least an affiliation between the teaching medical center and the patient care setting in the training of all the new health personnel.

No. 3, I would recommend that there be some type of deployment and employment mechanism that will actually place and maintain people in the place that they are needed, and also assist in at least avoiding the overproduction in certain areas that might occur if we simply base the training on a fixed number who become enrolled each year, regardless of whether there is a place known for them to go in advance, and I believe a place should be identified.

Mr. ROGERS. Wouldn't this be difficult to do with physician assistants because isn't the acceptance of physician assistants a process of physician education, in that physicians need to be converted to the use of these practitioners?

Dr. CASTLE. Yes; I think that is a dynamic process. It is one that is changing, but I think a program should have a commitment to begin that process when they begin their training process, not afterward.

Mr. ROGERS. Well, should we not train some even though at the beginning of their training there may not be enough physicians willing to use them?

Dr. CASTLE. Well, our experience in MEDEX I think shows you can actually accomplish that.

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Mr. ROGERS. You can?

Dr. CASTLE. Yes; starting with a new program you can identify enough people using the graduates from schools, and in our program we used people graduated from the University of Washington in Seattle.

Mr. ROGERS. Yes.

Dr. CASTLE. And graduates of that program convey what could be accomplished and generated sufficient to have more than adequate numbers of employers involved in the process of selecting the trainees before the class was fully filled. So I believe it can be done.

Mr. ROGERS. I understand.

Dr. CASTLE. It can be done. It is difficult and it costs money.

Mr. ROGERS. Yes.

Dr. CASTLE. I think that it is one of the things that distinguishes MEDEX from other assistant programs, they have taken on the task, and it looks like programs cost more, and they do because this is an aspect that they have considered as an essential ingredient of that type of training.

Mr. ROGERS. Yes.

Dr. CASTLE. No. 4, I think programs should train new health practitioners who will be suitable to serve in the National Health Services Corps, and I think that if this can be done in collaboration with the National Health Services Corps that would be preferable.

My fifth and final recommendation deals with the nurse practitioner training. If I am permitted to comment, I think that nurse practitioner programs should be supported. I think their training should take place in collaboration with other people who are delivering care. I think they should meet the same standards for accreditation of the program as well as certification of their graduates as any other physician assistant we are producing and employing.

[Testimony resumes on p. 642.]

[Dr. Castle's prepared statement and attachment follows:]

STATEMENT OF C. HILMON CASTLE, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE AND PRINCIPAL INVESTIGATOR, UTAH MEDEX PROGRAM, UNIVERSITY OF UTAH COLLEGE OF MEDICINE, SALT LAKE CITY, UTAH

INTRODUCTION

It is a genuine privilege to have the opportunity to provide testimony on H.R. 2956, a piece of legislation which I consider to be extremely important to the future of the physician's assistant movement in this country.

The pages which follow contain a brief overview of our five-year experience with the MEDEX approach to physician's assistant training and utilization, as well as a number of suggestions for specific changes in H.R. 2956 as it is now written. I have focused upon our experience with MEDEX simply because it is the method of physician's assistant training I know best and, also, because important data have recently been generated by the nine MEDEX programs regarding the distribution and employment of their graduates. I do not, however, wish to imply that I think that MEDEX is the only effective method of physician's assistant training, it is not. Numerous other mechanisms have been developed across the country which must be continued and further developed in the future.

While the changes in H.R. 2956 which I shall propose may appear somewhat minor in a document which will, undoubtedly, have such a major impact upon the health care delivery system of this country, they are, nonetheless, vital for insuring that competent and highly motivated physician's assistants will continue to be trained and employed in those communities which most urgently require additional primary care services.

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I. THE MEDEX EXPERIENCE: 1969–1974

The geographic and specialty maldistribution of American physicians and the resulting uneven availability of medical services in many parts of the country has been the primary stimulus for the rapid development of formal training programs for New Health Practitioners (NHPs) [1] during the past decade. Estimates of the numbers of NHP programs, program graduates, and trainees vary depending upon the source.

For example, various authors estimate that the numbers range from 40–60 Physician's Assistant (PA) programs, including MEDEX, and an equal number of Nurse Practitioner (NP) programs, with 1,200 PA graduates, 1,500–2,000 PA trainees, and only slightly fewer NP graduates and trainees.[2,3,4,5] Although a number of approaches to NHP training now exist, five basic models can be identified: a one to two year Nursing School based Family Nurse Clinician model for nurse practitioners; a six month to one year combined academic and on-the-job training model for nurses, e.g., the so-called "Primex" approach; a six to nine month Pediatric Nurse Practitioner model; a two year physician's assistant model (the "Duke" model); and MEDEX, a 12–24 month combined academic and on-the-job training model for physician extenders which utilizes students with extensive previous training and experience in the delivery of primary care services. To date, little information has been published concerning the employment of program graduates, their geographic distribution, specialty of the physicians with whom they work, or the type of practice organization in which they are employed. Thus, it has been difficult to determine whether or not the programs are meeting the purposes for which they were originally intended.

A. The MEDEX Deployment System.—The MEDEX concept, described elsewhere in detail,[6,7,8] is distinct from other NHP programs in that a specific strategy has been designed to place medex practitioners into areas of need prior to graduation. In brief, that strategy involves a mechanism for matching students in training with busy practicing physicians in communities which need additional manpower, as well as a requirement that physicians accept personal and financial responsibility for teaching and utilizing students within their own practice settings.

In contrast to the approach described above, most NHP programs (Family Nurse Practitioner, Physician's Assistant) confine their efforts to a student selection and training process in which an attempt is made to identify students with rural or inner-city backgrounds, and to train them in selected model primary care settings. The job search is carried out by students on the open market at the time of graduation. Some NHP programs (Primex) require physician sponsorship of students prior to admission and give preference to students from areas of need; the distinction between this approach and the MEDEX model seems to lie in the degree to which the preceptorship is used to develop utilization and supervisory patterns in the practices.

B. The Survey of MEDEX Programs.—In early 1974, the National Council of MEDEX Programs surveyed eight of its nine member programs to determine the impact of their deployment strategy on employment and distribution of program graduates. The survey, completed by program directors, included information on the number of graduates employed, the specialties of physician-employers (preceptors), the organization of the practices in which the medex were employed, and the size of the communities in which the employing practices were

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[1] NHP: A generic term used to include physician's assistants, physician's associates, MEDEX, and nurse practitioners.

[2] American Medical Association and United States Department of Health, Education, and Welfare. *Physician Support Personnel 1973–74.* DHEW Publication No. (NIH) 74-318.

[3] Sadler, Alfred M., Jr., Blair L. Sadler, and Ann A. Bliss. *The Physician's Assistant Today and Tomorrow.* New Haven: Yale University Press for Yale University School of Medicine, 1972.

[4] Fahy, Ellen T. "Interdependence: Who Shall be the Winner?" In *Intermediate Level Health Practitioners.* Ed. Vernon W. Lippard and Elizabeth F. Purcell. Baltimore: Port City Press for the Josiah Macy, Jr. Foundation, 1973.

[5] Fenderson, Douglas A. "A Manpower Evaluation Protocol." *Bulletin of the New York Academy of Medicine,* 2nd Series, 48:7:966–973, August 1972.

[6] Smith, Richard A., et al. "A Strategy for Health Manpower." *Journal of the American Medical Association,* 217:10:1362–1367, September 6, 1971.

[7] Smith, Richard A. "MEDEX." *Journal of the American Medical Association,* 211:11: 1843–1845, March 16, 1970.

[8] Wilson, William M., and C. Hilmon Castle. "The Utah MEDEX Demonstration Project: One Approach to the Intermountain Region's Health Manpower Problems." *Rocky Mountain Medical Journal,* 69:53–56, January 1972.

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located. Information was collected for a total of 245 of the 250 program graduates in full-time active practice at the time of the survey and for 207 students in training.

C. Results.—Between July 1, 1969 and December 31, 1974, a total of 514 students were accepted by MEDEX programs training students for placement in the continental U.S. Of those, 30 individuals either dropped out or were dismissed during the training period, an attrition rate of six percent. Of 277 individuals graduated from the eight programs, 250 (90 percent) are delivering care in full time practice settings. A total of 207 students were in training at the time the survey was completed (Table 1). At least 10 of the 27 graduates who are not now engaged in full-time practice are functioning as teachers either in MEDEX programs or in academic departments of universities. Three graduates have entered medical school or are pursuing premedical studies. Thus, approximately 95 percent of the program graduates are known to be employed as medex.

The majority (75 percent) of physicians with whom medex graduates and trainees are working are general practitioners or family practitioners (Table 2), and 88 percent are either GP/FPs, general internists or general pediatricians. Except for a recent increase in the number of trainee placements with emergency room physicians, the majority of which are associated with the Howard MEDEX Program which is focusing on inner city placements in Washington, D.C., no differences are apparent between the placements of graduates and trainees.

Most graduates (75 percent) are working in the fee-for-service system with physicians in solo practice (Table 3). Fourteen percent are working in institutional primary care settings such as neighborhood health centers, family health centers, VA hospitals, and hospital out-patient departments. Of the 22 graduates employed in pre-paid practices, 14 are from the MEDEX Northwest Program and are associated with Group Health Cooperative of Puget Sound, a large, pre-paid, group practice. The proportion of placements in the fee-for-service sector is lower for trainees (65 percent) than for graduates (75 percent), while the proportion of trainees placed in institutional settings (27 percent) is nearly double that of graduates (14 percent). However, most of the increase in institutional placements can be attributed to the Howard and Charles Drew Programs, both of which are primarily concerned with metropolitan placements involving institutionally-based health care. Among those programs concerned primarily with rural communities, there is no difference between graduate and trainee placements.

The majority of medex graduates and trainees (63 percent) are working with physicians in towns of less than 20,000 in size, and most of them are in towns of under 10,000 people (Table 4). Again, the trend toward urban placements when graduates and trainees are compared can be accounted for by the activities of the Charles Drew and Howard programs. When only the six rural-oriented programs are considered, 70 percent of graduate placements are in towns with populations of less than 20,000 people, and most of them are in towns of under 10,000 in size.

TABLE 1.—NUMBERS OF STUDENTS TRAINED AND GRADUATED IN MEDEX PROGRAMS BY PROGRAM[1]

[Through December 1973]

Program	Number graduates (a)	Number graduates not active practice (b)	Active grads (c)	Trainees (d)	Total (c and d)
Charles Drew	19	2	17	55	72
Howard				19	19
New England	62	[2] 11	[2] 51	34	85
North Dakota	43	3	40	14	54
Northwest	96	9	87	11	98
Pennsylvania State				30	30
South Carolina	17	1	16	29	45
Utah	40	1	39	15	54
Total	277	[3] 27	250	207	457

[1] Excludes MEDEX Pacific.

[2] Information on 11 not available at time of survey. According to the New England program, several of the 11 were in the process of moving from one practice to another and were not actively employed at the time of the survey.

[3] 10 percent.

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TABLE 2.—DISTRIBUTION OF MEDEX BY SPECIALTY OF PRECEPTOR PHYSICIAN WITH WHOM DEPLOYED

Specialty	Graduates	Percent	Trainees [1]	Percent	Total	Percent
GP/FP	190	76	126	75	316	76
General internal medicine	24	10	22	13	46	11
General pediatrics	2	1	4	2	6	1
Emergency medicine	3	1	10	6	13	3
Surgery, general	8	3	2	1	10	2
Other [2]	21	8	3	2	24	6
Information unavailable	2	1	1	1	3	1
Total	250	100	[3] 168	100	418	100

[1] These data represent the specialities of physicians who have been matched with a specific student, or who have entered the program as potential preceptor-employers but who have not yet been matched with a specific trainee.
[2] If physicians were listed as having a subspecialty area, e.g. nephrology, cardiology, etc., they were included in the "other" category.
[3] A total of 39 students, for whom specific slots have not been identified, are now in training in the Charles Drew and Howard programs. This reflects the longer training period of both programs in which identification of preceptors takes place during the training program rather than prior to it.

TABLE 3.—DISTRIBUTION OF MEDEX BY PRACTICE ORGANIZATION OF PRECEPTOR PHYSICIAN WITH WHOM EMPLOYED, ALL PROGRAMS

Practice organization	Graduates	Percent	Trainees	Percent	Total	Percent
1. Fee for service:						
Solo	93	37	60	36	153	37
Partnership (2)	52	21	21	12	73	17
Group (3 or more)	43	17	28	17	71	17
Subtotal	188	75	109	65	297	71
2. Prepaid groups: Subtotal	22	9	11	6	33	8
3. Institutions/public sector: Subtotal	36	14	45	27	81	19
4. Information unavailable	4	2	3	2	7	2
Total	250	100	[1] 168	100	418	100

[1] As explained in table 2, a total of 39 students, for whom sites have not yet been identified, are now in training.

TABLE 4.—DISTRIBUTION OF MEDEX BY SIZE OF TOWN IN WHICH PRECEPTOR-PHYSICIAN PRACTICE IS LOCATED, ALL PROGRAMS

Size of town	Graduates	Percent	Trainees	Percent	Total	Percent
Less than 10,000	139	56	78	46	217	52
10,000 to 19,999	36	14	12	7	48	11
20,000 to 49,999	32	13	17	10	49	12
50,000 to 99,999	10	4	10	6	20	5
100,000 and greater	33	13	51	30	84	20
Total	250	100	[1] 168	99	418	100

[1] As in tables 2 and 3, 39 students, for whom sites have not been identified, are in training.

D. Discussion.—The geographic and specialty maldistribution of physicians in the United States is well documented. Rousselot[9] reported in 1970 that only 19 percent of the nation's practicing physicians were in general practice, and only 44 percent delivered primary care in specialties other than family practice (i.e. internal medicine, pediatrics, obstetrics and gynecology).[9] In 1971, Cooper and Heald reported there were 133 counties in the United States without an active physician, while in 1968 there were only 98 doctorless counties.[10] Another recent survey indicates that 86 percent of all physicians are practicing in towns of more

[9] Rousselot, Louis M. "Federal Efforts to Influence Physician Education, Specialization Distribution Projections and Options." *The American Journal of Medicine*, 55:123–130, August 1973.
[10] Cooper, James K., and Karen Heald. "Is There a Doctor Shortage–" *Journal of the American Medical Association*, 227:12:1410–1411, March 25, 1974.

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than 50,000 people, and current trends suggest continuing physician maldistribution in the future.[11]

The distribution of medex graduates and trainees, in terms of both specialty and geographic location, is in marked contrast to that of physicians. The vast majority of medex trainees and graduates are working in those settings which most urgently need additional manpower, i.e., primary care family practices in rural and inner-city areas. Preliminary studies on relatively small samples of NHP graduates from the two year Physician's Assistant and Nurse Practitioner programs indicate that approximately 50 percent are employed in institutional and large group settings, predominantly in urban and suburban areas.[12 13 14] Employment rates for medex graduates (90 percent in full-time medical care delivery, 95 percent as medex) is quite high. The only comparable data is from the previously mentioned study of Pediatric Nurse Practitioners, in which 90 percent were employed at the time the study was undertaken. No other employment data are available.

It is interesting to note that the recent trend in MEDEX to include more women and members of minority groups, as has been reported elsewhere,[15] has not substantially altered the deployment patterns observed.

Little has been written about the factors affecting the employment and distribution of new health practitioners. Several authors have noted that economic incentives tend to create employment opportunities for NHPs primarily in larger group and institutional settings, especially those located in urban and suburban areas.[16 17 18] If so, the preliminary data available for physician's assistant and nurse practitioner distribution are not unexpected. One explanation for the unique distribution patterns of MEDEX graduates may be that MEDEX deployment activities counterbalance existing incentives in the market. For example, the MEDEX model contains both educational and recruitment systems which involve physicians in areas of need, as well as an 8 to 12 month preceptorship during which potential employers have a low cost opportunity to build up practice volume and to develop efficient and productive utilization patterns. This trial period, in turn, permits them to determine whether the economic impact of the medex within the practice justifies his/her employment.

E. Summary and Conclusions.—1. A survey of graduates of the eight MEDEX programs conducted in early 1974, revealed that 250 of the 277 graduates (90 percent) are involved in the full time delivery of medical care as medex and an additional 5% are engaged in training new medex. A total of 190 of 250 active graduates (76 percent) are employed by general and family practitioners, and 88 percent (219/250) are employed by physicians who list their specialty as general practice, family medicine, general internal medicine, general pediatrics or emergency medicine. Of the 250 active graduates, 188 (75 percent) are working with physicians in the fee-for-service system, the majority in either solo or two-man partnership practice arrangements. Two hundred and ten (84 percent) are employed in private practice. In terms of geographic distribution, 175 of the active graduates (70 percent) are employed in towns of less than 20,000 in size, and most of these (139 of 175) are located in towns of less than 10,000

2. Because of the limitations of available data, it is difficult to compare the effectiveness of the MEDEX model with other models for training NHPs in terms of placements into geographic, organizational and specialty areas of in size.

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[11] American Medical Association. *Distribution of Physicians in the United States, 1972.* Vol. 2/Metropolitan Areas. Chicago: Center for Health Services Research and Development, 1973.

[12] "The Physician's Assistant: How the PA Sees his Place in Medicine." *Patient Care,* 131–146, August 1, 1973.

[13] American Medical Association. *Health Care Functions and Responsibilities of Physician's Assistants: A Survey.* Chicago: Department of Health Manpower, Division of Medical Practice, American Medical Association, 1974.

[14] Ford, Loretta. "Experience with the Nurse Practitioners." Unpublished paper presented at the Fogarty International Center Workshop on Intermediate Level Health Practitioners, May 14–15, 1974, Bethesda, Maryland.

[15] National Council of MEDEX Programs. *A Progress Report on MEDEX Programs in the United States:* July 1, 1974. Unpublished report; available from University of Utah Press.

[16] Berki, Sylvester E. "The Economics of New Types of Health Personnel." In *Intermediate Level Health Practitioners.* Ed. Vernon W. Lippard and Elizabeth F. Purcell. Baltimore: Port City Press for the Josiah Macy, Jr. Foundation, 1973.

[17] Smith, Kenneth R. "Health Practitioners: Efficient Utilization and the Cost of Health Care." In *Intermediate Level Health Practitioners.* Ed. Vernon W. Lippard and Elizabeth F. Purcell. Baltimore: Port City Press for the Josiah Macy, Jr. Foundation, 1973.

[18] Ginzberg, Eli. *Men, Money and Medicine.* New York: Columbia University Press, 1969.

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need. Preliminary studies indicate that nearly 50 percent of graduates of other NHP programs are working in large group practices or institutional settings, predominantly in urban and suburban areas. However, more study is needed, not only of current placement patterns but also of the deployment mechanisms used and their effectiveness in providing competent practitioners to provide primary care in areas of greatest need.

II. PROPOSED ALTERATIONS TO H.R. 2956

The purpose of this section of my testimony is to present a rationale for proposed changes in those sections of H.R. 2956 which deal with physician's assistants (PA's) and nurse practitioners. This section is divided into two sub-sections, the first deals with PA's and includes a discussion of suggested guidelines for future support for PA training efforts, support for research concerning the impact of PA's and NP's on the medical care system, as well as support for the integration of PA's into the National Health Service Corps (NHSC) section of the health manpower bill. The second section deals with the proposed guidelines and support levels for nurse practitioner training in the Nursing Manpower Legislation (H.R. 2957).

I. Physician's assistants

A. Background. The legislation originally proposed (H.R. 2956) as it deals with PA's is apparently based upon several operational premises: 1) that medical schools and schools of osteopathy should be stimulated to develop PA programs; 2) that federal PA program support should be in the form of capitation; 3) that PA programs should develop decentralized training capabilities; 4) that PA programs need to be legislatively defined more specifically than existing PA program accreditation mechanisms have defined them; and 5) that an appropriate mechanism for dealing, in part, with the specialty and geographic maldistribution of health personnel is to increase the numbers of PA graduates through raising the eligibility requirement for federal support to a minimum enrollment of 25 students per class.

In the proposed changes and the following discussion, I have attempted to provide alternatives for dealing with the issues identified by drawing upon our experience with PA training and deployment over the past five years.

B. Support for PA training efforts.

1. Definition of PA Programs:

(i) The Office of Education (HEW) has recognized the Joint Review Committee (JRC)[1] and the Council on Medical Education (AMA) as the National body for the accreditation of Programs which train Assistants to the Primary Care Physician.

(ii) Although Educational Essentials have been developed for Assistants to the Primary Care Physician and for a variety of specialty PA training programs, the principal raison d'etre of the PA movement has and continues to be the preparation of assistants to the primary care physician.

(iii) Accordingly, it is my recommendation that the proposed legislation emphasize programs preparing assistants to the primary care physician. The proposed alternative wording (Section 701, Item 7) incorporates the definitions of such programs as prescribed by national accreditation guidelines. At present, a total of 49 programs have met these guidelines and are accredited by the JRC. In addition, 16 new programs have applied for accreditation.

2. Relationship to Schools of Medicine and Schools of Osteopathy:

(i) It is most encouraging to me that the proposed legislation (H.R. 2956) attempts to deal with the need to stimulate medical and osteopathy schools to participate more fully in the preparation of PA's, and to train PA's in conjunction with medical students and medical residents in primary care. The proposed changes which follow attempt to deal with both needs, at the same time obviating some problems which are likely to arise if the strict quid pro quo approach of the legislation is maintained.

(ii) Given the lethargic response of medical and osteopathy schools to previous opportunities for developing PA programs, the quid pro quo ap-

[1] American Academy of Family Physicians, American College of Physicians, American Academy of Physicians' Assistants, American Academy of Pediatrics, and the American Society of Internal Medicine.

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proach must be viewed as a punitive inducement for schools to develop PA training efforts in the future. It is, however, difficult for us to imagine that a real commitment to PA training under such circumstances would be either significant or carried out with a spirit of institutional support, and I am thus concerned about the resultant impact upon program quality and long term program survival.

(iii) Furthermore, after a period of rapid proliferation of programs, the PA movement has now begun to carefully evaluate its progress since 1970 in terms of training models and methods of standardizing graduate competence. In effect, the movement is in a period of consolidation and evaluation and is cautiously undertaking the development of improved methodologies which reflect our experience to date. I view with great concern the potential for a sudden and rapid proliferation of PA programs at this juncture in the development of new types of health workers. While I support an enlarged production capability, I do so only if such enlargement is concordant with demonstrated needs and demand. Given the current uncertainty surrounding reimbursement for PA services under Medicare-Medicaid, I think that the decision to enlarge existing production facilities should be carefully weighed before expanded incentives are provided for the creation of large numbers of new PA's.

(iv) It is also important to note that nearly half (20/49) of the existing programs preparing assistants to the primary care physician are not located in schools of medicine or osteopathy and, therefore, would be ineligible for support under the proposed legislation.

(v) The existing accreditation guidelines require that PA programs provide evidence of association with a medical faculty in order to be eligible for accreditation. Accreditation in turn is important both in terms of eligibility for federal funds, and also to insure that program graduates are eligible for practice in many states.

(vi) In view of (i)–(v) above, therefore, it is my recommendation that the requirement that schools develop PA programs in order to be eligible for capitation be dropped entirely. Furthermore, I feel that the proposed wording (Section 701, Item 7) will insure close working relationships with academic medical centers, which is clearly essential for any high quality PA training program.

3. Funding:

(i) By providing on-going support for the PA effort, the authors of the proposed legislation seem to recognize that PA programs have not yet and cannot be expected to become entirely self-supporting in the period covered by the legislation. While the principle underlying this position is laudable, both the capitation mechanism and the proposed level of support are inadequate and would insure the prompt demise of the vast majority of existing PA programs.

(ii) Surveys conducted by the Association for PA Programs (APAP), data from the Office of Special Programs (BHRD), and the recently concluded Government Accounting Office (GAO) report on PA training confirm that the cost to produce a PA graduate is approximately $10,000–$15,000 as compared to $112,400 to produce a board eligible family physician.

(iii) In a recently conducted survey, the APAP discovered that no member programs were receiving adequate state suport to continue operation should federal funds be provided at the level suggested in the legislation. Since most PA programs are between one and four years old, given the innovative nature of PA programs generally, and considering the costs of producing PA graduates, it should come as no surprise that few PA programs have managed to obtain the needed institutional support necessary to tap state educational funds at a level sufficient to survive.

(iv) While it has been suggested that training costs be met at least in part through increases in tuition, our experience indicates that students entering PA training are somewhat older and tend to have greater financial responsibilities than students in medical, osteopathic, dental, and nursing schools. It has also been demonstrated that most PA students are from lower socioeconomic backgrounds than the above named students. These factors suggest that loan funds would have to be provided to enable certain groups to participate in PA education. However, the relatively low earning potential of PA graduates ($12,000/average annual salary) would appear to argue for an alternative to a high tuition-loan approach for meeting training costs.

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(v) Another argument against the tuition approach is that it would force programs to rely solely on tuition for income production and thus would constitute a stimulus for increasing the numbers of enrollees. Again, I would argue that, if the production of PA's is increased, such an increase should be commensurate with demonstrated needs and demands rather than in response to the need for generating greater training income.

(vi) In the Committee Report No. 93–1509 concerning the Health Manpower Act of 1974, the process for determining net educational expenditures are described as follows: Net education expenditures describe the unfunded portion of education costs. The net is calculated by subtracting from education costs the income received from research and patient care activities (p. 18). The report further explains that net education expenditures are to be used as a basis for "establishing rates of capitation" (p. 20). Such expenditures "are the amounts that must be financed by tuition, fees, private endowment, and State and Federal appropriations." (p. 20). Since state support can be expected to develop slowly, and since tuition must be kept low in order to avoid penalizing the very students most likely to serve in underserved areas, it is clear that a continuing federal commitment to ongoing support of PA programs will be necessary during the legislative period under consideration.

(vii) If one accepts the average production cost figure for PA's ($10,000,–$12,000), recognizes that 40 programs are now in need of ongoing support for survival, and if one assumes an annual production of 25 graduates per program per year, we estimate that a total of $12,000,000 represents the expected educational expenditures for eligible PA programs during the next fiscal year. Assuming $1,000 per graduate in tuition revenues or a total of $1,000,000 in revenues, and assuming that state revenues will cover approximately 10% of estimated educational expenditures ($1.2 $\times$ 10^6), then $9,800,000 in federal monies will be necessary to meet the expected expenditures of existing programs during the fiscal year 1975. If new programs are to be encouraged (which I think unnecessary) additional revenues must be provided. I would like to recommend an allocation of $12,000,000 for the fiscal year 1975, of which $9.8 million would be earmarked for ongoing program support, and $2.2 million for further program development.

(viii) I would further recommend that the administrative mechanism for funding PA programs be contracts from the Secretary of HEW to eligible PA programs rather than capitation grants to schools of medicine and osteopathy. It has been our experience that, in the past, a substantial portion of capitation monies awarded to schools with PA programs has not been returned to the PA programs themselves. There is, unfortunately, no evidence that this rechanneling of funds will change. Consequently, I am convinced that the contract mechanism is the strongest method available for insuring that PA programs meet prescribed objectives and for insuring program stability and institutional support.

4. Definition of programs/models of training: The language in Section 770 of the proposed legislation incorporates, by its definition of a PA training program, a specific deployment strategy which includes decentralization of training. While I strongly encourage mandatory deployment systems, I feel that they can be implemented in more effective ways. I would suggest wording that would incorporate decentralization through pre-training recruitment of potential trainees and employers. This direct mechanism will provide the type of effective deployment system desired. The pre-training recruitment model should not be regarded as the only deployment mechanism available, however, since it is important to encourage the development of other deployment models which may prove to be equally effective in the future.

Also, because there is strong evidence that common curricular materials and experience overlap exists among institutions which train PA's medical students, and family practice residents, I would vigorously encourage legislation which will define programs in a manner that will promote interdisciplinary training systems with medical students and residents in primary care. It is also vital that, in the definition of programs, specific requirements for the continuation of and development of competent ongoing continuing medical educational programs for PA's and their employing physicians be included. This continuing educational requirement for PA programs stems from the increasing concern of the public and the profession for the need to assure continuing competence of practitioners.

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At the same time the National Commission for Certification of Assistants to the primary care physician is moving in the direction of recertification and possible re-examination.

5. Fixed enrollment vs. enrollment determined by demand: Again, while I am most sympathetic with the legislations' intent to foster increased PA utilization by requiring schools to maintain minimum class sizes and minimum yearly enrollments, our experience in the field indicates that the mere production of additional graduates will not insure that they will be employed and utilized in those communities in which they are most urgently needed. Consequently, I feel strongly that schools should be required to: (1) implement and/or develop proven mechanisms for assessing existing and future needs and demands for PA employment in their geographic regions; (2) maintain on-going systems for measuring changes in demand over time; and (3) develop and implement effective mechanisms for deploying students into areas of greatest need prior to graduation.

In this manner, schools would be required to establish minimum class sizes in accordance with identified community need and would be required to actively stimulate physician demand in order to avoid becoming mere training mills for a growing number of unemployed PA's. Further, if schools are encouraged to select students on the basis of those ethnic, economic, and cultural variables which can realistically be expected to influence their choices of practice locations, then the vast majority of PA's trained will be utilized where they are most urgently needed.

II. Nurse Practitioners

The recommendation that nurse practitioner programs meet, as a minimum, the essentials of an approved educational program for the assistant to the primary care physician, established by the American Medical Association's Council on Medical Education, in collaboration with the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Society of Internal Medicine, and the Association of American Medical Colleges, will undoubtedly be protested by representatives of the nursing profession. However, the rationale for this recommendation is based upon the following:

1. There is currently no national accrediting agency for primary care nurse practitioner programs, and to establish such a collaborative effort would take several years at significant costs.

2. The U.S. Office of Education currently recognizes a set of essentials for the Assistant to the Primary Care Physician as officially constituting the standards for all PA programs in primary health care.

3. Meeting these essentials as minimal requirements is in the best public interest and does not limit the scope of any nurse practitioner program. These essentials simply cover those areas where nurse practitioners and PA's perform the same medical functions in primary care.

4. The essentials further guarantee the production of generalists in primary care and prevent the extension of further fragmentation among health workers. Nursing schools tend to perpetuate the subspecialization of traditional medical education by developing separate and functionally isolated programs in primary health care, such as the pediatric nurse practitioner, the geriatric nurse practitioner, and the OB-Gyn practitioner.

5. In the struggle for professional identity, nursing schools which develop nurse practitioner programs without adequate medical input jeopardize, without question, the quality of the education for the primary care nurse practitioner.

6. The training of nurse practitioners to function as separate independent licensed practitioners is definitely not in the best interest of the public. Cooperative educational programs on the other hand, are more likely to lead to organized primary health care teams in the future.

7. Such standards will lead to greater job mobility for PA's and nurse practitioners and will provide potential employers, and the public, some guarantee that there are safeguards in effect which insure the clinical competence of all forms of New Health Practitioners.

SPECIFIC RECOMMENDATIONS FOR CHANGE, H.R. 2956 AND H.R. 2957

PROPOSED ALTERATIONS TO H.R. 2956

Existing.—Title I, Sec. 701, Item 7, Page 125, Lines 21–22 and Page 126, Lines 1–12.

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Proposed.—New heading to read: "Physician's Assistant Programs".

(7) For purposes of this section, the term 'programs for the training of physicians' assistants' means educational programs which meet guidelines prescribed by the Secretary in accordance with subparagraph (B) and which have as their objective the education of physician extenders who will, upon completion of their studies in such a program, be qualified to effectively provide primary health care.

(B) On or before March 1, 1975, after consultation with the appropriate existing accrediting bodies for primary care practitioners, and other organizations and agencies responsible for insuring professional competence, the Secretary shall prescribe guidelines for programs for physician assistants. Such guidelines shall, as a minimum, require—

(i) a program of classroom instruction and supervised clinical practice directed toward preparing physician extenders to serve as generalists in the delivery of primary care;

(ii) specific documentation of need and demand for the services of program graduates;

(iii) evidence that mechanisms exist for deploying graduates into primary care settings in medically underserved areas;

(iv) evidence that the program meets the minimum existing standards of program accreditation for primary care practitioners as recognized by the Secretary.

Existing.—Title IV, Sec. 401, Item 1 (B), Page 178.

Proposed.—Delete Lines 3, 4, 5, 6.

Existing.—Title IV, Sec. 401, Item (f), Page 182, "Authorizations & Appropriations."

Proposed.—To read: (B) There are authorized to be appropriated $12,000,000 for the fiscal year ending June 30, 1975, $15,000,000 for the fiscal year ending June 30, 1976, and $18,000,000 for the fiscal year ending June 30, 1977, for payments under grants and contracts under this section to educational institutions training physician assistants which meet the requirements outlined in Sec. 701, Item 7, Page 125, above.

Existing.—Page 163, Line 6.

Proposed.—Scholarships to obtain physicians, dentists, Physician's Assistants, and nurses.

Existing.—Page 170, Line 24.

Proposed.—Hiring physician's assistants, nurses, and other personnel.

Existing.—Page 174, Line 7.

Proposed.—Hiring physician's assistants, nurses.

Existing.—Page 189, Lines 24 and 25.

Proposed.—Delete (to include dental schools only).

Existing.—Page 190, Line 18.

Proposed.—Delete "physician's assistants".

Existing.—Page 191, Line 23.

Proposed.—Make "six weeks" read "4 months".

Existing.—Page 228, Line 1.

Proposed.—Add the word "measuring" to read "measuring and increasing".

PROPOSED ALTERATIONS TO H.R. 2957

Existing.—Sec. 822, Item (2)(A), Page 38.

Proposed.—(2)(A) For purposes of this section, the term 'programs for the training of nurse practitioners' means educational programs which meet guidelines prescribed by the Secretary in accordance with subparagraph (B) and which have as their objective the education of nurses who will, upon completion of their studies in such a program, be qualified to effectively provide primary health care.

Existing.—Item (2)(B), Page 38.

Proposed.—(2)(B) On or before March 1, 1975, after consultation with appropriate professional nursing organizations, professional medical organizations and colleges, existing accrediting bodies for primary care practitioners, and other organizations and agencies responsible for insuring professional competence, the Secretary shall prescribe guidelines for programs for nurse practitioners. Such guidelines shall, as a minimum, require—

(i) a program of classroom instruction and supervised clinical practice directed toward preparing nurses to serve as generalists in the delivery of primary care;

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(ii) specific documentation of need and demand for the services of program graduates;

(iii) evidence that mechanisms exist for deploying graduates into primary care settings in medically underserved areas;

(iv) evidence that the program meets the minimum existing standards of program accreditation for primary care practitioners as recognized by the Secretary.

Existing.—Item (2) (B) (d), Page 39.

Proposed.—(d) For the purposes of making payments under grants and contracts under this section there are authorized to be appropriated $12,000,000 for the fiscal year ending June 30, 1975, $15,000,000 for the fiscal year ending June 30, 1976, and $18,000,000 for the fiscal year ending June 30, 1977.

Mr. ROGERS. Who accredits your physician assistants programs?

Dr. CASTLE. There is a joint commission that reviews programs and accredits the program, made up of a number of organizations. The Council on Medical Organization in AMA is part of one such group; the American Academy of Pediatrics; The American College of Physicians; the American College of Medicine also belong to this group.

Mr. ROGERS. I see.

What about nurse practitioner programs?

Ms. DAGGETT. There are two things in process now. I think it might be more appropriate if Connie Holleran spoke.

Mr. ROGERS. We would be delighted to hear from Connie Holleran.

Ms. CONNIE HOLLERAN. The national association accredits practitioner programs in degree settings and A.N.A. is just beginning a program for those that are continuing education and not degree oriented.

Mr. ROGERS. I see. Thank you.

We also heard the training period in MEDEX can be done quickly. You have had some experience, which I believe Mr. Wilson spoke of, which was rather impressive.

Dr. CASTLE. I think it is impressive, but I think it is largely a matter of what the experience levels of our entering candidates are.

Mr. ROGERS. Certainly. You brought some in who had military service?

Dr. CASTLE. Yes, with much previous experience.

Mr. ROGERS. Medics?

Dr. CASTLE. Yes, sir, medical corpsmen. We have also selected nurses, and we have selected people who have been involved in primary care in one fashion or another.

Mr. ROGERS. Now what has been your experience with the young man or woman from the services? What experience have they had there?

Dr. CASTLE. It has been an excellent experience and we have selected the majority of our students from the services.

Mr. ROGERS. Time element of training?

Dr. CASTLE. We have used a 12-month period, 4 months in university medical center and the remaining 8 months with a preceptor who has worked with us even prior to the time the student begins his training. We assist the physician in preparing to be a preceptor and preparing to teach and follow the guidelines and recommendations we have for evaluation of the performance of students.

Mr. ROGERS. Now, do you give them all an examination or proficiency test?

Dr. CASTLE. We give them repeated proficiency tests throughout their training, not one final examination at the end.

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Mr. ROGERS. I see.

Dr. CASTLE. Also, they have all taken the national boards, which started in 1973.

Mr. ROGERS. I see. Who else takes the national boards? The comparable national boards of your MEDEX program.

Dr. CASTLE. Other physicians' assistance from 2-year programs.

Mr. ROGERS. From 2-year programs?

Dr. CASTLE. Yes.

Mr. ROGERS. Where you have had 1 year training from background of their service, what has been the result as far as standing on those examinations?

Dr. CASTLE. We have only had one such examination from which we know the final results.

Mr. ROGERS. I see.

Dr. CASTLE. We do not know yet the results of the latest examination in December 1974. But the previous year there was no difference in the performance of physicians' assistants from 2-year programs, MEDEX from a 1-year program, or nurse practitioners who took the examination. There was only a small number of nurse practitioners who took the exam, but, nevertheless, there were no differences in the failure rate or the mean scores of those three categories.

Mr. ROGERS. Well, that is pretty interesting. Thank you.

Dr. Piemme, you may have something. I remember very well our visit to George Washington, your emergency medical service setup, where you had it divided, as I recall, into two areas, one in which you really took care of emergencies, and the other you took care of primary care walk-ins.

STATEMENT OF THOMAS PIEMME, M.D.

Dr. PIEMME. That is right.

I might add, sir, it is a nurse practitioner who runs that side of the emergency room, and interns and residents clearly work as peers with her, and that is understood by the hospital. She is probably our expert on minor medical management.

Mr. ROGERS. Well, now, that is interesting. I would think Connie Holleran would want to get that out all over the country.

Dr. PIEMME. Mr. Chairman, I thought I would make a couple of generic comments, putting something in historical reference that still awes me as I think about it. The first student was accepted into the first physician assistants program at Duke University just 10 years ago, in 1965. The MEDEX programs began a year later; a nurse practitioner program in 1965 or 1966 at the University of Colorado. Within those 10 years we have now seen some 60 physicians' assistants programs develop, a similar number of nurse practitioner programs. This last December the second offering of the national certification examination was administered. We will have certified it in 2 years, 2,000 graduates, with another 1,500 currently enrolled in programs.

I am pleased to say that over the last 3 years we think we have resolved the issue of accreditation with the mechanism now recognized by the Commissioner of Education. I think we have resolved the issue of certification with the new National Commission on Certification that is operating under contract with the National Board of

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Medical Examiners, and as you heard, we are interested to learn that the nurse practitioners, the MEDEX and the 2-year practitioners do not perform differently on that examination.

We have had a number of legal issues resolved for us in this short span of time. Thirty-eight States have now adopted legislation that has altered medical practice acts to permit physicians to delegate to appropriately trained and certified persons those tasks that heretofore were thought to be the province exclusively of the physician.

Mr. ROGERS. Now, do these 38 States license physician assistants or nurse practitioners or MEDEX, as such?

Dr. PIEMME. No, sir.

Mr. ROGERS. Should they?

Dr. PIEMME. They should not, sir.

Mr. ROGERS. All right.

Dr. PIEMME. I think we have enough of licensed bodies of people who sooner or later build their own guilds. I think we all believe that this should be permissive legislation. It should allow the physician to delegate, as a function of his judgment, to people appropriately trained and certified. There are one or two States that have tried to delineate the specific functions that physician assistants can and cannot do. I find myself unable to do that. I am learning increasingly that physician assistants and nurse practitioners can do many things that 5 years ago I would have thought perhaps not appropriate, and under observation and assessment they do them exquisitely well.

Mr. ROGERS. As well as the doctor, sometimes?

Dr. PIEMME. Oh, yes. If one employs nurse practitioners or physician assistants, for example, in family practice centers, one finds the children get immunized, which they don't necessarily if the doctor is treating the child only when he or she is well.

Mr. ROGERS. And I assume there are many things a doctor would not normally do in his practice that the nurse practitioner becomes more adept at.

Dr. PIEMME. Like spending time with the patient, for example.

Mr. ROGERS. Surely.

Dr. PIEMME. That is very real. If one assesses time spent with the physician versus the nurse practitioner or physician's assistant one finds additional professional contact.

Mr. ROGERS. He can use his time——

Dr. PIEMME. Can use it more productively.

Mr. ROGERS. Yes.

Dr. PIEMME. We have a couple of unresolved issues that we haven't been able to accomplish over the last couple of years, but I think we have some insight into where we may be going. One is the reimbursement issue, and, as you know, the Social Security Administration has launched a major study on that. I think we are arriving at some consensus about a rational way that might be done.

Mr. ROGERS. You might let us have your thinking because this committee will now handle medicaid.

Dr. PIEMME. Yes; I understand that.

We are caught in a dilemma. If we reimburse the physician at 100 percent of his usual and customary fee for the performance of a task by a physician assistant or nurse practitioner who is being paid perhaps $14,000 or $15,000, it is possible that the physician might

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earn more money than he does now. And I think that might not be appropriate.

I wouldn't mind if the savings got passed off to the patient, or if the physician's assistant or nurse practitioner were paid at a higher level. But for the physician to realize an unreasonable increment in his salary should be guarded against.

On the other hand, if one doesn't provide satisfactory reimbursement then there is no incentive for the physician to use the physician assistant, when in fact the physician assistant can represent a very substantial economy in health care in this country. I think the thinking of a number of people is beginning to coalesce on a figure of something like 80 percent. And 80 percent would seem to be reasonable, providing an incentive.

After all, there is substantial overhead to having a physician assistant in one's office. One might allow 100 percent in the language that you have so often incorporated in bills in areas of need determined by the Secretary, that is, rural or urban areas of high impact. To encourage physicians there it would provide an even greater incentive. I think that is where it will come out.

I will be interested to see what the social security study does show when it is completed.

Mr. ROGERS. Yes. Thank you.

Dr. PIEMME. The issue of recertification is something that we are now addressing in the National Commission on Certification; how and when should be resolved within the next year.

I might speak to one thing raised earlier; that is, the issue of malpractice. I am pleased to say that in 10 years no physician's assistant, nor any physician who employs a physician assistant, has been sued for malpractice for an act of the physician assistant. I think that is a remarkable track record. As physicians are beginning to learn that, they are much more encouraged about the use of physician assistants.

Let me speak just a moment to the future that I think is going to tie in with some of the testimony you heard this morning. Dr. Fisher and I have recently had the experience of being asked to consult with several hospitals regarding the employment of physician assistants as replacements for the foreign medical graduates that they realize are no longer going to be available in the plentiful suppply they are today.

I think that there is a potential use here for the physician's assistant. If one takes the foreign medical graduate away, where do you find the first and second assistant at the operating table? Who does the physicals on admission? I think the physician's assistant, the MEDEX, the nurse practitioner, can indeed do that. That implies too that we may begin to see specialty tracking if one is going to go that route.

Surgeons are going to get more interested than they have been up to now in utilizing physician assistants. The National Board of Medical Examiners and the Commission on Certification, are beginning to talk about the alternatives if there seems to be somebody interested on the part of the American College of Surgeons toward this specialization.

Mr. ROGERS. I presume that it is inevitable.

Dr. PIEMME. I think it is going to be inevitable, and as the foreign medical graduates disappearance become a fait accompli, that position will be substantially enhanced. I think we are going to see substantial

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more health team development emerge from the joint training of family physicians, medical assistants, and new health practitioners, that is, nurse practitioners and physician assistants.

There are some unknowns. I don't know how many are needed, and I don't think we are going to know how many are needed. Every once in a while I get anxious—are all those we are turning out going to get employed in the next couple of years? Yet we find they indeed are employed, and employed at substantial salaries.

I don't think any of us would urge at the moment substantial enhancement of numbers we are turning out, however. I think the next 3 years should be a time for consolidation, for reinforcement, and learning about some of the other issues that we have yet unresolved.

I would urge, as Dr. Castle did, support for the existing programs, however, be made realistic. I would argue for the contract mechanism rather than capitation.

Medical institutions have a habit of taking the capitation and putting it toward programs that already exist for which they can't get reimbursement and the physician assistant program has to go fending for itself on some occasions.

I think the contract mechanism should be continued. Capitation is an option, of course.

Mr. ROGERS. Yes. Well, should we make it an option and then have some provision for contract continuation?

Dr. PIEMME. I think that dual approach would be appropriate.

Mr. ROGERS. In other words, we should encourage the programs but have some supplements for them, as necessary.

Dr. PIEMME. I think that would be a good idea.

Mr. ROGERS. Fine.

Mr. PIEMME. One byproduct of my statement that I think we should guard against about substantially increasing the numbers over the next 3 years, is that the current programs will have to remain small. In order for them to have autonomous fiscal viability they would all have to get much larger.

I think we are going to have to accept the fact that programs are not going to be cost-effective for the next 3 years. I would, however, hope at the conclusion of that period of time when we have resolved the unresolved issues and have a better purview on this employability and the ultimate viability of these programs, that they could then become self-sufficient. I would hate to see the nurse practitioner movement get into the box medical schools are in, for finding themselves having developed a very costly system of education that then has to depend endlessly on Federal support.

I will be happy to answer any questions.

Mr. ROGERS. Thank you.

Dr. Fisher, do you have any comments?

STATEMENT OF DONALD FISHER, M.D.

Dr. FISHER. I would like to introduce for the record some data that I think might be of interest to your committee. It has already been mentioned that there are 1,800 graduates in the country today. There are approximately 2,100 in the total universe that are in training right now. We are expecting 781 students to graduate this year. With an upward trend through 1975 to approximately 978 graduates, and

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with an additional 1,119 graduates in 1977 it looks like we have reached in 1977 a plateau of 1,119 graduates. This will give us a total number of graduates by 1977 of approximately 5,700.

I would also like to indicate for the record that of the 62 programs that exist today, 51 of them are in primary care, 5 are in surgery, 2 are in neurology and 4 are in orthopedics. There are 49 AMA approved training programs——

Mr. ROGERS. AMA approved?

Dr. FISHER. Right. That is the accrediting agency that we usually refer to as recognized by the Office of Education.

Dr. CASTLE. This is the joint commission.

Mr. ROGERS. The joint commission. I see.

Dr. FISHER. Out of the 62 programs, 31 of those are based in medical schools; 13 are in academic health centers; 5 are in junior or community colleges; 2 are in clinics with an academic program; 3 are in schools of allied health; 2 are in Federal establishments; 1 is in a Federal prison; 2 are in technical schools; 1 is in a nursing medical school and 2 are with clinical affiliates.

I would also like to mention for the record as executive director of the American Academy of Physician Assistants and association of programs that we are just completing the first comprehensive study on physician assistants that has been done to date. This study includes physician assistants, MEDEX, child health associates, and health assistants.

The initial tabulations are indicating that 88 percent of the graduates to date are practicing in primary care. Greater than 90 percent of the graduates are practicing as physician assistants. We are seeing in the total universe a little bit larger than 45 percent of the graduates practicing in populations of less than 20,000.

I would also like to submit for the record an additional overview of the physician's assistant concept for the committee by the Association of Physician Assistant programs. This synopsis reviews every one of the programs in our association, which now numbers 49.

Mr. ROGERS. Without objection it will be received in the record.

[The information referred to was not available to the committee at the time of printing.]

Mr. ROGERS. Thank you, Dr. Fisher.

Now, Mr. Wilson, do you have any comments?

Mr. WILSON. Just to say thank you very much, and we appreciate your having us.

Mr. ROGERS. We appreciate the help that you have given to the committee. We have been impressed with what you are doing, and we thank you for being here.

Dr. Carter?

Mr. CARTER. Just one question.

Mr. ROGERS. All right, sir.

Mr. CARTER. In your work you see an average of nine patients per day, is that correct?

Ms. DAGGETT. This is in the nursing home.

Mr. CARTER. Within the nursing home. These are nine new patients?

Ms. DAGGETT. Correct.

Mr. CARTER. And your charge per patient is $19, is that correct?

Ms. DAGGETT. Yes. This is not a program that I am in. This is one that is currently operating.

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Mr. CARTER. Does that include laboratory work, and so forth?

Ms. DAGGETT. Yes; my understanding is that it does.

Mr. CARTER. Yes. If you go to one nursing home and you see nine patients in the nursing home, your charge for that day would be $19 per patient, is that right?

Ms. DAGGETT. Yes.

Mr. CARTER. But that would include your hematologies and all, X-rays, and so on, is that correct?

Ms DAGGETT. That is my understanding. Again, this is not a program in which I have worked so that I can't answer that directly.

Mr. ROGERS. Maybe you could check and let us know for the record.

Ms. DAGGETT. I could check and let you know for the record.

Mr. ROGERS. Thank you.

[The following statement was received for the record:]

The $19 charge per patient does not include laboratory work and so forth, as Dr. Carter asked. It covers the cost of the Telemedicine visit.

Mr. ROGERS. I might say before we dismiss that we have a young man at the press table who has been covering this hearing this afternoon. Stand up for us over there, young man.

He is a real writer and he has been doing a good job.

Mr. Timothy Billings, we have been glad to have had you with us.

He has been very patient in listening to all this. He will probably turn out to be a doctor instead of a writer, or maybe a physician's assistant.

Mr. WILSON. Or a Congressman.

Mr. ROGERS. We are delighted to have you here. Thank you for helping the committee.

The committee stands adjourned.

[The following statements and letters were received for the record:]

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

In accordance with the Subcommittee's decision to limit its public hearings on health manpower legislation to certain selected witnesses, the American Dental Association respectfully submits the following written comments and recommendations regarding provisions of H.R. 2956 that are of particular concern to the Association as the representative of 100,000 practicing dentists in the United States. The Subcommittee's attention is invited to the comprehensive statement presented by the Association in May, 1974, on similar legislation that was then under consideration. It should be noted, however, that H.R. 2956 includes several new provisions that were not the subject of discussion during the health manpower hearings of last year.

The areas of special concern in the pending bill relate to: (1) student payback requirements, (2) additional mandatory enrollment increases, and (3) expanded function dental auxiliaries.

Student Payback Requirements.—Section 771(a) of H.R. 2956, as we understand it, requires as one of several conditions, that a school exact from each enrolled student an agreement that such student will pay to the U.S. Treasury in yearly installments following graduation an amount equivalent to the capitation grants awarded to the school on his behalf during his training period. Thus, a dental student upon completion of four years of training would be required to pay to the Treasury a debt in excess of $8,000 unless he received a waiver by serving in a shortage area through the National Health Service Corps or in the Indian Health Service. As a practical matter, most dental students would not be permitted to "work off" the debt through such service since the number of graduates (currently about 4,500 and an estimated 5,500 four years from now) will greatly exceed the number of critical shortage areas which currently number about 475 according to the Department of Health, Education, and Welfare. (Federal Register, October 23, 1974, p. 37756). It should be emphasized in this con-

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nection that the proposed federally-imposed burden of over $8,000 would be in addition to the existing educational expense per student which is now approaching $25,000 in several dental schools. Also worthy of consideration is the fact that the initial cost of establishing a dental office ranges upward from $30,000.

The American Dental Association believes it must object to these provisions both for reasons of principle and practicality.

There is, we believe, an inherent contradiction between the concept that our system of health education is a national resource and the proposed requirement that the products of that system must repay to the Federal government the amount of the public contribution toward their education. Proponents of this requirement have stated that such a student payback is justified because ". . . health professionals for the most part receive incomes that are not commensurate with the tuition and fees paid as students . . .". This is, in our opinion, a profoundly disturbing premise that is totally alien to the history of public education in this country.

It should also be recognized that the immediate impact of the proposed service versus financial payback would fall most directly on the minority and less affluent students in our health schools. Congress should give serious consideration before approving an approach that would, in effect, indenture certain groups of students to Federally required service in a shortage area while their more fortunate classmates may be able to avoid such service by repaying whatever capitation amounts were awarded.

We question as well how such a mechanism can be realistically administered if large numbers of future graduates do choose to meet their obligation in service rather than through payment. As indicated above, if the Department of Health, Education, and Welfare designates as many "shortage areas" as are necessary to accommodate applicants for service, there would be a potential need to annually identify 5,000 dentally underserved communities. Conversely, if the Department limits the number of assignments to those actually required for bona fide shortage areas, what mechanism will be employed to select from a surplus of service applicants? Additionally, the bill is silent on how graduates who enter military service will be treated with regard to the payback agreement they were forced to sign. In the past, twenty to thirty per cent of each dental graduating class has entered military service. Some of these are enlistees and others are committed because of scholarships received under the Armed Forces Health Professions Scholarship Program. The question arises as to whether these latter students will be subjected to a dual liability.

The ADA does believe that the dental profession, including our health professions schools and graduates, have a responsibility to address the health problems that affect our country. Geographic maldistribution of health care practitioners is one such problem. However it would, in our opinion, be a mistake to undertake such a coercive and inequitable approach as proposed in H.R. 2956 when existing programs have yet to achieve their potential. Because of severe budgetary constraints, the National Health Service Corps has to date assigned only a limited number of dental personnel to underserved communities. The companion program of corps scholarships assistance is just becoming operational. An extension and expansion of these authorities, as proposed in H.R. 2958, would appear to be a more reasonable and desirable approach if Congress is to truly evaluate the effectiveness of voluntary programs responding to the problems of geographic maldistribution.

In this connection, our Association believes that Congress should give serious consideration to the development of legislation that would provide (1) incentives under the income tax system for credits or deductions, (2) accelerated depreciation allowances, and (3) low interest government loans, for dentists who practice in underserved areas.

While recognizing that tax legislation is not within the jurisdiction of this Committee, we believe that the foregoing approach holds great promise, not only as a mechanism for attracting the graduating dental student to shortage areas, but also as an incentive for the older practicing dentist who may be considering relocating.

Enrollment Increase.—Section 771 of the proposed legislation lists five separate requirements that a school of dentistry must satisfy in order to qualify for capitation (institutional) grant support. One of these requirements permits a school to select the "option" of either an enrollment increase up to 10 first-year dental students or establish a program for the training of not less than 25 expanded function dental auxiliary students.

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For those dental schools that are currently operating at full capacity, the enrollment of additional dental students cannot be considered a realistic option. Likewise, it must be recognized that the dental auxiliary student generally receives training in the same facilities as the dental student. An overcrowded dental school that is unable to increase its class of first-year dental students by ten will find it equally impossible to establish or expand a program for the training of 25 new auxiliary students.

The enrollment increases proposed in H.R. 2956 would, if approved, represent the fourth such expansion of first-year students since the inception of institutional support on 1966. The ADA has expressed a continuing concern over the mandatory enrollment increases that have been a condition of this Federal assistance.

Today these warnings of an erosion in program quality from enforced student increases have become a reality. Within the past 24 months the recognized accrediting agency for dentistry has found it necessary to place seven dental education programs on less than a full approval status. The next scheduled meeting of the Commission on Accreditation will consider appeals from four additional schools to show cause why the accreditation status of their programs should not be lowered. Never in the recent history of dental accreditation have we experienced a situation even approaching the problem just described. In each instance, the program deficiencies that have been identified are directly related to lack of space, facilities and faculty for the additional students.

We have noted an apparent acknowledgement of this crisis in the Report which accompanied a similar bill (H.R. 17084) that passed the last session of Congress. The Report states in part ". . . the Committee does recognize that the requirements of previous legislation have resulted in enrollment increases which have pushed some schools to the bounds of their physical facilities . . ." Unfortunately this concern has not been carried forward into the health manpower legislation that has been introduced this year.

A partial solution to this dilemma can be achieved through the inclusion of a meaningful provision that authorizes a waiver of these requirements. The waiver provision currently provided in H.R. 2956 is similar to that authorized in the previous health manpower law. Our experiences with that provision were less than encouraging. Indeed, it was the government's rigid interpretation of that waiver authority that has resulted in the unfortunate accreditation action described earlier.

It is our belief that Congress should recognize the necessity of granting a waiver in those instances where fulfilling the requirements of the capitation program would lower the quality of education. In order for the Secretary (HEW) to make such a determination, it is essential that he have the advice and counsel of organizations qualified to evaluate the conditions at a given institution. We believe that this objective can best be accomplished by the statutory inclusion of nationally recognized accrediting bodies in the proposed waiver provisions of section 771 (b) (2) of H.R. 2956. The following amendment is suggested:

"The Secretary shall waive (in whole or in part) the requirement of paragraph (1) (A) with respect to any school of medicine, osteopathy, or dentistry, upon written notification by an accreditation body recognized by the Commissioner of Education for such purposes, that, because of limitations of physical facilities available to the school for training or because of other relevant actors—

(A) such school cannot increase its first-year enrollment of full-time students in accordance with clause (i) of such paragraphs; and (B) such school cannot offer a program for the training of physician assistants or a program for the training of expanded function dental auxiliaries to comply with clause (ii) of such paragraph; without lowering the quality of education provided in such schools."

Expanded Function Dental Auxiliaries.—H.R. 2956 authorizes annual payments of $650 to dental schools for the support of programs for the training of "expanded function dental auxiliaries." Title I of the bill directs the Secretary (HEW) to establish guidelines for these training programs requiring, among other things, that such individuals be trained to provide "primary" care under the supervision of a dentist or physician.

The ADA is most concerned with the administrative interpretation that might be applied to these guidelines. Our concern stems from the use of the term "provide primary dental care." There is, it would appear, some confusion over the appropriate role of the dental auxiliary and the physician assistant in the de-

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livery of health care. It must be understood that dental auxiliaries are not, of themselves, primary care practitioners. Both traditional and expanded function dental auxiliaries perform as a member of the dental health team in order to "assist" the dentist in providing primary dental care. This distinction is recognized in the various state laws that govern the delivery of dental care and must, we respectfully submit, be recognized in any proposed health manpower legislation.

Finally, it would not seem to be a prudent expenditure of public funds to support programs that train individuals in procedures that they will not be permitted under state dental laws to perform upon completion of their training. As we have noted in previous testimony before this Committee, there is no national uniformity of definition as to the characteristics of expanded function dental auxiliaries. Although a number of states have broadened their practice acts to permit the delegation of certain duties to auxiliary personnel, none of the states allow dental auxiliaries to deliver "primary" dental care on an independent basis. Therefore, we recommend that at a minimum, Federal support for the training of expanded function dental auxiliaries be approved only to the extent that such training is consistent with the applicable state practice acts governing the delegation of dental procedures.

It is recommended therefore that Title I, Section 101 (c), paragraph (9), be amended to read as follows:

"The term 'program for the training of expanded function dental auxiliaries' means an educational program which has as its objective the education of individuals who will, upon completion of an accredited program of studies, be qualified to assist in the provision of primary dental care under the direct supervision of a dentist in accordance with the prevailing state dental practice act."

Statement of the American Optometric Association

H.R. 2956

The American Optometric Association and the Association of Schools and Colleges of Optometry support the general concepts contained in H.R. 2956, the Health Manpower Act of 1975. However, the Associations believe that the thrust of this important legislation will be best served by making changes in its provisions pertaining to institutional support (level of capitation authorization and enrollment increase requirements).

First, we recommend that the capitation rate for optometry be established at $1,500 rather than at $800 as established by the expired Comprehensive Health Manpower Training Act of 1971. We concede that the $700 figure proposed in H.R. 2956 represents an increase from the existing appropriated capitation level, but the facts at hand fully justify the establishment of the capitation award to be set at $1,500 in order to maintain quality optometric education and provide a sufficient supply of optometric manpower.

Second, we believe that it is an error to ask the schools of optometry to continue to increase enrollment in existing facilities. Optometry has increased its enrollment well above mere compliance with federal requirements. Enrollment at these current levels should qualify an institution for federal capitation funds, and expansion requirements which may threaten the quality of the educational program should be modified to reflect the enrollment increases already achieved in the last four to five years.

THE NEED FOR ADEQUATE CAPITATION FUNDING

In its 1973 Report of the National Study of Optometric Education, the National Commission on Accrediting stated that "The major support for (optometric) instruction should be provided by a combination of funds from state and federal governments." The Commission then suggested three finance models. Finding an annual per student actual instruction cost of $5,500 (1973–74), the Commission's preferred financial model called for a sharing of costs between the federal government, state government and student. Establishing the federal capitation level of $1,500 for optometry schools would represent a more desirable percentage of federal funding than what is proposed ($1,500 equals 27% of cost of education; $700 equals 12% of cost of education). Approving an amendment to authorize a funding level for the schools of optometry would place the federal support

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given these schools closer to parity with the other direct health care professions.

The National Commission on Accrediting has found that the annual instructional costs per undergraduate medical and optometric students is of the same magnitude. We ask that the schools of optometry be afforded the same consideration as the podiatry schools, which under H.R. 2956 are authorized at a more realistic level of $1,500.

The schools and colleges of optometry fully recognize their responsibility to develop income sources in addition to federal capitation funding. Faced with constantly rising costs and tuition, the presidents and deans of the schools and colleges of optometry are continually seeking direct support from state legislatures as well as endowments and gifts from optometrists and the optical industry. However, these efforts are not enough. One-half of the twelve U.S. schools and colleges of optometry are private independent institutions; states that do not have university affiliated optometry schools must turn to the six private schools and colleges of optometry for their optometric manpower. Thus, these schools are very much a national resource and a national responsibility.

CONSEQUENCES OF INADEQUATE CAPITATION

Capitation grants have enabled the schools and colleges of optometry to improve the basic curriculum of our educational program. The amount of support received in past years has provided a partial base upon which mid-range planning has taken place at the institutional level.

If the use of capitation grants were traced throughout the institution's budget, federal support touches upon every aspect of our educational program.

"What will be the consequences if federal capitation funding is not established at an equitable level for optometry education?

"A situation will result where the overall operating budget will be decreased, while rising cost of education further compounds the institution's problem. As conditions worsen, maintenance services will be reduced or curtailed. The replacement of worn or outdated equipment will not be made. Basic upkeep services will, more than likely, be identified and cut before support personnel are called upon for release.

The scenario can be played out where reductions will finally hit the heart of the school, the faculty. Total enrollment must necessarily decrease, as the schools have less funds to spend per student. Enrollment could reach the total inadequate pre-1965 levels.

The clinical program of the colleges will suffer greatly. These are multi-purpose facilities, providing necessary practical experience for the third and fourth-year students, serving communities which might otherwise forego vision care services. These clinics range from the on-campus variety to off-campus clinics for the aged, for alcoholics, for the mentally retarded, and for low-income families. In some cases, the schools will have to close those clinics which cannot be self-supporting.

After the cuts in faculty, cuts in enrollment, discontinuation of certain clinical outreach programs, there still may remain tremendous deficits. Already, the optometric institutions have pushed their financial sources to the uppermost limits in gathering funds to cover increased enrollment required by the federal government in securing capitation. In some cases, there is no other source of funds. At this point, optometric educational facilities might begin shutting their doors. Yet, this would occur at precisely the time when the demand for more health professional manpower is heightened by the trend toward some form of National Health Insurance.

Ultimately, this type of action (decreased number of graduates per year) will be at the direct cost of the American citizen, who may be placed in a position of great difficulty in obtaining professional vision care. In this period of inflation, he will find that a diminished supply of optometrists has caused either an increase in the fees charged for optometric services or a tendency toward less complete vision care in order to handle the increased patient load. And this will occur against two backdrops: the reality that over half of our Nation's citizens have some form of eye disorder or impaired vision, and the fact that the American public is demanding increased quality in consumer services of all forms. Optometric care is no exception.

It is estimated that if optometric student capitation is established at $1,500, there will be an overall increase in the program budget of only $3,000,000 (this represents a 0.7% of the appropriated funds for FY 1974). Given the situation

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of an inadequate capitation level, from the institution's point of view and the small percentage increase in relationship to the total health manpower budget, we hope the Interstate and Foreign Commerce Committee would increase optometry's capitation rate to $1,500.

ENROLLMENT EXPANSION POLICY

We note that H.R. 2956 requires that the schools and colleges of optometry continue to increase their enrollment in order to qualify for capitation funding. It must be noted that since 1965, the optometry schools have increased their enrollment by 220%. Mandating such a continuing increase can only result in forcing schools to the brink of losing accreditation. Present education and clinic facilities designed to accommodate classes of 50 must now crowd in classes of 70–80 students. In the first two years of the four year program in optometry, the problem may not become apparent—teaching laboratory facilities can be brought in—but a significant crunch will occur in the final years when emphasis shifts to clinical work. Faculty teaching and clinic loads are also expanded to provide the services to the students.

Therefore, we urge the Congress to re-evaluate the enrollment expansion requirement for optometry schools. The schools have already expanded their enrollment dramatically and we fear that continued expansion in existing facilities will eventually force the schools into a situation where the quality of the educational system suffers and accreditation problems arise. If it is the intent of the Congress to increase the manpower output, the only viable means is the establishment of new schools. The bill does provide for support of new optometry schools. The Associations feel that this is a positive movement towards increasing the optometric manpower pool.

CONCLUSION

For these reasons the American Optometric Association and the Association of Schools and Colleges of Optometry respectfully recommend the establishment of a more realistic capitation level for optometry schools.

We stand ready to cooperate in implementing any requirements that Congress may impose as a condition for receiving federal funds for optometry schools. As in past years under the Comprehensive Health Manpower Training Act of 1971, optometry schools stand ready to respond to national priorities set by Congress.

The profession is concerned about the geographic maldistribution problem of primary care practitioners and we hope with Congress and the Department of Health, Education, and Welfare, this problem can be either alleviated or eliminated. However, we do recognize that optometry, with practitioners located in some 5,547 communities in the United States, may not face as critical a distribution problem as some other professions.

Optometry has an important role to play as a primary provider of eye and vision care. Our schools and colleges are dedicated to training expert professionals to provide the Nation with quality optometric care. But, in order to accomplish our stated goals, the Congress needs to support our educational institutions at a level that will reflect a per centum that is appropriate or in parity with other primary care professions.

STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION

H.R. 2958

The American Optometric Association, which represents the licensed profession of optometry throughout the United States, continues to support the concept of a National Health Service Corps and the general provisions of H.R. 2958.

Optometrists today are active in medically-underserved areas throughout the Nation. From the migrant labor camps of California and the Indian reservations of the Far West to the inner-city areas of New Orleans, Chicago, Washington and other urban centers, optometrists are providing needed skills and services. We have seen—through our professional work—that there must be a continuation and expansion of both the National Health Service Corps and the Public Health Service if we are to meet the national commitment to a full health entitlement for all citizens.

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Under existing legislation, optometrists are authorized to participate in the National Health Service Corps. To date, however, only one optometrist has been assigned to the NHSC. Other optometrists are participating in the U.S. Public Health Commissioned Corps.

What role should optometry have in the National Health Service Corps? Residents of medically-underserved areas are often crucially affected by a lack of optometric services. A study by Prof. Charlotte Muller—a highly respected health researcher—has shown that visual disabilities are four times more prevalent than average in families with incomes of less than $7,000 annually. At the 1974 meeting of the American Public Health Association, a paper presented by Dr. Joyce Adema indicated that 85% of those children who were identified as "aggressive" in her study had visual impairments. She found a distinct relationship between visual acuity, aggressive behavior, and reading ability. Through vision therapy, levels of aggression declined while reading performance improved by an average of more than two grades.

Optometry can bring unique skills to medically-underserved areas. Today's optometrist examines, diagnoses and treats conditions of the vision system. Equally important, optometry is frequently the only contact the medically-underserved have with the health-care system. The eye is an excellent gauge of general health which can often reveal—through proper examination—non-ocular problems such as high blood pressure, diabetes, and many other conditions.

To strengthen H.R. 2958 and the working concept of a National Health Service Corps, the American Optometric Association would suggest two changes in the proposed legislation.

First, primary health care providers such as optometrists should be specifically identified by name rather than as a lump category.

Second, forgiveness provisions and pay adjustment scales should apply equally to optometrists and other independent health care professionals.

Optometrists are eager to work with other health-care professionals to bring needed services and skills to underserved areas. The American Optometric Association—whose members live and work in 5,500 communities throughout the United States—looks forward to working with HEW in this effort and to stimulating community participation in this important program.

We strongly believe the two changes which we have proposed for H.R. 2958 will permit the National Health Corps to utilize more fully the complete scope of American health-care providers. The American Optometric Association urges you to consider and accept these two suggestions which we feel will maximize the full potential of the National Health Service Corps.

STATEMENT OF THE AMERICAN VETERINARY MEDICAL ASSOCIATION

The American Veterinary Medical Association appreciates this opportunity to comment on the continuing need for Federal financial assistance for veterinary medical education and ways in which H.R. 2956 could meet that need.

Federal priorities for health services are too frequently short sighted. Health care services are too often equated only with bed-side patient care. Although aiding those already afflicted is laudable and necessary, long-range health improvements require much more than that. Foster biomedical research, increasing the availability of protein foods, improving the environment, preventing disease—these are appropriate activities for the Federal government. Veterinary medicine is one of the health professions necessary to the successful conduct of these activities. H.R. 2956 with a few amendments will be an effective basis for providing Federal support of veterinary medical education. It can assist in increasing the number of educational opportunities, improving the quality of education, and making increased opportunities for the disadvantaged.

Today there are 19 colleges of veterinary medicine in the United States. Current fiscal year classes total about 1,650 students. In the 1970–71 academic year there were 18 colleges with entering classes totaling 1,430 students. Funds authorized by the Comprehensive Health Manpower Training Act of 1971 have been of vital assistance in providing the basic support for these added educational opportunities.

The only new program in veterinary medical education in the past fifteen years has been developed through Federal assistance at Louisiana State University. Several other universities have expanded facilities using Federal funds for part of the construction cost.

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Federal financial assistance in the education of veterinarians has been extremely important in increasing opportunities for entry into the profession and in improving the quality of education.

Animal health is always an important matter in food production. It has assumed a new priority in the United States today. Foods of animal origin, particularly meat, are the most expensive items in the family market basket, yet the producers of these foods are severely hampered by rising costs and severe losses from diseases. Veterinary medical service to the animal industries is a vital factor in our food production system.

Man's relationship to animal diseases continues to change because of ever-changing technology and life-styles. The problems of today will not be those of tomorrow. Success in the protection of people from diseases common to man and animals and in assuring an efficient animal industry for food production is dependent upon progressive veterinary medical education and research institutions and upon an adequate supply of highly competent veterinarians.

INSTITUTIONAL SUPPORT

There is now a shortage of veterinarians. There will be a shortage throughout the 1980s unless additional educational opportunities are developed soon. The people of eighteen states provide the major part of the support for the nineteen colleges of veterinary medicine. Yet each college is a national resource and its graduates serve the needs of the nation. Continuing Federal financial support is needed so that these institutions may serve the entire nation and so that students from all of the states may have opportunities for a veterinary medical education. Without continued Federal support, the gains in enrollment which have been made in the recent past will be lost. If the schools and colleges of veterinary medicine are supported totally by the residents of the states in which they are located, they are very susceptible to pressures to limit enrollments primarily or solely to students from that state. If this occurs, students from "have not" states will have little opportunity for a veterinary medical education. Many of the best potential veterinary medical students will be forced to make other career choices. A system providing for continuing institutional support grants is essential to maintain the present enrollment levels and to give reasonable assurance of educational opportunities for students of all states and from all economic, ethnic, and racial backgrounds. The provision of a maximum grant of $1500 per student year, while limited compared to the actual cost of veterinary medical education, will be important in maintaining the current level of enrollments and assuring opportunities for students in states without colleges of veterinary medicine.

STUDENT AID

The present system of student loans and scholarships is particularly effective in providing financial assistance to veterinary medical students. The average beginning veterinary medical student is about 22 years old and has had nearly four years of university work prior to admission to the veterinary medical college. At the time of graduation, this average student has devoted eight years to university education and is 26 years old. Approximately one-half of those graduating are married.

A continuing system of student financial aid is vitally needed. H.R. 2956 will provide for such a system.

FACILITIES CONSTRUCTION

Several of the schools and colleges of veterinary medicine have inadequate physical facilities. Some of them have probational accreditation due largely to inadequate physical plant resources. A system of Federal sharing in the cost of construction for these schools and colleges, such as provided for in H.R. 2956, is essential to prevent their loss of accreditation and to encourage the states which support them not to place severe restrictions upon student admissions from other

SPECIAL PROJECTS

The proposed use of special projects grants to support programs relating to disadvantaged individuals is a purpose of real value; however, there are several other types of projects which merit consideration for such funding. Veterinary medicine is in many respects unlike some of the other health professions. New authority should provide for use of special projects grants in several areas of need such as:

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1. Projects to select, encourage, stimulate, and specifically prepare veterinarians to serve rural areas which are without service for food-producing animals.
2. Increased training opportunities for veterinary medical students in the science of modern agribusiness including medical genetics and medical nutrition and the application of such science to animal health and performance.
3. Improvement in veterinary preventive medical education for all veterinary medical students.
4. Programs for improved utilization of resources through cooperative inter-college programs.
5. Establishment of undergraduate laboratory experience that will serve to provide selected outstanding undergraduate students who exhibit a potential interest in research and teaching an opportunity to experience the thrill of discovery in veterinary medical research.

FACULTY DEVELOPMENT

A system should be provided to encourage colleges to develop future teachers. A provision of the Comprehensive Health Manpower Training Act of 1971 authorized such a system of grants. H.R. 2956 in its present form would repeal that section. There will probably be five developing colleges recruiting faculties, at least 350 highly qualified persons, during the next several years. Providing these people and meeting the normal annual losses due to retirements and deaths, along with improving the quality of educational opportunities, indicates the need for specific grants to support faculty development opportunities.

FINANCIAL DISTRESS GRANTS

The provision of grant support on a special basis for institutions which face critical financial situations is essential. Two colleges of veterinary medicine have used this means of overcoming crises during the effective period of the Comprehensive Health Manpower Training Act of 1971. This authority is needed and should be continued.

STATEMENT OF THE AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES

The American Federation of State, County, and Municipal Employees submits this statement on health manpower legislation on behalf of the 200,000 members of this union who work in the field of health and also on behalf of the 700,000 members of this union who are consumers of health care. We, like many other organizations and individuals who are interested in the passage of a meaningful health program for Americans, have been concerned about the present maldistribution of health manpower. Our members in rural areas or urban ghettoes cannot get the health care they need.

AFSCME members who provide health care in the public sector see another dimension of the problem. While these aides, LPNs, RNs, technicians, and other allied health personnel provide the care available in areas with shortages of doctors and other health professionals, they themselves have almost no opportunity to move upward to fill professional jobs even though these jobs are in short supply. They are in a unique position to appreciate the fact that inadequate health care is not solely a problem of too few doctors.

The major methods of support for the development of an adequate supply of health manpower proposed in H.R. 2956 are: loans; National Health Corps scholarships tied to obligated service programs; and capitation payments to schools.

As a union, we support voluntary service for health professionals in underserved areas as payment for loan funds in lieu of cash. Similar programs of forgiveness exist in current NHSC legislation and could be expanded.

As a method of providing funds for students, we can also see an expanded role for the National Health Service Corps in recruiting students into the Corps, and providing them with a salary and educational expenses in return for a defined period of obligated service. This method of student support presently is available in military reserve programs as a method of providing scholarship money. AFSCME supports this type of program for training of health professionals who are a scarce national resource. We believe that the system proposed in H.R. 2956

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would have the effect of developing a rotating cadre of National Health Service Corps members who see obligated service as a stepping stone to a lucrative fee-for-service practice and would have a limited effect on long range manpower needs and communities.

In all cases of loans or scholarships, we find a double payback penalty—to be particularly for students who do not complete training or fail to become licensed. This puts inordinately heavy burdens on a student who must change career goals because of circumstances beyond the student's control. Such circumstances occur too often because counseling of students, particularly in allied health, is insufficient and frequently inaccurate. The double payback penalty would serve to decrease utilization of loans and scholarships by students who need them most—presently employed workers who are in career ladder programs and students from low-income families.

This union cannot support a payback system for students who attend schools which receive capitation grants. Under the proposed legislation, the student who attends a school which seeks to provide medically needed services pays a heavy price. In addition to tuition and fees, the student indirectly becomes responsible for subsidizing the school, by providing funds to the school in return for the student's period of obligated service. These funds are supposed to be used for student education, not the profit of the school. This formula requiring service or a double payback penalty puts the responsibility for solving the manpower distribution problem, primarily a maldistribution of physicians, on the health professionals at the lower income levels. The discriminatory effect is increased for students who require financial assistance in allied health and are ineligible for loans.

AFSCME deplores the discriminatory treatment of health professionals in H.R. 2956 as presently drafted, which further enhances the economic distances between physicians and other workers in health. We believe it is discriminatory because no capitation grants for allied health schools and no loans to allied health students are included. Recent popularly published surveys show physicians with an average income of $45,000 (including interns and residents) while allied health personnel are lucky to earn $10,000. H.R. 2956 further discriminates by allowing the Secretary to adjust the pay of physicians in the National Health Service Corps (not to exceed $1,000 per month) in order to pay what amounts to an exceedingly high prevailing rate at federal expense. National Health Service Corps physicians are seen as establishing fee-for-service practices with no impetus for HMO or hospital-based urban practice and are subsidized so they "won't lose anything."

(1) For example, if a NHSC professional is serving in a medical facility linked to a state institution or other public institutions (as in Sec. 747(d)(a)(C), this individual will be paid Corps salary. (2) AFSCME strongly supports the addition at public institutions as a focus for NHSC personnel service. We believe this inclusion will greatly improve care for patients in public institutions which currently have a great need for health personnel. (3) However, two questions arise. Are these personnels to receive the pay adjustment (of up to $1,000 a month) to make other salaries comparable to those in private practice? Second, will Corps personnel receive the $25,000 assistance grant to establish practices in areas near the public institution. (4) We can envision situations where Corps personnel will be working side-by-side with institutional personnel at widely differing rates of pay. (5) We believe questions such as these must be considered by the Committee in its deliberation on this bill.

While the legislation does develop new programs for the training of physicians assistants and expanded function dental auxiliaries (Title IV—Grants to Health Profession Schools), the capitation level and total authorization for this needed program seems low. AFSCME recommends that the capitation level be increased to $1,000 a student and the total authorization adjusted accordingly. With the current dramatic shortage of trained support personnel, we believe expanding these programs and increasing capitation support will enhance their value.

This union is committed to the development of career ladder programs in the health field as a means of providing adequate health manpower—with people who have already proved a level of dedication through years of service to patients. AFSCME members and other employed health workers who work daily in medically underserved areas should be prepared to be health professionals and these workers would need either a scholarship based on need or a grant program.

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AFSCME commends the Committee for the inclusion in Title V, Special Project Grants and Contracts, Section 782, Assistance to Individuals from Disadvantaged Backgrounds. However, we believe that this program should include a focus on recruitment of individuals already serving in health care on para-professional levels.

In addition, while we support the development of area health education centers (Section 783), we believe that career development programs should be specified in Section 783(a)(2) as a particular emphasis of training programs.

Title VI provides special project grants and contracts for training programs for allied health personnel (Section 795). AFSCME strongly supports the efforts of the Committee in this field, for our experience in sponsoring career development programs for allied health workers points up the need for training and educational programs.

In summary, the American Federation of State, County, and Municipal Employees supports the development of a comprehensive health manpower program which seeks to correct problems of personnel maldistribution. Therefore, we support voluntary service and accelerated payback mechanisms for low-interest loans which are available to all health professional students. We support an expanded National Health Service Corps scholarship program if inequities in payback arrangements are corrected. We cannot accept the present design of capitation payments which we find to be discriminatory against heatlh professionals in the lower wage rate categories, particularly allied health, and we have included corrective recommendations in our statement. All health professional programs covered in H.R. 2956 should include special grants for the development of career ladder programs for current health workers to become health professionals.

We will be happy to provide any service which we can to the Committee regarding the concerns of this union.

STATEMENT OF THE AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES, AFL–CIO

H.R. 2957

The American Federation of State, County, and Municipal Employees files this statement on the Nurse Training Act of 1975 (H.R. 2957) on behalf of the 200,000 members of this union who work in the field of health and also on behalf of the 700,000 members of the union who are consumers of health care.

We strongly support the intent of H.R. 2957 in developing and enlarging programs for nurses, including career development programs and advanced training programs.

The extension of capitation grants (Title II) and the increase in levels of support is extremely important to the continuation of educational programs. We commend the Committee for revising the allocation of grants and for providing capitation support to collegiate, associate, and diploma schools of nursing.

In addition to providing support to schools of nursing, we commend the Committee for the continuation of loan, traineeship and scholarship programs. Many nursing students would be unable to enroll in programs without these financial assistance programs. In addition, these funds increase the opportunity for low-income students to complete nurse training programs with a measure of financial security.

Title IV, Special Project Assistance, provides Federal financial incentives to develop new programs in nursing. We are pleased to see the strengthening of career ladder language (Section 820(a)(7)) to specify the upgrading of skills of paraprofessional nursing personnel who desire to become nurses.

In addition, we strongly support Section 820(a)(3) which sees to increase nursing education opportunities for individuals from disadvantaged backgrounds. We hope, in the criteria prescribed by the Secretary, that geographic areas such as rural areas and urban ghettos, will be included in the criteria determining "disadvantaged backgrounds," as well as income criteria.

AFSCME urges the Committee to adopt this bill in its present form, for we believe this approach would provide both increased opportunities for students to become nurses, as well as continuing education for nursing personnel.

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STATEMENT OF J. TEN NORRIS, PH. D., NATIONAL PRESIDENT, AND PHIL AARON, CHAIRMAN, LEGISLATIVE AFFAIRS, STUDENT AMERICAN MEDICAL ASSOCIATION (SAMA)

The Student American Medical Association (SAMA) appreciates this opportunity to submit testimony on health manpower legislation which will determine the terms and conditions under which physicians are trained in this country.

SAMA is an independent medical student organization with representation from nearly all of the country's medical schools. The organization is committed to the improvement of health care and the medical education system. Policy for the organization is established by our House of Delegates and implemented by a Board of Trustees with representation from across the country.

We are concerned with the outcome of the health manpower debate in Congress for several reasons:

First, we recognize that citizens of this nation are being denied their rights to access to quality medical care because of a maldistribution of health manpower. In simple terms, physicians and other health providers are not establishing practices in low income urban and rural areas.

Second, we have long been attempting on our own to focus the medical education system on the problems of health manpower distribution. The SAMA Foundation has operated medical education projects in rural areas which provide medical students with an introduction to the problems and rewards of practice in underserved areas.

Third, we believe that the method of financing medical education will influence the accountability of teaching institutions to the American public and their students.

Finally, we recognize that whatever course is taken by Congress will have an impact on the careers of our existing and future members.

Prior to commenting on the specific provisions which we believe should be incorporated in health manpower legislation, we wish to make a special request regarding the continued authority for the National Health Service Corps. We believe that this important program should be considered separately from the health manpower legislation. SAMA is aware that Corps legislation will have impact on the health manpower issue. However, we believe that many communities which the Corps plans to begin serving in July of 1975 would suffer if the authorization for this program is held up in the debate over health manpower. The Corps must be considered as a critical service program. Therefore, we urge that Congress move ahead in extending and expanding the authorization for the National Health Service Corps.

In regard to health manpower policy, SAMA supports the adoption of legislation which:

1. Requires service in areas deficient in health manpower in return for a scholarship covering tuition and a stipend to cover living expenses.

2. Incorporates a "buy-out" provision that would allow the student to change his mind between the time (s)he accepts the loan and the time (s)he decides on a location for practice.

3. Allows for student choice in the acceptance of the "service for scholarship" arrangement, or alternate methods of financing their medical education.

SAMA feels that support of health manpower legislation that includes these provisions is consistent with its desire to resolve geographic maldistribution problems of health care delivery in this country. Although we see how the country's frustration with the medical profession has led to consideration of legislation requiring universal mandatory service for physicians, we believe this could be counterproductive. The degree of coercion involved in required service could lead to disgruntled providers in underserved areas. They might merely serve their time and leave with no basic improvement in the community's health care.

Financial incentives to medical students will aid in the process of getting primary care physicians to underserved areas. However, there is extensive evidence that the medical education process itself is a major barrier to meeting the nation's health needs. The majority of physicians are trained in large urban institutions by researchers and super specialists. Ambulatory primary care is scant or absent in the training process. Most physicians graduate from medical school without ever having been in a physician's office. If the nation's health problems

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are to be effectively addressed, the medical education process must be revamped to reflect those concerns.

We would also urge that Congress consider the support of research into medical schools' admission criteria and their effects on career choice and demonstration projects for preceptorship programs in remote areas as adjuncts to an overall health manpower policy. Limited studies suggest that the interests and preparation of medical school applicants affect their later career choice and their commitment to practicing in underserved areas. Preceptorship programs away from the medical center may also serve to motivate more students to pursue primary care training rather than sub-specialty training.

In summary, SAMA believes that many citizens suffer because of a serious maldistribution of health manpower, that students should have a choice of serving in an underserved area in return for a tuition and stipend scholarship as one approach to solving this problem, and that the medical education process must be reoriented to address today's health needs.

Statement of the National Easter Seal Society For Crippled Children and Adults

The National Easter Seal Society for Crippled Children and Adults operates approximately 250 outpatient rehabilitation centers delivering medical rehabilitation services to about 230,000 disabled individuals a year. Our services include physician services, physical therapy, occupational therapy, and speech pathology including audiology. As providers of such services, we are acutely aware of the need for trained personnel in the therapies. Our programs need more well-trained physical therapists, occupational therapists and speech pathologists.

We would urge the House Subcommittee in its consideration of health manpower legislation to provide adequate support for the training of these therapeutic personnel. We are supportive of Part H, of H.R. 2956, training programs for allied health personnel in that we believe it may provide the support necessary for the training of essential rehabilitation therapists. We are somewhat concerned, however, because it is not clear from the definition of the term "allied health personnel" that the program is intended to focus on physical therapy, occupational therapy and speech pathology. We are aware of the fact that some schools of allied health which have received support under the allied health training program do train such therapists. However, there is no specific reference to such therapists in the definition nor in the listing of educational programs in Section 796. The definition of allied health personnel in Section 795 seems to focus on areas such as physicians, assistants, technical and otherwise.

We would urge the Subcommittee to extend its definition to specifically include the therapists mentioned above.

To the extent that the allied health training program is not an appropriate vehicle for the support of institutions training physical therapists, occupational therapists and speech pathologists as well as other health-related professionals such as social workers and rehabilitation counselors, involved in the health delivery system, we would urge the Subcommittee to consider additional legislative authority for the training of such professionals.

Statement of Mary Ann Largen, Coordinator, N.O.W. National Rape Task Force

For some time there has been a growing recognition by law enforcement officials and community leaders that in order to facilitate the effectiveness of the criminal justice system, the needs of the victims of violent crimes must be met by the government.

In no area of criminal violence is this need more visible than in the area of rape victimization. The growing incidence of rape and other forms of sexual assault has produced a major national health and mental health problem through the unmet health care needs of its victims and their families.

The Rape Prevention and Control Act represents a recognition that the system for responding to rape is not only defective but also harmful to its victims. The object of the Rape Prevention and Control Act would be to not only undertake a national effort against rape, but a national effort in *support of the victim.*

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The National Organization for Women wishes to point out that the testimony before this Committee of Secretary of Health, Education, and Welfare, Mr. Casper W. Weinberger, was misleading in that his objection to the placement of the rape prevention and control program under the auspices of the National Institute of Mental Health was based on his concern that the need for singling out rape "from the many forms of psychiatrically deviant behavior" was not sufficiently justified.

Hopefully, by "psychiatrically deviant behavior" Mr. Weinberger was referring to the rapist and not the victim. In which case, Mr. Weinberger has missed the whole point of the Rape Prevention and Control Act.

While research into the motivations of offenders and methods of rehabilitation is essential to any crime control program, and is provided for in this legislation, it is not the major focus of the legislation. The major focus in on that historically and critically overlooked population—the *victims* of crime.

Only when victim needs, services, and rights are more adequately determined through research and implemented by action, will the criminal justice system be able to determine the scope and impact of the crime and be able to deal with it more effectively. Only then can the goals of rape prevention and control be realistically met.

Despite Mr. Weinberger's protestations that HEW and NIMH "with existing authority and with research funding levels . . . can undertake . . . an adequate investigation into the causes, treatment, and prevention of rape", it is to be noted that to date this agency has devoted only the most minute attention to this area of behavioral research.

Further, the entire budget of the Center for Studies of Crime and Delinquency totals $3 million, which must be used to support the Center's entire research program and other priorities.

It is evident that the agency's existing authority and limited funding are, in fact, totally inadequate to undertake a comprehensive program to deal with rape.

Rape is a unique, complex, and little understood crime. The undertaking by HEW of the programs called for in the Rape Prevention and Control Act will, of course, be a challenge to that agency. We would hope that Mr. Weinberger is not backing away from that challenge by misconstruing the facts.

The support of the 93rd Congress for this legislation was overwhelming. The National Organization for Women believes that the current members of Congress will demonstrate the same insight and concern for women in the actions it takes in the 94th Congress.

STATEMENT OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

The American College of Emergency Physicians (ACEP) is pleased to have this opportunity to present its comments and views on health manpower before the Committee. We fully appreciate the extent and magnitude of your deliberations and commend you for your diligent pursuit and resolution of these important issues. We will confine our comments to emergency medicine.

Other organizations, such as the American Medical Association and the Association of American Medical Colleges can most appropriately comment on the Committee's concerns in regard to medical school support, foreign medical graduates, and geographic distribution and specialty distribution of physicians.

Because we are an organization of emergency physicians, we believe we are in a unique position to comment specifically on Section 786 of H.R. 2956, "Emergency Medical Services Training."

The American College of Emergency Physicians was formed in 1968 by a group of physicians responding to the growing public clamor for improved emergency medical care. ACEP has grown rapidly and now has over 5,500 members whose primary interest is the delivery of emergency medical care. Its members work in university hospitals, non-university teaching hospitals, large municipal hospitals, in community hospitals, and in other health care facilities.

The primary goal of the College is physician education in emergency medicine and the adequate provision of emergency medical services to the American public. The College sponsors national and regional scientific meetings, conferences and seminars for the exchange of professional information with leaders in community emergency medicine. It makes available informed representatives to the local and national councils of government to assist in government's efforts to develop policy.

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The requirements for an approved emergency medicine residency providing proper educational and clinical experience have been developed. These "Essentials of a Residency Training Program in Emergency Medicine" are being considered by the AMA's Council on Medical Education, and we expect that these will emerge as the formal criteria for graduate education leading to specialty board certification.

Because ACEP was not recognized as a national medical specialty society until 1973, and because emergency medicine did not convene as a provisional scientific section within AMA until 1974, statistics are lacking as to how many physicians have emergency medicine as their primary or secondary specialty. The American College of Emergency Physicians has identified over 5,500 physicians involved in emergency medicine and studies of this group show that approximately two-thirds are full-time emergency physicians. More directly, ACEP has identified approximately 3,350 physicians *practicing full-time* in the field today with *no formal training in emergency medicine.*

The chart below indicates the growth in emergency medicine residencies.

Year	Emergency medicine residency programs	Emergency medicine residents in training
1970	2	3
1971	5	11
1972	7	24
1973	16	42
1974	26	72
1975	32	165

The specialty of emergency medicine is experiencing dynamics different from other specialties in regard to numbers and distribution. It is estimated that 15,000 physicians are practicing emergency medicine throughout the country, the overwhelming majority of whom do so without *formalized* training in this critical area.

The 32 existing residencies will graduate approximately 40 emergency physicians this year. If graduate training opportunities are to be made available to the total emergency physician manpower by the end of the current decade, 180 emergency medicine residency programs must be in operation at that time.

As you know, the provisions for emergency medical services training were created by P.L. 93–154, the Emergency Medical Services Systems Act of 1973, amending Title VII, to provide grants and contracts to educational entities to "meet the cost of training programs in the techniques and methods of providing emergency services . . . ." We are extremely pleased that this Committee and the Congress understand and support this provision.

Since enactment of the EMS Act, the College has closely followed the implementation of the law and believes that it is being administered in a judicious manner within the resources available. We have been particularly interested in Section 776 of the current health manpower law as it relates to emergency medical services training.

It is our understanding that most of the grants and contracts awarded under this Section have been for the training of emergency medical technicians—ambulance, emergency medical technicians—advanced, emergency medical dispatchers, and emergency department nurse training, although some funds have been available for physician continuing education and training.

We continue to support the need for the training of appropriate non-physician manpower in emergency medical services. However, we also feel that it is necessary to insure that physicians themselves are properly trained and that the new medical school graduate receive his residency training in an approved clinical emergency setting. The well-trained, qualified emergency physician is the responsible professional in emergency medical services systems for the supervision and quality of training for all emergency medical services personnel. By insuring the adequacy of his training, the benefits are twofold; improved patient care by the emergency physician in the hospital and improved patient care by prehospital emergency medical services personnel functioning under his direction.

Further, we believe that the most rapid path to the successful upgrading of training of emergency medical technicians, emergency department nurses, and

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other EMS personnel, particularly in small communities and rural areas, is to increase the number of qualified emergency physicians practicing in these areas.

ACEP submits that these needs will best be served by "earmarking" one-third of the funds appropriated for Section 786, "Emergency Medical Services Training", for the support and operation of emergency medicine residencies.

Additionally, we believe that there is a need to provide emphasis that these clinical experiences be made available in community hospitals, the same as the provision in the bill for primary care residencies. Because the greatest need for a qualified emergency physician occurs in the more than 3,800 community hospitals which staff emergency rooms or departments, it appears to us there is a need to provide clinical emergency medicine training in these settings.

At the same time, we recommend including additional language encouraging the establishment of Departments of Emergency Medicine within the appropriate academic settings, i.e., medical colleges and university hospitals.

Attached to this statement is a "Fact Sheet" developed by the College which outlines our concern. Additionally, the College has prepared a statement entitled "Emergency Medical Service: Problems, Programs, and Policies," which we believe may be of assistance to you.

We thank the Committee for this opportunity to present our views.

FACT SHEET: HEALTH MANPOWER AUTHORITIES, H.R. 2956

THE PROBLEM

Emergency Medicine

Approximately 70,000,000 Americans will be treated in hospital emergency departments during 1975.

Accidents are the leading cause of death in the age range 1 to 44 years. 120,000 Americans will die accidentally this year.

Some 800,000 emergencies which terminate in death occur annually in the United States.

As many as 15,000 physicians are practicing emergency medicine throughout the country, the overwhelming majority of whom do so without *formalized* training in this critical field.

SOLUTIONS TO THE PROBLEM

American College of Emergency Physicians

The American College of Emergency Physicians (ACEP) provides professional leadership in the field of comprehensive emergency medical services, with emphasis on the need for physician education in emergency medicine.

Founded in 1968, ACEP currently represents a physician membership of more than 5,500 practitioners of emergency medicine.

ACEP requires 150 hours of continuing medical education during each three years of membership, and provides accredited educational programs designed to meet these in-service requirements.

ACEP is concentrating its efforts on encouraging the continuing growth of emergency medicine residency training programs across the country (32 in 1975) and the ultimate development of a professional board examination to certify competency in emergency medicine.

Year	Emergency medicine residency programs	Emergency medicine residents in training
1970	2	3
1971	5	11
1972	7	24
1973	16	42
1974	26	72
1975	32	165

"If graduate training opportunities in emergency medicine are to be available to meet projected manpower needs and projected emergency department patient visits by the year 2000, a total of 180 emergency medicine residency training programs, graduating approximately 700 qualified emergency physicians per year, must be in operation by the end of the current decade.

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CURRENT LEGISLATIVE AUTHORITY

(*Title VII—Section 776—"Emergency Medical Services Training."*)

Established to meet the training needs for personnel involved in EMS systems by authorizing training grants and contracts to defined educational intsitutions.

Most funds to date have been for training programs for emergency medical technicians, emergency nurses, and paramedics, although some has been for emergency physician continuing education and training.

SUGGESTIONS TO IMPROVE

American College of Emergency Physicians

ACEP recommends the inclusion of language encouraging the establishment of emergency medicine residency training programs to train qualified emergency physicians.

ACEP recommends that community hospitals be eligible for funding for the establishment of emergency medicine residency programs.

ACEP recommends that additional language be included encouraging the establishment of Departments of Emergency Medicine within universities and hospitals.

To satisfy this critical training need, ACEP recommends that one-third of actual appropriation under this Section be specified for emergency medicine residency programs.

Therefore, ACEP supports an authorized appropriation of $10 million annually to meet the needs for training of all personnel involved in emergency medical services.

JUSTIFICATION

The well-trained, qualified emergency physician is the responsible professional in emergency medical services systems for the supervision and quality of training for all emergency medical services personnel. By insuring the adequacy of his training, the benefits are twofold; improved patient care by the emergency physician in the hospital and improved patient care by prehospital emergency medical services personnel functioning under his direction.

The current authority limits establishment of emergency medicine residencies by not extending funding eligibility to the community hospital.

Current awards under the existing authority are heavily weighted for the training of non-physician emergency medical services personnel.

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Emergency Medical Services: Problems, Programs and Policies

A Statement Prepared by the Committee on Public Policy of the American College of Emergency Physicians

I. The "state" of emergency medical services (EMS) nationally

The provision of emergency medical care in the United States is not the product of a concerted, organized or coordinated effort to provide high quality emergency health services in all parts of the country. Instead, services of high quality exist and contrast with many others of low quality. The statistics of any two areas may vary considerably as do the planning, the resources, the knowledge and the concern. Growing interest nationally in this deplorable "state" has caused some significant changes. Facts are emerging which help to define the long neglected problems. Goals are being defined toward which planners may project their efforts. Advances are being made locally which increase the options available for those working to effect improvements. Problems at national, state, regional and local levels are being delineated and weighed to determine their priority for government activity. While not an exhaustive collection, some of these are enumerated here:

A. Facts

1. Accidents	Accidents are the leading cause of death in the age range 1 to 44.
2. Cardiovascular disease	Cardiovascular disease accounted for about 1,100,000, or 54%, of the total deaths in the United States in 1972. About 600,000 of these were sudden deaths and more than 350,000 occurred within the community outside the hospital.
3. Total deaths from emergencies	Some 700,000 medical and surgical emergencies which terminate in death occur annually in the United States.
4. Emergency hospital visits	About sixty million patients visited hospital emergency departments last year. In some hospitals these visits have shown an increase of 600% since World War II. Nationally the average annual increase in visits is 10%.
5. Physicians in emergency medical practice	There are approximately 15,000 physicians practicing emergency medicine in hospitals throughout the country.
6. Ambulance surveys	A survey of ambulances has shown that as few as 37% meet minimal design standards.
7. Training of ambulance personnel	In 1970, only 5% of the nation's ambulance attendants met minimum standards of training recommended by the American College of Surgeons, the Department of Transportation, the National Academy of Sciences or the Department of Health, Education, and Welfare. Five percent had no training. A standard American Red Cross first-aid course had been given to only 33%.
8. Ambulance-hospital communication	Direct communication with the hospitals served is not within the communication capability of 94% of ambulances.

B. Goals

1. Accident victim salvage	It has been projected that 18,000 accident victims out of the 115,000 who die annually might be saved if proper immediate care were rendered.
2. Coronary heart disease salvage	Preventable pre-hospital coronary heart disease deaths have been conservatively estimated to number 50,000/year.
3. Salvage of other emergency victims	At least 5,000 of the deaths from other causes such as poisonings, drownings, obstetrical complications, etc., are deemed preventable.

C. Advances

1. Staffing models	Models for effective emergency department physician staffing have been devised.
2. Emergency capability guidelines	Authoritative guidelines for the determination and categorization of capabilities of hospital emergency medical services have been developed.
3. Communication systems	Sophistication in the forms and capabilities of voice communication systems has been achieved.
4. Technician training	A basic training program for the emergency medical technician (EMT) has acquired national support and stature.
5. Data transmission	Telemetric communication of physiologic data such as the electrocardiogram to distant personnel has permitted highly specialized treatment to be provided remote from medical facilities.

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6. Transportation — Ambulance services utilizing specialized vehicles and equipment, including standard aircraft and helicopters, have been provided effectively with civilian community, and occasionally military, resources.

7. Supporting services — Trauma units, critical care units, burn centers and other specialized services have been developed as adjuncts to primary emergency service facilities.

D. Problems

1. Local, state and regional difficulties

a) System coordination — At each level there has been a need for coordination, for concerted, controlled effort, to implement and integrate existing technology within a rational system.

b) Planning initiative — Groups representative of all the interests to be served have infrequently joined together in planning their common goals. Thus changes have often favored only those with parochial interest and initiative.

c) Assistance — Both technical and financial assistance may be essential to the development and operation of emergency medical systems and sub-systems. Neither is readily available.

d) Sources of funds — A common source for administration of financial resources has not existed and many areas and groups have vied for scarce funds from multiple sources.

2. Federal problems

a) Agency enigma — Federal agencies appear disorganized and uncommunicative. The programs of one are uncoordinated with those of another leading to mutually contradictory or otherwise illogical activities.

b) Information scarcity — Information on activities at the federal level is scarce, deficient or nonexistent. When available it is frequently difficult to obtain.

c) Confounded funding — Where federal funds may be available upon appropriate application their sources are multiple, mixed and confusing. Applications for grants are frequently overwhelmingly complex and costly demanding the employment of a grant specialist. The expertise necessary to apply for funds and the cost of application often prove impossible burdens for the applicant. Neither is supplied or subsidized by the funding agency.

d) Low priority — Despite the immense annual drain on human and financial resources resulting from their neglect, emergency medical services continue to be a low priority item.

e) Low budget — Annual federal budget delegated to emergency medical service problems is miniscule and precludes vigorous activity.

f) Multiple foci of activity — The absence of a single focus for emergency medical services as a whole leaves responsibility for failures within the system undefined. Accountability, under these circumstances, is also absent.

II. Role of ACEP

A. ACEP position

The American College of Emergency Physicians acknowledges its responsibility to provide professional leadership in the field of emergency medical services.

Through a combination of definition, review and comment, ACEP has assumed a "position" with respect to the issues, problems and alternative solutions confronting emergency medical services.

The statement of the ACEP position has been prepared in abbreviated outline or summary form. Narrative comment is provided for amplification.

The required elements of a local emergency medical services system are reviewed in Part III. In Part IV organization for the federal level is proposed to cope with the problems identified and to provide a mechanism for support that will effect improvement in the total system.

III. Elements of emergency medical services at the local level

A. Communications

ACEP supports the concept of centralized, coordinated communications for emergency medical services with the following components and characteristics.

1. Central network with appropriate communication linkages
   a) Public
   b) Other areas — state and national

A central area-wide communication network should be developed with appropriate linkages to other communication systems as well as to special emergency service resources and to the public.

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c) Disaster communications system
d) Emergency operations system
e) Emergency departments
f) Transportation services
g) Ambulances
h) Rapid medical information systems (ACCESS, poison control centers, etc.)

2. Universal emergency telephone number, 911

A common, highly visible method of obtaining access to the system by the public is essential. Where access is by telephone, the universal emergency telephone number, 911, should be the number utilized.

3. Trained personnel

Personnel receiving distress calls should have specialized medical training to permit appropriate communication with the public and proper decision making in medical emergencies. Multilingual capability may be required and should be available.

4. Network functions and capabilities

a) Dispatch

Centralized dispatch of appropriate services should be provided.

b) Voice communications
1) Rescue personnel on the scene
2) Emergency Departments and hospitals.
3) Fire, safety, law enforcement and health personnel
4) Appropriate primary care centers
5) Local physicians in rural areas

Direct voice communication, rather than relay of information contained in messages, is an efficient method of transferring medical information. The network should provide the capability of voice communication between the individuals and services outlined.

c) Telemetry

Telemetric data facilities may expand the capability of personnel by permitting distant consultation with physicians regarding physiologic measurements. Telemetry between the scene of the emergency and the emergency department, or a physician in the field or at home, is valuable.

d) Early notification system

Early notification systems for remote areas, eg, highway emergency telephone services, should be a component of the central network.

e) Continuous message monitoring

Continuous monitoring and recording capability is essential for review of activity, education of personnel, improvement of patient care, education of the public, research in system operations, and medico-legal purposes.

B. Transportation

A wide variety of systems provide emergency medical transportation and many conveyances are utilized. The emergency physician and local emergency facilities should be involved in these extra-hospital activities which significantly influence the outcome of care rendered to their patients.

1. Ground ambulance systems

a) National standards

The Secretary of Health, Education, and Welfare, in consultation with appropriate professional and private organizations, should promulgate a set of national standards for vehicles, equipment, and the systems utilizing them. Standards have been developed by the National Academy of Sciences/National Research Council, the American College of Surgeons, the American Heart Association and others. These should be reviewed and utilized as applicable.

b) Phased application

National standards should be applied in an orderly, stepwise fashion to avoid disruption and confusion in present services.

c) Flexible response

The goal of providing the most appropriate response for the specific emergency is achieved through gradations in the form of response. Such stratification gives flexibility to the system of response. Where feasible such flexibility in ground ambulance systems should be developed.

d) Local needs

Specific systems must be capable of satisfying local needs. These are affected by factors such as terrain, population density, population age, land use and others which influence the numbers and kinds of emergencies which may be expected. Local EMS councils and other planning bodies must define these needs and approve the local system with the capability to meet them.

e) Research
1) Standards
2) Equipment
3) Vehicles

As research in the elements and systems of ground transportation has been minimal, data upon which standards are to be based remain insecure. Studies should be undertaken to evaluate equipment and its optimal arrangement, vehicles for both routine and specialized tasks and

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4) Needs 5) Evaluation	circumstances, methods of assessment of the needs for a variety of transportation services and methods of evaluation of the efficacy or effectiveness of the existing transportation system.
2. Air transportation	Helicopters and fixed wing aircraft have served emergency medical services by providing for rescue as well as for transportation of patients, equipment and personnel.
a) Indications	Air ambulance services may be indicated in areas poorly accessible to ground transportation vehicles, where ground distances or traffic create excessive delays, or where the services to be provided must be transported to patients in remote areas.
b) Utilization	Utilization of air ambulance services for emergency transportation has been limited by the additional burden of technical and financial problems they impose. They do not always offer a simple, feasible, or efficient alternative to ground transportation. Against this background, their utilization should be considered when their special characteristics provide a solution to difficult problems of a specific area.
c) Integration	Air ambulances should be integrated and coordinated with other transportation modalities that affect the total emergency transportation capability of the area served.
d) Military	Where air ambulance services appear appropriate, and a full account of public and private resources is inadequate to meet civilian needs, consideration of military resources for emergency helicopter services is encouraged. Programs such as MAST (Military Assistance to Safety and Traffic) should be explored.
e) Research	Studies defining appropriate and optimal utilization of aircraft resources are indicated.
3. Sea transportation	
a) Air-sea rescue	Technology developed by Coast Guard for air-sea rescue should be applied to medical emergencies occurring at sea.
b) Coordination	Full use should be made of Coast Guard and military capability in combination with the emergency medical system to coordinate the provision of emergency services to victims at sea.
4. Self transportation	
a) Public education	Programs of public education in the transportation of ill and injured persons are important. These have been coupled in some countries to driver licensing requirements. School programs should be explored.
1) Advertising	Advertising outlets and techniques may serve as media for public information and instruction on conduct during emergencies. These should not be neglected.
b) Facility identification	A national, uniform highway sign, glyph, and marker program is required to permit identification of facilities providing 24 hour, physician-staffed emergency medical services.
C. Facilities	
1. Emergency departments within hospitals	
a) Standards	Emergency departments should be provided with national guidelines and standards against which they may measure their performance.
1) Promulgation and review	The Secretary of Health, Education, and Welfare, in consultation with public and professional organizations should review existing standards and guidelines for emergency department design and equipment. A set of national standards, subject to periodic review and revision, should be promulgated.
2) Scope	Standards should be comprehensive, covering all aspects of the facilities including location, design, equipment and service capabilities.
3) Flexible	Standards should accommodate local conditions, geographic differences, special situations and unique resources. They should encourage conservation of resources by discouraging unnecessary duplication of services. Specifics relating to size, design, equipment, and other properties should be determined by qualitative and quantitative data defining patient loads on the facility.
4) Comprehensible	The emergency service capability of a facility should be expressed in standardized form recognizable and comprehensible to the public.
b) Design	
1) Proven methods	Efforts should be made to promote utilization of proven methods. This tends to ensure that facilities and equipment are most efficiently and effectively designed, acquired, maintained and renovated.

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2) Assistance	Technical assistance with design and equipment of emergency departments should be available.
3) Accessibility	The emergency department should be accessible to all local forms of transportation and clearly identified by unmistakable signs, glyphs or markers.
4) Research	To assist in meeting growing demands upon facilities, prototype facilities reflecting a wide variety of types should be developed. Research aimed at providing and evaluating design, equipment and performance is essential.
c) Planning and Coordination	The operation of a facility should relate to the total comprehensive community EMS program of the local community EMS council.
2. Emergency facilities outside hospital	
a) Coordination	The operation of free standing facilities, first-aid satellites, etc., should be integrated and coordinated with the remainder of the emergency health services system serving the area.
b) Regulation	Free standing facilities should be subject to standards and approval specific to their function but consistent with the standards for hospital-based facilities.
3. Special care units within hospitals	Emergency services are frequently provided or demanded within specialized or other units of the hospital. These include burn units, coronary care units, medical and surgical intensive care units, trauma units, pediatric emergency centers, surgery and radiology.
a) Standards	Standards for the design and equipment of special care units should be developed, as for emergency departments, by the Secretary of Health, Education, and Welfare consistent with those of the Joint Commission on Accreditation of Hospitals and other appropriate authoritative sources.
b) Staffing	Adjunctive units should be adequately staffed by appropriately trained personnel 24 hours per day.
D. Manpower and education	Emergency medical care is a team effort involving large numbers of allied health care personnel. The success of the medical efforts of any one individual is strongly dependent on the skills and efforts of all the others. Thus the manpower capabilities at many levels, and the educational programs to assure the capabilities at each level, are a major concern.
1. Physician resources	
a) Problems	
1) Shortages of emergency physicians	There are significant shortages of physicians qualified to render emergency services in hospital emergency departments. There are similar shortages of physicians qualified to provide training programs for other physicians in this field. There are almost no emergency physicians available for leadership in programs to improve emergency medical services in the community.
2) Shortages of educational programs	While the need for physicians specially trained in the many facets of emergency medicine continues to grow yearly, educational programs aimed at meeting these needs are just now beginning their development. Existing programs cannot alleviate present shortages let alone consider the challenges of future needs.
b) Programs	
1) Staffing	
A) Availability	There should be 24-hour physician coverage of emergency departments, based on patient demands and hospital capabilities.
B) Conservation of resources	Unnecessary duplication of services should be avoided so that available physicians may be efficiently deployed within a community and appropriately occupied while providing patient care.
C) Research	Studies of physician staffing problems are essential to solve technical and socio-economic difficulties that interfere with the above provisions.
2) Standards	
A) Source	Minimal standards for quality of care in the setting of emergency services shall be developed through the ACEP.
B) Implementation	
i) Departmental peer review	Adherence to the standards of emergency care should be assured by a system of peer review of emergency physicians' services. Peer review should be developed as an integral part of emergency department operations and integrated with the department's program of continuing medical education.
ii) Medical staff control	Each emergency physician, in conformity with the requirements of the Joint Commission on Accreditation of Hospitals, shall be a member of the

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hospital medical staff and subject to all regulations and privileges of the medical staff.

3) Status

A) Departmental — Emergency departments require the status of a major clinical department within the hospital. The director should serve, in like manner with those of other clinical services, with the same privileges and prerogatives, on the hospital executive committee.

B) Professional — Emergency medicine should be given board status as a medical specialty. Emergency physicians should seek eligibility and certification by that board under criteria developed by ACEP through the Council on Medical Education of the AMA.

4) Role

A) Community and community hospital — Emergency physicians must be aware of the significant responsibility that must be borne for the form, variety and quality of emergency services within the community. In addition to the role in patient care within the hospital there must be significant involvement in emergency patient care within the community.

B) EMS councils — Emergency physicians are encouraged to actively participate on community EMS councils. No council should operate without having an emergency physician among its members.

5) Orientation — Emergency physicians have sought careers with several different orientations. Physicians are needed who possess interests in any and all of the various categories.

A) Clinical — Emergency physicians with primarily clinical interests devote most of their time to the care of patients in hospital emergency departments.

B) Academic — Physicians with academic interests in emergency medicine are essential for the development of the educational programs for physicians and other emergency health service personnel.

C) Research — Physicians interested in developing and conducting studies upon which emergency health services methods and techniques may rest with a sound base are essential.

2. Physician education

a) General characteristics — The increase of emergency residency programs should be encouraged to keep pace with the rapid proliferation of educational programs designed for continued ongoing education for the emergency specialist as well as for the rapid and efficacious introduction of the second career physician.

1) Multilevel — The differing backgrounds, levels of training, education, and interests of physicians in emergency medicine require that consideration be given to the provision of multilevel programs of broad scope.

2) Comprehensive — Programs must be comprehensive, exposing the physician to all types of clinical and administrative problems and settings. Where the latter are restricted, alternate settings should be observed or discussed.

3) Medical school base — The education of emergency physicians should be conducted by departments of emergency medicine within medical schools. These departments should enjoy "chair" status. Graduate training, within approved residencies, should be conducted under, or in association with, these emergency medicine departments.

4) Community hospital support — Emergency physician education should include significant exposure to the community hospital environment through which most of emergency health services are provided, and to which most emergency health problems are brought.

5) Innovations and unique features — As emergency health services are fundamentally community based, programs should be oriented toward community emergency needs and services. Area Health Education Centers (AHEC) should include emergency medical program capability. Computer assisted instruction techniques should be widely applied.

b) Undergraduate education

1) Features of curricula

A) First aid and life support — All medical and dental students should be taught proper methods of rendering first-aid as well as the basic elements of life-support, such as cardiopulmonary resuscitation, in emergencies. This material should be provided early in the educational curriculum and repeatedly reinforced.

B) Stimulation — Medical schools should be capable of providing students who wish to enter a career in emergency medicine with sufficient appropriate exposure and experience, including clinical and administrative problem solving.

C) Clinical challenges — Clinical clerkships, electives and preceptorships in emergency medicine should be available to those students wishing to take them. In addition,

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emergency methods and techniques should have a structured place in the curriculum of all medical students.

D) Evolution — Programs should be responsive to the recommendations of ACEP, the University Association for Emergency Medical Services (UA/EMS), and the Society for Critical Care Medicine, organizations sensitive to the demands made upon emergency medical capabilities.

c) Postgraduate education

1) Emergency medicine residencies

A) Medical school administration — Residency programs should be administered by the department of emergency medicine of the medical school.

B) Certification — Residencies should be approved by the AMA Council on Medical Education as appropriate for preparation for certification by a board in emergency medicine.

C) Breadth

i) Facilities — Exposure to clinical material in all types of facilities is mandatory. This will include the university setting with the city or county hospital, the large and small community hospital, and the non-hospital setting.

ii) Experience — Both clinical and administrative experience must be provided. Preceptorship methods should be incorporated to expand these experiences.

iii) Responsibilities — Graded responsibility in both clinical and administrative spheres is a requisite. A period of responsibility for a department as well as for a community program or plan should be included.

D) Standards — ACEP standards with respect to curricula should serve as a guide to developing and maintaining residency programs.

E) Funding — Starting and operational funds for emergency residencies should be provided under the comprehensive Health Manpower Training Act of 1971. Additional sources must be sought.

2) Midcareer or second career physician education

A) Program types

i) Clinical fellowships — Clinical fellowships provide full-time programs to develop patient-care skills within the emergency department.

ii) On-the-job courses — These courses offer those physicians entering emergency medicine from another discipline on-the-job training of limited duration. Both overview courses and relevant in-depth courses are appropriate.

B) Program sources — Fellowships and limited duration courses of training should be provided through the hospital emergency department and under the department of emergency medicine of appropriate medical educational institutions.

C) Goals

i) Comprehensive — Goals of midcareer or second career programs should include the provision of comprehensive training in the field and an appropriate preparation for certification by the board in emergency medicine.

3) Postgraduate training/research — Fellowship programs that will encourage and train in research techniques applied to systems of emergency care, clinical and administrative, are required.

4) Continuing medical education

A) Audience
i) Current EMS physician
ii) Physicians in other specialties
iii) Physicians in training in both EMS and other specialties

The ongoing educational needs of physicians in emergency medicine must be met by a variety of programs aimed at a broad physician audience.

B) Location — The focus of most continuing education programs must be the emergency department. This serves a vital function in both the care of patients and physician education.

C) ACEP consultation — Standards for continuing education in medicine are being developed by many national organizations. Where these impinge on emergency medicine programs, consultation with ACEP should be sought in their preparation.

D) Self assessment — Self assessment testing is a form of continuing education. Tests prepared

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	or endorsed by ACEP should be utilized.
E) Evaluation	Studies are indicated that will provide yardsticks by which both present and projected continuing education programs may be evaluated.
F) Peer review	Peer review mechanisms must be related to continuing medical education in a manner that permits immediate assessment of needs. Relevance of continuing educational programs to local demands may be maintained by the peer review mechanism. The mechanism should assess demands both upon medical and administrative skills which are created by the local EMS system. Periodic recertification requirements should also be developed within the peer review system.
G) Innovation i) Computer Interrogatory Textbook (CIT) ii) Malpractice iii) No-fault	Innovation in programs of continuing education should be encouraged. Such innovation is valuable in instruction, testing, self assessment, and peer review. The Computer Interrogatory Textbook, an innovative program of ACEP encompassing all of these areas, is a stimulating example. Programs which relate continuing education to malpractice prevention and no-fault insurance concepts are other examples.
3. Nurse education	
a) Undergraduate education	
1) First aid and life support	All nursing students should be given explicit training and experience in proper methods of rendering first-aid and in basic elements of life-support procedures such as CPR.
b) Postgraduate/continuing education	
1) Comprehensive *A) Breadth* *B) Depth*	Comprehensive training in the breadth of emergency medical problems must be made available. In-depth training aimed at appropriate clinical areas is also essential.
2) Directed to needs *A) EDNA*	Training programs should be related to the needs of emergency nurses as they are defined by the Emergency Department Nurses Association and should be conducted with their sponsorship.
c) Emergency nurse practitioner (RN) 1) Curriculum 2) Programs 3) Certification	While there is evidence to suggest the special benefits to be derived through the use of this specialized nurse practitioner, the training programs and their curricula as well as the certification mechanism and criteria must be developed.
4. Emergency medical technicians (EMT)	
a) Standards	National standards for licensing of EMTs, at the state level, must be developed. These should encompass the various levels of education, training and performance.
b) Education 1) EMT — basic 2) EMT — advanced	Courses for basic and advanced training should be completed for each category followed by certification through an appropriate body.
c) Licensing	Licensing should be dependent both on initial certification and a program of mandatory recertification at periodic intervals.
5. Physician assistant a) Education b) Role c) Certification	Presently a two year educational program is contemplated for the assistant to the physician in emergency medicine. Additional study is essential to define the future role to be played by this health worker. Training leading to certification and a certification mechanism are required.
E. Organization of local emergency medical services.	
1. Community based	The unit within which emergency medical services are organized is the local community. This may conform to the geography of the Comprehensive Health Planning "b" agency, to that of multiple "b" agencies, or to a small portion of a single "b" agency area. The latter situation may arise in a community smaller in area than a "b" agency but ahead of the agency in planning. As the record of effectiveness of CHP agencies is unimpressive, this information is provided solely for reference. Regional Medical Program (RMP) offices may serve as a nucleus of the community unit, they have performed well in this sphere.
2. Representation a) Providers b) Public agencies c) Community consumers	There should be broad representation within the organization of all major groups involved with the provision, control and reception of services. This includes providers such as physicians and ambulance technicians, public safety agency personnel, police and fire, and interested individuals within the community, consumers of health services.
3. Resources	A complete list of resources should be compiled indicating local sources of equipment, personnel, emergency and social services. The list should include potential resources that may be tapped by establishing a liaison

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	with emergency health facilities and related services outside the organizational area.
4. Coordination	The local organization should be aware of surrounding area programs and should lend its efforts toward area and regional coordination of services.
5. Planning	
a) Planning unit	The planning unit or agency should be the local unit of government or a locally designated entity.
b) Corporate structure	Planning should be accomplished by a corporate entity. The corporation may be municipal, private—nonprofit, or even private—for profit as in the case of a corporation providing planning under contract to a municipality or a foundation.
c) Comprehensive	Planning should be comprehensive with respect to both services and the methods of financing them.
d) Coordination	Planning should be coordinated with that going on in adjacent areas and that under supervision of involved state agencies.
6. Operations	
a) Comprehensive	A corporate agency should provide for the operations of a comprehensive system, an "under-one-roof" operating concept. The corporation may have any of the characteristics enumerated under "corporate structure" above.
1) Components	The system components may be either integral or external to the corporation. Where an element of the system is external as in the case of an ambulance service under contract to a municipal corporation the latter should bear the responsibility for the performance. Any of the components may have the structure enumerated above under "corporate structure."
b) Standards	Personnel and equipment involved in the operation should conform to standards set by the Secretary of Health, Education, and Welfare. After consultation with the various public and private organizations involved in providing emergency medical services, the Secretary should promulgate a variety of EMS models, adaptable to differing local requirements, and upon which communities may base their individual systems.
c) Capabilities	The system capabilities should be classified according to standards set by authoritative bodies including the American Medical Association, the American Hospital Association, and the ACEP.
d) Availability	The system should operate in such a manner as to insure that emergency health services shall be available to medically under-served populations.
e) Unit record system	A unit record system should be utilized. Such a system insures that a single comprehensive medical record is prepared incorporating prehospital EMT reports, emergency department records and inpatient records. Problem oriented record systems and coding mechanisms for data retrieval should be studied and incorporated where feasible.
1) Problem oriented records	
2) Data retrieval	
7. Quality assessment	
a) Goals	Reduction of accidental deaths is one measure of the quality of the system. Other indices of quality must be developed and monitored. In particular, the development of indices of the quality of all aspects of patient care need to be encouraged.
b) Records	Good record systems are known to affect the quality of medical care. Records should provide documentation and confirmation of care rendered so that the outcome may be related to the care provided in a comprehensible manner.
c) Peer review	Indices of quality should be sought through peer review. The review format should be closely allied with the overall programs of continuing medical education.
d) Research	Determination of realistic "quality" standards for total EMS systems is a major research goal.
8. Financing	
a) Sources	Federal and state funds should be available to communities to develop local emergency medical service systems.
b) Scope	Grants should be available to communities for planning, development, acquisition of property and equipment and, where necessary, for operation.
c) Community support	Financing proposals should provide a mechanism for self support of the system. A schedule should be developed under which federal and state funds are phased out and local financing takes over. The latter may include third party payment through Medicare-Medicaid and other health insurance plans.

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F. Public Education

1. Topics
   a) Accident prevention
   b) First aid
   c) Self help
   d) Resources
      1) Availability
      2) Utilization

Public education should promote development of public and private school programs, adult education courses and advertising outlets for instruction and information. Such topics as accident prevention, first-aid, medical self help and community resources should be covered.

2. Evaluation

Methods of evaluation of the program must be developed with the view toward continually incorporating more rapid and effective methods of communication of public information.

IV. Elements of emergency medical services at the federal level

A. Problems

Mega-government causes confusion at the local level. In Part I. D. 2. there were listed many of the problems that exist at the federal level. These problems combine to limit the effectiveness of the federal government as a positive force for improvement of services. The more severe problems may actually lead to interference with local efforts. The problems previously cited may be restated in a more constructive way as needs within the federal system.

B. Needs

1. Cooperation

Cooperative interdepartmental and interagency activity is a pressing need.

2. Conservation

Avoidance of wasteful duplication of efforts is essential.

3. Executive influence

Presidential emphasis of EMS program needs would revitalize activity and provide direction.

4. Assistance
   a) Technical

Aid and guidance in the utilization of existing knowledge and the implementation of existing technology would be welcome.

   b) Financial

A "one-door" funding source would reduce confusion in seeking funds for contemplated improvements.

5. Productive research

Research efforts within the EMS sphere need to be increased and channeled into productive areas.

C. Proposed organization

1. Centralized authority within HEW

A single focus of emergency medical service activity should exist at the federal level within the Department of Health, Education, and Welfare. This would eliminate multicentric efforts with confusing, overlapping or even contradictory authority and goals.

   a) Executive control

The centralized authority should be under the control of a director appointed by the President.

      1) Powers and activities

A) Standards

The authority should promulgate standards for emergency medical services.

B) Data collection and information dissemination

The authority should engage in the collection of data on EMS systems. It should service, or operate, a national clearinghouse for the dissemination of EMS information.

C) Coordination and implementation

All federal EMS programs and activities, including the implementation of EMS systems, should be coordinated within the authority.

D) Technical assistance

The capability of providing technical assistance to local programs should be developed and offered.

E) Financial administration

Administration of funds should be coordinated within the authority so that they are delivered through a single channel at the local community level.

F) Annual report

An annual report of activities should be prepared and delivered to the President and the Congress.

2. Interagency technical committee
   a) Executive level

An interagency technical committee should be formed to serve at the executive office level.

   b) Composition

The committee should be comprised of representatives from each of the federal government agencies and departments engaged directly or remotely in EMS activities.

   c) Function

The committee should offer information services providing an overview of federal EMS activities. It should also serve as a monitor of their progress. In the initial stages it should determine the activities of the office of emergency medical services. Reports of the technical committee on

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	these matters should be made to the national EMS council to be described.
3. National EMS Council	
a) Composition	A national EMS council should be formed consisting of prominent authorities in the field of emergency medicine, serving on stipend, continuing their routine work in their field.
b) Activity	The council should serve in an advisory function on national EMS activity.
1) Advisory 2) Review and approval	It should also review and approve major projects giving consideration to technical and scientific merit as well as to feasibility.
D. Support mechanism	
1. Grants and contracts	
a) Systems projects	
1) Types *A) Planning* *B) Development* *C) Components* *D) Operation*	Federal grants should be made available to support local community activity involving planning, development, and acquisition of components, including facilities and equipment, for a community emergency medical service system. Grants should also be made to permit initiation of system operations.
2) Recipients *A) Municipal* *B) Private—nonprofit* *C) Private—for profit*	Grants should be available to both public and private applicants. Operations for profit should not be excluded. Applications for support of total systems as well as system elements should be considered.
3) Applications	
A) Guidelines	Guidelines and criteria for applicants which are reasonable and comprehensible should be developed. These should encourage applicants for grants rather than deter them.
B) Assistance	Free technical assistance should be offered by the government to the grant applicant in the preparation of a definitive application for available funds.
C) Incentives	Incentives for the grant applicant, such as priority status, should be available where comprehensive system planning is undertaken.
D) Requirements	Applicants should be required to give evidence of long term viability of plans as well as means of local assumption of financial support for the operation of the system. Local autonomy must be sought, if not achieved, by supported programs.
b) Training	
1) Recipients	In addition to universities, funds should be available to organizations, both formal and informal, including groups of physicians who are actively involved in, or contemplating, EMS training and educational programs.
2) Curricula	Funds should be provided for curriculum development.
3) Priorities	Funds should be provided for teaching institutions with emergency services that have established major clinical or academic departments of emergency medicine. They should also be available for establishing chairmanship of departments of emergency medicine. Incentives are needed, such as grant priority, for institutions which have such departments functioning or planned.
4) Innovation	Innovative ideas, such as the Computer Interrogatory Textbook (CIT), currently in development by ACEP, should receive special attention. Unique curricula and training methods, or plans for utilization of new personnel, are further examples.
5) Authority	The Comprehensive Health Manpower Act of 1971 (Primary Care Residencies) or Section 774 on special projects provide current federal mechanisms for funding these programs.
c) Research	Numerous areas of research with significant and immediate EMS implications need to be funded. Only those of highest priority are cited.
1) Areas	
A) Evaluation	The method of determining or evaluating the efficacy of a system is in need of intensive study. A portion of grant funds for any project determined to be a pilot or demonstration of a system of providing EMS should be withheld until evaluation is performed.
B) Clinical	Clinical research in emergency and critical medical and surgical problems needs support.
C) Data management	Record keeping and data retrieval methods deserve exhaustive study.
D) Quality	Research aimed at establishing realistic and achievable measures of quality, a difficult to determine but much sought commodity within all EMS sytems, must be supported.

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d) Special 1) Helicopters and special purpose vehicles 2) Prevention 3) Self help 4) Public education	Grants and contracts in support of elements of EMS systems which create frequent interest but are infrequently studied or implemented deserve consideration. Helicopters and special purpose vehicles and their applications to specific problems are of interest. Methods of prevention of emergencies, self help, and modes of public influence and education should be considered.
2. Loans and loan guarantees	Loans to areas capable of developing internal resources may substitute for grants and contracts. The concerns and priorities for loans should not differ from those of contracts with respect to the purpose of funding. Both capital and operating costs should be funded by loans.

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AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
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STATEMENT OF JUNE ROTHBERG, PRESIDENT, AMERICAN ASSOCIATION OF COLLEGES OF NURSING

Mr. Chairman: My name is June Rothberg. I am Dean of the School of Nursing of Adelphi University and I am the current president of the Association of Colleges of Nursing ("AACN"). It is in the latter capacity that I am presenting testimony today.

First of all, I want to endorse the concepts and provisions of the existing Nurse Training Act. Under this legislation we are making good progress in meeting our Nation's needs for well-trained nurses. Since the enactment of the Nurse Training Act in 1963, the number of baccalaureate nursing programs in colleges and universities has increased from 177 to 296 and the number of graduates of baccalaureate programs has increased from 6,800 to 13,364. At the master's level, graduations have increased from 1,282 in 1963 to 2,135 in 1972. Although much doctoral education for nurses is not supported by NTA funds, it is of interest to note that in 1968, only 31 nurses completed doctoral degrees as compared with 58 in 1972.

ENDORSEMENT OF H.R. 2957

The AACN supports H.R. 2957. Its provisions are compatible with the nursing education recommendations and resolution adopted by the American Association of Colleges of Nursing earlier this year. A copy of these recommendations and the resolution are attached to this Statement.

THE ROLE OF NURSING

In the formulation of legislation to support the education of nursing personnel, it is essential to keep in mind the expanding role of the nursing profession in the health care team. In the future, nurse-generalists and nurse-specialists will be able to provide independently for the health care needs of people. Practitioners of nursing are needed who are prepared at advanced levels for independent and collaborative health care delivery in a variety of settings. For example, among the nurse-specialists we require nurse-midwives and clinical specialists in pediatrics. There is an especially critical need for geriatric nurses prepared to deal therapeutically with our large geriatric population—those who are institutionalized, as well as those living in the community. Among the nurse-generalists, we require family nurse practitioners to deal with the health care and health education needs of relatively-well families, and to give care to patients and families faced with chronic illness. Currently, nurse-generalists and nurse-specialists are in demand to undertake responsibilities not only in primary, acute, and chronic illness centers, but are needed even more for the educational and research programs so that a new generation of nurse leaders can be produced. Attached to my testimony are examples of an independent nursing practice.

Unfortunately, however, the full potential of nursing has not always been realized. One of the key reasons that nursing's talents are not fully unfolded is that at this time there is a real shortage in nursing leadership at the patient care, organizational, and educational levels. Nursing leaders are critically needed for the development of new modes of health care delivery and for the generation and transmission of the substative core of nursing knowledge through research. There is a need for researchers and for prepared faculty in all nursing programs. These nurse leaders can best be prepared in collegiate nursing schools in baccalaureate, master's and doctoral programs. Therefore, we believe that our top priority should be to prepare the nursing personnel for tomorrow who will move in these significant leadership directions.

In view of the demonstrated effectiveness of nurses in the performance of primary care activities and in the improvement of health care services in complex institutions, one becomes deeply concerned over the small number of nurses prepared to provide leadership in a variety of health care settings. Of the 778,470 nurses employed in 1972, only 111,475 of them (14.3%) had preparation at the baccalaureate or higher degree. When one looks at graduate education levels of nurses, one finds 24,885 nurses, or 3.2% of the total employed nurse population, with master's degrees and a mere 1,100 with doctoral preparation. This last figure represents 1/10 of 1% of all nurses. Thus with only 14% of all nurses prepared for leadership purposes, this is where the true shortage in nursing exists! Never before has the cry for leadership in diverse areas of nursing been so apparent as today.

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We must reach a level at least 40% of all nurses prepared for leadership roles by the end of this decade. It is imperative that 15%—not 3%—of nurses hold graduate degrees in order to fulfill the roles previously described.

It is particularly disturbing to this Association that there is recognition of neither the expanding role of nurses in the delivery of health services nor of the increasing demands for nurse manpower by the Administration in its own proposal for financial assistance for health manpower training. The HEW budget request for 1975 mentions the possibility of an oversupply of nurses. We obviously do not have an oversupply of practitioners prepared for leadership roles!

SPECIFIC RECOMMENDATIONS

As I mentioned earlier, this Association recomemnds enactment of H.R. 2957. There are, however, some specific suggestions that we would propose for your consideration.

1. First, I want to endorse the provisions of H.R. 2958, pertaining to the National Health Service Corps. We are pleased that nurses are specified as one of the health specialists eligible for this program that seeks to provide underserved communities with health manpower. We believe HEW should be urged to enroll more nurses in this program and to publish the list of underserved areas with respect to nurses.

2. With respect to H.R. 2957, we recommend that institutional support on a capitation basis equal one-third of net educational costs for all nursing programs. We are deeply concerned that the IOM study completely ignored the costs of sciences basic to nursing (chemistry, anatomy and physiology, microbiology, etc.) in computing the costs of nursing education. These courses and their costs are an integral part of the education necessary for preparing nurses. We would be glad to work with the Committee staff on the technical aspects if an alternative formula is adopted.

3. We are very pleased to see that the importance of graduate education is recognized by H.R. 2957 in the case of construction and in the case of institutional support on a per capita basis. If one-third of the Institute of Medicine annual educational cost of $4,814 per graduate student are to be covered, however, the $1,200 under Section 4(a)(1)(B) should be increased to $1,600. Such support should be restricted to institutions with students enrolled in graduate degree programs.

4. We are concerned that under special projects, there is no authority for research in nursing practice, nor is there any provision for institutional support of efforts by schools and colleges to impact on and improve health care delivery and nursing services via research.

In the developmental phases of a university-based research program, colleges have a need for funds for planning, consultation, research instruments, library holdings, and for space for both doctoral students and for research facilities. Since, as shown in the IOM study, faculties in schools of nursing devote the bulk of their activities to teaching, and committee activities, they can't be spared to do research. Thus, funds to hire additional faculty to cover teaching responsibilities will be necessary to enable present faculty release time to carry out those research projects which are considered part of the responsibilities of medical and dental school faculties and are funded as part of the costs of these programs.

RESPONSE TO THE ADMINISTRATION POSITION

The Administration has indicated that it opposes the 1975 amendments to the Nurse Training Act on basically four grounds: (1) excessive authorizations; (2) inclusion of capitation grants; (3) failure to deal with geographic maldistribution; and (4) nursing authority is separated from other health manpower authorities.

EXCESSIVE AUTHORIZATIONS

The authorizations in this bill are lower than those in the 1971 bill which the President signed and are not significantly higher than the FY 1974 program level. The basic point is that the Administration simply does not want to fund nursing schools, particularly through capitation. The Institute of Medicine study contracted by HEW clearly supports the need for operating support to schools of nursing, however.

CAPITATION

As mentioned above, the IOM study documents the need for operating support

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for schools of nursing through capitation. In fact, the capitation levels of H.R. 2957 are less substantial than the IOM study recommends, which is ¼ to ⅓ of the cost of education (even though the IOM study did not include the cost of basic science education). The Administration has argued that there is no general shortage of nurses and therefore no need for capitation. We have clearly indicated in this testimony the shortage in the area of leadership positions.

GEOGRAPHIC MALDISTRIBUTION

First, the degree of any geographic maldistribution for nurses is of a relatively minor nature. The range of nurses per 100,000 population is not great. Second, schools of nursing are quite well distributed nationally, which minimizes the degree of any maldistribution. The Administration cites the Southeastern states as examples of maldistribution. Yet, North Carolina has 47 schools of nursing, Georgia—28, Florida—27, and Tennessee—26, while the national average is about 20 schools of nursing to each state. Third, the issue of maldistribution *is* dealt with in H.R. 2957, in the special projects section and in the National Health Service Corps bill which specifically cites nurses as eligible for the program. We believe that this emphasis is more than adequate to meet the issue of maldistribution in nursing, a problem we do not believe to be of major proportions.

SEPARATE AUTHORITY

This issue is specious. The premise is that because a program is in a separate bill it cannot be considered or related to other programs. Clearly, issues can be considered simultaneously without being treated in the same bill. Each year the Administration itself proposes bills such as bills on aging and rehabilitation, that clearly relate to health services and manpower, but which they propose separately, and with justification. The choice of legal vehicles, a separate or consolidated bill, is not a programmatic matter. In addition, separate authority leads to greater accountability by program administrators to the public for their management.

CONCLUSION

In closing, let me endorse again the principal provisions of H.R. 2957. We urge its speedy enactment.

AMERICAN ASSOCIATION OF COLLEGES OF NURSING, RESOLUTION—

Whereas, new legislation is being proposed for health manpower which will focus on problems of primary care and on distribution while seeking to maintain current levels of training capacity and output;

Whereas, the profession of nursing is the largest single provider of health care delivery services;

Whereas, the nursing profession takes full responsibility for the preparation and practices of its own practitioners;

Whereas, it has been demonstrated that nursing is essential for providing easy accessibility into the health care system;

Whereas, within a prepaid health care delivery system, the client population will be without limits;

Whereas, experimentation and research in health care delivery are necessary for improvement of nursing services to people;

Whereas, there is an under representation of minority groups in professional nursing, especially at the higher education levels;

Whereas, the profession of nursing is in dire need of leaders in education, administration, and research; therefore be it

Resolved, that the following changes be made in existing laws to strengthen and expand the Public Health Service programs of Federal assistance for nurse training:

(a) Institutional support for schools of nursing should be increased to more nearly reflect one-third of all educational costs, with a special increment per graduate student added to the basic formula.

(b) Traineeships should be continued for the graduate education of nurses as well as student loans and scholarships for undergraduate students.

(c) Continue the current authority for project grants to schools of nursing with emphasis on programs to expand the enrollment and retention of disadvantaged students, to increase training capacity for advanced training at the graduate level, for expanding training capacity in such specialty areas as nurse

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midwives, family health nurses, pediatric and adult nurse practitioners, to support nursing research and demonstration projects to improve the quality of patient care and to explore new methods of multi-disciplinary health care delivery, in addition to dealing with maldistribution of health personnel.

(d) Continue the authorization for construction with the establishment of priorities for facilities for the advanced training of nurses and renovation of existing facilities.

* * *

RECOMMENDATIONS OF THE AMERICAN ASSOCIATION OF COLLEGES OF NURSING FOR THE SUPPORT OF NURSE EDUCATION

1. There is a shortage of nurses, particularly in the areas of teaching, administration and patient-care that require advanced training at the graduate level.

2. This shortage will become more critical with the enactment of national health insurance due to the reduction of financial barriers to health services.

3. In 1974 the Congress approved a total of $154,000,000 for nurse training in the areas of institutional support, student assistance and construction assistance, with the proviso that up to 5 percent of these funds could be withheld. The latter provision means that only $146,000,000 might be available.

4. The American Association of Colleges of Nursing recommends continued funding at this level with increases based on enrollment expansion and cost-of-living.

5. The Association also recommends the following changes in existing law to strengthen and expand the Public Health Service program of Federal assistance for nurse training:

(a) Continue the authorization for construction with the establishment of priorities for facilities for the advanced training of nurses and renovation of existing facilities.

(b) Continue the authority for project grants to schools of nursing with emphasis on programs to expand the enrollment of disadvantaged students, to increase training capacity for advanced training at the graduate level, for expanding training capacity in such specialty areas as nurse midwives, family health nurses, pediatric nurses and nurse practitioners, to experiment with new methods of health service delivery and to deal with maldistribution of health personnel.

(c) Institutional support for schools of nursing through capitation grants should be increased to more nearly reflect one-third of educational costs, with an increment per graduate student added to the basic formula.

(d) Traineeships should be continued for the advanced training of nurses as well as student loans and scholarships for undergraduate students.

STATEMENT OF LOGAN COLLEGE OF CHIROPRACTIC, ST. LOUIS, MO.

Mr. Chairman and Members of the Subcommittee: The Logan College of Chiropractic of St. Louis, Missouri, is grateful for the opportunity to present its views on legislation to modify and extend the federal role in the education of health professionals. At the onset let me state emphatically that federal assistance is vital if chiropractic schools are to continue providing health professionals to meet the Nation's health needs, particularly because of the increasing difficulty institutions are finding in meeting rapidly rising costs.

Logan College of Chiropractic is one of several institutions engaged in the education of chiropractors at the undergraduate and graduate level. The College is thoroughly dedicated to providing interested and qualified students an education that prepares them to be confident professional men and women.

The College enrolled its first class, a small group of seven, in 1935. Today, enrollment approximates 500 students who are pursuing their course of study at Logan's new, modern, 103-acre campus in suburban St. Louis.

Chiropractic is the second largest profession providing comprehensive health care to its patients. There are approximately 24,000 licensed chiropractors in the United States. Furthermore, chiropractors are licensed in all 50 states and the District of Columbia.

There are 13 colleges of chiropractic located throughout the United States. Attending these colleges are approximately 6500 students.

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Chiropractic education has made great strides within the last few years. Late in 1974 the Council on Chiropractic Education, an accrediting body for chiropractic educational institutions, was granted recognition by the United States Commissioner of Education. Prior to that time several individual insitutions, Logan College of Chiropractic included, were certified as "institutions of higher education" by the United States Office of Education.

Not only has chiropractic education made great strides in the past few years, but the profession as a whole has made similar advancements. Chiropractic services are now covered in various federal programs, incluiding Medicare, Medicaid and the Federal Employees Compensation Act. Also, the National Institutes of Health recently conducted a three-day conference concerning spinal manipulation and intends to conduct intensive research into the principles of chiropractic, a goal that has long been sought by the chiropractic profession.

Chiropractic can best be described as a drugless system of healing in which chief emphasis is placed on the nervous system and its control of the body functions. It is through alterations of this control system and the following alternation in body function that maintains health or causes disease.

The practice of chiropractic is concerned primarily with the structural or mechanical problems of the body, especially of the spine, in relation to the effects they have on the nervous system and, in turn, on body function. The educational program at Logan College of Chiropractic is designed to educate students in this basic principle of chiropractic.

As stated earlier, Logan College of Chiropractic was founded to provide intensive and thorough training for students of chiropractic. This includes a full knowledge of the structure and function of the human body, enabling the graduate doctor to carry his responsibility to his patient in performing a complete physical examination, making the proper diagnosis, providing the necessary chiropractic care or referring the patient to a doctor in another field if it should be necessary. To gain this knowledge, a student must successfully complete 5,240 classroom hours spread over a four-year period of time. Instruction includes courses in anatomy, physiology, chemistry, pathology, bacteriology, hygiene, diagnosis, gynecology, obstetrics, pediatrics, X-ray, geriatrics, principles of chiropractic, jurisprudence, clinical practice and physical therapy. The plan of the curriculum is a purposeful one; each course is taught in proper sequence as a "building block" upon which the next course is laid. The student's understanding of body structure and function develops from one hour to the next as the courses become more and more advanced.

As the knowledge and understanding of the human body in chiropractic grows, the student becomes a professional man interested in the physical condition of his patient. The skill of spinal manipulation is refined throughout the courses until the student becomes an artist in adjustment. He becomes capable and anxious to apply his knowledge and skill to relieve the problems he finds in his patient practice as an extern in the College clinic. I am proud to add the College's clinic has been chosen by several local organizations and educational facilities to conduct physical examinations of their members and students.

The Logan College professional program is based on the firm belief that chiropractic students should be liberally educated in addition to being competently trained in the basic science of chiropractic skills. Consequently, it is the policy of Logan College that completion of two years (60 semester hours) of education at an accredited college be required prior to enrollment at Logan. Logan College is committed to the idea that the best education is one which in addition to producing a highly skilled doctor of chiropractic produces an individual able to reason, think and explore the great heritage of our ideas in the vast body of knowledge accumulated in literature, humanities and the sciences, and who is able to wrestle with the issues and values of contemporary society.

In light of the present high level of chiropractic education and the chiropractic profession, Logan College respectfully requests that the Committee amend H.R. 2956 to include schools of chiropractic in the health manpower legislation.

Logan College recognizes that problems in health care are centered, in part, around the inadequate supply of physicians and other health professionals, the distribution of physicians geographically and by specialty, and the quality of services provided, and that chiropractic schools can contribute to their solution. We also believe that diversity is a strength of American chiropractic schools and that each school can make its greatest contribution to the solution of these problems in different ways, depending on its particular characteristics.

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Federal support and assistance for chiropractic educational programs is critical during these times of severe financial stress on chiropractic schools. Consequently, we urge that Congress recognize chiropractic educational institutions as the national resource that it is and provide assistance to chiropractic educational institutions on the same basis that it provides assistance to other health professional educational institutions.

STATEMENT OF PALMER COLLEGE OF CHIROPRACTIC, DAVENPORT, IOWA

The Palmer College of Chiropractic is pleased to have this opportunity to submit its statement in support of inclusion of chiropractic educational institutions in the Health Manpower Act of 1975 (H.R. 2956). Federal assistance is vital if chiropractic schools are to continue providing health professionals to meet the Nation's health needs, particularly because of the increasing difficulties health profession institutions are finding in meeting rapidly rising costs.

Palmer College of Chiropractic, the largest chiropractic educational institution in the United States, is located in Davenport, Iowa. Its enrollment exceeds 2,000 students. It was founded in 1895 by Dr. D. C. Palmer, the founding father of the chiropractic profession.

Chiropractic, from its discovery in 1895 by Dr. Palmer, to the dynamic, aggressive profession that it is today, ranks as the fastest growing health profession providing service to millions of people throughout the world. It is estimated that more than 24,000 doctors of chiropractic have cared for more than 40 million patients in the United States alone.

Through vigorous efforts of the pioneers of chiropractic, the profession has established sound philosophies and rigorous professional standards, and has gained public confidence. More than 600 insurance companies now regularly pay claims for chiropractic health care. In addition, chiropractic is covered in various federal health programs, including Medicare, Medicaid and the Federal Employees Compensation Act. Furthermore, the National Institutes of Health is conducting intensive research into the principles of chiropractic, a goal long sought by our profession.

There are approximately 6500 students attending the 13 chiropractic colleges located throughout the United States. Students at these institutions are being trained to join the largest profession using drugless healing science in America today and whose philosophy and success are built on the proven concept that abnormal functions of the body are the result of interference with the transmission of normal nerve impulses.

Higher education institutions serve a variety of functions in providing educational opportunities to youth at the post-high school level. Palmer College of Chiropractic has aimed its program toward one major objective—the education of qualified, competent, responsible doctors of chiropractic who are educationally and professionally competent to care for patients. This is accomplished through the analyzing and adjusting of sections of the spinal column to maintain and restore neuromuscular-skeletal stability as the major contributing factor to their health.

The College recognizes that the problems in health care are centered, in part, around the supply of physicians and other health professionals, the distribution of physicians geographically and by specialty, and the quality of services provided, and that chiropractic schools can contribute to the solution. The College also believes that diversity is a strength of American chiropractic schools and that each school can make its greatest contribution to the solution of these problems in different ways depending on its particular characteristics.

The chiropractic educational institutions have made significant strides in educating its students. The curricula is of high quality; every school provides study in the subjects of anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chemistry, histology, pathology, and principles and practice of chiropractic, including clinical instruction in vertebral palpitation, nerve tracing and adjusting, plus courses in the use and effect of X-ray and chiropractic analysis.

Because of the high-level state of chiropractic education in America today and the equally high status of the chiropractic profession today, the Palmer College of Chiropractic respectfully requests that this Committee amend H.R. 2956 to provide for the inclusion of chiropractic educational institutions on the same basis as other health profession educational institutions. Federal support

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for chiropractic educational programs is critical during this time of severe financial distress on our schools, and we plead with Congress to provide recognition of our institutions with respect to the Health Manpower Act.

STATEMENT OF THE MAHARISHI INTERNATIONAL UNIVERSITY

Mr. Chairman, Members of the Subcommittee: In previous testimony we have outlined the programs of Maharishi International University for training health personnel throughout the country. We would like to draw to your attention at this time the University's achievements in video cassette production and broadcast television capabilities over the past year.

A. VIDEO CASSETTE PRODUCTION

At its video production studios in Switzerland, New York and California, Maharishi International University (MIU) has edited several thousand hours of material in all academic disciplines for distribution to over 800 external learning centers worldwide. Videotaped courses range from basic study of the traditional disciplines and the study of the Science of Creative Intelligence (SCI), to presentations made by respected scholars, artists, businessmen, military leaders and government officials at 22 international SCI symposia held since 1970.

In addition, specialists from the fields of education, health and rehabilitation, in conjunction with Maharishi Mahesh Yogi, have been producing MIU video courses for training allied health personnel. Personnel from every MIU external learning center are now being trained through these courses under the guidance of resident faculty members and physicians, in order to enable each center to effectively service special population needs.

Research on the effectiveness of SCI in various health areas continues to expand at a rapid rate; presently, over 300 experiments are underway in 18 countries. Through the use of videotaped courses, over 8,000 teachers of SCI are kept abreast of the most recent advancements in these fields at advanced teacher training courses held twice yearly.

The usefulness of SCI in alcohol and drug abuse prevention and rehabilitation, in mental health therapy and criminal rehabilitation is now well documented. What is lacking at this time is a sufficient number of trained personnel to handle the increasing demand for SCI programs in each of these areas. MIU, therefore, has been expending considerable effort to implement regional training programs structured around videotaped course packages, to increase the number of SCI teachers available to work in health-related concerns.

B. BROADCAST TELEVISION

Television station KSCI in Los Angeles will be airing MIU educational programs. Other groups planning to submit applications for stations in Washington, D.C., Chicago, Illinois, and Buffalo, New York, have indicated interest in MIU programs.

In November 1974, a group of MIU engineers constructed the first broadcast television facility for the country of Nepal at the request of its government. Similar requests for educational broadcasting facilities have been expressed by other governments to MIU.

In the developing countries, the knowledge will be broadcast locally, utilizing low-power transmitters and special color receivers. Since reliability and simplicity are essential in a system of this nature and scope, Maharishi International University has selected a team of specialists to develop and, in some cases, locally manufacture standardized low-cost receivers and transmitters in modular form for ease of maintenance by unskilled personnel. By means of televised courses originated from these local stations, it will be possible to attend the majority of MIU undergraduate courses prepared by the resident faculty and eminent visiting faculty from renowned universities around the world.

Special programs for working adults and the elderly will specifically address the problems of the current "generation gap", which the Science of Creative Intelligence uniquely solves. These programs will permit the responsible and senior citizens of every country to regain a sense of knowledgeability and au-

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thority in matters of concern to their community, which in turn will help to preserve local cultural values and traditions. By providing a strong supporting program of lectures and local seminars, these stations will maintain the setting for a self-aware community to examine its own rapid progress. This evolution is brought about by the widespread growth in creativity and intelligence that results from the increasing availability of the knowledge of the Science of Creative Intelligence. Degree programs may also be offered in cooperation with local employers to workers in every field of social activity.

Since in most countries the network will make use of special receivers, the television project will not interfere with local systems and may serve as a virtually closed-circuit, exclusive educational facility. Utilizing the most modern and efficient studio and transmission equipment, MIU television stations will enliven the communities in which they operate by dissemination of knowledge and materials that can directly enhance each individual's daily achievements and reopen the awareness of every community to those qualities of life that must be preserved if social harmony and well-being are to be maintained.

The Center for Global Television of Maharishi International University has evolved a system for implementing low-cost, nationwide educational television projects, including a five-stage construction plan and an international broadcast arrangement whereby heads of state of every participating nation may regularly address their nations and, in the years to come, the people of the entire world.

Independent television stations in the U.S.A., Chile, the Philippines, and Iran have already requested regular program series from Maharishi International University and, at present, regular World Plan News reports which present the global progress of the World Plan through film, videotape, slides and live discussion, are being distributed by MIU to these countries for broadcasting.

According to its originator, Maharishi Mahesh Yogi, Global Television "making full use of the most developed technology will strengthen and enrich the basis of culture in each area by bringing the knowledge and experience of the pure field of Creative Intelligence to individuals in every area of the globe. Only through Global Television can this be done directly, quickly and effectively while at the same time providing a means of expression of the traditional cultural and spiritual values through locally originated programs."

For further information on Global Television address inquiries to: Center for Global Television, Maharishi International University, Fairfield, Iowa 52556.

C. CONCLUSION AND RECOMMENDATIONS

Maharishi International University, by virtue of its ability to draw upon international expertize for program development, its proven capabilities in programming and hardware design and manufacturing, and its success in establishing and maintaining local external learning centers, has by its own resources implemented a nationwide program consistent with the aims of these bills. In order to effectively respond to present and furture needs, additional sources of funding are essential. Because of MIU's proven capability to establish economically self-supporting training programs, because of the need for trained SCI paraprofessionals, and because of the cost-effective potential of video training program production, we urge an expansion of government support for MIU television facilities and program development in health areas.

STATEMENT OF HENRY K. SILVER, M.D., PROFESSOR OF PEDIATRICS, UNIVERSITY OF COLORADO SCHOOL OF MEDICINE, DENVER, COLO., AND PATRICIA A. MCATEE, M.S., ASSISTANT PROFESSOR OF PEDIATRICS, UNIVERSITY OF COLORADO SCHOOL OF MEDICINE

Striking needs exist for many more highly qualified health professionals to provide increased and improved primary health care to individuals of all ages.

The evidence at hand conclusively demonstrates that the least expensive, most practical, and most acceptable method of preparing the needed health professionals in a relatively short period of time is to train thousands of additional nurse practitioners to be primary health care providers.

Nurse practitioners are capable of considerable independent decision-making, can provide extensive diagnostic and therapeutic services for a wide variety of patients, and are able to perform many of the functions and activities which heretofore have been the sole province of the physician.

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Since 1964 when the first nurse practitioner program was developed, studies have shown that:

"1. Nurse practitioners can care for approximately three-fourths of all patients coming to ambulatory settings for primary health care;

"2. They can assess overall health status, take complete histories, perform thorough physical examinations, counsel patients with many different problems, evaluate and manage most of the acute and chronic disorders of those who are ill or injured, and provide preventive and ongoing health care for those who are well;

"3. Nurse practitioners can care for a wide variety of patients (children, adults, the elderly, the acutely ill in emergency rooms, those in intensive therapy units, those in nursing homes, as well as many others);

"4. Nurse practitioners have a high degree of agreement with physicians in assessing the health status of patients;

"5. Nurse practitioners can practice as associates and colleagues of physicians and provide health care for at least one half more patients than physicians alone;

"6. Nurse practitioners can provide sharply focused health counseling that patients are more likely to follow;

"7. Nurse practitioners are well accepted by patients and health professionals as primary health care providers;

"8. In addition to the large number of nurse practitioners practicing in private offices, many nurse practitioners practice in rural areas, on native American Indian reservations, in low income urban neighborhoods, and in other underserved areas where they help to increase access to health care and provide better distribution of needed health services.

Federal legislation covering programs of assistance for nurse training should include the following provisions:

1. The Secretary of Health, Education, and Welfare should be allowed "to make grants to and enter into contracts with public or non-profit private schools of nursing, medicine, and public health, public or non-profit private hospitals, and other public or private entities to meet the cost of projects to: a) plan, develop, and operate, b) significantly expand, or, c) maintain existing programs for the training of nurse practitioners."

At present most nurse practitioner programs are not administered solely by schools of nursing; a recent survey of pediatric nurse practitioner programs revealed that only 25 of 62 programs were administered by such schools. Eleven were administered jointly by schools of nursing and medicine, 10 by schools of medicine, 14 were by health departments, medical groups, or the military, one by a school of health science, and one by a school of public health. Increasing evidence suggests that the ideal is collaborative administration by schools of nursing and medicine, or at a minimum, ongoing active medical collaboration by physicians in programs administered by collegiate or diploma schools of nursing.

2. Provisions should be written into Federal legislation to assure that appropriate professional nursing and medical organizations are consulted to establish guidelines to be used as a base in defining the training of nurse practitioners. As a minimum, these guidelines should require—

(a) A defined program of classroom instruction and supervised clinical practice directed toward preparing nurses to deliver primary health care.

(b) There should be a minimum course of study of at least four months of classroom instruction as well as a minimum of four months of satisfactory clinical practice as a nurse practitioner under the supervision of a physician for the medical aspects of the role.

The guidelines that have already been established for various nurse practitioner programs (including those preparing pediatric nurse practitioners and school nurse practitioners) recommend a four-month educational course of classroom instruction. Those who have worked with nurse practitioners have also found that nurses graduating from four-month courses of study are effective, competent, and entirely satisfactory nurse practitioners and providers of primary care. Any requirement for an educational experience longer than four months would have the effect of inhibiting the training of nurse practitioners and would be harmful to the entire nurse practitioner movement since many nurses cannot afford (and should not be required) to spend longer than four months in a course of study that can be presented quite adequately in that period of time.

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(c) There should be a minimum level of enrollment in each class of not less than eight students.

Most established nurse practitioner programs have found that they can function only if they have small classses of eight or ten students. The success of nurse practitioner teaching programs depends on having a relatively high ratio of faculty to students. It would be impossible for most programs to have a satisfactory faculty/student ratio if training programs were required to have larger classes. Furthermore, most schools of nursing and medicine, teaching hospitals, and medical and nursing centers do not have sufficient clinical facilities to provide larger classes of nurse practitioner students with the clinical experience that they require.

3. Provision should also be made so that grants and contracts may include the costs of preparing faculty to teach in nurse practitioner programs.

There are additional provisions that should be incorporated into future legislation that is necessary for the implementation of a more extensive national program of nurse practitioner preparation.

A National Nurse Practitioner Program, in addtiion to supporting the planning, development and establishment of new nurse practitioner training programs, should foster research in nurse practitioner education, should support the modification of existing programs of nursing education to teach nurse practitioner concepts and skills, and should continue to support existing nurse practitioner programs in those areas (geriatrics, school health, pediatrics, family health, etc.) where a pressing need for specially-trained nurse practitioners has been demonstrated. Funding should go primarily to those programs that meet guidelines similar to those already established jointly by nursing and medical organizations and to those programs that meet accreditation criteria when these are established.

Requiring faculty members of schools of nursing to become nurse practitioners by having them take courses of study in established nurse practitioner programs is the only way that faculty members could obtain the practical and theoretical knowledge that is necessary for them to have in order to understand the new and expanded role and increased responsibilities assumed by the nurse practitioners in providing primary care.

The teaching of nurse practitioner concepts and skills by nursing faculty who have themselves graduated from standard nurse practitioner programs should become an integral part of the basic undergraduate curriculum in schools of nursing. This would allow nursing students to obtain sufficient knowledge of this discipline of nursing to be able to decide whether they want to choose it from among the many fields of nursing. Throughout nursing school, students should assess and manage health care problems in a variety of social, economic, cultural, and behavioral situations so as to obtain an understanding of their influence on health and disease and on optimum patient care.

A period of supervised orientation and applied practical clinical experience (a "nursing internship") should also become part of the undergraduate curriculum of schools of nursing so that students would, under supervision, be able to apply the knowledge and skills of the nurse practitioner in ambulatory clinical settings. The nursing internship should be part of the last year in nursing school.

During the first half of the internship, students should have practical clinical experience in providing direct care in various traditional settings (including outpatient departments, hospital wards, public health facilities, patients' homes, physicians' offices, and operating rooms) to patients of all ages and with a variety of problems. In the second half of the internship year, students should be given the opportunity to practice the nurse practitioner role in a wide variety of clinical settings. They could choose the specialty area (e.g., pediatrics, geriatrics, industrial health, family health, school health, mental health, obstetrics) in which they planned to practice and could fully integrate their roles as nurse practitioners under the supervision of specially prepared faculty. Upon completion of this portion of the internship, nurses would be prepared to practice as qualified nurse practitioners.

As another part of a national nurse practitioner program, funding should also be made available for the development and implementation of programs to prepare other nursing health workers (e.g., licensed practical nurses, nurses' aides) to become "assistant nurse practitioners." After a relatively short course of study, the assistant nurse practitioner could serve in a community to provide the basic assessment and management skills needed in emergency situations,

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care for a variety of minor health problems, offer certain preventive services, and provide triage for those problems requiring attention from health personnel with more training. Those chosen for assistant nurse practitioner training should be selected from underserved areas to which they will return and should know cultural differences, local languages, neighborhood life styles, and family and ethnic values from the firsthand experience of having lived with the people to be served. Allowing these individuals to utilize their natural and social skills as well as the additional newly acquired elementary nursing skills would increase the likelihood that assistant nurse practitioners would remain to practice in their local communities.

Programs for nurse practitioners, whether they be at the postgraduate or continuing education level, or pat of undergraduate courses of study, should be developed and implemented jointly and cooperatively by nursing and medicine. Both professions should be involved in the preparation and evaluation of primary health care providers who will be responsible for many functions previusly reserved entirely to physicians. Nursing and medicine need to work together to develop a more effective primary health care delivery system.

A national nurse practitioner program would be relatively simple to implement since it is based on an accepted and traditional system of education and practice which is already functioning and would require little modification in order to be put into full operation. Implementation of a national program would result in the preparation of thousands of additional nurse practitioners of all types who would:

Favorably affect the health care of millions of people.

Provide health care to many individuals who presently receive inadequate care.

Upgrade the entire level of health care available to all segments of the population.

Be significantly less expensive than any other alternative method of providing health care.

Encourage foreign-trained physicians to remain in their own countries where there is usually a great demand for them rather than encouraging them to come to the United States.

Be an expeditious and practical means of preparing the large number of health professionals needed to meet our immediate and long-range requirements for increased and improved health care.

STATEMENT OF LOUIS E. GONZALES, D.D.S., FACULTY MEMBER, SCHOOL OF DENTISTRY, UNIVERSITY OF CALIFORNIA

I am Dr. Louis Gonzales, member of the faculty at the University of California, School of Dentistry. I hold the title of Clinical Instructor of Fixed Prosthodontics and Oral Diagnosis and am also the Co-educational Informational Director of the Recruitment, Admission and Retention Program for Minority and/or Disadvantaged Students in the Field of Dental Health. This project is currently funded under the Health Manpower Act of 1971. We have been funded since 1972. Our application for a third year of funding was approved but not funded due to federal cutbacks. We have been sitting on an extension of funds since January of this year. Our funds have been extended through the end of June, 1975.

I would like to quote herewith a statement by Dr. Theodore Aranda, Director, Academic Reinforcement Program at the College of Dentistry, Howard University:

"The need for national efforts to increase and retain minority students in Dentistry is a very simple, nationally recognized and statistically proven one. There are just too few dentists serving minority communities, and no serious and sober disagreement can be raised about that. The solution is as simple as the fact itself. Dental students from minority groups must be increased because they, by reason of ethnic, familial and traditional experience, are the most likely to return to their original community or its immediate proximity or to reside within serving distance of one not too disparite from their original. Quit obviously, the increase in minority admissions is too susceptible to political and statistical disception and is meaningless without a commensurately proportional increase in graduation. Not graduation, per se, of minority students who have merely been pushed through dental halls and clinics, but rather the graduation of dentists of caliber who have been afforded all the facilities, have mastered all the required skills and have successfully completed the dental training. So that when

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a minority student graduates, he does so with his and the school's complete confidence of having been thoroughly trained and not just ushered through a program facade suffered by the school only for itself—adulatory and financial benefit, but ridden with misgivings about minority competence and trainability."

I am submitting to you an addendum to a report entitled, "The Beginning of a Journey, Volume 2, Site Reports" prepared by ABT Associates, Inc. 55 Wheeler Street, Cambridge, Mass. 02138, a Study to Document the Effects of Altering Traditional Dental Schools, Recruitment and Admissions Policies for Minority Students. Included is an objective analysis of our program at the University of California, School of Dentistry, San Francisco, California.[1]

In Summary, this report documents the following: 1. In terms of admissions, statistics show that 25% of entering classes comprise minority and/or disadvantaged students. These students are selected on the basis of merit and on their sensitivity and awareness of the health care needs of their particular communities. In terms of recruitment, undergraduate students are contacted in the state of California and adjoining western states which do not have dental schools.

2. Our attrition rate is virtually nil. Students perform at all levels of class standings and many have excelled in more than one field.

3. The statistics in this report show us to be a successful program. Reinforcing Dr. Aranda's statement that minority professionals are more likely to return to their communities than regular students.

4. The last two classes that have been graduated under the two years of federal support have gone back to their communities 100% except for those who entered into the armed services or postgraduate school.

STATEMENT OF T. BYRON COLLINS, S.J., SPECIAL ASSISTANT TO THE PRESIDENT, GEORGETOWN UNIVERSITY, AND SEYMOUR ALPERT, M.D., VICE PRESIDENT, GEORGE WASHINGTON UNIVERSITY

Mr. Rogers, Mr. Carter and Members of the Committee:

I am Fr. T. Byron Collins, S.J., Special Assistant to the President of Georgetown University. With me is Seymour Alpert, M.D., Vice President of George Washington University.

It is a pleasure to appear before your Committee to present a request on the pending Health Manpower Bill.

We strongly endorse the provision on student loans which provides borrowing of full tuition plus a cost of living allowance.

We request that a sub-section be inserted in the capitation section that would read:

"The Medical and Dental Schools in the District of Columbia are eligible to receive awards of up to $5,000 per year for each full time medical student enrolled and up to $3,000 per year for each full time dental student enrolled for the purpose of meeting the operating costs of these schools in order to maintain excellence."

The reason for this request is that our schools are a national resource, not merely because of student composition from all states, but mainly because we are located in the District of Columbia and provide substantial health manpower resources to the Federal government in the D.C. Metropolitan Area.

As this Committee is aware, we have had to petition in past years that the health manpower financial distress section be increased so as to provide funds to allow our schools to continue in operation.

A provision under the capitation section would seem to be logical and we recommend its inclusion in this bill.

The 1975 enrollment at George Washington Medical School is 610 students and at Georgetown University Medical School 840 students and the Georgetown University Dental School has 600 students.

STATEMENT OF ROBERTO D. MONTOYA, M.D., M.P.H., LOS ANGELES, CALIF.

Mr. Chairman and members of the subcommittee, my name is Robert Montoya. I am speaking as a private citizen. I am a physician, and I have been active in

[1] May be found in committee's files.

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Chicano health manpower development since 1968, working with several organizations in this area.

I wish to speak to Section 782, Assistance to Individuals from Disadvantaged Backgrounds, of H.R. 2956, the Health Manpower Act of 1975.

I will try to limit my remarks to the group I know best, Chicanos, but some of my comments may also apply to other ethnic groups.

STATEMENT OF NEED

Generally our people suffer from a poorer health status than the rest of the U.S. population, as just a few statistics will demonstrate. In a 1970 study in Los Angeles County, 7 health districts were compared in occurrence rates for 24 diseases. The East Los Angeles district, which is over 80% Chicano in population, ranked first, second or third in occurrence rates in 23 of these 24 diseases. In terms of mortality, a recent Colorado study showed that the life expectancy of Chicanos was 56.7 years, while for the rest of the population it was 67.8 years. Many more similar health statistics for Chicanos could be cited.

There are many causes for the present situation, one of them being the severe shortage of trained Chicano health professionals. This shortage can be shown by the following: in 1969 we did a study of the physicians in the East Los Angeles and Northeast health districts, areas which are overwhelmingly Chicano. We found that there were 154 physicians in the community. Of that number, approximately 35 were Spanish-surnamed. Further, of those 35, less than 10 had graduated from U.S. medical schools. The rest of these 35 physicians were from Latin American countries. Nationally, available data indicates that there are approximately 400 Chicano physicians. Applying this to what is probably a low census count of 6.3 million Chicanos in 1970, one arrives at a Chicano physician/Chicano population ratio of approximately 1 Chicano physician per 16,000 Chicano persons (the general U.S. ratio is 1 physician per 616 persons). A very similar situation exists in other health professions. In terms of pharmacists, who serve as a primary source of health information and services for many poor people, data is available for some southwestern states. In Colorado, Mexican-American pharmacists represent .9% of the practicing pharmacists, while we are over 13% of the population. In Arizona, 3.2% of the pharmacists are Mexican-American, although we are over 20% of the population. In California only 1.2% of the pharmacists are Mexican-American, although we are over 16% of the population. Similar situations exist in other health professions.

Trained Chicano health professionals are not seen as a panacea for all the health problems affecting our people, but their knowledge, experience and caring for our people will go a long way toward some solutions, in several ways.

In recent years there has been a considerable increase in the number of Chicanos receiving health professional training, as the following table shows:

A. TOTAL MEXICAN-AMERICAN ENROLLMENT IN U.S. MEDICAL SCHOOLS

Academic year	Total enrollment	Mexican-American	Percent of total
1968-69	35,833	59	0.2
1970-71	37,690	92	.2
1970-71	40,238	148	.4
1971-72	43,650	252	.6
1972-73	47,366	361	.8
1973-74	50,716	496	1.0

B. TOTAL MEXICAN-AMERICAN ENROLLMENT IN U.S. DENTAL SCHOOLS

1971-72	17,153	67	0.4
1972-73	18,209	119	.7
1973-74	19,369	174	.9

Source: Adapted from "Minorities and Women in the Health Fields, DHEW Publication No. (HRA 75-22).

In 1973-74 there were only 12 Mainland Puerto Rican students, from a population of over 1½ million.

The increase in numbers for Chicanos are impressive; there is a substantial percentage increase each year. We have now reached about ¼ of parity, using

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a more realistic population base of 8 million, in the medical and dental school population. But, in medicine, even at the present rates of increase in numbers of Chicanos in medical school, it will take 14 years for us to reach parity in the medical school population, and fully 38 years to reach a Chicano physician to Chicano population ratio equal to that currently in the U.S. for the general population (Dr. Henry Herrera, Chicano Health Professionals, Agenda, Winter 1974).

This time period must be telescoped. More Spanish-speaking students must be informed, counselled, encouraged and provided services to pursue these careers.

To a considerable degree, programs such as those to be funded under section 782 are responsible for the increases above, but these efforts should be increased. As an example, the National Chicano Health Organization (N.C.H.O.) has one counsellor-coordinator for the entire state of Texas, other active persons in this field being at the University of Texas Medical Center and in El Paso. One of his primary activities is to help organize and service N.C.H.O. chapters at undergraduate colleges. This he did, but when he had gotten about 15 chapters active, he had to stop as he could not adequately service any more. Consequently, there are several colleges in the state with substantial Chicano enrollments having no Chicano health manpower development services. Similar situations exist in other programs i.e. more could be done if more resources were available.

Minority health manpower development efforts must be increased in order to shorten the time it will take for there to be adequate numbers of trained minority health professionals to service the needs of our own people. The great majority of those Chicanos in training desire and plan to practice in Chicano communities. Very few of the recently graduated Chicano physicians have completed their training, as most are still in internships and residencies. We do have data from the University of California Dental School showing that Chicano graduates have set up practice in Chicano communities. Of the 14 graduates in 1973 and 1974 who have set up practice, all 14 are serving predominantly Chicano populations.

In the present bill, and in other existing laws, considerable amounts of funds are authorized or expended to provide personnel and services in shortage areas, as where most minority persons live. The sooner minority health personnel practice in such areas and become permanent health care resources for these communities, the sooner will federal funds not be needed to provide health care personnel for these areas.

I would therefore advocate that the present federal effort in this area be doubled. At the time of the full Committte on Interstate and Foreign Commerce mark-up session on H.R. 17084 (predecessor to H.R. 2596), Congressman Moss offered an amendment which was accepted without dissent to double the present federal effort in this area. The authorization was thus doubled from $10 million to $20 million, but the $10 million figure was based on incorrect information that the total federal effort in this area was that authorized under section 774b of the expiring law i.e. the $6.9 million in Special Health Career Opportunity Grants. Further staff research subsequent to that mark-up session documented that the federal effort for programs that would be authorized under section 782 was approximately $16.4 million, as shown below:

	Millions
772 Special project grants	5.5
774b Special health career opportunity grants	6.9
Contracts under 772(a) and 774(a)	3.5
Schools of public health	.456
Total	16.356

The $20 million authorized in the present bill would just barely maintain the present federal effort. I would therefore advocate authorizations of $35 million, $40 million and $45 million over the three years of the legislation.

STATEMENT OF ANDY STERGACHIS, STUDENT, COLLEGE OF PHARMACY, WASHINGTON STATE UNIVERSITY

Mr. Chairman, Members of the Committee, I am Andy Stergachis, a pharmacy student at Washington State University. Presented herein are my views regarding the Health Manpower Act of 1975, particularly as it relates to pharmacy education. As a senior pharmacy student actively involved in professional and academic affairs and as a recipient of a Health Profession Scholarship and Loan

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I feel that I am in a position to provide the Committee with helpful information for their consideration.

I have received a patient-oriented pharmacy education, made available through continual federal support of clinical pharmacy and clinical pharmacology programs. The outcome of my five years academic experience is my ability to provide proper health care to the patient in relations to their drug therapy. Many proposed roles for the pharmacist are truly being practiced by today's graduates.

The patient's health and welfare has become the center of attention, as each member of the health care team provides those services which they are uniquely trained to provide.

As pharmacy graduates enter practice and utilize their educational background, the value of a clinical pharmacy emphasis becomes apparent. Such practice has been demonstrated as being cost-effective and in the patient's best interest.

In many instances, the cost of pharmacy education has risen far above the student's own resources. I received federal assistance in the form of a Health Professions Scholarship and Loan at a time when my own resources couldn't have paid for my health profession education. I discovered that general scholarships and loans are difficult to obtain due to the sharp competition for these alternative sources of financial assistance.

I commend the Subcommittee on Health and Environment for including Health Profession Loans for pharmacy students as a provision of the Health Manpower Act of 1975. These loans provide assistance to many deserving and needy students who might otherwise be excluded from obtaining a pharmacy education due to the cost burden. Assistance levels should be in line with the actual average annual expense of pharmacy students. The Institute of Medicine's *Costs of Education in the Health Professions* is a data source in this regard.

Scholarships are an important source of financial assistance for disadvantaged or low-income students. Unfortunately the Subcommittee on Health and Environment eliminated the Health Professions Scholarship program for pharmacy students in its draft of the Health Manpower Act of 1975. Health Profession Scholarships have enabled many pharmacy students, including myself, meet the cost of education. The federal government benefits from this program once these students enter practice and serve the public as a national resource.

In this "age of accountability" it is no wonder that the Congress wants the public to realize a return on federal monies allocated to various worthwhile programs. This seems to be the underlying concept in the proposed capitation funds available to eligible pharmacy schools. The Health Manpower Act of 1975 requires that incoming pharmacy students sign an agreement with the federal government to either pay back all capitation funds the pharmacy school receives on the student's behalf, or enter a federal program or enter a manpower shortage area to cancel repayment of those monies.

There are some problems inherent with the latter alternative. Positions in federal health programs utilizing the pharmacy graduate's drug-use skills are not available in a large enough amount. For example, of all the health professionals which the National Health Service Corps utilizes, only 1–2% have been pharmacists. The federal government should take advantage of the pharmacy student's desire to practice pharmacy in a professionally satisfying manner in the patient's best interest and incorporate their services into HEW health programs to a greater degree than is presently available. Otherwise, the pressure of loan repayments and capitation funds repayment could hinder the quality of the pharmacy graduate's performance. The Committee should also keep in mind that the pharmacy student's income upon graduation and his or her potential income is far less than that acquired by other members of the health care team—notably the physician.

In summary, the health profession assistance programs have been important sources of financial aid to many pharmacy students. I ask that the Health Professions Loan program be continued at levels which coincide with the cost of pharmacy education.

I feel that this Committee in its good judgement should reinstate the Health Professions Scholarship program for disadvantaged or needy pharmacy students. In addition, the Committee should stipulate the HEW health programs incorporate pharmacy graduates into their programs in a manner utilizing their professional expertise.

With this support, the public will benefit from the services which pharmacy can and is willing to provide.

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NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS
Washington, D.C., February 10, 1975.

Hon. PAUL ROGERS,
Chairman, Health and the Environment Subcommittee, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: In view of the fact that the Public Health and Environment Subcommittee plans to hold further hearings and reconsider health manpower legislation similar to H.R. 17084, I would like to submit the following comments and enclosed suggested changes in the legislation for your consideration. These suggestions are submitted on behalf of the National Council of Community Mental Health Centers.

I would like first to express our strong support for many of the concepts in this bill, particularly the new remote site training requirements for Schools of Medicine and the expansion of the Area Health Education Centers program. These two programs, together with some of the other initiatives in the bill, could greatly increase the number of physicians who chose to serve in medically underserved areas, and will also have an important impact on the education of these students in two neglected areas: delivery of primary care and the delivery of services through an organized care setting. These thrusts clearly fit neatly into the overall health policy which your Subcommittee is formulating, through enactment of health services and health planning and development legislation.

We would, however, like to point out the important role which could be played in this process by community mental health centers. Under the legislation you are proposing, mutually beneficial relationships between the CMHCs and health manpower programs could develop, but without more emphasis on this relationship in both the legislation and the report there will be much resistance in the medical school community which will impede such developments.

For instance, CMHCs provide primary care in the mental health area through a comprehensive system which emphasizes ambulatory care. Here are three major areas, which the Subcommittee clearly intends should be emphasized more in the future, together in one program.

CMHCs, for instance, should be part of many AHEC programs (and we suggest report language to point this out); and CMHCs should be added to this list of programs which can be utilized to provide remote site training, which now includes neighborhood health centers and family health centers.

In addition, we would like to suggest one important amendment to the remote site training program to require that a set percentage of these funds be used specifically for mental health program training. We suggest at least 15%, which is in in line with other mental health set asides in the Comprehensive Health Services legislation and Head Start program. Schools would be free, of course, to spend more than this amount if they so chose.

The need for such a set aside is twofold: first the history of federal health programs designed to meet general health and mental health needs shows that unless some specific requirement is built in, mental health is discriminated against in terms of funding. Secondly, a set aside for mental health would result in greater attention being paid by many residents—not only those specializing in psychiatry—to this important area. Mental health is not solely a medical specialty. The set aside for mental health is not intended to single out one group of residents for special treatment—it is proposed as a means of ensuring that many students receive some exposure in this area. For instance, mental health training for primary care physicians would seem to be essential, and it would be of benefit to many others.

Finally, we would like to endorse the principle expressed through this legislation that students benefitting from federal funding of health manpower programs should be required to pay back the federal government or to serve for a period in the National Health Service Corps. However, we would strongly urge you to consider expanding this requirement for service in the Corps so as to include all students benefitting from federal aid to medical schools.

Our suggested amendments to the bill and to the report, relating to training of physician assistants and nurse practitioners, allied health training, requirements for remote site training and AHECs, are enclosed.

Sincerely,

JONAS V. MORRIS,
Governmental Affairs.

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Enclosure.

NCCMHC SUGGESTED AMENDMENTS TO HEALTH MANPOWER BILL, H.R. 17084

The following amendments are suggested to H.R. 17084—new language is italic.

1. Training of Physician Assistants and Nurse Practitioners

Sec. 101(c)(7): line 21 of page 2: amend to read:
"to effectively provide primary health *or mental health* care under the"
and line 4 of page 3: amend to read:
"students to deliver primary health *or mental health* care and (ii) a"
and, line 12 of page 3: amend to read:
"be qualified to effectively provide primary health *or mental* health care"
and line 20 of page 3: amend to read:
"nurses to deliver primary health *or mental health* care and (ii) a"

2. Allied Health Training

Sec. 795, line 2 of page 98: amend to read:
"and other health *or mental health* professionals in the delivery of health"

3. Grants for Health Professions Schools, Requirements for Remote Site Training

Sec. 771(b)(1)(B)(ii): beginning on line 15, page 66: amend to read:
"(I) the application for a grant under section 770 of each school which has joined in the submission of the plan contains or is supported by reasonable assurances satisfactory to the Secretary that each such school will obligate to implement the plan an amount equal to not less than 25 percentum of the amount received under such grants; *and further, if the application for a grant is made by a School of Medicine, that not less than an amount equal to 15 per centum of the amount expended pursuant to this section will be used for training full-time students and students enrolled in programs for the training of physicians assistants, in mental health facilities or programs.*"

CALIFORNIA SCHOOL OF PROFESSIONAL PSYCHOLOGY,
San Francisco, Calif., February 18, 1975.

Congressman PAUL G. ROGERS,
House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: I very much appreciate your consideration of amending professional schools of psychology into the Health Manpower Act of 1975, H.R. 2956. I bring this matter to your attention not simply because I view psychology as a health profession and appropriate to include in this Act, but because support of this stage in the development of our professional schools, as a new avenue for the training of psychologists, could have maximum impact and substantially increase the production of needed health manpower.

Let me set the issue in context. As I believe you know, there are departments of psychology in most major universities across the country. Recent reports from the American Psychological Association indicate that there are 134 doctoral level programs in clinical psychology, of which 98 are accredited by the Association. Collectively, all the graduate departments awarded just over 2,600 Ph.D.'s in 1973. Doctorates in professional and clinical psychology (the largest specialty group) totaled 833, for an average of 6.2 from each of these 134 programs.

The departments of psychology at both Baylor and Illinois, have established separate divisions of psychology awarding the Psy.D., as has the Hahnemann Medical School (Department of Psychiatry) in Philadelphia. Though providing a welcome emphasis on professional psychology, each has total graduate student body of from 35–50 so that the annual yield will be on the order of 10–15 doctorates apiece. Some variants on this theme are under consideration in a few other locations.

The professional school of psychology, however, is characterized by having a separate administration and budget. It is not a component of a university department or other professional school. They are presided over by a dean or person of higher academic rank. Moreover, the training is focused to the professional-

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scientist or frankly professional models where supervised clinical training is a major component of training from the outset, in contrast to the scientist-professional model of the traditional programs.

The California School of Professional Psychlogy is psychology's first autonomous, free-standing professional school and became operational in 1970. It was preceded by the establishment of a Graduate School of Psychology at the Fuller Theological Seminary in Pasadena, California. Then, in 1973, Adelphia University (N.Y.), with a long-standing emphasis on clinical psychology, established the second professional school of psychology within a university setting. With the current academic year, the New Jersey Graduate School of Applied and Professional Psychology opened at Rutgers. These are the four truly professional schools of psychology in the country, though several others are under close consideration. Implementing these new, more educationally productive and content relevant, programs is especially difficult in the present fiscal climate. Availability of support under the Health Manpower Training Act would have a real catalytic effect on the development of the professional school of psychology. The profession is ready and the product publicly needed.

The professional school predominantly trains clinical psychologists though there may be other doctoral specialties in professional psychology having a clear-out health focus, such as the child and family practice specialty at our Los Angeles Campus.

The years of masters' level study or qualifying years for doctoral candidacy are the periods when any significant level of attrition occurs. Thus, I would recommend for maximum return, that support be directed to the post masters, doctoral component of the training, essentially the last two to three years of what is ordinarily nine years of academic preparation.

The training costs in these later critical years are probably comparable to those of medicine and dentistry—specialized training clinics are needed. Rather than "captive" hospital settings and biological laboratories, there is a need for specialized training centers. The training is characterized by a heavy ratio of clinical supervision, which at the outside requires one full-time equivalent faculty member for not more than eight trainees. Moreover, the competence level of these clinical supervisors must be substantial.

The California School of Professional Psychology with its four campuses is clearly the largest of the present four. In 1975 from three campuses, we shall graduate close to 100 Ph.D.'s (contrast to the national total of 833 above), and when all campuses have reached maturity in 1978, assuming we can sustain our progress, we expect to graduate about 175 annually. The other professional schools of psychology also concentrate on training clinical psychologists. The program at Rutgers is too new to derive any reliable productivity estimates, Adelphi however will graduate about 25 Ph.D.'s annually, and Fuller about 16. It would be reasonable to estimate a collective output of 225 Ph.D.'s from these four programs, a very large share of the clinicians from but few schools. Again, developmental support at this stage could really significantly increase the training of psychology health manpower, and facilitate the development of additional training resources.

The number of clinical doctoral (past masters) candidates would currently be on the order of 240 at the California School of Professional Psychology (Fresno Campus still expanding), 80 at Fuller, 75 at Adelphi, and possibly reaching 60 at Rutgers; collectively, 455. Implementation of programs in New York and Ohio where they are under consideration and possibly other areas, could very substantially increase the output.

While there is a surplus of non-clinical new Ph. D.'s, there is a current shortage in the health field. Convention placement officers report more positions than candidates in clinical psychology, and we have yet to experience the impact of recent Federal health legislation in which psychology is explicitly recognized as a primary provider:

1. PL 93-112.—The Rehabilitation Act of 1973.
2. PL 93-363.—Amending the Federal Employees Health Benefits Act.
3. PL 93-222.—The Health Maintenance Organizations Development Act of 1973 (through the Regulations).
4. PL 93-416.—Amending the U.S. Code relating to work injuries compensation of Federal employees.
5. PL 93-203.—The Comprehensive Manpower Program (through the Regulations) (see also the Work Incentive Program (WIN)).

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These follow upon recognition under CHAMPUS accorded in 1970 and CHAMPVA in 1973. Also, there are now freedom of choice laws in 19 states (six passed in 1974), providing for direct access to psychologists in disability and health insurance plans. The advent of National Health Insurance will surely heighten the demand.

The CAMPUS experience gives some indication of the potential utilization of psychological services. In the ten state reporting area, psychologists were the providers for 19 percent of all outpatient visits in fiscal 1973, 23 percent in 1974, second only to psychiatry in volume.

Though clinical psychologists are active in a wide variety of health settings, and increasingly involved in the psychological aspects of all health problems, in general, the major proportion of their professional activity bears on mental disorder. Psychological practice is predominantly ambulatory in nature and the distribution of psychologists appears reasonably congruent to that of the general population.

The Biometrics Branch of N.I.M.H., based on a 1971 actual usage level of almost 2 percent, estimated that there were shortages in mental health personnel for services to children and the elderly. With comprehensive coverage under N.H.I., utilization will predictably rise as all persons are covered, raising the prospect of very significant manpower shortages.

It may be worth noting that the climate within the Administration towards recognition of clinical psychologists as primary health providers appears to have grown more positive. In his recent speech on November 21 before the Conference of State and Territorial Mental Health, Alcohol, nd Drug Abuse Authorities, then Assistant Secretary for Health, Doctor Charles Edwards commented, "The tradition that all services must be provided by a physician or under his guidance is now giving way to practical reality." "As an example of this trend . . . all government employees' insurance plans will permit payment for psychologists, without requiring a physician's supervision." He went on to say, "This more practical attitude should be enouraged by all of us."

I hope this provides a useful background for your consideration. The inclusion of the professional schools of psychology in the Health Manpwer Act of 1975, for the training of clinical psychologists, would have a catalytic impact on the production of these health professionals. I ask your support. If I can be of assistance in this matter, please call upon me.

Sincerely yours,

HERBERT DORKEN, Ph. D.,
Advisor in Program Development.

AMERICAN ASSOCIATION OF
MEDICAL ASSISTANTS, INC.,
Chicago, Ill., February 19, 1975.

Congressman PAUL G. ROGERS,
Chairman, Health Subcommittee, U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ROGERS: As you and your colleagues meet to consider legislation concerning allied health manpower, we would like to take the opportunity to acquaint you with the American Association of Medical Assistants and its member constituency. In previous allied health legislation and in several federal documents related to allied health, medical assisting has not been listed as an allied health vocation. We strongly hope this situation will be corrected in new or revised legislation because medical assistants are essential members of the health care team.

Virtually every practicing physician employs one to three medical assistants. Without them some 200,000 medical offices in this country literally could not function. Indispensable to the physician's practice, these assistants carry enormous responsibility—to a degree unequalled by most other allied health practitioners.

The typical medical assistant carries responsibility in both administrative and clinical areas of the medical office practice, with duties ranging from scheduling appointments to assisting with physical examinations, from completing insurance forms to performing routine laboratory tests. Enclosed is a list of the duties the medical assistant is trained to perform, and a brief perusal will show you that

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the medical assistant is one of the most versatile of all allied health personnel.

Perhaps it is because of their varied responsibilities that medical assistants have had an identity problem. Unlike other allied health professionals who have a narrow but clearly defined and specialized role in the hospital or clinic setting, the medical assistant is a generalist—one capable of performing many different tasks in the physician's office. There is no doubt that such variety has diluted the medical assistant's identity in the minds of some legislators, HEW officials, and the public at large.

AAMA's efforts to rectify this situation have made some headway recently. Last June a Senator introduced into the June 19, 1974, Congressional Record a statement asking Congress to recognize the role played by medical asisstants in the health care system in this country. Generally, however, the government has failed to recognize the occupation in federal documents and publications.

This lack of recognition works not only to our disadvantage but also to that of schools and colleges offering medical assisting programs. Qualified instructors are critically needed in this field, but federal funding for training institutes has been denied because of the preferential treatment accorded allied health vocations more easily defined than ours. (See attached excerpt from HEW publication entitled "Allied Health Professions: Grants for Training Institutes.")

In serving as the spokesman for the occupation, we would like you to have information on the nature and scope of this association.

AAMA is a non-profit organization which is by far the largest, most influential, and active organization representing medical assistants. In recognition of the important role of medical assistants, the American Medical Association's House of Delegates has formally commended the objectives and accomplishments of AAMA on five separate occasions since 1956 (copies enclosed). AAMA is the only allied health organization singled out for such repeated accolades of this type.

The association is composed of practicing medical assistants whose primary objectives are (1) to inspire its members to serve the medical field and the public, and (2) to provide educational services to increase the knowledge and professionalism of its members. We have made great strides in the past decade to meet these objectives. Among our primary accomplishments are widely respected programs in accrediting educational programs for medical assistants and in credentialing competent medical assistants.

ACCREDITATION OF EDUCATIONAL PROGRAMS

Years ago physicians were obliged to train their own office employees, because there were no educational programs in this field. With encouragement from the American Medical Association and AAMA, who led the way in setting curriculum standards, schools and colleges began to inaugurate medical assisting programs.

In 1974, AAMA and the AMA Council on Medical Education were collaboratively recognized by the U.S. Commissioner of Education as an official agency to accredit medical assisting programs in both public and proprietary institutions. As of February 1975, 95 medical assisting programs in 89 institutions have been accredited, and a continuous stream of other institutions are applying for accreditation.

AAMA also collaborates with AMA and the American Academy of Pediatrics to accredit programs for the medical assistant in the field of pediatrics. We are also currently collaborating with AMA and two ophthalmological organizations on the development of a curriculum for the ophthalmic medical assistant.

CREDENTIALING FOR COMPENTENCY

AAMA conducts a nation-wide certification program for medical assistants who demonstrate a high level of competency by passing examinations which test both clinical and administrative competency in either general or pediatric medical assisting. The interest in this program the past few years has been phenomenal; this year alone more than 2,300 individuals have applied to take the examination.

According to the Bureau of Labor Statistics, U.S. Department of Labor, opportunities for employment of medical assistants are expected to be excellent through the 1970's, and rapid growth in the occupation is predicted during the next decade.

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Because medical assisting is an essential health occupation, because the demand for qualified, trained assistants is increasing rapidly, and because there is great need for a deeper awareness of the occupational entity, AAMA urges you and your fellow Congressmen (1) to include medical assisting in the lexicon of allied health careers to be covered by pending legislation and (2) to encourage inclusion of this essential occupation in government publications related to allied health.

Sincerely yours,

DENE R. MURRAY,
Executive Director.

Enclosures.

DUTIES OF A MEDICAL ASSISTANT

Listed below are the duties performed by one or more medical assistants in the average medical office:

1. Effectively schedule appointments (in person and by telephone).
2. Pull patients' files for day' tm.spspoaentin S9.h
3. Receive patients.
4. Take and record patient's statistical data and medical history at request of the physician.
5. Prepare and drape patients for examination.
6. Take blood pressures and temperatures and weigh patients.
7. At the doctor's request and under his supervision:
   a. Collect blood samples.
   b. Take ECG's.
   c. Perform basal metabolism tests.
8. Assist the physician with patient examinations, treatment and minor surgery.
9. Give certain medications and injections under the doctor's supervision.
10. Explain the nature of examination, diagnostic tests, and/or treatment to the patient at doctor's request.
11. Know how to handle patients when the physician is away from the office.
12. Assist in the collection of specimens (Pap smears, throat cultures).
13. Set up patients' files, enter notes or make corrections on records; review them for completeness and accuracy.
14. Review, separate and purge medical record files as instructed.
15. Obtain patient's signature on permission forms (to release records, to operate, or to perform diagnostic procedures).
16. Arrange hospital admissions and/or laboratory and x-ray procedures, as requested by the physician, and advise patients accordingly.
17. Schedule surgeries.
13. Set up patients' files, enter notes or make corrections on records; review
19. Perform simple routine laboratory procedures (urinalysis, simple blood tests); collect and prepare specimens for transportation to laboratory.
20. Record and maintain laboratory, x-ray and ECG data on patients' records.
21. Instruct patients regarding proper preparation for tests ordered by the physician.
22. Prepare and replenish supplies in doctor's bag so that it is in constant readiness.
23. Sterilize instruments and assume maintenance of diagnostic equipment.
24. Dispose of contaminated and disposable items.
25. Receive and organize the handling of medication samples.
26. Order office, laboratory, and medical supplies, and maintain inventory of all three.
27. Handle emergencies:
a. Know how to reach the physician when he is out of the office.
b. Seek help from qualified nurse or another physician.
c. Describe nature of patient's illness or injury.
d. Position patient in safe and comfortable position.
e. Apply first aid if necessary.
f. Call poison control center.
g. Arrange for hospital emergency room treatment.
h. Explain doctor's unavailability to patients in reception room.
28. Handle the telephone:
a. Check with answering service and record messages.
b. Make appointments.

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c. Make calls for the physician.
d. Receive calls from patients, laboratories, other physicians, solicitors, and the doctor's family.
e. Answer questions concerning the patient's illness and the doctor's fees and hours.
f. Take laboratory reports.
29. Deal with representatives of pharmaceutical companies, equipment manufacturers, other physicians, doctor's family, and other callers.
30. Handle children accompanying patients.
31. Supervise maintenance personnel (cleaning and other), and see that the office is kept in a neat, attractive and sanitary condition at all times.
32. Supervise other office personnel.
33. Handle correspondence:
a. Incoming: (1) Open and sort mail, screening it in accord with the doctor's wishes; (2) Flag important mail to his attention; (3) Summarize articles and other materials as requested.
b. Outgoing: (1) Answer the doctor's routine mail, upon instruction from him as to handling; (2) Take medical dictation; (3) Transcribe shorthand or machine dictation; (4) Type all correspondence, including medical reports to other physicians, insurance reports, and other types of reports.
34. File all correspondnce and medical records, including x-rays, and ECG's.
35. Operate business machines and assume responsibility for their maintenance.
36. Perform daily posting of charges and collections.
37. Arrange meetings, conferences and/or travel accommodations.
38. Prepare monthly statements.
39. Handle credit arrangements with patients.
40. Assist with follow-up collections.
41. Handle payments by cash and/or check and make out receipts.
42. Keep financial records (daily record of charges and payments; records of accounts receivable; trial balance; monthly profit and loss sheet).
43. Prepare payroll and any necessary government forms (withholding, FICA, unemployment, state disability).
44. Pay professional bills.
45. Assume all banking duties (regular deposits, reconciling bank statements).
46. Prepare information for accountant for tax returns.
47. Discuss and explain the doctor's fees to patients.
48. Accept, endorse and record checks reecived for payment on account.
49. Establish and control petty cash fund.
50. Discuss and explain insurance coverage to patients.
51. Complete insurance forms:

a. Indemnity insurance forms for patients to submit his claim.
b. Forms for filing assigned insurance claims.
c. Medicare payment request forms.
d. Medicaid Claim forms.
e. Workmen's compensation forms.
f. Blue Shield payment request forms.

52. Review and, if necessary, appeal insurance disallowances to achieve satisfactory resolution.
53. Gather data to complete statutory reports for government agencies.
54. Attend meetings and participate in community activities related to the doctor's practice.

—Developed by the AAMA Curriculum Review Board.

* * *

EXCERPT FROM HEW PUBLICATION: "ALLIED HEALTH PROFESSIONS: GRANTS FOR TRAINING INSTITUTES"

REVIEW CRITERIA

Factors that will be considered in evaluating grant applications include the following:
1. Relationship of the contents of the course to: a. The stated objectives of this grant program; b. The training needs in current and emerging allied health program areas.

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2. Clarity and completeness of the course description.
3. Appropriateness and effectiveness of teaching methods in achieving training objectives.
4. Qualifications of the instructional staff.
5. Prospective composition of the group to be trained.
6. Cost of the proposed training relative to the objectives.
7. Success of previous offerings of this course, or related courses, if any.
8. Evidence of ability to recruit trainees and estimated number to be accommodated during each offering.
9. Methods proposed to evaluate effectiveness of the training.

In the review of applications for support for Training Institute Grants, priority will be given in the following order to:

A. Programs designed to provide advanced training to individuals to serve as allied health educators in the following categories:

Baccalaureate Level

Dential Hygienist; Dietitian; Medical Record Librarian; Medical Technologist; Occupational Therapist; Optometric Technologist; Physical Therapist; Radiologic Technologist; Sanitarian.

Associate of Arts Degree Level

Dental Assistant; Dental Laboratory Technician; Dietary Technician; Inhalation Therapy Technician; Medical Laboratory Technician; Medical Record Technician; Occupational Therapy Assistant; Opthalmic Assistant; Optometric Technician; Sanitarian Technician; X-ray Technician.

B. Programs designed to provide advanced training to individuals to serve as allied health administrators, supervisors, and specialists in the above categories.

* * *

AMERICAN MEDICAL ASSOCIATION

HOUSE OF DELEGATES ANNUAL CONVENTION, CHICAGO, ILL.

RESOLUTION

(Passed Unanimously, June 25, 1974)

Introduced by: California Delegation.
Subject: #109 American Association of Medical Assistants.

Whereas, the American Association of Medical Assistants is not only an outstanding professional organization dedicated to the education and self-improvement of medical assistants, but is the one and only professional organization endorsed and continuously supported through liaison activities by organized medicine at all levels; and

Whereas, it is recognized that the loyalty and allegiance and devotion of the members of this organization to their doctor-employers and to organized medicine in the majority of instances goes well beyond the common grounds of employer-employee relationship; and

Whereas, the Medical Assistants Association is probably the most constant, able and devoted ally of the medical profession; and

Whereas, the American Association of Medical Assistants is a nonprofit organization, totally pledged against ever becoming a union; therefore be it

Resolved, That the American Medical Association hereby commend the American Association of Medical Assistants for their devotion and accomplishments in the field of medical assistant education, both locally and nationally; and be it further

Resolved, That the American Medical Association request all state medical associations to continue active, formal support of this organization and further urges individual physicians to pay the dues of their medical assistants so that membership in this most important and worthwhile organization will continue to grow.

* * *

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HOUSE OF DELEGATES CLINICAL SESSION, DENVER, COLO.

RESOLUTION

December 2, 1969

Introduced by: Oklahoma Delegation.
Subject: No. 37—Support of American Association of Medical Assistants; No. 38—Medical Assistants' Placement Bureaus.

Resolutions 37 and 38 strongly supported the work of the American Association of Medical Assistants and encouraged medical societies to develop placement bureaus for medical assistants.

Because both resolutions were directed toward the same general objective, the following combined Resolution was passed unanimously:

Resolved, That the House of Delegates of the American Medical Association urge constituent and county medical societies to establish placement bureaus for medical assistants as a service to such personnel; and be it further

Resolved, That the American Medical Association reaffirm its support of the American Association of Medical Assistants and its purposes of advancing the education and upgrading the services of its members; and be it further

Resolved, That the House of Delegates encourage the individual members of the American Medical Association to urge their employees to become AAMA members by offering whatever incentives appear to be appropriate.

* * *

HOUSE OF DELEGATES, HOUSTON, TEX.

RESOLUTION

(Passed November 27, 1967)

Introduced by: Texas Delegation.
Subject: Physician Encouragement of American Association of Medical Assistants and its Education Programs.

Whereas, the American Association of Medical Assistants has achieved a membership of more than 12,000 in less than 10 years, and

Whereas, even with that impressive growth, the potential membership of AAMA doubtless is 20 times that number, and

Whereas, physicians should stimulate membership and participation in this fine national organization which endeavors to make even more effective allies of those who work for them in their offices and in hospitals in the interest of patient care, and

Whereas, physicians can profit by reviewing the AAMA's objectives and programs which are set forth in pamphlets which are available from its headquarters at 510 North Dearborn Street,[1] Chicago, therefore be it

Resolved, That the AMA House of Delegates urges every physician to become fully acquainted with the objectives and programs of the American Association of Medical Assistants, and to encourage his own assistants to seek membership in the national organization and its local and state affiliates, and to participate in their educational and certification programs.

* * *

HOUSE OF DELEGATES, LOS ANGELES, CALIF.

RESOLUTION

(Passed November 28, 1962)

Introduced by: Nevada Delegation.
Subject: American Association of Medical Assistants.

Whereas, the American Association of Medical Assistants has as its objectives basically the same purposes as the American Medical Association; and

Whereas, the American Association of Medical Assistants has, in its short span of six years growth, rendered inestimable services not only to the people of America but also to the medical profession; and

Whereas, the potential for growth and service of the American Association of Medical Assistants is recognized by the American Medical Association; therefore be it

[1] Current address: One East Wacker Drive, Chicago, Illinois 60601.

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Resolved, That the American Medical Association express to the American Association of Medical Assistants its sincere appreciation for the dedicated and unselfish assistance and work in the combined goal of the two organizations in continually striving to improve the character of medical standards; and be it further

Resolved, That the American Medical Association wholeheartedly endorse the program and functions of the American Association of Medical Assistants and encourages every physician who has in his employ or under his supervision medical assistants who are eligible for membership in the American Association of Medical Assistants to urge all these assistants not only to join the American Association of Medical Assistants but to actively participate in their programs.

* * *

HOUSE OF DELEGATES, SEATTLE, WASH.

RESOLUTION

(Passed November 27, 1956)

Introduced by: G. F. Gsell, M.D., Delegate, Kansas Society.
Subject: Suggested Resolution Commending Medical Assistants Organizations.

Whereas, a national organization, the American Association of Medical Assistants, recently has been formed, and

Whereas, fourteen state medical assistant associations were represented at this organizational meeting, and

Whereas, the objectives of this organization are to inspire members to render honest, loyal, more efficient services to the profession and the public; to strive to cooperate with the profession in improving public relations; to render educational services for the self-improvement of its members and to stimulate a feeling of fellowship and cooperation among the societies; and to encourage and assist in forming local and state assistants societies, and

Whereas, many county and state medical societies have endorsed or sponsored medical assistants organizations, and many physicians served as advisors to local and state associations, and

Whereas, a physicians advisory committee to the American Association of Medical Assistants is provided for in their constitution and by-laws, therefore be it

Resolved, That the American Medical Association commends the objectives of the American Association of Medical Assistants and its sincere desire to work closely with the medical profession in improving medical service and medical public relations.

PHYSICIANS NATIONAL HOUSESTAFF ASSOCIATION,
Washington, D.C., February 21, 1975.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee Health & the Environment, House Interstate and Foreign Commerce Committee, House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: As President of the Physicians National Housestaff Association, I would like to express the views of our organization on certain aspects of H.R. 2956. Time and space do not allow a comprehensive discussion and presentation of our philosophy at this moment. Since we did not have the chance to testify previously, I would hope that the opportunity would be made available for our expanded views to be heard at a future date.

The PNHA is an independent organization founded in 1972, composed of over 100 local Housestaff organizations representing over 10,000 interns and residents in the United States. Our goals are to improve patient care and working conditions in teaching hospitals and clinics. We advocate the use of collective bargaining in our employee relationships with these institutions. The average house officer is about 27 years old, works from 70 to 100 hours per week, and is approximately $5,000 in debt. He earns a starting salary of about $10,700 per year, and his hourly wage often falls below that of many other hospital employees.

PNHA also represents uniformed service physicians serving two-year obligations, including those in the U.S. Public Health Service. PNHA is vitally concerned about the impact of manpower legislation on patient care and working conditions in the hospitals and clinics we serve. We recognize many problems in health care delivery in the United States, a major one being the lack of a comprehensive

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system in which health professionals and institutions are responsive and accountable to the needs and desires of the public. This accountability should extend to the expenditure of public funds. H.R. 2956 establishes the principle of accountability for funds used to help subsidize medical education. In essence, the bill attacks conditions for the receipt of federal financial assistance to institutions and students involved in health education. PNHA supports this concept as a legitimate public policy position. We do take issue, however, with certain specific provisions incorporated in the proposed legislation, as will be discussed below.

The problems of maldistribution of physicians by geography and specialty were well documented by testimony before your Committee last year. We are especially impressed and concerned with the fact that, despite efforts by the private sector and government at all levels, the maldistribution problem appears to be increasing in magnitude.

It is clear that a new approach to this major problem is indicated and PNHA supports the concept of a service obligation in return for scholarship assistance. We are concerned, however, that an expanded program of scholarships with service obligations and loans with service payback might discriminate unfairly against low income students who might selectively be forced into service obligations. We therefore support the concept of:

1. Equitable access to scholarships and loans for all students who wish to volunteer. The scholarships should cover tuition and a cost-of-living allowance. The loans should inculde forgiveness in return for service.

2. Special low interest loans to disadvantaged students who prefer not to accept a scholarship or loan with obligatory service requirements.

3. A stringent buy-out provision for scholarship recipients defaulting on service obligations. Students who do not complete training or physicians who fail to become licensed should be exempted from such an extra burden.

4. A rational approach to manpower allocation for service obligation programs such that the needs of both rural *and* urban communities are met (see later discussion on designation of areas).

Regarding capitation grants to medical schools, PNHA supports the continuation of this type of federal funding and agrees with the concept of quid pro quo requirements as conditions for receipt of capitation. We do, however, take issue with the capitation payback requirement for all students for the following reasons:

1. It amounts to a forced loan that is without precedent and is discriminatory against health professional students, especially those from low income families.

2. It puts the responsibility for solving manpower distributing problems solely on students, thereby decreasing federal leverage on the medical education system itself.

3. It would place overemphasis on a payback mechanism, when the real need is the initiation of necessary innovation in medical schools.

Unfortunately, the whole area of service obligations does not discuss the long-term ramifications of such programs. There are critical questions to be answered:

1. Will the service positions be able to retain the manpower rotating through?

2. Will a system of two-year rotating physicians practicing in underserved areas lead to an unsatisfactory two-class approach to health care delivery?

3. Will problems of morale and inadequate funding determine this federally organized effort?

4. Will overemphasis on primary care lead to a deterioration in specialty care delivery

We hope the answers to these questions are no. Progressive, constructive ongoing problem-solving in these areas will be needed based on a harmonious effort by the medical profession, government and general public working together. This element has obviously been lacking in the past and PNHA is willing to work with the government and the health consumer for achievement of the goals outlined in this manpower legislation.

Next, we find the service options contained in the legislation to be too limited. PNHA agrees with the testimony presented to your committee, which demonstrated a major lack of primary care providers in rural and inner city areas. Indeed, we would recomend that a better definition of medical underservice be developed which allows recognition of pockets of inner city underservice in geographical units smaller than the census tracts. We note that current National Health Service Corps designations almost completely ignore the health problems of the urban dwellers. As housestaff working predominantly in large urban hospitals, we know there is a massive lack of quality primary care services being provided to our patients. A major priority for service, then, should be to *both* rural and urban medically under-served populations.

In addition, there are other locations of under service which have not been

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considered in testimony or adequately incorporated into the proposed legislation—specifically public hospital facilities. The health consumer is well aware of the problems of waiting times in emergency rooms and in hospital ambulatory care facilities in the inner city. As PNHA helps housestaff to fight for basic minimum rights as employees and improvements to patient care, the problems of a lack of sufficient manpower in public hospitals and clinics become a very key issue. With threatened reductions in numbers of housestaff positions later in the legislation, the question arises as to who will help provide the care in the hospitals where housestaff are the primary physicians.

PNHA therefore recomends that criteria be established which will permit designation of inadequately staffed public hospital, emergency room and clinic facilities as areas of medical underservice. Physicians completing residencies could elect to serve their obligation in these areas, resulting in better distribution of manpower and improved care for patients.

In calling for improvement in the supply of urban health manpower we naturally have a question related to the issue of residency allocation, which establishes an arbitrary limitation on the number of residency positions. We feel that proper consideration has not been given to whether house officer staffing would be adequate to support ongoing patient care requirements. The legislation seems to assume that residency is merely a training requirement for becoming a practitioner at a later date. By allocating positions by hospital specialty, the legislation might well have the desirable affect of re-aligning the geographic and specialty distribution of post residency medical practitioners. However, residents are not merely trainees but also employed full-time practitioners who spend over 70% of their time delivering care and who in the current health care delivery system are irreplaceable. If the bill would limit the number of residencies available, an already over-burdened housestaff would be expected to perform even more prodigious feats, an unfair and unrealistic expectation.

In short, the first year residency allocation established at 125% of graduating medical students in any given year is questionable. With a significant expansion of medical school enrollment, such a determination might be reasonable. At current or slight increased levels of graduates, the 125% provision would exacerbate a problem which presently forces health institutions to realize large numbers of foreign medical graduates as cheap labor, some of whom do not receive the support required to carry out their responsibilities.

It is estimated that several thousand residencies might be lost. We feel it is obvious that the impact of the loss of this physician manpower pool must be studied. This loss would probably be sustained across a broad spectrum of both university affiliated and non-affiliated teaching hospitals. In fact, the non-affiliated teaching hospitals which are suspected of providing questionable training, comprise only 10% of the residency slots in question. We feel that the arbitrary limitation on positions available to FMGs should be deferred until adequate increases in domestic medical enrollment have been achieved. This expansion should be an immediate priority. While a study is being carried out, PNHA proposes a freeze on the overall number of residencies being offered in the United States.

Finally, the foreign medical graduates physicians who have been under attack deserve to be heard. Attached to this letter is a copy of a task force report on the foreign medical graduate situation entitled Foreign Medical Graduates in Medical Education and Health Care in the United States: Analysis and Recommendations.[1] It is authored by Drs. Thampy, Swarajan, Smith, and Tarr; three of whom are FMGs. It eloquently states the position of the FMG physician and refutes many of the misconceptions that have been perpetrated against these physicians who have served the United States so well in time of need.

Thank you for your attention to this letter and statement. PNHA welcomes the opportunity to provide any assistance desired by the committee.

Sincerely,

ROBERT G. HARMON, M.D., *President.*

[1] May be found in committee files.

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COUNCIL FOR THE ADVANCEMENT OF THE PSYCHOLOGICAL PROFESSIONS AND SCIENCES,
Washington, D.C., February 25, 1975.

Hon. PAUL G. ROGERS,
Chairman, Public Health and Environment Subcommittee, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Rayburn House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: Transmitted herewith is a communication from Gordon F. Derner, Ph. D., Dean of the Institute of Advanced Psychological Studies, Adelphi University, Garden City, New York. Dean Derner is herein indicating support for the inclusion of psychology in *H.R. 2956, "Health Manpower Act of 1975."*

I would ask that Dean Derner's communication be included in the record of hearings on February 21, 1975, under the auspices of the Institute.

Many thanks.

Sincerely,

JACK DONAHUE, *Executive Director.*

Enclosure.

[Mailgram]

GARDEN CITY, N.Y., *February 2, 1975.*

JACK DONAHUE,
I St. NW.
Washington, D.C.

In reference to the Health Manpower Act of 1975, H.R. 17084, may I encourage the inclusion of psychology as a discipline warranting support as a health field. A very sizeable proportion of people suffering from illness have problems requiring psychological intercession, further in institutions where psychological services are available incidence of need for other medical help has decreased. Psychological services are especially needed for children, as dean of the first university based professional school in psychology I have had continuing contact with a large number of highly qualified applicants who cannot be admitted and therefore the public is deprived of their services. Since most graduates work in public clinics and hospitals their services are available at a much needed point of entry. Programs for training such personnel are handicapped by the shortage of funds which bring about limitations in the size of newly admitted classes. May I therefore respectfully recommend that psychology be included as one of the 7 disciplines to receive health manpower training benefits.

GORDON F. DERNER, *Dean,*
The Institute of Advanced Psychological Studies,
Adelphi University.

AMERICAN COLLEGE OF RADIOLOGY,
Chicago, Ill., Chevy Chase, Md., February 26, 1975.

Hon. PAUL ROGERS,
Subcommittee on Health, Committee on Commerce, Rayburn Office Building, Washington, D.C.

DEAR MR. ROGERS: The enclosed material is submitted to you and your colleagues on the Subcommittee on Health on behalf of the 9600 members of the American College of Radiology, the physician specialists who use X-rays and other forms of radiation for the diagnosis and treatment of disease.

For more than a decade, members of the College have been concerned about the supply of radiologic manpower to meet the nation's needs for our services. From a position of recognized shortage in 1964, we moved to a vigorous program of recruitment and expansion of training programs which doubled the ranks of the specialty since that time.

Three years ago, we felt it appropriate to begin making our own detailed assessment of our response and of the nation's projected needs for radiologic services. The enclosed preliminary report is the result of our fact finding and deliberations. We expect to continue refining and updating the materials in it. However, we are now satisfied that the major conclusions are valid and that the areas of concern identified are significant to the future ability of the specialty to provide needed services to Americans.

We would submit the entire report for your files and for the committee's reference. We would respectfully request that this letter and section II, the con-

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clusions of the report, be made part of the record of your hearings on HR 2956 and other health manpower proposals.

Sincerely,

PAUL A. RIEMENSCHNEIDER, M.D.,
President, Chairman ad hoc Committee on Manpower Studies.

SECTION II.—CONCLUSIONS

1. The Task Force concludes that, overall, at the present time there exists neither a substantial shortage nor an impending surplus of radiologists and that an increase in the number of residents being trained is not indicated. At the same time any substantial decrease in the number of residents will lead to a significant shortage of manpower in the near future. Such a decrease might come to pass if, as appears likely, programs in general radiology are discontinued in the near future and/or restrictive measures are adopted regarding foreign medical graduates. Although there appears to be a state of equilibrium in respect to the factors of demand for services, availability of services and training of additional radiologists this steady state is only true when viewed on a national basis and in the milieu of medical practice as carried out today.

2. There appears to be a geographic imbalance in the distribution of radiologists and presumably the availability of their services. This imbalance favors certain states in the southwest and northeast regions as well as the state of Florida.

3. A shortage of fully trained therapeutic radiologists exists and will likely persist until well into the 1980's. The Task Force believes special efforts should be made to upgrade the skills and knowledge of general radiologists in order to maximize their ability to partially fill this void.

4. It appears that some 70% of imaging procedures in nuclear medicine are performed by radiologists and that radiology clearly predominates among departments responsible for providing nuclear medicine services. Current information suggests a need for more residents in this field.

5. The survey carried out by the Task Force suggests a possible need to train more residents in sub-specialties of diagnostic radiology such as pediatric radiology, neuroradiology, cardiac radiology and vascular radiology. Because of the small numbers involved in these sub-specialties and because the survey included only nine states, the Task Force believes additional information on these needs should be obtained before more definitive conclusions are reached.

6. It has been estimated that currently there is a shortage of 150 radiologists in the federal services. Special attention may be needed to meet the ongoing requirement of the federal services.

7. Over the past ten years encouraging progress appears to have been made in respect to increasing the number of full-time positions in radiology in United States medical schools. The possibility that this progress may be more apparent than real is discussed in Section II.

8. An ongoing body of the College should be charged with the responsibility for continuation of the surveillance, analytic and reporting functions begun by the Task Force and its predecessors. This body should report to the Council and Board of Chancellors as necessary but at least every five years. Time and resources have limited the extent to which the important subject of *facilities* could be addressed in this report. Further, the Task Force was also charged with studying the manpower situation in Canada. This matter is being given consideration by the Canadian Association of Radiologists and interchange of information should be carried out between the ACR and the CAR. Moreover, we live in a rapidly changing world and there are many factors which in isolation or in concert can markedly change the situation as it looks today in regard to radiological services and manpower. Tables 1 and 2 list some of the factors.

TABLE 1.—SOME FACTORS CONTRIBUTING TO INCREASED DEMAND

Any kind of national health care insurance plan (because of upsurge in demand for medical care).
HMOs (because of lack of financial dis-incentives to the patients).

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"Preventicare" with survey radiological examination (despite absence of justifiable clinical yields).
Efforts, if successful, to deliver medical services to urban "have-nots".
Increasing complexity of radiologic examinations with more radiologist time per procedure.
Restriction of provision of radiologic services to qualified specialists (as in Kennedy-Griffith bill.)
Improvement in radiation therapy.
Expansion of nuclear medicine and increased participation in the field by radiologists.
Increased role of radiologists in ultra sound, thermography and other imaging modalities.
Expansion of occupational health programs (pneumoconiosis, etc.).
Continued population growth.
New medical schools
Larger radiologic faculties.

TABLE 2.—SOME FACTORS CONTRIBUTING TO DECREASED DEMAND

Influence of more widespread knowledge and concern among physicians regarding benefit-risk problems in diagnostic radiology.
Influence of efficacy studies.
Influence of peer review.
Restrictions on payment for radiological services.
Performance of radiological procedures by other than radiologists.
Increased use of allied health personnel
Mechanisms for increasing the radiologist's efficiency.
Centralization and regionalization of radiation therapy.
Rationalization of malpractice claims with ultimate decrease in diagnostic examinations for "medico-legal" purposes.
Zero population growth.

NATIONAL MEDICAL ASSOCIATION, INC.,
Washington, D.C., February 27, 1975.

Hon. PAUL G. ROGERS
Chairman, Subcommittee on Health and the Environment, Interstate and Foreign Commerce Committee, Rayburn House Office Building, Washington, D.C.

DEAR MR. ROGERS: In response to the notification in the Congressional Record of February 6, 1975, the National Medical Association (NMA) wishes to comment on HR 2956—the Health Manpower Act of 1975 which we understand to be identical with HR 17804, as enacted by the House of Representatives in December of 1974.

We wish to express:

1. Unequivocal opposition to that part of Section 771 which stipulates that beginning in school year 1976–77, each medical school as a condition of further capitation support would contract with each student enrolled in the school whereby each student would agree to pay back to the Federal Government the amount which the medical school received from the Federal Government to educate such student;

2. Conditional opposition to Section 1401 which would impose an absolute limit on the number of medical residencies, and which would empower DHEW, acting through the Coordinating Council on Medical Education, to determine the number and location of all medical residencies;

3. Strong support for the retention and full-scale development of the Physician Shortage Area Scholarship Program (Section 784 of the Public Health Service Act); and

4. Unalterable support for Section 782, which aids efforts to recruit and retain disadvantaged minorities into health professions schools.

In the subsequent abbreviated discussion, the National Medical Association (NMA) recommends alternative approaches to those features of the legislation which we are prompted to oppose for reasons of conscience and conviction.

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DISCUSSION

NMA's position relative to the requirement that Students Repayment for Capitation Support Provided to Medical Schools—and—Retention of the Physician Shortage Area Scholarship Program.

Payback by students of capitation funds advanced by the Federal Government to medical schools is unprecedented as well as unconscionable. Effecting the requirements of Section 77(a)(3)(c) would only result in burdening a student in a manner which forces him/her to opt for enlistment in the National Health Service Corps or contracting with the Secretary to practice primary care in a shortage area. This provision has too much of the element of coercion to be conscionable.

NMA fails to see the need for so drastic a measure. We believe the approach of the Senate (Beall amendment) adopted on September 24, 1974 (120 Cong. Rec. S17430) is by far superior, as well as, more preferable. Under the Beall approach, capitation assistance to medical schools would be conditioned by a requirement that 25 percent of persons accepted for admission to each medical school must agree to practice general, internal medicine, family medicine, or general pediatrics in a shortage area for a two-year period. Such service could be performed in the National Health Service Corps which the Senate's version continues or by reason of agreements made under the National Health Service Corps.

While not opposed to the National Health Service Corps, we believe it should not be the only program providing physicians for shortage areas. As the Committee's own report indicates (see House Report 93–1509 at page 34) the National Health Service Corps (NHSC) has located 85 percent of its projects in rural areas, and only 15 percent in urban areas, as the Committee points out, NHSC has given *insufficient emphasis* to the needs of urban areas containing populations which experience critical shortages of and access to personal health services. Given the historical inability of the NHSC to meet the needs of urban inner city areas, it would be the height of folly to abandon the Physician Shortage Area Program (PSAP) since it is the only program which allows a student who is from a physician shortage area to receive funding for his education upon his agreement to return on a service for scholarship basis to that area to engage in the practice of primary care. PSAP, while not funded for much of the period it has been on the books, would, in our view, be the one viable vehicle to assure available, accessible and continuous primary care to residents of inner city areas within urban America.

Opposition to Limitation on the Number of Residencies—Opposition to the DHEW Establishing Medical School Residency Programs

NMA fully recognizes that there are geographic imbalances and *perhaps* far too many general surgeons, as distinct from primary practitioners. We are in agreement with those who urge that not less than 50 percent of residency positions should be in the primary care specialties of general internal medicine, general pediatrics, and family medicine. However, we do not agree that allocation of residencies through a Federal fiat is the solution. We would urge that the Committee achieve these goals by a review of the legislation to ascertain if the bill, as drawn, would provide the necessary funding so that schools could establish full time Departments of Family Medicine which would have within their aegis general internal medicine and general pediatrics. We believe that medical schools should be financially encouraged to achieve the desired shift in emphasis, rather than ordered to do so.

In this connection we are well aware that there is always the possibility of impoundments of appropriations. Nevertheless, we are certain that a fully and adequately supported program of both Federally assisted Family Medicine Training Grants and Federally assisted independent departments of family medicine within the Nation's medical schools would accomplish the shift to the type of residency programs needed to assure an adequate supply of primary physicians. We strongly urge that the Committee review the authorizing language set forth in Section 788 (applicable to support for instruction in family medicine) and Section 781 (applicable to support for family medicine training grants) in light of the Supreme Court's decision announced on February 18, holding that by reason of the particular wording of the Federal Pollution Control Act P.L. 92–500, Congress was deemed to so have intended the construction of Federally

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assisted water pollution control projects so that the Executive Branch had no legal basis to withhold nine billion dollars in sewer grants. We believe that there is a judicially accepted legislative drafting technique which, if applied to H.R. 2956, as a whole, and most particularly to support of family medicine, residencies so that the compulsion, inherent in much of the Committee's approach to Federally mandated residencies, could be avoided.

Respectfully submitted,

VERNAL G. CAVE, M.D., *President.*

AMERICAN DENTAL HYGIENISTS' ASSOCIATION,
Washington, D.C., Office, February 27, 1975.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Environment Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Rayburn House Office Building, Washington, D.C.

DEAR MR. ROGERS: The American Dental Hygienists' (ADHA) and American Dental Assistants Association (ADAA) are pleased to submit a Record Statement on H.R. 2956 and H.R. 2958 to be included with the proceedings of the Subcommittee on Health and the Environment at the conclusion of hearings on health manpower and National Health Service Corps legislation.

Since the American Dental Hygiensts' Association submitted a Record Statement on the Health Manpower bill approved by the House during the 93rd Congress, we are not repeating our testimony of May, 1974. The enclosed Record Statement is presented on behalf of ADHA and ADAA jointly and is addressed primarily to the definition of Expanded Function Dental Auxiliaries (EFDA) and to the qualifications of individuals who may enroll in the EFDA training programs described in H.R. 2956.

We will appreciate having the joint association statement included in the record of the recent hearings conducted by the Subcommittee.

Very sincerely,

BEN F. MILLER, III,
Washington Consultant.

Enclosure.

STATEMENT OF THE AMERICAN DENTAL HYGIENISTS' AND THE AMERICAN DENTAL ASSISTANTS ASSOCIATION'S

The American Dental Hygienists' Association and the American Dental Assistant Association are pleased to have an opportunity to submit a record statement to the Subcommittee on Public Health and Environment on legislative proposals that will exert a major impact on allied health and health professions education and training.

The American Dental Hygienists' Association (ADHA) is the voice of the dental hygiene profession in the United States, with a current combined active and student membership of 25,000. Dental hygienist who are allied health personnel licensed in all 50 states. Under the direction of the dental profession, they provide important preventive patient care and oral health education services for the dental patient.

The American Dental Assistants Association (ADAA) representing 26,000 active and student members, speaks for the dental assistants profession in the United States. ADAA, in cooperation with the American Dental Association (ADA), sponsors a national certification program for dental assistants, administered by the Certifying Board of the ADAA. The certified dental assistant (CDA) provides vital chairside, four-handed dentistry assistance to the nation's dentists.

The ADHA submitted a record statement on Health Manpower Education and Training to the Subcommittee on Public Health and Environment on May 28, 1974. To the extent that H.R. 2956 and H.R. 2958 remain unchanged in content with the predecessor bill approved by the House of Representatives of the 93rd Congress, the ADHA statement of May 28, 1974 will not be repeated at this time. However, ADHA is pleased to be joined by the ADAA in submitting this record statement to the Subcommittee. The two associations would like to address those portions of H.R. 2956 and H.R. 2958 that relate to the definition of

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expanded duty dental auxiliaries (EFDA's) and capitation programs for one-year EFDA training programs.

For the record, the ADAA adds its voice of support to the ADHA statement of May 28, 1974 in urging the Congress to provide continued federal funding of allied health education and training programs. The two associations are fully aware of the Administrations intent and desire to phase out and terminate funding for allied health training. We find these proposals to be ill-considered at a time when a National Health Insurance program stands as one of the highest priorities for the enactment of legislation by the 94th Congress.

EXPANDED DUTY DENTAL AUXILIARIES IN H.R. 2956 AND H.R. 2958 (AND SIMILAR OR IDENTICAL BILLS)

ADHA and ADAA are pleased that the features of H.R. 17084 of the 93rd Congress, relating to the definition of EFDA's and capitation support of EFDA training, have been carried over into H.R. 2956 and H.R. 2958. We view the inclusion of physician extenders, and EFDA capitation grants for medical and dental schools as providing incentives to the medical and dental profession to improve delivery systems and to hold down health care delivery costs, through the use of supportive personnel that are qualified to provide some of the less complex patient care services. The two associations stand prepared to assist the Congress and the dental profession in developing the guidelines and regulations required to administer such new legislation, so that new education and training programs can be developed to assure that the highest quality of patient care is delivered by expanded duty dental auxiliaries.

Similarly ADHA and ADAA believe that creating eligibility for EFDA's in the National Health Service Corps (NHSC) and in the NHSC Scholarship program of H.R. 2958, represents a significant landmark in broadening the base of dental hygiene and dental assistant practice. We believe that RDH's and CDA's are eminently qualified to enter advanced training programs to enter EFDA service. Accordingly, we support the provisions of H.R. 2958.

Furthermore, the two associations support the provisions of H.R. 2956 that provide dental schools with an option to expand dental school enrollment, or to establish or maintain a program to train EFDA's. We believe that providing this option to dental schools is of great significance to dental hygienists and dental assistants who are already serving the dental profession in important supportive ways. We commend the obvious intent of Congress to maximize the availability of and acces to dental care to a larger segment of the population that can be achieved by placing a greater responsibility on the current dental auxiliary work force.

DISCUSSION OF AMERICAN DENTAL ASSOCIATION TESTIMONY ON H.R. 2956, FEBRUARY 21, 1975

ADHA and ADAA share the concern of the American Dental Association, expressed in its recent record statement to the Subcommittee, to ensure that the definition of the EFDA provides a strong foundation for the development of this expanded auxiliary concept within the framework of prevailing state dental practice acts. It seems to follow that insertion into the definition of language which is not consistent among the practice acts of the several states, such as the word "direct" should be carefully avoided. Our two associations, therefore, prefer the original language used to define the EFDA in H.R. 2956, amended only to add "in accordance with the prevailing dental practice acts." ADHA and ADAA believe that it is essential to the delivery of maximum quality dental health care to the greatest number of people—indeed essential to the strength and viability of the dental profession—that the state boards of dental examiners interpret the precise meaning of the terminology in the practice acts, and that they ensure that the utilization of dental auxiliaries is in accord with these acts.

In addition, we wish to emphasize that ADHA and ADAA want to play a productive role in the development of the guidelines and regulations which will be needed to administer the new law when it is enacted. Already in anticipation of the passage of the health manpower bill by the 94th Congress, the associations have conferred with HEW officials to express a unified view concerning the qualifications that EFDA's should be able to demonstrate, and concerning the nature and level of EFDA training, the one year training program described in H.R. 2956. We are confident that this program can have an important effect on

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the delivery of dental health care without the slightest sacrifices to quality of that care. We will continue to work strongly to that end.

As the concept of an EFDA develops as a mechanism to extend the services of dentists, the two associations believe that the existing workforce of dental hygienists and dental assistants can and will become the key resource that will enable the dental profession to increase and expand its productivity. ADHA and ADAA commend the Subcommittee, in its design of new health manpower legislation, for recognizing this important dental manpower resource.

We jointly urge that HEW guidelines required to administer the new legislation take full cognizance of the minimum credentials conferred upon graduates of accredited schools of dental hygiene and dental assisting. Both associations believe that entry into EFDA training programs should be confined to dental hygiene and dental assisting students, currently enrolled in accredited programs, or already licensed and/or certified personnel, thereby assuring the public that the quality of dental care will be maintained as the services become practically available to greater segments of the population.

ADHA and ADAA urge that Congress and appropriate HEW administrative agencies concur with their view that the 18,000 students currently preparing for careers in accredited dental hygiene and dental assisting educational programs represent the source of EFDA's who will be enrolled in new training programs, and in the NHSC Scholarship program. In addition, the entire combined licensed dental hygiene and certified dental assistants work force represents a vast source of candidates for EFDA training through advanced and continuing education programs. We firmly believe that dental auxiliaries who will be trained to provide primary patient care should have formal education to perform such services. Both associations are vitally concerned that the future development of EFDA's be accomplished without compromise of the systems of education and regulation recognized nationwide, as essential to the protection of the general public.

CONCLUSION

This record statement of the ADHA and ADAA is intended to reaffirm views expressed in the ADHA testimony of May, 1974 on the Health Manpower legislation approved by the House of Representatives of the 93rd Congress. In addition, it is intended to express our support of H.R. 2956 and H.R. 2958 (and similar or identical bills) now being considered by the Subcommittee on Public Health and Environment. Both associations wish to assure the Subcommittee of their commitment to assist the Department of Health, Education, and Welfare to implement the programs outlined in the current, pending health manpower and National Health Service Corps bills.

We commend the Subcommittee for taking the initiative and providing the leadership in the Congress to provide essential federal support for the education and training of allied health and health profession personnel. We endorse and share the Subcommittee's view that continuity of these programs, long established as a result of a cordial and constructive federal and private sector partnership, must be maintained and further improved, in order to provide the highest quality of oral health care—together with greater access to this health care service—for the people of this nation.

CHAMBER OF COMMERCE OF THE UNITED STATES,
Washington, D.C. February 28, 1975.

Re Health Manpower Act of 1975, H.R. 2956.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health and Environment, Interstate and Foreign Commerce Committee, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: The Chamber of Commerce of the United States supports, in general, the voluntary approach to help solve health manpower problems contained in H.R. 2956.

In general, we support the national goal of a health care system that would assure quality care for all Americans. We believe such a system should maximize the advantages of individual freedom of choice and flexibility.

The Chamber supports national health insurance legislation that provides mandated, universal, comprehensive coverage built on our current systems. Meeting our goals on health and medical care necessitates, however, more than just adopting a program to pay for the eventually adopted national health insurance plan. It also requires the development and optimum utilization of quality health

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manpower, increasing the effectiveness of delivery systems, and assuring efficiency and control of costs.

The business community is the largest private consumer of health care in the nation, paying over $20 billion annually for health benefits. We welcome the opportunity to express our concerns about the health manpower shortages that exist in some areas and the maldistribution of specialists and primary care physicians throughout the nation. Our interest in health manpower relates both to the cost of professional medical care and the increased demands on available health personnel that will result from the adoption of a national health insurance plan.

The Chamber recognizes the achievements of prior health manpower legislation first enacted in 1963. Since then, the United States has made progress in terms of overall supply of physicians and health manpower. H.R. 2956 is a positive effort to correct the imbalances in geographic location and type of physician specialties in the United States today, and to continue current federal programs to assist health professional schools and their students.

Our specific comments on H.R. 2956 are as follows:

Title III—Student Loan Assistance and the National Health Service Corps

The bill contains provisions to revise and extend the authority for student loans and for the National Health Service Corps to assist those individuals willing to serve in the Corps with scholarship assistance. The Chamber supports these provisions. Without such assistance, a large number of well qualified students would otherwise be unable to complete their education because of the high costs.

We favor voluntary solutions to the problem of geographic maldistribution of physicians and dentists. Mandatory assignment of medical personnel will not solve the problem of access to quality care. This is especially true where such mandatory assignments are limited to physicians alone, who apparently would be expected to practice without skilled health professional assistance.

Title IV—Grants to Health Professional Schools

A variety of factors influence location decisions of health professionals. Professional relationships, economic factors, the need for service and prior student exposure to a given area greatly influence a health proessional's decision.

Health professional schools should be encouraged to coordinate and provide health manpower education in remote areas. These areas present special problems for practicing physicians and dentists. We support curriculum changes whereby students would receive on-site training in such areas to acquaint them with these special problems.

Title V—Special Project Grants and Contracts

We support the expanded authority for training in family medicine and general dentistry. To improve the specialty mix of physicians and dentists, incentives should be provided to practitioners and health education centers to attract and retain an adequate supply of qualified professionals in the fields of preventive and early disease detection. These specialties should be accorded special recognition so that medical and dental schools will train more family physicians and dentists.

Title VI—Public and Allied Health Personnel

This Title would authorize funds for project grants for allied health training. Providing medical care to meet the true needs of medically underserved areas is a complex socio-economic problem. The Nation does not need, nor can we afford, a highly skilled physician in every hamlet in America. Neither can we afford to have a lot of half-empty rural hospitals. We must use our ingenuity and capacity to train allied health personnel paramedicals and nurse practitioners who can quickly spot serious problems and call for help or have the patient quickly transported to medical centers.

Foreign Medical Graduates

The great influx of foreign medical graduates is affecting, and in some cases undermining, the quality of health care delivered.

While some foreign trained physicians are highly competent, many foreign medical graduates have language difficulties and do not have training comparable to American-trained graduates. The public interest requires a good screening process before any doctor is permitted to practice. But there should be no arbitrary exclusion of these physicians from practice in the United States.

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The Chamber supports comparable licensing of foreign medical graduates and U.S. medical school graduates. We recommend inclusion of such a provision in the bill.

Conclusion

National Chamber policy on "Health Manpower Goals, Development and Utilization" is contained on Attachment A.

In general, we support the voluntary approach to help solve health manpower problems contained in H.R. 2056. We would appreciate your consideration of the above comments and inclusion of this statement in the hearing record.

Cordially,

HILTON DAVIS,
General Manager,
Legislative Action.

Attachment.

Attachment A

NATIONAL CHAMBER POLICY DECLARATIONS ON HEALTH MANPOWER GOALS, DEVELOPMENT, AND UTILIZATION

Goals.—The development of more and better health manpower during the current decade should be sought by subscribing to several goals, including:

Establishment of several new university health science centers, and of more university health education centers;

Encouraging university health science centers to help coordinate and guide health manpower education and to cooperate in developing better systems for delivery of health care;

Improving, through incentives to practitioners and health education centers, the geographic distribtuion and specialty mix of physicians and dentists;

Development and expansion of education and/or training program for physician's and dentist's assistants and associates;

Acceleration of medical dental education;

A large increase in entrants' places in medical and dental schools;

Positive efforts to increase admissions to medical and dental schools for women and minorities;

Comparable licensing of foreign medical graduates and U.S. medical school graduates.

Providing medical care to medically under-served areas is a complex socio-economic problem. Efforts should be directed towards educating a community to its true medical needs and the means of achieving it through communication, transportation and the use of paramedical services.

In light of present knowledge, mandatory assignment of medical personnel will not solve the geographic problems of access to quality medical care.

Manpower Development.—To provide access to health care for those in rural areas and in the inner cities, the federal government should make loans to students for costs of education in the health professions and skills, with the provision that such loans would be forgiven if such persons will deliver their services for a period of time in some area of manpower or service shortage.

To attract and retain an adequate supply of qualified professionals in the fields of preventive and early disease detection, these individuals should be accorded special recognition and levels of compensation commensurate with their education and experience.

Utilization.—Detailed state licensing for various professions in the health field is expensive, restrictive and often unnecessary. Licensing of paramedical personnel such as physician's assistants or other health professionals would seriously restrict the supply and the effective use of such personnel in the delivery of health care. Phyicians and hospitals should be licensed to employ such personnel if they are qualified or certified as qualified.

DEMOCRATIC NATIONAL COMMITTEE,
Washington, D.C., March 3, 1975.

Congressman PAUL G. ROGERS,
U.S. House of Representatives, Washington, D.C.

DEAR PAUL: With the exception of hearings that impact directly upon party affairs, it is not often that I attempt to involve myself directly in legislative

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matters. I am writing to you at this time, however, to lend my voice and support to H.R. 2957 of which you are the primary sponsor.

This bill, as I understand it, has provisions for federal government assistance in the building and maintaining of nurse training facilities around the country. As a member of the Board of Trustees of the Presbyterian Hospital of Dallas, I can testify that the passage of this bill would greatly assist in the establishment of a badly needed nursing program in Dallas. This program is being developed by the Presbyterian Hospital in joint venture with the Texas Women's University and would go a long way toward easing the drastic shortage of qualified registered nurses in Dallas.

Thank you for your assistance in this matter.

Sincerely,

ROBERT S. STRAUSS, *Chairman.*

AMERICAN PUBLIC HEALTH ASSOCIATION,
Washington, D.C., March 4, 1975.

Hon. PAUL G. ROGERS,
Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROGERS: I am writing on behalf of the American Public Health Association to seek your support for amendments to H.R. 2956, the Health Manpower Act of 1975, that would provide for health training programs and traineeships in preventive medicine and environmental health. These amendments are described and set forth in the attachment.

These amendments would not entail costs on an annual basis in excess of $2 million for institutional support and $2 million in traineeships for expanding our training in preventive medicine and environmental health.

With best wishes, I am

Sincerely,

C. ARDEN MILLER, M.D.,
President.

Enclosure.

PREVENTIVE MEDICINE AND ENVIRONMENTAL HEALTH PROGRAMS AMENDMENTS

The attached amendments to H.R. 2956 make preventive medicine and environmental health programs eligible for assistance under the following four authorities: Training programs for public and community health personnel; Institutional grants for graduate programs in health; Traineeships as an adjunct to institutional grants for graduate programs in health; Training programs for allied health personnel.

Institutional and student assistance for preventive medicine and environmental health is desirable for several reasons. First, while programs in preventive medicine have been absent from some schools and considered on a less than equal basis with other programs, preventive medicine has been accepted as an effective and extremely cost beneficial method for maintaining the health of the people. The committee's work on the development and enactment of the Health Maintenance Organization Act is a manifestation of the importance of preventive medicine.

While environmental health activities have been supported in the past, much of these activities supported have been restricted to classical environmental health activities such as plumbing, sewage treatment and the like. Support for programs in environmental health services should continue for the classical reasons. However, they should be further expanded because of the threat to health which is occurring from various man-made contaminants and pollutants heretofor not in existence or not determined before as threats to health. These air and water pollutants and contaminants, while not exceeding our known defense technology, frequently exceed our in-place or operational technology. Accordingly, a need exists for moving this known technology to operational use through programs of institutional and student support.

Amend Sec. 790 by striking sub-section (3) and adding the following new subsection (3):

(3) the development and improvement of individual and community knowledge of health (including environmental health and preventive medicine) and the health care system, or

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Amend Sec. 791(a) by striking all after the first comma and adding:
the Secretary shall make annual grants to public or non-profit educational entities to support the graduate educational programs of such entities in health administration, hospital administration, health planning, environmental health and preventive medicine.

Amend Sec. 795 by striking all after the last comma and adding:
or (2) assisting environmental engineers and other personnel in environmental health control and preventive medicine activities.

Amend Sec. 796(a) by striking Subsection (3)(B) and adding:
(B) a higher degree, in medical technology, environmental health technology, preventive medicine technology, opthalmic dispensing, dental hygiene, or other of the curricula for the training of allied health personnel as the Secretary may by regulation specify and other methods and curricula (including model curricula) for training various types of allied health personnel.

[Whereupon, at 4:15 p.m. the committee was adjourned.]

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HEALTH SERVICES PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

ON

H.R. 2954

(and all other similar and related bills)

A BILL TO AMEND THE PUBLIC HEALTH SERVICE ACT AND RELATED LAWS TO REVISE AND EXTEND PROGRAMS OF HEALTH REVENUE SHARING AND HEALTH SERVICES, AND FOR OTHER PURPOSES

AND

H.R. 2955

(and all other similar and related bills)

A BILL TO AMEND THE DEVELOPMENTAL DISABILITIES SERVICES AND FACILITIES CONSTRUCTION ACT TO REVISE AND EXTEND THE PROGRAMS AUTHORIZED BY THAT ACT

FEBRUARY 19, 1975

Serial No. 94–4

Printed for the use of the
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HEALTH SERVICES PROGRAMS

WEDNESDAY, FEBRUARY 19, 1975

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

The subcommittee met at 2 p.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers, chairman, presiding.

Mr. ROGERS. The subcommittee will come to order, please. Our hearing today is on H.R. 2954, the Health Revenue Sharing and Health Services Act of 1975 and H.R. 2955, the Developmental Disabilities Amendments of 1975, and all similar and related bills.

These bills, which were introduced on February 6 by myself and 10 other members of the Subcommittee on Health and the Environment, are identical to legislation which was prepared in the 93d Congress by the Subcommittee on Public Health and Environment but failed to become law.

The first, H.R. 2954, is identical to the conference report on H.R. 14214 of the last Congress which was pocket vetoed by President Ford after adjournment of the last Congress because, we are told, its provisions conflicted with administration policy, and its authorizations were excessive.

The second, H.R. 2955, is identical to H.R. 14215 in the 93d Congress as it passed the House of Representatives. In the last Congress this legislation was under consideration in conference at the end of the year.

It is my feeling that these are good pieces of legislation which would continue programs, whose legislative authority has already expired, for an additional 2 years, 1975 and 1976 with modest growth and reasonable evolution in their policy.

With the exception of the administration, it is my understanding and according to testimony, both measures have the support of all associations and organizations known to this committee and have been the subject of very little controversy.

Since they were the subject of extensive hearings and public markup sessions in the last Congress, we have limited this hearing to an oral presentation by the administration during which I expect we will focus on the reasons for their veto of H.R. 14214.

Other organizations and individuals concerned with these programs who feel the need to correct the existing record or enlarge upon it have been encouraged to submit statements for the record which, without objection, will appear with that of the administration and will be available for consideration by members of the subcommittee.

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Without objection the text of H.R. 2954, H.R. 2955, and a list of all other identical and similar bills to be considered by the subcommittee will be printed at this point in the record.
[The bills and listing referred to follow:]

94TH CONGRESS
1ST SESSION

H. R. 2954

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 6, 1975

MR. ROGERS (for himself, MR. PREYER, MR. SYMINGTON, MR. CARNEY, MR. SCHEUER, MR. WAXMAN, MR. HEFNER, MR. FLORIO, MR. CARTER, and MR. HEINZ) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Public Health Service Act and related laws to revise and extend programs of health revenue sharing and health services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Health Revenue Sharing and Health Services Act of 1975".

TITLE I—HEALTH REVENUE SHARING

SEC. 101. This title may be cited as the "Special Health Revenue Sharing Act of 1975".

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SEC. 102. Section 314 (d) of the Public Health Service Act is amended to read as follows:

"Comprehensive Public Health Services

"(d) (1) From allotments made pursuant to paragraph (4), the Secretary may make grants to State health and mental health authorities to assist in meeting the costs of providing comprehensive public health services under State plans approved under paragraph (3).

"(2) No grant may be made under paragraph (1) to the State health or mental health authority of any State unless an application therefor has been submitted to and approved by the Secretary and unless—

"(A) the State has submitted to the Secretary a State plan for the provision of comprehensive public health services and has had the plan initially approved by him under paragraph (3); or

"(B) in the case of a State which has had a State plan initially approved under such paragraph, the Secretary, upon his annual review of the State plan of the State, determines that the plan and the activities undertaken under it continue to meet the requirements of such paragraph.

An application for a grant under paragraph (1) shall be submitted in such form and manner and shall contain such information as the Secretary may require.

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"(3) A State plan for the provision of comprehensive public health services shall include such information and assurances as the Secretary may find necessary for approval of the plan and shall be comprised of the following three parts:

"(A) An administrative part setting out a program for the performance of the activities prescribed by the public health service and mental health service parts of the State plan, which program shall—

"(i) provide for administration, or supervision of administration, of such activities by the State health authority or, with respect to mental health activities, by the State mental health authority;

"(ii) set forth policies and procedures to be followed in the expenditure of funds received from grants made under paragraph (1);

"(iii) contain or be supported by assurances satisfactory to the Secretary that (I) the funds paid to the State public and mental health authorities under grants made under paragraph (1) will be used to make a significant contribution toward providing and strengthening public health services in the various political subdivisions of the State; (II) such funds will be made available to other public or nonprofit private agencies, institutions, and organi-

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zations, in accordance with criteria which the Secretary determines are designed to secure maximum participation of local, regional, or metropolitan agencies and groups in the provision of such services; (III) such funds will be used to supplement and, to the extent practical, to increase the level of non-Federal funds that would otherwise be made available for the purposes for which the grant funds are provided and not to supplant such non-Federal funds; and (IV) the plan is compatible with the total health program of the State;

"(iv) provide that the State health authority or, with respect to mental health activities, the State mental health authority, will, from time to time, but not less often than annually, (I) review and evaluate its State plan and submit to the Secretary appropriate modifications thereof, (II) report to the Secretary (by such categories as the Secretary may prescribe) a description of the services provided pursuant to the public health service and mental health service parts of the State plan in the preceding fiscal year and the amount of funds spent by such categories for the provision of such services, and (III) report to the Secretary the extent to which services provided under the State plan for persons

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with developmental disabilities and for the prevention and treatment of alcohol and drug abuse or integrated with services provided under the plan through community mental health centers;

"(v) provide that the State health authority or, with respect to mental health activities, the State mental health authority will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of such reports;

"(vi) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds paid under grants under paragraph (1); and

"(vii) include provisions, meeting such requirements as the Civil Service Commission may prescribe, relating to the establishment and maintenance of personnel standards on a merit basis;

"(viii) contain such additional provisions as the Secretary may find necessary for the proper and efficient operation of the State plan.

"(B) A public health service part setting out a plan for the provision within the State of public health serv-

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ices (other than mental health services). Such plan shall be prepared by the State health authority and shall—

"(i) require that such services provided within the State be provided in conformity with the applicable provisions and requirements of any comprehensive State health plan developed with assistance provided under subsection (a) of this section;

"(ii) include an assessment of the most serious public health problems that exist within the State, based upon data pertaining to mortality and morbidity within the State and to the economic impact of public health problems within the State and upon other appropriate information; and

"(iii) provide for programs relating to environmental health, health education, preventive medicine, health manpower and facilities licensure, and, commensurate with the extent of the problem, services for the prevention and treatment of hypertension, drug abuse, drug dependence, alcohol abuse, and alcoholism.

"(C) A mental health service part setting out a plan for the provision within the State of mental health services. Such plan shall be prepared by the State mental health authority and shall—

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"(i) require that such services provided within the State be provided in conformity with the applicable provisions and requirements of any comprehensive State Health plan developed with assistance provided under subsection (a) of this section;

"(ii) include an assessment of the most serious mental health problems that exist within the State, based upon data pertaining to mortality and morbidity within the State and to the economic impact of mental health problems within the State and upon other appropriate information;

"(iii) include a detailed plan designed to eliminate inappropriate placement of persons with mental health problems in institutions and to improve the quality of care for those with mental health problems for whom institutional care is appropriate;

"(iv) prescribe minimum standards for the maintenance and operation of mental health programs and facilities (including community mental health centers) within the State and for the enforcement of such standards; and

"(v) provide for assistance to courts and other public agencies and to appropriate private agencies to facilitate (I) screening by community mental health centers (or, if there are no such centers, other

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appropriate entities) of residents of the State who are being considered for inpatient care in a mental health facility to determine if such care is necessary, and (II) provision of followup care by community mental health centers (or, if there are no such centers, by other appropriate entities) for residents of the State who have been discharged from mental health facilities.

The Secretary shall approve a State plan submitted to him which meets the requirements of subparagraphs (A), (B), and (C) of this paragraph and such other requirements as he is authorized to prescribe under this paragraph. The Secretary shall review annually each State plan which has been initially approved by him and the activities undertaken under the plan to determine if the plan and such activities continue to meet the requirements of such subparagraphs.

"(4) In each fiscal year the Secretary shall, in accordance with regulations, allot the sums appropriated for such year under paragraph (7) among the States on the basis of the population and the financial need of the respective States. The populations of the States shall be determined on the basis of the latest figures for the population of the States available from the Department of Commerce.

"(5) The Secretary shall determine the amount of any grant under paragraph (1); but the amount of grants made

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in any fiscal year to the public and mental health authorities of any State may not exceed the amount of the State's allotment available for obligation in such fiscal year. Payments under such grants may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary.

"(6) In any fiscal year—

"(A) not less than 15 per centum of a State's allotment under paragraph (4) shall be made available only for grants under paragraph (1) to the State's mental health authority for the provision of mental health services pursuant to its State plan, and not less than 22 per centum of a State's allotment under paragraph (4) shall be available only for establishing and maintaining under the State plan programs for the screening, detection, diagnosis, prevention, and detection of hypertension; and

"(B) not less than—

"(i) 70 per centum of the amount of a State's allotment which is made available for grants to the mental health authority, and

"(ii) 70 per centum of the remainder of the State's allotment,

shall be available only for the provision under the State plan of services in communities of the State.

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"(7) For the purpose of making grants under paragraph (1) there are authorized to be appropriated $160,000,000 for the fiscal year ending June 30, 1975, and $160,000,000 for the fiscal year ending June 30, 1976."

TITLE II—FAMILY PLANNING PROGRAMS

SEC. 201. This title may be cited as the "Family Planning and Population Research Act of 1975".

SEC. 202. (a) Section 1001(c) of the Public Health Service Act is amended (1) by striking out "and" after "1973;" and (2) by inserting after "1974" the following: "; $150,000,000 for the fiscal year ending June 30, 1975; and $175,000,000 for the fiscal year ending June 30, 1976".

(b) Section 1003(b) of such Act is amended (1) by striking out "and" after "1973;" and (2) by inserting after "1974" the following: "; $4,000,000 for fiscal year ending June 30, 1975; and $5,000,000 for the fiscal year ending June 30, 1976".

(c) Section 1004 of such Act is amended to read as follows:

"RESEARCH

"SEC. 1004. (a) The Secretary may—

"(1) conduct, and

"(2) make grants to public or nonprofit private entities and enter into contracts with public or private entities and individuals for projects for,

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research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population.

"(b) (1) To carry out subsection (a) there are authorized to be appropriated $60,000,000 for the fiscal year ending June 30, 1975, and $75,000,000 for the fiscal year ending June 30, 1976.

"(2) No funds appropriated under any provision of this Act (other than this subsection) may be used to conduct or support the research described in subsection (a)."

(d) Section 1005(b) of such Act is amended (1) by striking out "and" after "1973;" and (2) by inserting after "1974" the following: "; $1,500,000 for the fiscal year ending June 30, 1975; and $2,000,000 for the fiscal year ending June 30, 1976".

(e) The last sentence of section 1006(c) of such Act is amended by inserting immediately before the period the following: "so as to insure that economic status shall not be a deterrent to participation in the programs assisted under this title".

SEC. 203. (a) Title X of such Act is amended by inserting after section 1008 the following new section:

"PLANS AND REPORTS

"SEC. 1009. (a) Not later than four months after the close of each fiscal year, the Secretary shall make a report to

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the Congress setting forth a plan to be carried out over the next five fiscal years for—

"(1) extension of family planning services to all persons desiring such services,

"(2) family planning and population research programs,

"(3) training of necessary manpower for the programs authorized by this title and other Federal laws for which the Secretary has responsibility and which pertain to family planning programs, and

"(4) carrying out the other purposes set forth in this title and the Family Planning Services and Population Research Act of 1970.

"(b) Such a plan shall, at a minimum, indicate on a phased basis—

"(1) the number of individuals to be served by family planning programs under this title and other Federal laws for which the Secretary has responsibility, the types of family planning and population growth information and educational materials to be developed under such laws and how they will be made available, the research goals to be reached under such laws, and the manpower to be trained under such laws;

"(2) an estimate of the costs and personnel require-

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ments needed to meet the purposes of this title and other Federal laws for which the Secretary has responsibility and which pertain to family planning programs; and

"(3) the steps to be taken to maintain a systematic reporting system capable of yielding comprehensive data on which service figures and program evaluations for the Department of Health, Education, and Welfare shall be based.

"(c) Each report submitted under subsection (a) shall—

"(1) compare results achieved during the preceding fiscal year with the objectives established for such year under the plan contained in such report;

"(2) indicate steps being taken to achieve the objectives during the remaining fiscal years of the plan contained in such report and any revisions necessary to meet these objectives; and

"(3) make recommendations with respect to any additional legislative or administrative action necessary or desirable in carrying out the plan contained in such report."

(b) Section 5 of the Family Planning Services and Population Research Act of 1970 is repealed.

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TITLE III—COMMUNITY MENTAL HEALTH CENTERS

SEC. 301. This title may be cited as the "Community Mental Health Centers Amendments of 1975".

SEC. 302. (a) The Congress finds that—

(1) community mental health care is the most effective and humane form of care for a majority of mentally ill individuals;

(2) the federally funded community mental health centers have had a major impact on the improvement of mental health care by—

(A) fostering coordination and cooperation between various agencies responsible for mental health care which in turn has resulted in a decrease in overlapping services and more efficient utilization of available resources,

(B) bringing comprehensive community mental health care to all in need within a specific geographic area regardless of ability to pay, and

(C) developing a system of care which insures continuity of care for all patients,

and thus are a national resource to which all Americans should enjoy access; and

(3) there is currently a shortage and maldistribu-

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tion of quality community mental health care resources in the United States.

(b) The Congress further declares that Federal funds should continue to be made available for the purposes of initiating new and continuing existing community mental health centers and initiating new services within existing centers, and for the monitoring of the performance of all federally funded centers to insure their responsiveness to community needs and national goals relating to community mental health care.

SEC. 303. The Community Mental Health Centers Act is amended to read as follows:

"TITLE II COMMUNITY MENTAL HEALTH CENTERS

"PART A—PLANNING AND OPERATIONS ASSISTANCE

"REQUIREMENTS FOR COMMUNITY MENTAL HEALTH CENTERS

"SEC. 201 (a) For purposes of this title (other than part B thereof), the term 'community mental health center' means a legal entity (1) through which comprehensive mental health services are provided—

"(A) principally to individuals residing in a defined geographic area (referred to in this title as a 'catchment area'),

"(B) within the limits of its capacity, to any indi-

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vidual residing or employed in such area regardless of his ability to pay for such services, his current or past health condition, or any other factor, and

"(C) in the manner prescribed by subsection (b), and (2) which is organized in the manner prescribed by subsection (c).

"(b) (1) The comprehensive mental health services which shall be provided through a community mental health center shall include—

"(A) inpatient services, outpatient services, day care and other partial hospitalization services, and emergency services;

"(B) a program of specialized services for the mental health of children, including a full range of diagnostic, treatment, liaison, and followup services (as prescribed by the Secretary);

"(C) a program of specialized services for the mental health of the elderly, including a full range of diagnostic, treatment, liaison, and followup services (as prescribed by the Secretary);

"(D) consultation and education services which—

"(i) are for a wide range of individuals and entities involved with mental health services, including health professionals, schools, courts, State and local law enforcement and correctional agencies,

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members of the clergy, public welfare agencies, health services delivery agencies, and other appropriate entities; and

"(ii) include a wide range of activities (other than the provision of direct clinical services) designed to (I) develop effective mental health programs in the center's catchment area, (II) promote the coordination of the provision of mental health services among various entities serving the center's catchment area, (III) increase the awareness of the residents of the center's catchment area with respect to the nature of mental health problems and the type of mental health services available, and (IV) promote the prevention and control of rape and the proper treatment of the victims of rape;

"(E) assistance to courts and other public agencies in screening residents of the center's catchment area who are being considered for referral to a State mental health facility for inpatient treatment to determine if they should be so referred and provision, where appropriate, of treatment for such persons through the center as an alternative to inpatient treatment at such a facility;

"(F) provision of followup care for residents of

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its catchment area who have been discharged from a mental health facility;

"(G) a program of transitional half-way house services for mentally ill individuals who are residents of its catchment area and who have been discharged from a mental health facility; and

"(H) provision of each of the following service programs (other than a service program for which there is not sufficient need (as determined by the Secretary) in the center's catchment area, or the need for which in the center's catchment area the Secretary determines is currently being met):

"(i) A program for the prevention and treatment of alcoholism and alcohol abuse and for the rehabilitation of alcohol abusers and alcoholics.

"(ii) A program for the prevention and treatment of drug addiction and abuse and for the rehabilitation of drug addicts, drug abusers, and other persons with drug dependency problems.

"(2) The provision of comprehensive mental health services through a center shall be coordinated with the provision of services by other health and social service agencies in the center's catchment area to insure that persons receiving services through the center have access to all such health and social services as they may require. The center's

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services (A) may be provided at the center or satellite centers through the staff of the center or through appropriate arrangements with health professionals and others in the center's catchment area, (B) shall be available and accessible to the residents of the area promptly, as appropriate, and in a manner which preserves human dignity and assures continuity and high quality care and which overcomes geographic, cultural, linguistic, and economic barriers to the receipt of services, and (C) when medically necessary, shall be available and accessible twenty-four hours a day and seven days a week.

"(c) (1) (A) The governing body of a community mental health center (other than a center described in subparagraph (B)) shall (i) be composed where practicable, of individuals who reside in the center's catchment area and who, as a group, represent the resident of that area taking into consideration their employment, age, sex, and place of residence, and other demographic characteristics of the area, and (ii) meet at least once a month, establish general policies for the center (including a schedule of hours during which services will be provided), approve the center's annual budget, and approve the selection of a director for the center. At least one-half of the members of such body shall be individuals who are not providers of health care services.

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"(B) In the case of a community mental health center which before the date of enactment of the Community Mental Health Centers Amendments of 1975 was operated by a governmental agency and received a grant under section 220 (as in effect before such date), the requirements of subparagraph (A) shall not apply with respect to such center, but the governmental agency operating the center shall appoint a committee to advise it with respect to the operations of the center, which committee shall be composed of individuals who reside in the center's catchment area, who are representative of the residents of the area as to employment, age, sex, place of residence, and other demographic characteristics, and at least one-half of whom are not providers of health care services.

"(C) For purposes of subparagraphs (A) and (B), the term 'provider of health care services' means an individual who receives (either directly or through his spouse) more than one-tenth of his gross annual income from fees or other compensation for the provision of health care services or from financial interests in entities engaged in the provision of health care services or in producing or supplying drugs or other articles for use in the provision of such services, or from both such compensation and such interests.

"(2) A center shall have established, in accordance

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with regulations prescribed by the Secretary, (A) an on-going quality assurance program (including utilization and peer review systems) respecting the center's services, (B) an integrated medical records system (including a drug use profile) which, in accordance with applicable Federal and State laws respecting confidentiality, is designed to provide access to all past and current information regarding the health status of each patient and to maintain safeguards to preserve confidentiality and to protect the rights of the patient, (C) a professional advisory board, which is composed of members of the center's professional staff, to advise the governing board in establishing policies governing medical and other services provided by such staff on behalf of the center, and (D) an identifiable administrative unit which shall be responsible for providing the consultation and education services described in subsection (b) (1) (D). The Secretary may waive the requirements of clause (D) with respect to any center if he determines that because of the size of such center or because of other relevant factors the establishment of the administrative unit described in such clause is not warranted.

"GRANTS FOR PLANNING COMMUNITY MENTAL HEALTH CENTER PROGRAMS

"SEC. 202. (a) The Secretary may make grants to public and nonprofit private entities to carry out projects to

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plan community mental health center programs. In connection with a project to plan a community mental health center program for an area the grant recipient shall (1) assess the needs of the area for mental health services, (2) design a community mental health center program for the area based on such assessment, (3) obtain within the area financial and professional assistance and support for the program, and (4) initiate and encourage continuing community involvement in the development and operation of the program. The amount of any grant under this subsection may not exceed $75,000.

"(b) A grant under subsection (a) may be made for not more than one year, and, if a grant is made under such subsection for a project, no other grant may be made for such project under such subsection.

"(c) The Secretary shall give special consideration to applications submitted for grants under subsection (a) for projects for community mental health centers programs for areas designated by the Secretary as urban or rural poverty areas. No applications for a grant under subsection (a) may be approved unless the application is recommended for approval by the National Advisory Mental Health Council.

"(d) There are authorized to be appropriated for payments under grants under subsection (a) $5,000,000 for the fiscal year ending June 30, 1975, and $5,000,000 for the fiscal year ending June 30, 1976.

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"GRANTS FOR INITIAL OPERATION

"SEC. 203. (a) (1) The Secretary may make grants to—

"(A) public and nonprofit private community mental health centers, and

"(B) any public or nonprofit private entity which—

"(i) is providing mental health services.

"(ii) meets the requirements of section 201 except that it is not providing all of the comprehensive mental health services described in subsection (b) (1) of such section, and

"(iii) has a plan satisfactory to the Secretary for the provision of all such services within two years after the date of the receipt of the first grant under this subsection,

to assist them in meeting their costs of operation (other than costs related to construction).

"(2) Grants under subsection (a) may only be made for a grantee's costs of operation during the first eight years after its establishment. In the case of a community mental health center or other entity which received a grant under section 220 (as in effect before the date of enactment of the Community Mental Health Centers Amendments of 1975), such center or other entity shall, for purposes of grants under subsection (a), be considered as being in

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operation for a number of years equal to the sum of the number of grants in the first series of grants it received under such section and the number of grants it received under this subsection.

"(b) (1) Each grant under subsection (a) to a community mental health center or other entity shall be made for the costs of its operation for the one-year period beginning on the first day of the month in which such grant is made.

"(2) No community mental health center may receive more than eight grants under subsection (a). No entity described in subsection (a) (1) (B) may receive more than two grants under subsection (a). In determining the number of grants that a community mental health center has received under subsection (a), there shall be included any grants which the center received under such subsection as an entity described in paragraph (1) (B) of such subsection.

"(c) The amount of a grant for any year made under subsection (a) shall be the lesser of the amounts computed under paragraph (1) or (2) as follows:

"(1) An amount equal to the amount by which the grantee's projected costs of operation for that year exceed the total of State, local, and other funds and of the fees, premiums, and third-party reimbursements which the grantee may reasonably be expected to collect in that year.

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"(2) (A) Except as provided in subparagraph (B), an amount equal to the following percentages of the grantee's projected costs of operation: 80 per centum of such costs for the first year of its operation, 65 per centum of such costs for the second year of its operation, 40 percentum of such costs for the third year of its operation, 35 per centum of such costs for the fourth year of its operation, 30 per centum of such costs for the fifth and sixth years of its operation, and 25 per centum of such costs for the seventh and eighth years of its operation costs for the fifth year of its operation, 50 per centum of such costs for the sixth year of its operation, 40 per centum of such costs for the seventh year of its operation, and 30 per centum of such costs for the eighth year of its operation.

In any year in which a grantee receives a grant under section 204 for consultation and education services, the costs of the grantee's operation for that year attributable to the provision of such services and its collections in that year for such services shall be disregarded in making a computation under paragraph (1) or (2) respecting a grant under subsection (a) for that year.

"(d) (1) There are authorized to be appropriated for payments under initial grants under subsection (a)

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$85,000,000 for the fiscal year ending June 30, 1975, and $100,000,000 for the fiscal year ending June 30, 1976.

"(2) For the fiscal year ending June 30, 1976, and for each of the succeeding seven fiscal years, there are authorized to be appropriated such sums as may be necessary to make payments under continuation grants under subsection (a) to community mental health centers and other entities which first received an initial grant under this section for the fiscal year ending June 30, 1975, or the next fiscal year and which are eligible for a grant under this section in a fiscal year for which sums are authorized to be appropriated under this paragraph.

"(e) (1) Any entity which has not received a grant under subsection (a), which received a grant under section 220, 242, 243, 251, 256, 264, or 271 of this title (as in effect before the date of enactment of the Community Mental Health Centers Amendments of 1975) from appropriations under this title for a fiscal year ending before July 1, 1974, and which would be eligible for another grant under such section from an appropriation for a succeeding fiscal year if such section were not repealed by the Community Mental Health Centers Amendments of 1975 may, in lieu of receiving a grant under subsection (a) of this section, continue to receive a grant under each such repealed section under which it would be so eligible for another grant—

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"(A) for the number of years and in the amount prescribed for the grant under each such repealed section, except that—

"(i) the entity may not receive under this subsection more than two grants under any such repealed section unless it meets the requirements of section 201, and

"(ii) the total amount received for any year (as determined under regulations of the Secretary) under the total of the grants made to the entity under this subsection may not exceed the amount by which the entity's projected costs of operation for that year exceed the total collections of State, local, and other funds and of the fees, premiums, and third-party reimbursements, which the entity may reasonably be expected to make in that year; and

"(B) in accordance with any other terms and conditions applicable to such grant.

In any year in which a grantee under this subsection receives a grant under section 204 for consultation and education services, the staffing costs of the grantee for that year which are attributable to the provision of such services and the grantee's collections in that year for such services shall be disregarded in applying subparagraph (A) and the provision of the repealed section applicable to the amount of the

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grant the grantee may receive under this subsection for that year.

"(2) An entity which receives a grant under this subsection may not receive any grant under subsection (a).

"(3) There are authorized to be appropriated for the fiscal year ending June 30, 1975, and for each of the next six fiscal years such sums as may be necessary to make grants in accordance with paragraph (1).

"GRANTS FOR CONSULTATION AND EDUCATION SERVICES

"SEC. 204. (a) (1) The Secretary may make annual grants to any community mental health center for the costs of providing the consultation and education services described in section 201 (b) (1) (D) if the center—

"(A) received from appropriations for a fiscal year ending before July 1, 1974, a staffing grant under section 220 of this title (as in effect before the date of enactment of the Community Mental Centers Amendments of 1975) and may not because of limitations respecting the period for which grants under that section may be made receive under section 203 (e) an additional grant under such section 220; or

"(B) has received or is receiving a grant under subsection (a) or (e) of section 203 and the number of years in which the center has been in operation (as determined in accordance with section 203 (a) (2)) is

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not less than four (or is not less than two if the Secretary determines that the center will be unable to adequately provide the consultation and education services described in section 201 (b) (1) (D) during the third or fourth years of its operation without a grant under this subsection).

"(2) The Secretary may also make annual grants to a public or non-profit private entity—

"(A) which has not received any grant under this title (other than a grant under this section as amended by the Community Mental Health Centers Amendments of 1975),

"(B) which meets the requirements of section 201 except, in the case of an entity which has not received a grant under this section, the requirement for the provision of consultation and education services described in section 201 (b) (1) (D), and

"(C) the catchment area of which is not within (in whole or in part) the catchment area of a community mental health center,

for the costs of providing such consultation and education services.

"(b) The amount of any grant made under subsection (a) shall be determined by the Secretary, but no such grant to a center may exceed the lesser of 100 per centum of such

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center's costs of providing such consultation and education services during the year for which the grant is made or—

"(1) in the case of each of the first two years for which a center receives such grant, the sum of (A) an amount equal to the product of $0.50 and the population of the center's catchment area, and (B) the lesser of (i) one-half the amount determined under clause (A), or (ii) one-half of the amount received by the center in such year from charges for the provision of such services;

"(2) in the case of the third year for which a center receives such a grant, the sum of (A) an amount equal to the product of $0.50 and the population of the center's catchment area, and (B) the lesser of (i) one-half the amount determined under clause (A), or (ii) one-fourth of the amount received by the center in such year from charges for the provision of such services; and

"(3) (A) except as provided in subparagraph (B), in the case of the fourth year and each subsequent year thereafter for which a center receives such a grant, the lesser of (i) the sum of (I) an amount equal to the product of $0.125 and the population of the center's catchment area, and (II) one-eighth of the amount received by the center in such year from charges for the provision of such services, or (ii) $50,000; or

"(B) in the case of the fourth year and each subse-

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quent year for which a center receives such a grant, the sum of (i) an amount equal to the product of $0.25 and the population of the center's catchment area, and (ii) the lesser of (I) the amount determined under clause (i) of this subparagraph, or (II) one-fourth of the amount received by the center in such year from charges for the provision for such services if the amount of the last grant received by the center under section 220 of this title (as in effect before the date of the enactment of the Community Mental Health Amendments of 1975) or section 203 of this title, as the case may be, was determined on the basis of the center providing services to persons in an area designated by the Secretary as an urban or rural poverty area.

For purposes of this subsection, the term 'center' includes an entity which receives a grant under subsection (a) (2).

"(c) There are authorized to be appropriated for payments under grants under this section $4,000,000 for the fiscal year ending June 30, 1975, and $9,000,000 for the fiscal year ending June 30, 1976.

"CONVERSION GRANTS

"SEC. 205. (a) The Secretary may make not more than two grants to any public or nonprofit entity which—

"(1) has an approved application for a grant under section 203 or 211, and

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"(2) can reasonably be expected to have an operating deficit, for the period for which a grant is or will be made under such application, which is greater than the amount of the grant the entity is receiving or will receive under such application,

for the entity's reasonable costs in providing mental health services which are described in section 201(b)(1) but which the entity did not provide before the date of the enactment of the Community Mental Health Centers Amendments of 1975. For purposes of this section, the term 'projected operating deficit' with respect to an entity described in the preceding sentence means the excess of its projected costs of operation (including the costs of operation related to the provision of services for which a grant may be made under this subsection) for a particular period over the total of the amount of State, local, and other funds (including funds under a grant under section 203, 204, or 211) received by the entity in that period and the fees, premiums, and third-party reimbursements to be collected by the entity during that period.

"(b)(1) Each grant under subsection (a) to an entity shall be made for the same period as the period for which the grant under section 203 or 211 for which the entity had an approved application is or will be made.

"(2). The amount of any grant under subsection (a) to

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any entity shall be determined by the Secretary, but no such grant may exceed that part of the entity's projected operating deficit for the year for which the grant is made which is reasonably attributable to its costs of providing in such year the services with respect to which the grant is made.

"(c) There are authorized to be appropriated for payments under grants under subsection (a) $20,000,000 for the fiscal year ending June 30, 1975, and $20,000,000 for the fiscal year ending June 30, 1976.

"GENERAL PROVISIONS RESPECTING GRANTS UNDER THIS PART

"SEC. 206. (a) (1) No grant may be made under this part to any entity or community mental health center in any State unless a State plan for the provision of comprehensive mental health services within such State has been submitted to, and approved by, the Secretary under section 237.

"(b) No grant may be made under this part unless—

"(1) an application (meeting the requirements of subsection (c)) for such grant has been submitted to, and approved by, the Secretary; and

"(2) the proposed use of grant funds in any area under the jurisdiction of a State or area health planning agency established under the Public Health Service Act has been reveiwed to the extent provided by law by such agencies to determine whether such use is

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consistent with any plans which such agencies have developed for such area, and with respect to—

"(A) the need for a community mental health center in such area;

"(B) the definition of the catchment area to be served, which shall be determined after consideration of any such area previously designated;

"(C) the need for the services to be offered;

"(D) in the case of an applicant described in section 203(a)(1)(B), the applicant's plans for developing comprehensive mental health services;

"(E) the adequacy of the resources of the applicant for the direct provision of mental health services and the adequacy of agreements with the applicant for the indirect provision of such services;

"(F) the adequacy of the applicant's arrangements for the appropriate use of and integration with existing health delivery services and facilities to assure optimum utilization of and nonduplication of such services and facilities and to assure continuity of patient care, including arrangements of the applicant with health maintenance organizations and community health centers serving individuals who reside in or are employed in the area served by the applicant for the provision by the applicant of mental

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health services for the members and patients of such organizations and centers;

"(G) the adequacy of arrangements of the applicant for the coordination of its services with those of other health and social service agencies including, where appropriate, exchange of staff resources; and

"(H) any other factor which the State or area health planning agency determines to be significant for purposes of planning and coordination of health services for the area within the jurisdiction of such planning agency.

"(c) (1) An application for a grant under this part shall be submitted in such form and manner as the Secretary shall prescribe and shall contain such information as the Secretary may require. Except as provided in paragraph (3), an application for a grant under section 203, 204, or 205 shall contain or be supported by assurances satisfactory to the Secretary that—

"(A) the community mental health center for which the application is submitted will provide, in accordance with regulations of the Secretary (i) an overall plan and budget that meets the requirements of section 1861 (z) of the Social Security Act, and (ii) an effective procedure for developing, compiling, eval-

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uating, and reporting to the Secretary statistics and other information (which the Secretary shall publish and disseminate on a periodic basis and which the center shall disclose at least annually to the general public) relating to (I) the cost of the center's operation, (II) the patterns of utilization of its services, (III) the availability, accessibility, and acceptability of its services, (IV) the impact of its services upon the mental health of the residents of its catchment area, and (V) such other matters as the Secretary may require;

"(B) such community mental health center will, in consultation with the residents of its catchment area, review its program of services and the statistics and other information referred to in subparagraph (A) to assure that its services are responsive to the needs of the residents of the catchment area;

"(C) to the extent practicable, such community mental health center will enter into cooperative arrangements with health maintenance organizations serving residents of the center's catchment area for the provision through the center of mental health services for the members of such organizations under which arrangements the charges to the health maintenance organizations for such services shall be not less than the actual costs of the center in providing such services;

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"(D) in the case of a community mental health center serving a population including a substantial proportion of individuals of limited English-speaking ability, the center has (i) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (ii) identified an individual on its staff who is bilingual and whose responsibilites shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences;

"(E) such community mental health center has (i) established a requirement that the health care of every patient must be under the supervision of a member of the professional staff, and (ii) provided for having a member of the professional staff available to furnish necessary mental health care in case of emergency;

"(F) such community mental health center has provided appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

"(G) in the case of an application for a grant under section 203 for a community mental health center which will provide services to persons in an area designated by the Secretary as an urban or rural poverty area, the ap-

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plicant will use the additional grant funds it receives, because it will provide services to persons in such an area who are unable to pay therefor;

"(H) such community mental health center will develop a plan for adequate financial support to be available, and will use its best efforts to insure that adequate financial support will be available, to it from Federal sources (other than this part) and non-Federal sources (including, to the maximum extent feasible, reimbursement from the recipients of consultation and education services and screening services provided in accordance with sections 201 (b) (1) (D) and 201 (b) (1) (E)) so that the center will be able to continue to provide comprehensive mental health services when financial assistance provided under this part is reduced or terminated, as the case may be;

"(I) such community mental health center (i) has or will have a contractual or other arrangement with the agency of the State in which it provides services, which agency administers or supervises the administration of a State plan approved under title XIX of the Social Security Act, for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under such

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a State plan, or (ii) has made or will make every reasonable effort to enter into such an arrangement;

"(J) such community mental health center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

"(K) such community mental health center (i) has prepared a schedule of fees or payments for the provision of its services designed to cover its reasonable costs of operation and a corresponding schedule of discounts to be applied to the payment of such fees or payments which discounts are adjusted on the basis of the patient's ability to pay; (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for services in accordance with such approved schedules, and (II) to collect reimbursement for health services to persons described in subparagraph (J) on the basis of the full amount of fees and payments for such services without application of any dis-

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count, and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph; and

"(L) such community mental health center will adopt and enforce a policy (i) under which fees for the provision of mental health services through the center will be paid to the center, and (ii) which prohibits health professionals who provide such services to patients through the center from providing such services to such patients except through the center.

An application for a grant under section 203 shall also contain a long-range plan for the expansion of the program of the portion of such increased costs to be paid from Federal cation is submitted for the purpose of meeting anticipated increases in demand by residents of the center's catchment area for the comprehensive mental health services described in section 201 (b) (1). Such a plan shall include a description of planned growth in the programs of the center, estimates of increased costs arising from such growth, estimates of the portion of such increased costs to be paid from Federal funds, and anticipated sources of non-Federal funds to pay such increased costs.

"(2) The Secretary may approve an application for a grant under section 203, 204, or 205 only if the application is recommended for approval by the National Advisory

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Mental Health Council, the application meets the requirements of paragraph (1), and, except as provided in paragraph (3), the Secretary—

"(A) determines that the facilities and equipment of the applicant under the application meet such requirements as the Secretary may prescribe;

"(B) determines that—

"(i) the application contains or is supported by satisfactory assurances that the comprehensive mental health services (in the case of an application for a grant under section 203 or 205) or the consultation and education services (in the case of an application for a grant under section 204) to be provided by the applicant will constitute an addition to, or a significant improvement in quality (as determined in accordance with criteria of the Secretary) of, services that would otherwise be provided in the catchment area of the applicant;

"(ii) the application contains or is supported by satisfactory assurances that Federal funds made available under section 203, 204, or 205, as the case may be, will (I) be used to supplement and, to the extent practical, increase the level of State, local, and other non-Federal funds, including third-party health insurance payments, that would in

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the absence of such Federal funds be made available for the applicant's comprehensive mental health services, and (II) in no event supplant such State, local, and other non-Federal funds;

"(iii) in the case of an applicant which received a grant from appropriations for the preceding fiscal year, determines that during the year for which the grant was made the applicant met, in accordance with the section under which such grant was made, the requirements of section 201 and complied with the assurances which were contained in or supported the applicant's application for such grant; and

"(iv) in the case of an application for a grant the amount of which is or may be determined under section 203(c)(2)(B) or 204(b)(3)(B) or under a provision of a repealed section of this title referred to in section 203(c) which authorizes an increase in the ceiling on the amount of a grant to support services to persons in areas designated by the Secretary as urban or rural poverty areas, that the application contains or is supported by assurances satisfactory to the Secretary that the services of the applicant will, to the extent feasible, be utilized by a significant number of persons residing

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in an area designated by the Secretary as an urban or rural poverty area and requiring such services.

"(3) In the case of an application—

"(A) for the first grant under section 203(a) for an entity described in section 203(a)(1)(B), or

"(B) for the first grant under section 203(e),

the Secretary may approve such application without regard to the assurances required by the second sentence of paragraph (1) of this subsection and without regard to the determinations required of the Secretary under paragraph (2) of this subsection if the application contains or is supported by assurances satisfactory to the Secretary that the applicant will undertake, during the period for which such first grant is to be made, such actions as may be necessary to enable the applicant, upon the expiration of such period, to make each of the assurances required by paragraph (1) and to enable the Secretary, upon the expiration of such period, to make each of the determinations required by paragraph (2).

"(4) In each fiscal year for which a community mental health center receives a grant under section 203, 204, or 205, such center shall obligate for a program of continuing evaluation of the effectiveness of its programs in serving the needs of the residents of its catchment area and for a review of the quality of the services provided by the center not less than an amount equal to 2 per centum of the amount obli-

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gated by the center in the preceding fiscal year for its operating expenses.

"(5) The costs for which grants may be made under section 203, 204, or 205 shall be determined in the manner prescribed in regulations of the Secretary issued after consultation with the National Advisory Mental Health Council.

"(6) An application for a grant under section 203, 204, or 205—

"(A) may not be disapproved, and

"(B) may not be approved for a grant which is less than the amount of the grant received by the applicant under such section in the preceding fiscal year,

on the ground that the applicant has not made reasonable efforts to secure payments or reimbursements in accordance with assurances provided under subparagraphs (I), (J), and (K) of subsection (c) (1) unless the Secretary first informs such applicant of the respects in which he has not made such reasonable efforts and the manner in which his performance can be improved and gives the applicant a reasonable opportunity to respond. Applications disapproved, and applications approved for reduced amounts, on such grounds shall be referred to the National Advisory Mental Health Council for its review and recommendations respecting such approval or disapproval.

"(d) An application for a grant under this part which is

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submitted to the Secretary shall at the same time be submitted to the State mental health authority for the State in which the project or community mental health center for which the application is submitted is located. A State mental health authority which receives such an application under this subsection may review it and submit its comments to the Secretary within the forty-five-day period beginning on the date the application was received by it. The Secretary shall take action to require an applicant to revise his application or to approve or disapprove an application within the period beginning on the date the State mental health authority submitted its comments or on the expiration of such forty-five-day period, whichever occurs first, and ending on the ninetieth day following the date the application was submitted to him.

"(e) Not more than 2 per centum of the total amount appropriated under sections 203, 204, and 205 for any fiscal year shall be used by the Secretary to provide directly through the Department technical assistance for program management and for training in program management to community mental health centers which received grants under such sections or to entities which received grants under section 220 of this title in a fiscal year beginning before the date of the enactment of the Community Mental Health Centers Amendments of 1975.

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"(f) For purposes of subsections (b), (c), (d), and (e) of this section, the term 'community mental health center' includes an entity which applies for or has received a grant under section 203 (a), 203 (e), or 204 (a) (2).

"PART B—FINANCIAL DISTRESS GRANTS

"GRANT AUTHORITY

"SEC. 211. The Secretary may make grants for the operation of any community mental health center which—

"(1) (A) received a grant under section 220 of this title (as in effect before the date of enactment of the Community Mental Health Centers Amendments of 1975) and, because of limitations in such section 220 respecting the period for which the center may receive grants under such section 220, is not eligible for further grants under that section; or

"(B) received a grant or grants under section 203 (a) of this title and, because of limitations respecting the period for which grants under such section may be made, is not eligible for further grants under that section; and

"(2) demonstrates that without a grant under this section there will be a significant reduction in the types or quality of services provided or there will be an inability to provide the services described in section 201 (b).

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"GRANT REQUIREMENTS

"SEC. 212. (a) No grant may be made under section 211 to any community mental health center in any State unless a State plan for the provision of comprehensive mental health services within such State has been submitted to, and approved by, the Secretary under section 237. Any grant under section 211 may be made upon such terms and conditions as the Secretary determines to be reasonable and necessary, including requirements that the community mental health center agree (1) to disclose any financial information or data deemed by the Secretary to be necessary to determine the sources or causes of that center's financial distress, (2) to conduct a comprehensive cost analysis study in cooperation with the Secretary, (3) to carry out appropriate operational and financial reforms on the basis of information obtained in the course of the comprehensive cost analysis study or on the basis of other relevant information, and (4) to use a grant received under section 211 to enable it to provide (within such period as the Secretary may prescribe) the comprehensive mental health services described in section 201 (b) and to revise its organization to meet the requirements of section 201 (c).

"(b) An application for a grant under section 211 must contain or be supported by the assurances prescribed by subparagraphs (A), (B), (C), (D), (E), (F), (G),

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(I), (J), (K), and (L) of section 206(c)(1) and assurances satisfactory to the Secretary that the applicant will expend for its operation as a community mental health center, during the year for which such grant is sought, an amount of funds (other than funds for construction, as determined by the Secretary) from non-Federal sources which is at least as great as the average annual amount of funds expended by such applicant for purpose (excluding expenditures of a nonrecurring nature) in the three years immediately preceding the year for which such grant is sought. The Secretary may not approve such an application unless it has been recommended for approval by the National Advisory Mental Health Council. The requirements of section 206(d) respecting opportunity for review of applications by State mental health authorities and time limitations on actions by the Secretary on applications shall apply with respect to applications submitted for grants under section 211.

"(c) Each grant under this section to a grantee shall be made for the projected costs of operation (except the costs of providing the consultation and education services described in section 201(b)(1)(D)) of such grantee for the one-year period beginning on the first day of the first month in which such grant is made. No community mental health center may receive more than three grants under section 211.

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"(d) The amount of a grant for a community mental health center under section 211 for any year shall be the lesser of the amounts computed under paragraph (1) or (2) as follows:

"(1) An amount equal to the amount by which the center's projected costs of operation for that year exceed the total of State, local, and other funds and of the fees, premiums, and third-party reimbursements which the center may reasonably be expected to collect in that year.

"(2) An amount equal to the product of—

"(A) 90 per centum of the percentage of costs—

"(i) which was the ceiling on the grant last made to the center in the first series of grants it received under section 220 of this title (as in effect before the date of the enactment of the Community Mental Health Centers Amendments of 1975), or

"(ii) prescribed by subsection (c) (2) of section 203 for computation of the last grant to the center under such section,

whichever grant was made last, and

"(B) the center's projected costs of operation in

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the year for which the grant is to be made under section 211.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 213. There are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1975, and $15,000,000 for the fiscal year ending June 30, 1976, for payments under grants under section 211.

"PART C—FACILITIES ASSISTANCE

"ASSISTANCE AUTHORITY

"SEC. 221. (a) From allotments made under section 227 the Secretary shall pay, in accordance with this part, the Federal share of projects for (1) the acquisition or remodeling, or both, of facilities for community mental health centers, (2) the leasing (for not more than twenty-five years) of facilities for such centers, (3) the construction of new facilities or expansion of existing facilities for community mental health centers if not less than 25 per centum of the residents of the centers' catchment areas are members of low-income groups (as determined under regulations prescribed by the Secretary), and (4) the initial equipment of a facility acquired, remodeled, leased, or constructed with financial assistance provided under payments under this part. Payments shall not be made for the construction of a new facility or the expansion of an existing one unless the Sec-

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retary determines that it is not feasible for the recipient to acquire or remodel an existing facility.

"(b) (1) For purposes of this part, the term 'Federal share' with respect to any project described in subsection (a) means the portion of the cost of such project to be paid by the Federal Government under this part.

"(2) The Federal share with respect to any project described in subsection (a) in a State shall be the amount determined by the State agency of the State, but, except as provided in paragraph (3), the Federal share for any such project may not exceed 66⅔ per centum of the costs of such project or the State's Federal percentage, whichever is the lower. Prior to the approval of the first such project in a State during any fiscal year, the State agency shall give the Secretary written notification of (A) the maximum Federal share, established pursuant to this paragraph, for such projects in such State which the Secretary approves during such fiscal year, and (B) the method for determining the specific Federal share to be paid with respect to such project; and such maximum Federal share and such method of Federal share determination for such projects in such State during such fiscal year shall not be changed after the approval of the first such project in the State during such fiscal year.

"(3) In the case of any community mental health

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center which provides or will, upon completion of the project for which application has been made under this part, provide services for persons in an area designated by the Secretary as an urban or rural poverty area, the maximum Federal share determined under paragraph (2) may not exceed 90 per centum of the costs of the project.

"(4) (A) For purposes of paragraph (2), the Federal percentage for (i) Puerto Rico, Guam, American Samoa, and the Virgin Islands shall be 66⅔ per centum, and (ii) any other State shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the average per capita income of the fifty States and the District of Columbia.

"(B) The Federal percentages under clause (ii) of subparagraph (A) shall be promulgated by the Secretary between July 1 and September 30 of each even-numbered year, on the basis of the average of the per capita incomes of the States subject to such Federal percentages and of the fifty States and the District of Columbia for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgation.

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"APPROVAL OF PROJECTS

"SEC. 222. (a) For each project for a community mental health center facility pursuant to a State plan approved under section 237, there shall be submitted to the Secretary, through the State agency of the State, an application by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more such agencies join in the project, the application may be filed by one or more of such agencies. Such application shall set forth—

"(1) a description of the site for such project;

"(2) plans and specifications therefor in accordance with the regulations prescribed by the Secretary under section 236;

"(3) except in the case of a leasing project, reasonable assurance that title to such site is or will be vested in one or more of the agencies filing the application or in a public or other nonprofit agency which is to operate the community mental health center;

"(4) reasonable assurance that adequate financial support will be available for the project and for its maintenance and operation when completed;

"(5) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a construction or remodeling

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project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c);

"(6) a certification by the State agency of the Federal share for the project; and

"(7) the assurances described in section 206(c)(2).

Each applicant shall be afforded an opportunity for a hearing before the State agency respecting its application.

"(b) The Secretary shall approve an application submitted in accordance with subsection (a) if—

"(1) sufficient funds to pay the Federal share for the project for which the application was submitted are available from the allotment to the State;

"(2) the Secretary finds that the application meets the applicable requirements of subsection (a) and the community mental health center for which the application was submitted will meet the requirements of the

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State plan (under section 237) of the State in which the project is located; and

"(3) the Secretary finds that the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State, as determined under the State plan.

No application shall be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing. The Secretary may not approve an application under this part for a project for a facility for a community mental health center or other entity which received a grant under section 220, 242, 243, 251, 256, 264, or 274 of this title (as in effect before the date of the enactment of the Community Mental Health Centers Amendments of 1975) from appropriations for a fiscal year ending before July 1, 1974, unless the Secretary determines that the application is for a project for a center or entity which upon completion of such project will be able to significantly expand its services and which demonstrates exceptional financial need for assistance under this part for such project. Amendment of any approved application shall be subject to approval in the same manner as an original application.

"PAYMENTS

"SEC. 223. (a) (1) Upon certification to the Secretary by the State agency, based upon inspection by it, that work

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has been performed upon a construction or remodeling project, or purchases for such a project have been made, in accordance with the approved plans and specifications, and that payment of an installment is due to the applicant, such installment shall be paid to the State, from the applicable allotment of such State, except that (1) if the State is not authorized by law to make payments to the applicant, the payment shall be made directly to the applicant, (2) if the Secretary, after investigation or otherwise, has reason to believe that any act (or failure to act) has occurred requiring action pursuant to subsection (c) of this section, payment may, after he has given the State agency notice of opportunity for hearing pursuant to such section, be withheld in whole or in part, pending corrective action or action based on such hearing, and (3) the total payments with respect to such project may not exceed an amount equal to the Federal share of the cost of such project.

"(2) In case an amendment to an approved application is approved or the estimated cost of a construction or remodeling project is revised upward any additional payment with respect thereto may be made from the applicable allotment of the State for the fiscal year in which such amendment or revision is approved.

"(b) Payments from a State allotment for acquisition

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and leasing projects shall be made in accordance with regulations which the Secretary shall promulgate.

"(c) (1) If the Secretary finds that—

"(A) a State agency is not substantially complying with the provisions required by section 237 to be in a State plan or with regulations issued under section 236;

"(B) any assurance required to be in an application filed under section 222 is not being carried out;

"(C) there is substantial failure to carry out plans and specifications approved by the Secretary under section 222; or

"(D) adequate State funds are not being provided annually for the direct administration of a State plan approved under section 237,

the Secretary may take the action authorized under paragraph (2) of this subsection if the finding was made after reasonable notice and opportunity for hearing to the involved State agency.

"(2) If the Secretary makes a finding described in paragraph (1), he may notify the involved State agency, which is the subject of the finding or which is connected with a project or State plan which is the subject of the finding, that—

"(A) no further payments will be made to the State from allotments under section 227; or

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"(B) no further payments will be made from allotments under section 227 for any project or projects designated by the Secretary as being affected by the action or inaction referred to in subparagraph (A), (B), (C), or (D) of paragraph (1),

as the Secretary may determine to be appropriate under the circumstances; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments from such allotments may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurance or plans and specifications or to provide adequate State funds, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

"SEC. 244. If—

"(1) the Secretary refuses to approve an application for a project submitted under section 222, the State agency through which such application was submitted, or

"(2) any State is dissatisfied with the Secretary's action under section 223(c) or 237(c), such State, may appeal to the United States court of appeals for the circuit in which such State agency or State is located, by

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filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of facts and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so

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specifically ordered by the Court, operate as a stay of the Secretary's action.

"RECOVERY

"SEC. 225. If any facility of a community mental health center remodeled, constructed, or acquired with funds provided under this part is, at any time within twenty years after the completion of such remodeling or construction or after the date of its acquisition with such funds—

"(1) sold or transferred to any person or entity (A) which is not qualified to file an application under section 222, or (B) which is not approved as a transferee by the State agency of the State in which such facility is located, or its successor; or

"(2) not used by a community mental health center in the provision of comprehensive mental health services, and the Secretary has not determined that there is good cause for termination of such use,

the United States shall be entitled to recover from either the transferor or the transferee in the case of a sale or transfer or from the owner in the case of termination of use an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the center is situated) of so much of such facility or center as constituted an approved project or projects, as the

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amount of the Federal participation bore to the cost of the construction of such project or projects. Such right of recovery shall not constitute a lien upon such facility or center prior to judgment.

"NONDUPLICATION

"SEC. 226. No grant may be made under the Public Health Service Act for the construction or modernization of a facility for a community mental health center unless the Secretary determines that there are no funds available under this part for the construction or modernization of such facility.

"ALLOTMENTS TO STATES

"SEC. 227. (a) In each fiscal year, the Secretary shall, in accordance with regulations, make allotments from the sums appropriated under section 228 to the several States (with State plans approved under section 237) on the basis of (1) the population, (2) the extent of the need for community mental health centers, and (3) the financial need of the respective States; except that no such allotment to any State, other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands, in any fiscal year may be less than $100,000. Sums so allotted to a State other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands, in a fiscal year and remaining unobligated at the end of such

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year shall remain available to such State for such purpose in the next fiscal year (and in such year only), in addition to the sums allotted for such State in such next fiscal year. Sums so allotted to the Virgin Islands, American Samoa, Guam, or the Trust Territory of the Pacific Islands in a fiscal year and remaining unobligated at the end of such year shall remain available to it for such purpose in the next two fiscal years (and in such years only), in addition to the sums allotted to it for such purpose in each of such next two fiscal years.

"(b) The amount of an allotment under subsection (a) to a State in a fiscal year which the Secretary determines will not be required by the State during the period for which it is available for the purpose for which allotted shall be available for reallotment by the Secretary from time to time, on such date or dates as he may fix, to other States with respect to which such a determination has not been made, in proportion to the original allotments of such States for such fiscal year, but with such proportionate amount for any of such other States being reduced to the extent it exceeds the sum the Secretary estimates such State needs and will be able to use during such period; and the total of such reductions shall be similarly reallotted among the States whose proportionate amounts were not so reduced. Any amount so reallotted to a State in a fiscal year shall be deemed to be

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a part of its allotment under subsection (a) in such fiscal year.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 228. There are authorized to be appropriated $15,000,000 for the fiscal year ending June 30, 1975, and $15,000,000 for the fiscal year ending June 30, 1976, for allotments under section 227.

"PART E—GENERAL PROVISIONS

"DEFINITIONS

"SEC. 235. For purposes of this title—

"(1) The term 'State' includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, the Trust Territory of the Pacific Islands, and the District of Columbia.

"(2) The term 'State agency' means the State mental health authority responsible for the mental health service part of a State's plan under section 314(d) of the Public Health Service Act.

"(3) The term 'Secretary' means the Secretary of Health, Education, and Welfare.

"(4) The term 'National Advisory Mental Health Council' means the National Advisory Mental Health Council established under section 217 of the Public Health Service Act.

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PART D—RAPE PREVENTION AND CONTROL

"RAPE PREVENTION AND CONTROL

"SEC. 231. (a) The Secretary shall establish within the National Institute of Mental Health an identifiable administrative unit to be known as the National Center for the Prevention and Control of Rape (hereinafter in this section referred to as the 'Center').

"(b) (1) The Secretary, acting through the Center, may, directly or by grant, carryout the following:

"(A) A continuing study and investigation of—

"(i) the effectiveness of existing Federal, State, and local laws dealing with rape;

"(ii) the relationship, if any, between traditional legal and social attitudes toward sexual roles, the act of rape, and the formulation of laws dealing with rape;

"(iii) the treatment of the victims of rape by law enforcement agencies, hospitals or other medical institutions, prosecutors, and the courts;

"(iv) the causes of rape, identifying to the degree possible—

"(I) social conditions which encourage sexual attacks,

"(II) motivations of offenders, and

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"(III) the impact of the offense on the victim and the family of the victim;

"(v) sexual assaults in correctional institutions;

"(vi) the actual incidence of forcible rape as compared to the reported cases and the reasons therefor; and

"(vii) the effectiveness of existing private and local and State government education and counseling programs designed to prevent and control rape.

"(B) The compilation, analysis, and publication of summaries of the continuing study conducted under subparagraph (A) and the research and demonstration projects conducted under subparagraph (E). The Secretary shall annually submit to the Congress a summary of such study and projects together with recommendations where appropriate.

"(C) The development and maintenance of an information clearinghouse with regard to—

"(i) the prevention and control of rape;

"(ii) the treatment and counseling of the victims of rape and their families; and

"(iii) the rehabilitation of offenders.

"(D) The compilation and publication of training materials for personnel who are engaged or intend to engage in programs designed to prevent and control rape.

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"(E) Assist community mental health centers and other qualified public and nonprofit private entities in conducting research and demonstration projects concerning the control and prevention of rape, including projects (i) to research and demonstrate alternative methods of planning, developing, implementing, and evaluating programs used in the prevention and control of rape, the treatment and counseling of victims of rape and their families, and the rehabilitation of offenders; and (ii) involving the application of such methods.

"(F) Assist community mental health centers in meeting the costs of providing consultation and education services respecting rape.

"(2) For purposes of this subsection, the term 'rape' includes forcible, statutory, and attempted rape, homosexual assaults, and other criminal assaults.

"(c) The Secretary shall appoint an advisory committee to advise, consult with, and make recommendations to him on the implementation of subsection (b). The Secretary shall appoint to such committee persons who are particularly qualified to assist in carrying out the functions of the committee. A majority of the members of the committee shall be women. Members of the advisory committee shall receive compensation at rates, not to exceed the daily equivalent of the annual rate in effect for grade GS–18 of the General

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Schedule, for each day (including traveltime) they are engaged in the performance of their duties as members of the advisory committee and, while so serving away from their homes or regular places of business, each member shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as is authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

"(d) For the purpose of carrying out subsection (b), there are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1975, and $10,000,000 for the fiscal year ending June 30, 1976.

"REGULATIONS

"SEC. 236. Regulations issued by the Secretary for the administration of this title shall include provisions applicable uniformly to all the States which—

"(1) prescribe the general manner in which the State agency of a State shall determine the priority of projects for community mental health centers on the basis of the relative need of the different areas of the State for such centers and their services and requiring special consideration for projects on the basis of the extent to which a center to be assisted or established upon completion of a project (A) will, alone or in conjunction with other centers owned or operated by the

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applicant for the project or affiliated or associated with such applicant, provide comprehensive mental health services for residents of a particular community or communities, or (B) will be part of or closely associated with a general hospital;

"(2) prescribe general standards for facilities and equipment for centers of different classes and in different types of location; and

"(3) require that the State plan of a State submitted under section 237 provide for adequate community mental health centers for people residing in the State, and provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor.

The National Advisory Mental Health Council shall be consulted by the Secretary before the issuance of regulations under this section.

"STATE PLAN

"SEC. 237. (a) A State plan for the provision of comprehensive mental health services within a State shall be comprised of the following two parts:

"(1) An administrative part containing provisions respecting the administration of the plan and related matters. Such part shall—

"(A) provide for the designation of a State

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advisory council to consult with the State agency in administering such plan which council shall include (i) representatives of non-government organizations or groups, and of State agencies, concerned with planning, operation, or utilization of community mental health centers or other mental health facilities, and (ii) representatives of consumers and providers of the services provided by such centers and facilities who are familiar with the need for such services;

"(B) provide that the State agency will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports;

"(C) provide that the State agency will from time to time, but not less often than annually, review the State plan and submit to the Secretary appropriate modifications thereof which it considers necessary; and

"(D) include provisions, meeting such requirements as the Civil Service Commission may pre-

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scribe, relating to the establishment and maintenance of personnel standards on a merit basis.

"(2) A services and facilities part containing provisions respecting services to be offered within the State by community mental health centers and provisions respecting facilities for such centers. Such part shall—

"(A) be consistent with the mental health services part of the State's plan under section 314 (d) of the Public Health Service Act;

"(B) set forth a program for community mental health centers within the State (i) which is based on a statewide inventory of existing facilities and a survey of need for the comprehensive mental health services described in section 201 (b); (ii) which conforms with regulations prescribed by the Secretary under section 236; and (iii) which shall provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor;

"(C) set forth the relative need, determined in accordance with the regulations prescribed under section 236, for the projects included in the program described in subparagraph (B), and, in the case of projects under part C, provide for the completion of such projects in the order of such relative need;

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"(D) emphasize the provision of outpatient services by community mental health centers as a preferable alternative to inpatient hospital services; and

"(E) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of centers which receive Federal aid under this title and provide for enforcement of such standards with respect to projects approved by the Secretary under this title.

"(b) The State agency shall administer or supervise the administration of the State plan.

"(c) A State shall submit a State plan in such form and manner as the Secretary shall by regulation prescribe. The Secretary shall approve any State plan (and any modification thereof) which complies with the requirements of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

"(d) (1) At the request of any State, a portion of any allotment or allotments of such State under section 227 for any fiscal year shall be available to pay one-half (or such smaller share as the State may request) of the expenditures found necessary by the Secretary for the proper and efficient administration of the provisions of the State plan approved

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under this section which relate to construction projects for facilities for community mental health centers; except that not more than 5 per centum of the total of the allotments of such State for any fiscal year, or $50,000, whichever is less, shall be available for such purpose. Amounts made available to any State under this paragraph from its allotment or allotments under section 227 for any fiscal year shall be available only for such expenditures (referred to in the preceding sentence) during such fiscal year or the following fiscal year. Payments of amounts due under this paragraph may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine.

"(2) Any amount paid under paragraph (1) to any State for any fiscal year shall be paid on condition that there shall be expended from State sources for each year for administration of such provisions of the State plan approved under this section not less than the total amount expended for such purposes from such sources during the fiscal year ending June 30, 1968.

"CATCHMENT AREA REVIEW

"SEC. 238. Each agency of a State which administers or supervises the administration of a State's health planning functions under a State plan approved under section 314 (a) of the Public Health Service Act shall, in consultation with that State's mental health authority, periodically review the

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catchment areas of the community mental health centers located in that State to (1) insure that the sizes of such areas are such that the services to be provided through the centers (including their satellites) serving the areas are available and accessible to the residents of the areas promptly, as appropriate, (2) insure that the boundaries of such areas conform, to the extent practicable, with relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs, and (3) insure that the boundaries of such areas eliminate, to the extent possible, barriers to access to the services of the centers serving the areas, including barriers resulting from an area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation.

"STATE CONTROL OF OPERATIONS

"SEC. 239. Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any community mental health center with respect to which any funds have been or may be expended under this title.

"RECORDS AND AUDIT

"SEC. 240. (a) Each recipient of assistance under this title shall keep such records as the Secretary shall prescribe,

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including records which fully disclose the amount and disposition by such recipient of the proceeds of such assistance, the total cost of the project or undertaking in connection with which such assistance is given or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

"(b) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients that are pertinent to the assistance received under this title.

"NONDUPLICATION

"SEC. 241. In determining the amount of any grant under part A, B, or C for the costs of any project there shall be excluded from such costs an amount equal to the sum of (1) the amount of any other Federal grant which the applicant for such grant has obtained, or is assured of obtaining, with respect to such project, and (2) the amount of any non-Federal funds required to be expended as a condition of such other Federal grant.

"DETERMINATION OF POVERTY AREA

"SEC. 242. For purposes of any determination by the Secretary under this title as to whether any urban or rural

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area is a poverty area, the Secretary may not determine that an area is an urban or rural poverty area unless—

"(1) such area contains one or more subareas which are characterized as subareas of poverty;

"(2) the population of such subarea of subareas constitutes a substantial portion of the population of such rural or urban area; and

"(3) the project, facility, or activity, in connection with which such determination is made, does, or (when completed or put into operation) will, serve the needs of the residents of such subarea or subareas.

"PROTECTION OF PERSONAL RIGHTS

"SEC. 243. In making grants under parts A and B, the Secretary shall take such steps as may be necessary to assure that no individual shall be made the subject of any research involving surgery which is carried out (in whole or in part) with funds under such grants unless such individual explicitly agrees to become a subject of such research.

"REIMBURSEMENT

"SEC. 244. The Secretary shall, to the extent permitted by law, work with States, private insurers, community mental health centers, and other appropriate entities to assure that community mental health centers shall be eligible for reimbursement for their mental health services to the same extent as general hospitals and other licensed providers.

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"SHORT TITLE

"SEC. 245. This title may be cited as the 'Community Mental Health Centers Act'.".

SEC. 305. (a) Not later than one year after the date of the enactment of this Act the Secretary of Health, Education, and Welfare shall make a report to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate setting forth a plan, to be carried out in a period of five years, for the extension of comprehensive mental health services through community mental health centers to persons in all areas in which there is a demonstrated need for such services. Such plan shall, at a minimum, indicate on a phased basis the number of persons to be served by such services and an estimate of the cost and personnel requirements needed to provide such services.

(b) Not later than eighteen months after the date of the enactment of this Act the Secretary of Health, Education, and Welfare shall submit to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate a report setting forth (1) national standards for care provided by community mental health centers, and (2) criteria for evaluation of community mental health centers and the quality of the services provided by the centers.

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TITLE IV—MIGRANT HEALTH CENTERS

MIGRANT HEALTH CENTERS

SEC. 401. (a) Section 319 of the Public Health Service Act is amended to read as follows:

"MIGRANT HEALTH

"SEC. 319. (a) For purposes of this section:

"(1) The term 'migrant health center' means an entity which either through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities provides—

"(A) primary health services,

"(B) as may be appropriate for particular centers, supplemental health services necessary for the adequate support of primary health services,

"(C) referral to providers of supplemental health services and payment, as appropriate and feasible, for their provision of such services,

"(D) environmental health services, including, as may be appropriate for particular centers, the detection and alleviation of unhealthful conditions associated with water supply, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing, and other environmental factors related to health,

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"(E) as may be appropriate for particular centers, infectious and parasitic disease screening and control,

"(F) as may be appropriate for particular centers, accident prevention, including prevention of excessive pesticide exposure, and

"(G) information on the availability and proper use of health services,

for migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers, within the area it serves (referred to in this section as a 'catchment area').

"(2) The term 'migratory agricultural worker' means an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes for the purposes of such employment a temporary abode.

"(3) The term 'seasonal agricultural workers' means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker.

"(4) The term 'agriculture' means farming in all its branches, including—

"(A) cultivation and tillage of the soil,

"(B) the production, cultivation, growing, and harvesting of any commodity grown on, in, or as an ad-

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junct to or part of a commodity grown in or on, the land, and

"(C) any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity described in subparagraph (B).

"(5) The term 'high impact area' means a health service area or other area which has not less than six thousand migratory agricultural workers and seasonal agricultural workers residing within its boundaries for more than two months in any calendar year. In computing the number of workers residing in an area, there shall be included as workers the members of the families of such workers.

"(6) The term 'primary health services' means—

"(A) services of physicians and, where feasible, services of physicians' assistants and nurse clinicians;

"(B) diagnostic laboratory and radiologic services;

"(C) preventive health services (including children's eye and ear examinations to determine the need for vision and hearing correction, perinatal services, well child services, and family planning services);

"(D) emergency medical services;

"(E) transportation services as required for adequate patient care; and

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"(F) preventive dental services.

"(7) The term 'supplemental health services' means services which are not included as primary health services and which are—

"(A) hospital services;

"(B) home health services;

"(C) extended care facility services;

"(D) rehabilitative services (incluing physical therapy) and long-term physical medicine;

"(E) mental health services;

"(F) dental services;

"(G) vision services;

"(H) allied health services;

"(I) pharmaceutical services;

"(J) therapeutic radiologic services;

"(K) public health services (including nutrition education and social services);

"(L) health education services; and

"(M) services which promote and facilitate optimal use of primary health services and the services referred to in the preceding subparagraphs of this paragraph. including, if a substantial number of the individuals in the population served by a migrant health center are of limited English-speaking ability, the services of outreach

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workers fluent in the language spoken by a predominant number of such individuals.

"(b) (1) The Secretary shall assign to high impact areas and any other areas (where appropriate) priorities for the provision of assistance under this section to projects and programs in such areas. The highest priorities for such assistance shall be assigned to areas in which reside the greatest number of migratory agricultural workers and the members of their families for the longest period of time.

"(2) No application for a grant under subsection (c) or (d) for a project in an area which has no migratory agricultural workers may be approved unless grants have been provided for all approved applications under such subsections for projects in areas with migratory agricultural workers.

"(c) (1) (A) The Secretary may, in accordance with the priorities assigned under subsection (b) (1), make grants to public and nonprofit private entities for projects to plan and develop migrant health centers which will serve migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers, in high impact areas. A project for which a grant may be made under this subparagraph may include the cost of the acquisition and modernization of existing buildings (including the costs of amortizing the principal

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of, and paying the interest on, loans) and the costs of providing training related to the management of migrant health center programs, and shall include—

"(i) an assessment of the need that the workers (and the members of the families of such workers) proposed to be served by the migrant health center for which the project is undertaken have for primary health services, supplemental health services, and environmental health services;

"(ii) the design of a migrant health center program for such workers and the members of their families, based on such assessment;

"(iii) efforts to secure, within the proposed catchment area of such center, financial and professional assistance and support for the project; and

"(iv) initiation and encouragement of continuing community involvement in the development and operation of the project.

"(B) The Secretary may make grants to or enter into contracts with public and nonprofit private entities for projects to plan and develop programs in areas in which no migrant health center exists and in which not more than six thousand migratory agricultural workers and their families reside for more than two months—

"(i) for the provision of emergency care to

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migratory agricultural workers, seasonal agricultural workers, and the members of families of such migratory and seasonal workers;

"(ii) for the provision of primary care (as defined in regulations of the Secretary) for such workers and the members of their families;

"(iii) for the development of arrangements with existing facilities to provide primary health services (not included as primary care as defined under regulations under clause (ii)) to such workers and the members of their families; or

"(iv) which otherwise improve the health of such workers and their families.

Any such program may include the acquisition and modernization of existing buildings and the cost of providing training related to the management of programs assisted under this subparagraph.

"(2) Not more than two grants may be made under paragraph (1) (A) for the same project, and if a grant or contract is made or entered into under paragraph (1) (B) for a project, no other grant or contract under that paragraph may be made or entered into for the project.

"(3) The amount of any grant made under paragraph (1) for any project shall be determined by the Secretary.

"(d) (1) (A) The Secretary may, in accordance with

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priorities assigned under subsection (b) (1), make grants for the costs of operation of public and nonprofit private migrant health centers in high impact areas.

"(B) The Secretary may, in accordance with priorities assigned under subsection (b) (1), make grants for the costs of the operation of public and nonprofit entities which intend to become migrant health centers, which provide health services in high impact areas to migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers, but with respect to which he is unable to make each of the determinations required by subsection (f) (2). Not more than two grants may be made under this subparagraph for any entity.

"(C) The Secretary may make grants to and enter into contracts with public and nonprofit private entities for projects for the operation of programs in areas in which no migrant health center exists and in which not more than six thousand migratory agricultural workers and their families reside for more than two months—

"(i) for the provision of emergency care to migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers;

"(ii) for the provision of primary care (as defined

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in regulations of the Secretary) for such workers and the members of their families:

"(iii) for the development of arrangements with existing facilities to provide primary health services (not included as primary care as defined under regulations under clause (ii)) to such workers and the members of their families; or

"(iv) which otherwise improve the health of such workers and the members of their families.

Any such program may include the acquisition and modernization of existing buildings and the cost of providing training related to the management of programs assisted under this subparagraph.

"(2) The costs for which a grant may be made under paragraph (1)(A) or (1)(B) may include the costs of acquiring and modernizing existing buildings (including the costs of amortizing the principal of, and paying the interest on, loans); and the costs for which a grant or contract may be made under paragraph (1) may include the costs of providing training related to the provision of primary health services, supplemental health services, and environmental health services, and to the management of migrant health center programs.

"(3) The amount of any grant made under paragraph (1) shall be determined by the Secretary.

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"(e) The Secretary may enter into contracts with public and private entities to—

"(1) assist the States in the implementation and enforcement of acceptable environmental health standards, including enforcement of standards for sanitation in migrant labor camps and applicable Federal and State pesticide control standards; and

"(2) conduct projects and studies to assist the several States and entities which have received grants or contracts under this section in the assessment of problems related to camp and field sanitation, pesticide hazards, and other environmental health hazards to which migratory agricultural workers, seasonal agricultural workers, and members of their families are exposed.

"(f) (1) No grant may be made under subsection (c) or (d) and no contract may be entered into under subsection (c) (1) (B), (d) (1) (C), or (e) unless an application therefor is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary shall prescribe. An application for a grant or contract which will cover the costs of modernizing a building shall include, in addition to other information required by the Secretary—

"(A) a description of the site of the building,

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"(B) plans and specifications for its modernization, and

"(C) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on the modernization of the building will be paid wages at rates not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act).

The Secretary of Labor shall have with respect to the labor standards referred to in subparagraph (C) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

"(2) The Secretary may not approve an application for a grant under subsection (d) (1) (A) unless the Secretary determines that the entity for which the application is submitted is a migrant health center (within the meaning of subsection (a) (1)) and that—

"(A) the primary health services of the center will be available and accessible in the center's catchment area promptly, as appropriate, and in a manner which assures continuity;

"(B) the center will have organizational arrange-

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ments, established in accordance with regulations of the Secretary, for (i) an ongoing quality assurance program (including utilization and peer review systems) respecting the center's services, and (ii) maintaining the confidentiality of patient records;

"(C) the center will demonstrate its financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

"(D) the center (i) has or will have a contractual or other arrangement with the agency of the State in which it provides services which agency administers or supervises the administration of a State plan approved under title XIX of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under such a State plan, or (ii) has made or will make every reasonable effort to enter into such an arrangement;

"(E) the center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX

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of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

"(F) the center (i) has prepared a schedule of fees or payments for the provision of its services designed to cover its reasonable costs of operation and a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay, (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for services in accordance with such schedules, and (II) to collect reimbursement for health services to persons described in subparagraph (E) on the basis of the full amount of fees and payments for such services without application of any discount, and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph;

"(G) the center has established a governing board which (i) is composed of individuals a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center, and (ii) establishes general policies for the center (including the selection of services to be provided by the center and a schedule of hours during which services

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will be provided), approves the center's annual budget, and approves the selection of a director for the center;

"(H) the center has developed, in accordance with regulations of the Secretary, (i) an overall plan and budget that meets the requirements of section 1861 (z) of the Social Security Act, and (ii) an effective procedure for compiling and reporting to the Secretary such statistics and other information as the Secretary may require relating to (I) the costs of its operations, (II) the patterns of utilization of its services, (III) the availability, accessibility, and acceptability of its services, and (IV) such other matters relating to operations of the applicant as the Secretary may, by regulation, require;

"(I) the center will review periodically its catchment area to (i) insure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers, in the area promptly and as appropriate, (ii) insure that the boundaries of such area conform, to the extent practicable, with relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs, and (iii) insure that the boundaries of such area eliminate,

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to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation; and

"(J) in the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has (i) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (ii) identified an individual on its staff who is bilingual and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences.

"(3) In considering applications for grants and contracts under subsection (c) or (d) (1) (C), the Secretary shall give priority to applications submitted by community-based organizations which are representative of the populations to be served through the projects, programs, or centers to be assisted by such grants or contracts.

"(4) Contracts may be entered into under this sec-

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tion without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(g) The Secretary may provide (either through the Department of Health, Education, and Welfare or by grant or contract) all necessary technical and other nonfinancial assistance (including fiscal and program management and training in such management) to any migrant health center or to any public or private nonprofit entity to assist it in developing plans for, and in operating as, a migrant health center, and in meeting the requirements of subsection (f) (2).

"(h) (1) There are authorized to be appropriated for payments pursuant to grants and contracts under subsection (c) (1) $5,000,000 for the fiscal year ending June 30, 1975, and $5,000,000 for the fiscal year ending June 30, 1976. Of the funds appropriated under this paragraph for the fiscal year ending June 30, 1975, not more than 30 per centum of such funds may be made available for grants and contracts under subsection (c) (1) (B), and of the funds appropriated under this paragraph for the next fiscal year, not more than 25 per centum of such funds may be made available for grants and contracts under such subsection.

"(2) There are authorized to be appropriated for payments pursuant to grants and contracts under subsection (d) (1) (other than for payments under such grants and contracts for the provision of inpatient and outpatient hos-

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pital services) and for payments pursuant to contracts under subsection (e) $60,000,000 for the fiscal year ending June 30, 1975, and $65,000,000 for the fiscal year ending June 30, 1976. Of the funds appropriated under the first sentence for the fiscal year ending June 30, 1975, there shall be made available for grants and contracts under subsection (d) (1) (C) an amount equal to the greater of 30 per centum of such funds or 90 per centum of the amount of grants made under this section for the preceding fiscal year for programs described in subsection (d) (1) (C). Of the funds appropriated under the first sentence for the fiscal year ending June 30, 1976, there shall be made available for grants and contracts under subsection (d) (1) (C) an amount equal to the greater of 25 per centum of such funds or 90 per centum of the amount of grants made under this section for the preceding fiscal year for programs described in subsection (d) (1) (C) which received grants under this section for the fiscal year ending June 30, 1974. Of the funds appropriated under this paragraph for any fiscal year, not more than 10 per centum of such funds may be made available for contracts under subsection (e).

"(3) There are authorized to be appropriated for payments under grants and contracts under subsection (d) (1) for the provision of inpatient and outpatient hospital services

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$10,000,000 for the fiscal year ending June 30, 1975, and $10,000,000 for the fiscal year ending June 30, 1976."

(b) Section 217 of the Public Health Service Act is amended by adding after subsection (f) the following new subsection:

(g) (1) Within one hundred and twenty days after the date of the enactment of this subsection, the Secretary shall appoint and organize a National Advisory Council on Migrant Health (hereinafter in this subsection referred to as the 'Council') which shall advise, consult with, and make recommendations to, the Secretary on matters concerning the organization, operation, selection, and funding of migrant health centers and other entities under grants and contracts under section 310.

"(2) The Council shall consist of fifteen members, at least twelve of whom shall be members of the governing boards of migrant health centers or other entities assisted under section 310. Of such twelve members who are members of such governing boards, at least nine shall be chosen from among those members of such governing boards who are being served by such centers or grantees and who are familiar with the delivery of health care to migratory agricultural workers and seasonal agricultural workers. The remaining three Council members shall be individuals

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qualified by training and experience in the medical sciences or in the administration of health programs.

"(3) Each member of the Council shall hold office for a term of four years, except that (A) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; and (B) the terms of the members first taking office after the date of enactment of this subsection shall expire as follows: four shall expire four years after such date, four shall expire three years after such date, four shall expire two years after such date, and three shall expire one year after such date, as designated by the Secretary at the time of appointment.

"(4) Section 14(a) of the Federal Advisory Committee Act shall not apply to the Council.".

(c) (1) The Secretary of Health, Education, and Welfare (hereinafter in this subsection referred to as the "Secretary") shall conduct or arrange for the conduct of a study of—

(A) the quality of housing which is available to agricultural migratory workers in the United States during the period of their employment in seasonal agricultural activities while away from their permanent abodes;

(B) the effect on the health of such workers of

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deficiencies in their housing conditions during such period; and

(C) Federal, State, and local government standards respecting housing conditions for such workers during such period and the adequacy of the enforcement of such standards.

In conducting or arranging for the conduct of such study, the Secretary shall consult with the Secretary of Housing and Urban Development.

(2) Such study shall be completed and a report detailing the findings of the study and the recommendations of the Secretary for Federal action (including legislation) respecting such housing conditions shall be submitted to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate within eighteen months of the date of the enactment of this first Act making appropriations for such study.

TITLE V—COMMUNITY HEALTH CENTERS

COMMUNITY HEALTH CENTERS

SEC. 501. (a) Part C of title III of the Public Health Service Act is amended by adding after section 329 the following new section:

"COMMUNITY HEALTH CENTERS

"SEC. 330. (a) For purposes of this section, the term

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'community health center' means an entity which either through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities provides—

"(1) primarily health services,

"(2) as may be appropriate for particular centers, supplemental health services necessary for the adequate support of primary health services,

"(3) referral to providers of supplemental health services and payment, as appropriate and feasible, for their provision of such services,

"(4) as may be appropriate for particular centers, environmental health services, and

"(5) information on the availability and proper use of health services,

for all residents of the area it serves (referred to in this section as a 'catchment area').

"(b) For purposes of this section:

"(1) The term 'primary health services' means—

"(A) services of physicians and, where feasible, services of physicians' assistants and nurse clinicians;

"(B) diagnostic laboratory and radiologic services;

"(C) preventive health services (including children's eye and ear examinations to determine the need

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for vision and hearing correction, perinatal services, well child services, and family planning services) ;

"(D) emergency medical services;

"(E) transportation services as required for adequate patient care; and

"(F) preventive dental services.

"(2) The term 'supplemental health services' means services which are not included as primary health services and which are—

"(A) hospital services;

"(B) home health services;

"(C) extended care facility services;

"(D) rehabilitative services (including physical therapy) and long-term physical medicine;

"(E) mental health services;

"(F) dental services;

"(G) vision services;

"(H) allied health services;

"(I) pharmaceutical services;

"(J) therapeutic radiologic services;

"(K) public health services (including nutrition education and social services) ;

"(L) health education services; and

"(M) services which promote and facilitate optimal use of primary health services and the services referred

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to in the preceding subparagraphs of this paragraph, including, if a substantial number of the individuals in the population served by a community health center are of limited English-speaking ability, the services of outreach workers fluent in the language spoken by a predominant number of such individuals.

"(3) The term 'medically underserved population' means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.

"(c) (1) The Secretary may make grants to public and nonprofit private entities for projects to plan and develop community health centers which will serve medically underserved populations. A project for which a grant may be made under this subsection may include the cost of the acquisition and modernization of existing buildings (including the costs of amortizing the principal of, and paying the interest on, loans) and shall include—

"(A) an assessment of the need that the population proposed to be served by the community health center for which the project is undertaken has for primary health services, supplemental health services, and environmental health services;

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"(B) the design of a community health center program for such population based on such assessment;

"(C) efforts to secure, within the proposed catchment area of such center, financial and professional assistance and support for the project; and

"(D) initiation and encouragement of continuing community involvement in the development and operation of the project.

"(2) Not more than two grants may be made under this subsection for the same project.

"(3) The amount of any grant made under this subsection for any project shall be determined by the Secretary.

"(d) (1) (A) The Secretary may make grants for the costs of operation of public and nonprofit private community health centers which serve medically underserved populations.

"(B) The Secretary may make grants for the costs of the operation of public and nonprofit private entities which provide health services to medically underserved populations but with respect to which he is unable to make each of the determinations required by subsection (c) (2).

"(2) The costs for which a grant may be made under paragraph (1) may include the costs of acquiring and modernizing existing buildings (including the costs of amortizing the principal of, and paying interest on, loans)

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and the costs of providing training related to the provision of primary health services, supplemental health services, and environmental health services, and to the management of community health center programs.

"(3) Not more than two grants may be made under paragraph (1) (B) for the same entity.

"(4) The amount of any grant made under paragraph (1) shall be determined by the Secretary.

"(e) (1) No grant may be made under subsection (e) or (d) unless an application therefor is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary shall prescribe. An application for a grant which will cover the costs of modernizing a building shall include, in addition to other information required by the Secretary—

"(A) a description of the site of the building.

"(B) plans and specifications for its modernization, and

"(C) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on the modernization of the building will be paid wages at rates not less than those prevailing on similar work in the locality as deter-

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mined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act).

The Secretary of Labor shall have with respect to the labor standards referred to in subparagraph (C) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176, 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

"(2) Except as provided in subsection (d) (1) (B), the Secretary may not approve an application for a grant under subsection (d) unless the Secretary determines that the entity for which the application is submitted is a community health center (within the meaning of subsection (a)) and that—

"(A) the primary health services of the center will be available and accessible in the center's catchment area promptly, as appropriate, and in a manner which assures continuity;

"(B) the center will have organizational arrangements, established in accordance with regulations prescribed by the Secretary, for (i) an ongoing quality assurance program (including utilization and peer review systems) respecting the center's services, and (ii) maintaining the confidentiality of patient records;

"(C) the center will demonstrate its financial re-

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sponsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

"(D) the center (i) has or will have a contractual or other arrangement with the agency of the State in which it provides services which agency administers or supervises the administration of a State plan approved under title XIX of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under such a State plan, or (ii) has made or will make every reasonable effort to enter into such an arrangement;

"(E) the center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

"(F) the center (i) has prepared a schedule of fees or payments for the provision of its services designed to cover its reasonable costs of operation and a

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corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay, (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for services in accordance with such schedules, and (II) to collect reimbursement for health services to persons described in subparagraph (E) on the basis of the full amount of fees and payments for such services without application of any discount, and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph;

"(G) the center has established a governing board which (i) is composed of individuals a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center, and (ii) meets at least once a month, establishes general policies for the center (including the selection of services to be provided by the center and a schedule of hours during which services will be provided), approves the center's annual budget, and approves the selection of a director for the center;

"(H) the center has developed, in accordance with regulations of the Secretary, (i) an overall plan and budget that meets the requirements of section 1861(z)

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of the Social Security Act, and (ii) an effective procedure for compiling and reporting to the Secretary such statistics and other information as the Secretary may require relating to (I) the costs of its operations, (II) the patterns of utilization of its services, (III) the availability, accessibility, and acceptability of its services, and (IV) such other matters relating to operations of the applicant as the Secretary may, by regulation, require;

"(I) the center will review periodically its catchment area to (i) insure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate, (ii) insure that the boundaries of such area conform, to the extent practicable, with relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs, and (iii) insure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation; and

"(J) in the case of a center which serves a population including a substantial proportion of individuals of

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limited English-speaking ability, the center has (i) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (ii) identified an individual on its staff who is bilingual and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences.

"(f) The Secretary may provide (either through the Department of Health, Education, and Welfare or by grant or contract) all necessary technical and other nonfinancial assistance (including fiscal and program management and training in such management) to any public or private nonprofit entity to assist it in developing plans for, and in operating as, a community health center, and in meeting the requirements of subsection (e) (2).

"(g) (1) There are authorized to be appropriated for payments pursuant to grants under subsection (c) $20,000,000 for the fiscal year ending June 30, 1975, and $20,000,000 for the fiscal year ending June 30, 1976.

"(2) There are authorized to be appropriated for payments pursuant to grants under subsection (d) $240,000,000

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for the fiscal year ending June 30, 1975, and $260,000,000 for the fiscal year ending June 30, 1976."

(b) Section 314 (e) of the Public Health Service Act is repealed.

TITLE VI—MISCELLANEOUS

DISEASES BORNE BY RODENTS

SEC. 601. (a) Section 317 (h) (1) of the Public Health Service Act is amended by striking out "and RH disease" and inserting in lieu thereof ", RH disease, and diseases borne by rodents."

(b) Section 317 (d) (3) of such Act is amended by striking out "$23,000,000 for the fiscal year ending June 30, 1975" and inserting in lieu thereof "$38,000,000 for the fiscal year ending June 30, 1975".

HOME HEALTH SERVICES

SEC. 602. (a) (1) For the purpose of demonstrating the establishment and initial operation of public and nonprofit private agencies (as defined in section 1861 (o) of the Social Security Act) which will provide home health services (as defined in section 1861 (m) of the Social Security Act) in areas in which such services are not otherwise available, the Secretary of Health, Education, and Welfare may, in accordance with the provisions of this section, make grants to meet the initial costs of establishing

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and operating such agencies and expanding the services available through existing agencies, and to meet the costs of compensating professional and paraprofessional personnel during the initial operation of such agencies or the expansion of services of existing agencies.

(2) In making grants under this subsection, the Secretary shall consider the relative needs of the several States for home health services and preference shall be given to areas within a State in which a high percentage of the population proposed to be served is composed of individuals who are elderly, medically indigent, or both.

(3) Applications for grants under this subsection shall be in such form and contain such information as the Secretary shall prescribe by regulation.

(4) Payment of grants under this subsection may be made in advance or by way of reimbursement or in installments as the Secretary may determine.

(5) There are authorized to be appropriated $12,000,000 for the fiscal year ending June 30, 1976, for payments under grants under this subsection.

(b) (1) The Secretary of Health, Education, and Welfare may make grants to public and nonprofit private entities to assist them in demonstrating the training of professional and paraprofessional personnel to provide home health serv-

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ices (as defined in section 1861 (m) of the Social Security Act).

(2) Applications for grants under this subsection shall be in such form and contain such information as the Secretary shall by regulations prescribe.

(3) Payment of grants under this section may be made in advance or by way of reimbursement, or in installments, as the Secretary shall determine.

(4) There is authorized to be appropriated $3,000,000 for the fiscal year ending June 30, 1976, for payments under grants under this subsection.

COMMITTEE ON MENTAL HEALTH AND ILLNESS OF THE ELDERLY

SEC. 603. (a) The Secretary of Health, Education, and Welfare shall appoint a Committee on Mental Health and Illness of the Elderly (hereinafter in this section referred to as the "Committee") to make a study of and recommendations respecting—

(1) the future needs for mental health facilities, manpower, research, and training to meet the mental health care needs of elderly persons,

(2) the appropriate care of elderly persons who are in mental institutions or who have been discharged from such institutions, and

(3) proposals for implementing the recommenda-

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tions of the 1971 White House Conference on Aging respecting the mental health of the elderly.

(b) Within one year from the date of enactment of this Act the Secretary shall report to the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives the findings of the Committee under the study under subsection (a) and the Committee's recommendations under such subsection.

(c) (1) The Committee shall be composed of nine members appointed by the Secretary of Health, Education, and Welfare. The Committee shall include at least one member from each of the fields of psychology, psychiatry, social science, social work, and nursing. Each member of the Committee shall by training, experience, or attainments be exceptionally qualified to assist in carrying out the functions of the Committee.

(2) Members of the Committee shall receive compensation at a rate to be fixed by the Secretary, but not exceeding the daily equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule, for each day (including traveltime) during which they are engaged in the actual performance of duties vested in the Committee. While away from their homes or regular places of business in the performance of services for the Committee,

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members of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 (b) of title 5 of the United States Code.

(d) The Committee shall cease to exist thirty days after the submission of the report pursuant to subsection (b).

COMMISSION FOR CONTROL OF EPILEPSY

SEC. 604. (a) The Secretary of Health, Education, and Welfare shall establish a temporary commission to be known as the Commission for the Control of Epilepsy and Its Consequences (hereinafter referred to in this section as the "Commission").

(b) It shall be the duty of the Commission to—

(1) make a comprehensive study of the state of the art of medical and social management of the epilepsies in the United States;

(2) investigate and make recommendations concerning the proper roles of Federal and State governments and national and local public and private agencies in research, prevention, identification, treatment, and rehabilitation of persons with epilepsy;

(3) develop a comprehensive national plan for the control of epilepsy and its consequences based on the

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most thorough, complete, and accurate data and information available on the disorder; and

(4) transmit to the President and the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives, not later than one year after the date of enactment of this Act, a report detailing the findings and conclusions of the Commission, together with recommendations for legislation and appropriations, as it deems advisable.

(c) (1) The Commission shall be composed of nine members to be appointed by the Secretary of Health, Education, and Welfare. Such members shall be persons, including consumers of health services, who, by reason of experience or training in the medical, social, or educational aspects of the epilepsies, are especially qualified to serve on such Commission.

(2) The Secretary shall designate one of the members of the Commission to serve as Chairman and one to serve as Vice Chairman. Vacancies shall be filled in the same manner in which the original appointments were made. Any vacancy in the Commission shall not affect its powers.

(3) Any member of the Commission who is otherwise employed by the Federal Government shall serve without compensation in addition to that received in his regular

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employment, but shall be entitled to reimbursement for travel, subsistence, and other necessary expenses incurred by him in the performance of his duties on the Commission.

(4) Members of the Commission, other than those referred to in paragraph (3), shall receive compensation at rates, not to exceed the daily equivalent of the annual rate in effect for grade GS–18 of the General Schedule, for each day (including traveltime) they are engaged in the performance of their duties and, while so serving away from their homes or regular places of business, each member shall be allowed travel expenses, including per diem in lieu of subsistence in the same manner as is authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

(d) The Commission shall cease to exist thirty days after the submission of the final report required by subsection (b) (4).

COMMISSION FOR CONTROL OF HUNTINGTON'S DISEASE

SEC. 605. (a) The Secretary of Health, Education, and Welfare shall establish a temporary commission to be known as the Commission for the Control of Huntington's Disease and Its Consequences (hereinafter referred to in this section as the "Commission").

(b) It shall be the duty of the Commission to—

(1) make a comprehensive study of the state of the

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art of medical and social management of Huntington's disease in the United States;

(2) investigate and make recommendations concerning the proper roles of Federal and State governments and national and local public and private agencies in research, prevention, identification, treatment, and rehabilitation of persons with Huntington's disease;

(3) develop a comprehensive national plan for the control of Huntington's disease and its consequences based on the most thorough, complete, and accurate data and information available on the disorder; and

(4) transmit to the President and the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives, not later than one year after the date of enactment of this Act, a report detailing the findings and conclusions of the Commission, together with recommendations for legislation and appropriations, as it deems advisable.

(c) (1) The Commission shall be composed of nine members to be appointed by the Secretary of Health, Education, and Welfare. Such members shall be persons, including consumer of health services, who, by reason of experience or training in the medical, social, or educational aspects of

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Huntington's disease, are especially qualified to serve on such Commission.

(2) The Secretary shall designate one of the members of the Commission to serve as Chairman and one to serve as Vice Chairman. Vacancies shall be filled in the same manner in which the original appointments were made. Any vacancy in the Commission shall not affect its powers.

(3) Any member of the Commission who is otherwise employed by the Federal Government shall serve without compensation in addition to that received in his regular employment, but shall be entitled to reimbursement for travel, subsistence, and other necessary expenses incurred by him in the performance of his duties on the Commission.

(4) Members of the Commission, other than those referred to in paragraph (3), shall receive compensation at rates, not to exceed the daily equivalent of the annual rate in effect for grade GS–18 of the General Schedule, for each day (including traveltime) they are engaged in the performance of their duties and, while so serving away from their homes or regular places of business, each member shall be allowed travel expenses, including per diem in lieu of subsistence in the same manner as is authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

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(d) The Commission shall cease to exist thirty days after the submission of the final report required by subsection (b) (4).

HEMOPHILIA PROGRAMS

SEC. 606. Title XI of the Public Health Service Act is amended by adding after part C the following new part:

"PART D—HEMOPHILIA PROGRAMS

"TREATMENT CENTERS

"SEC. 1131. (a) The Secretary may make grants to and enter into contracts with public and nonprofit private entities for projects for the establishment of comprehensive hemophilia diagnostic and treatment centers. A center established under this subsection shall provide—

"(1) access to the services of the center for all individuals suffering from hemophilia who reside within the geographic area served by the center;

"(2) programs for the training of professional and paraprofessional personnel in hemophilia research, diagnosis, and treatment;

"(3) a program for the diagnosis and treatment of individuals suffering from hemophilia who are being treated on an outpatient basis;

"(4) a program for association with providers of health care who are treating individuals suffering from hemophilia in areas not conveniently served directly by

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such center but who are more conveniently (as determined by the Secretary) served by it than by the next geographically closest center;

"(5) programs of social and vocational counseling for individuals suffering from the hemophilia; and

"(6) individualized written comprehensive care programs for each individual treated by or in association with such center.

"(b) No grant or contract may be made under subsection (a) unless an application therefor has been submitted to and approved by the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

"(c) An application for a grant or contract under subsection (a) shall contain assurances satisfactory to the Secretary that the applicant will serve the maximum number of individuals that its available and potential resources will enable it to effectively serve.

"(d) In considering applications for grants and contracts under subsection (a) for projects to establish hemophilia diagnostic and treatment centers, the Secretary shall—

"(1) take into account the number of persons to be served by the programs to be supported by such centers and the extent to which rapid and effective use

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will be made by such centers of funds under such grants and contracts, and

"(2) give priority to projects for centers which will operate in areas which the Secretary determines have the greatest number of persons in need of the services provided by such centers.

"(e) Contracts may be entered into under subsection (a) without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(f) There are authorized to be appropriated to make payments under grants and contracts under subsection (a) $3,000,000 for the fiscal year ending June 30, 1975, $5,000,000 for the fiscal year ending June 30, 1976.

"BLOOD SEPARATION CENTERS

"SEC. 1132. (a) The Secretary may make grants to and enter into contracts with public and nonprofit private entities for projects to develop and expand, within existing facilities, blood-separation centers to separate and make available for distribution blood components to providers of blood services and manufacturers of blood fractions. For purposes of this section—

"(1) the term 'blood components' means those constituents of whole blood which are used for therapy and which are obtained by physical separation processes which result in licensed products such as red blood

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cells, platelets, white blood cells, AHF-rich plasma, fresh-frozen plasma, cryoprecipitate, and single unit plasma for infusion; and

"(2) the term 'blood fractions' means those constituents of plasma which are used for therapy and which are obtained by licensed fractionation processes presently used in manufacturing which result in licensed products such as normal serum albumin, plasma, protein fraction, prothrombin complex, fibrinogen, AHF concentrate, immune serum globulin, and hyperimmune globulins.

"(b) In the event the Secretary finds that there is an insufficient supply of blood fractions available to meet the needs for treatment of persons suffering from hemophilia, and that public and other nonprofit private centers already engaged in the production of blood fractions could alleviate such insufficiency with assistance under this subsection, he may make grants not to exceed $500,000 to such centers for the purposes of alleviating the insufficiency.

"(c) No grant or contract may be made under subsection (a) or (b) unless an application therefor has been submitted to and approved by the Secretary. Such an application shall be in such form, submitted in such manner, and contain such information as the Secretary shall by regulation prescribe.

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"(d) Contracts may be entered into under subsection (a) without regard to section 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(e) For the purpose of making payments under grants and contracts under subsections (a) and (b), there are authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1975, and $5,000,000 for the fiscal year ending June 30, 1976."

TECHNICAL AMENDMENTS

SEC. 607. (a) Section 399c of the Public Health Service Act (added by Public Law 93-222) is redesignated as section 399A.

(b) The section 472 of the Public Health Service Act (entitled "Peer Review of Grant Applications and Control Projects") is redesignated as section 475.

(c) Section 317(d) of the Public Health Service Act is amended (1) by striking out "communicable and other disease" in paragraphs (1) and (2), and (2) by striking out "communicable and other disease" the second time it occurs in paragraph (3).

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94TH CONGRESS
1ST SESSION

H. R. 2955

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 6, 1975

Mr. ROGERS (for himself, Mr. PREYER, Mr. SYMINGTON, Mr. CARNEY, Mr. SCHEUER, Mr. WAXMAN, Mr. HEFNER, Mr. FLORIO, Mr. CARTER, Mr. HASTINGS, and Mr. HEINZ) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Developmental Disabilities Services and Facilities Construction Act to revise and extend the programs authorized by that Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Developmental Disabilities Amendments of 1975".

EXTENSION OF DEMONSTRATION AND TRAINING GRANTS

SEC. 2. (a) Section 122 (b) of the Developmental Disabilities Services and Facilities Construction Act (hereinafter in this Act referred to as the "Act") is amended by striking out "and" after "1973;" and by inserting after "1974" the

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following: "; $12,000,000 for the fiscal year ending June 30, 1975; and $15,000,000 for the fiscal year ending June 30, 1976".

(b) Section 124 of the Act is amended to read as follows:

"PAYMENTS

"SEC. 124. Payments of grants under section 122 shall be made in advance or by way of reimbursement, and on such conditions as the Secretary may determine.".

SPECIAL PROJECT GRANTS

SEC. 3. Section 130 of the Act is amended to read as follows:

"SPECIAL PROJECT GRANTS

"SEC. 130. (a) The Secretary may make grants to public or nonprofit private entities for—

"(1) demonstration projects for the provision of services to persons with developmental disabilities who are also disadvantaged because of their economic status or the location of their residences,

"(2) technical assistance relating to services and facilities for persons with developmental disabilities, including assistance in State and local planning or administration,

"(3) training of specialized personnel needed for the provision of services for persons with developmental

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disabilities, or for research directly related to such training,

"(4) developing or demonstrating new or improved techniques for the provision of services to persons with developmental disabilities, or

"(5) gathering and disseminating information relating to developmental disabilities.

"(b) No grant may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information as the Secretary shall by regulation prescribe. The Secretary may not approve such an application unless the State in which the applicant's project will be conducted has a State plan approved under section 134.

"(c) The amount of any grant under subsection (a) shall be determined by the Secretary; and payments under such grants may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary. In determining the amount of any grant under subsection (a) for the costs of any project there shall be excluded from such costs an amount equal to the sum of (1) the amount of any other Federal grant which the applicant has obtained, or is assured of obtaining, with respect to such project, and (2) the amount of any

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non-Federal funds required to be expended as a condition of such other Federal grant.

"(d) For the purpose of making payments under grants under subsection (a), there are authorized to be appropriated $15,000,000 for the fiscal year ending June 30, 1975, and $15,000,000 for the fiscal year ending June 30, 1976. Of the funds appropriated under this subsection for any fiscal year, not less than 30 per centum of such funds shall be used for projects of national significance, as determined by the Secretary.

"(e) No funds appropriated under the Public Health Service Act or under this Act (other than under subsection (d) of this section) may be used to make grants under subsection (a)."

STATE ALLOTMENTS

SEC. 4. (a) Section 131 of the Act is amended to read as follows:

"AUTHORIZATION OF APPROPRIATIONS FOR ALLOTMENTS

"SEC. 131. For allotments under section 132, there are authorized to be appropriated $50,000,000 for the fiscal year ending June 30, 1975, and $85,000,000 for the fiscal year ending June 30, 1976."

(b) Subsection (a) of section 132 of the Act is amended to read as follows:

"(a) (1) (A) In each fiscal year, the Secretary shall,

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in accordance with regulations and subparagraph (B) of this paragraph, allot the sums appropriated for such year under section 131 among the States on the basis of—

"(i) the population,

"(ii) the extent of need for services and facilities for persons with developmental disabilities, and

"(iii) the financial need,

of the respective States. Sum allotted to the States under this section shall be used in accordance with approved State plans under section 134 for the provision under such plans of services and facilities for persons with developmental disabilities.

"(B) The allotment of the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands under subparagraph (A) of this paragraph in any fiscal year shall not be less than $50,000. The allotment of each other State in any fiscal year shall not be less than the sum of—

"(i) $100,000, and

"(ii) if the sums appropriated under section 131 for the fiscal year in which the allotment is made exceed the amount authorized to be appropriated under such section for the fiscal year ending June 30, 1971, an amount which bears the same ratio to $100,000 as the difference between the amount so appropriated and the amount authorized to be appropriated for the fiscal year

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ending June 30, 1971, bears to the amount authorized to be appropriated for the fiscal year ending June 30, 1971.

"(2) In determining, for purposes of paragraph (1) (A) (ii), the extent of need in any State for services and facilities for persons with developmental disabilities, the Secretary shall take into account the scope and extent of the services specified, pursuant to section 134(b) (5), in the State plan of such State approved under section 134.

"(3) Sums allotted to a State in a fiscal year and designated by it for construction and remaining unobligated at the end of such year shall remain available to such State for such purpose in the next fiscal year (and in such year only), in addition to the sums allotted to such State in such next fiscal year; except that if the maximum amount which may be specified for construction pursuant to section 134(b) (15) for a year plus any part of the amount so specified pursuant thereto for the preceding fiscal year and remaining unobligated at the end thereof is not sufficient to pay the Federal share of the cost of construction of a specific facility included in the construction program of the State developed pursuant to section 134(b) (13), the amount specified pursuant to such section for such preceding year shall remain available for a second additional year for the purpose of paying the Federal share of the cost of construction of such facility.

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"(4) Of the amount allotted to any State under paragraph (1) for the fiscal year ending June 30, 1975, not less than 10 per centum of that allotment shall be used by such State, in accordance with the plan submitted pursuant to section 134(b)(20), for the purpose of assisting it in developing and implementing plans designed to eliminate inappropriate placement in institutions of persons with developmental disabilities, and to improve the quality of care and the state of surroundings of persons for whom institutional care is appropriate; and of the amount alloted to any State for each succeeding fiscal year, not less than 30 per centum of that allotment shall be used by such State for such purposes."

(c) Section 132(e) of the Act is repealed.

(d)(1) Subsection (b) of section 132 of the Act is amended by striking out "this part" each place it occurs and inserting in lieu thereof "the State plan".

(2) Section 134(b)(4) of the Act is amended by striking out "under this part" and inserting in lieu thereof "under section 132".

(3) Section 138 of the Act is amended by striking out "under this part" each place it occurs and inserting in lieu thereof "under section 132".

CONSTRUCTION PROJECTS

SEC. 5. (a) Sections 135 and 136 of the Act are repealed.

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(b) Section 134 (b) of the Act is amended by striking out "and" after the semicolon at the end of paragraph (17), by redesignating paragraph (18) as paragraph (21), and by inserting the following new paragraphs after paragraph (17):

"(18) provide reasonable assurance that adequate financial support will be available to complete the construction of, and to maintain and operate when such construction is completed, any facility, the construction of which is assisted with sums allotted under section 132;

"(19) provide reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on any construction project assisted with sums allotted under section 132 will be paid at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act); and the Secretary of Labor shall have with respect to the labor standards specified in this paragraph the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c);

"(20) contain a plan designed to eliminate inap-

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propriate placement in institutions of persons with developmental disabilities, and to improve the quality of care and the state of surroundings of persons for whom institutional care is appropriate; and".

(c) The headings of sections 137 and 138 of the Act are each amended by inserting "CONSTRUCTION," after "PLANNING,".

(d) Section 137 of the Act is amended (A) by striking out in subsection (a) (1) ", other than expenditures for construction,"; and (B) by amending subsection (b) to read as follows:

"(b) For purposes of subsection (a), the Federal share with respect to any State for the fiscal year ending June 30, 1975, and for the next fiscal year shall be 75 per centum of the expenditures incurred by the State during such year under its State plan approved under section 134."

(e) Section 140 of the Act is amended to read as follows:

"NONDUPLICATION

"SEC. 140. In determining the amount of any State's Federal share of the expenditures incurred by it under a State plan approved under section 134, there shall be disregarded (1) any portion of such expenditures which are financed by Federal funds provided under any provision of law other than section 132, and (2) the amount of any non-

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Federal funds required to be expended as a condition of receipt of such Federal funds."

GENERAL PROVISIONS AND CONFORMING AMENDMENTS

SEC. 6. (a) Section 134 of the Act is amended by adding at the end the following new subsection:

"(d) For purposes of any determination by the Secretary for purposes of subsection (b) (11) as to whether any urban or rural area is a poverty area, the Secretary may not determine that an area is an urban or rural poverty area unless—

"(1) such area contains one or more subareas which are characterized as subareas of poverty;

"(2) the population of such subarea or subareas constitutes a substantial portion of the population of such rural or urban area; and

"(3) the project, facility, or activity, in connection with which such determination is made, does, or (when completed or put into operation) will, serve the needs of the residents of such subarea or subareas."

(b) Part C of the Act is amended by adding after section 140 the following new section:

"RECOVERY

"SEC. 141. If any facility with respect to which funds have been paid under section 132 shall, at any time within twenty years after the completion of construction—

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"(1) be sold or transferred to any person, agency, or organization (A) which is not a public or nonprofit private entity, or (B) which is not approved as a transferee by the State agency designated pursuant to section 134 or its successor; or

"(2) cease to be a public or other nonprofit facility for the mentally retarded or persons with other developmental disabilities, unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the applicant or other owner from the obligation to continue such facility as a public or other nonprofit facility for the mentally retarded or persons with other developmental disabilities,

the United States shall be entitled to recover from either the transferor or the transferee (or, in the case of a facility which has ceased to be a public or other nonprofit facility for the mentally retarded or persons with other developmental disabilities, from the owners thereof) an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the facility is situated) of so much of such facility as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction

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of such project or projects. Such right of recovery shall not constitute a lien upon such facility prior to judgment."

(c) (1) Part A of the Act is amended to read as follows:

"PART A—GENERAL PROVISIONS

"DEFINITIONS

"SEC. 101. For purposes of this title:

"(1) The term 'State' includes Puerto Rico, Guam, American Samoa, the Virgin Islands, the Trust Territory of the Pacific Islands, and the District of Columbia.

"(2) The term 'facility for persons with developmental disabilities' means a facility, or a specified portion of a facility, designed primarily for the delivery of one or more services to persons with one or more developmental disabilities.

"(3) The terms 'nonprofit facility for persons with developmental disabilities' and 'nonprofit private institution of higher learning' mean, respectively, a facility for persons with developmental disabilities and an institution of higher learning which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual; and the term 'nonprofit private agency or organization' means an agency or organization which is such a corporation or association or which is owned and operated by one or more of such corporations or associations.

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"(4) The term 'construction' includes construction of new buildings, acquisition, expansion, remodeling, and alteration of existing buildings, and initial equipment of any such buildings (including medical transportation facilities); including architect's fees, but excluding the cost of offsite improvements and the cost of the acquisition of land.

"(5) The term 'cost of construction' means the amount found by the Secretary to be necessary for the construction of a project.

"(6) The term 'title', when used with reference to a site for a project, means a fee simple, or such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Secretary finds sufficient to assure for a period of not less than fifty years undisturbed use and possession for the purposes of construction and operation of the project.

"(7) The term 'developmental disability' means a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or a neurological condition of an individual found by the Secretary to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, which disability originates before such individual attains age eighteen, which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individual.

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"(8) The term 'services for persons with developmental disabilities' means specialized services or special adaptations of generic services directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with such a disability, and such term includes diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, training, education, sheltered employment, recreation, counseling of the individual with such disability and of his family, protective and other social and socio-legal services, information and referral services, follow-along services, and transportation services necessary to assure delivery of services to persons with developmental disabilities.

"STATE CONTROL OF OPERATIONS

"SEC. 102. Except as otherwise specifically provided nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility for the mentally retarded or persons with other developmental disabilities with respect to which any funds have been or may be expended under this title.

"RECORDS AND AUDIT

"SEC. 103. (a) Each recipient of assistance under this title shall keep such records as the Secretary shall prescribe,

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including (1) records which fully disclose (A) the amount and disposition by such recipient of the proceeds of such assistance, (B) the total cost of the project or undertaking in connection with which such assistance is given or used, and (C) the amount of that portion of the cost of the project or undertaking supplied by other sources, and (2) such other records as will facilitate an effective audit.

"(b) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients of assistance under this title that are pertinent to such assistance.

"SHORT TITLE

"SEC. 104. This title may be cited as the Developmental Disabilities Services and Facilities Construction Act."

(2) Section 100 and part D of the Act and title IV of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 are repealed.

(d) Sections 137, 138, 139, 140, and 141 of part C of the Act are redesignated as sections 135, 136, 137, 138, and 139, respectively.

STUDY

SEC. 7. (a) The Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the "Sec-

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retary") shall, in accordance with section 101(7) of the Act (defining the term "developmental disability"), determine the neurological conditions of individuals which should be included as developmental disabilities for purposes of the programs authorized by parts B and C of the Act. Within six months of the date of enactment of this Act the Secretary shall make such determination and shall make a report thereon to the Congress specifying the neurological conditions which he determined should be so included, the neurological conditions which he determined should not be so included, and the reasons for each such determination. After making such report, the Secretary shall periodically, but not less often than annually, review the neurological conditions not so included as developmental disabilities to determine if they should be so included. The Secretary shall report to the Congress the results of each such review.

(b) (1) The Secretary shall contract for the conduct of an independent objective study to determine (A) if the basis of the definition of the developmental disabilities with respect to which assistance is authorized under such parts B and C is appropriate and, to the extent that it is not, to determine an appropriate basis for determining which disabilities should be included and which disabilities should be excluded from the definition, and (B) the nature and adequacy of services

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provided under other Federal programs for persons with disabilities not included in such definition.

(2) A final report giving the results of the study required by paragraph (1) and providing specifications for the definition of developmental disabilities for purposes of such parts B and C shall be submitted by the organization conducting the study to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate not later than eighteen months after the date of enactment of the first Act making an appropriation for such study.

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IDENTICAL AND SIMILAR BILLS TO BE CONSIDERED BY THE SUBCOMMITTEE

H.R. 264, introduced by Mr. Boland on January 14, 1975;
H.R. 265, introduced by Mr. Boland on January 14, 1975;
H.R. 407, introduced by Mr. Fish on January 14, 1975;
H.R. 408, introduced by Mr. Fish on January 14, 1975;
H.R. 500, introduced by Mr. Heinz on January 14, 1975;
H.R. 501, introduced by Mr. Heinz on January 14, 1975;
H.R. 667, introduced by Mr. Murphy of New York on January 14, 1975;
H.R. 668, introduced by Mr. Murphy of New York on January 14, 1975;
H.R. 678, introduced by Mr. Murphy of New York on January 14, 1975;
H.R. 686, introduced by Mr. Murphy of New York on January 14, 1975;
H.R. 687, introduced by Mr. Murphy of New York on January 14, 1975;
H.R. 692, introduced by Mr. Murphy of New York on January 14, 1975;
H.R. 838, introduced by Mr. Peyser on January 14, 1975;
H.R. 946, introduced by Mr. Roe on January 14, 1975;
H.R. 1022, introduced by Mr. Shriver on January 14, 1975;
H.R. 1023, introduced by Mr. Shriver on January 14, 1975;
H.R. 1208, introduced by Mr. Young of Florida on January 14, 1975;
H.R. 1262, introduced by Mr. Delaney on January 14, 1975;
H.R. 1736, introduced by Mr. Steelman on January 20, 1975;
H.R. 1795, introduced by Mr. Carter on January 23, 1975;
H.R. 1969, introduced by Mr. Quillen on January 23, 1975;
H.R. 2133, introduced by Mr. Carter on January 27, 1975;
H.R. 2303, introduced by Mrs. Burke of California on January 29, 1975;
H.R. 2432, introduced by Mr. Dodd on January 30, 1975;
H.R. 2472, introduced by Mr. Roe (for himself, Mr. Anderson of California, Mr. Ashley, Mr. Badillo, Mr. Brown of California, Mr. Carney, Mr. Cotter, Mr. Drinan, Mr. Edwards of California, Mr. Eilberg, Mr. Guyer, Mr. Harrington, Mr. Helstoski, Mr. Hyde, Mr. McFall, Mr. Melcher, Mr. Roncalio, Mr. Sisk, Mr. Solarz, Mr. Steiger of Arizona, Mr. Studds, Mr. Thompson, Mr. Traxler, Mr. Vigorito, and Mr. Won Pat) on January 30, 1975;
H.R. 2691, introduced by Mr. Lehman on February 4, 1975; and
H.R. 3485 introduced by Mr. Roe (for himself, Ms. Abzug, Mr. Boland, Mr. Brown of Michigan, Mr. Cleveland, Mr. Edgar, Mr. Ford of Tennessee, Mr. Gaydos, Mr. Giaimo, Ms. Holtzman, Mr. Madigan, Mr. Mazzoli, Mr. Minish, Mr. Mitchell of Maryland, Mr. Mollohan, Mr. Patten, Mr. Rodino, Mr. Roybal, Mr. Sarbanes, Mr. Stark, Mr. Stokes, Mr. Tsongas, Mr. Waxman, Mr. Whitehurst, and Mr. Winn) on February 20, 1975.

Mr. ROGERS. As our witness here today we are very pleased to have the Honorable Caspar Weinberger, the Secretary of Health, Education, and Welfare who has brought with him a number of his colleagues from the Department.

Mr. Secretary, it is a pleasure to have you with us today and you may want to introduce your colleagues or anyone else that you have with you. I think you have met most of the members of the subcommittee here. Others will be coming along, so we are delighted to welcome you to the subcommittee. We are pleased to have you with us and would be pleased to receive your statement.

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STATEMENT OF HON. CASPAR W. WEINBERGER, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY THEODORE COOPER, M.D., ACTING ASSISTANT SECRETARY FOR HEALTH; STANLEY THOMAS, JR., ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT; STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION; AND LOUIS M. HELLMAN, M.D., DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS, OFFICE OF ASSISTANT SECRETARY FOR HEALTH

Secretary WEINBERGER. Thank you very much, Mr. Chairman. Mr. Chairman, members of the committee, this is a great honor and pleasure for us and we are delighted to be here. This is the first time we have had an opportunity to present testimony this year but we have, as you know, had an opportunity to have a short briefing session a few days ago and we are delighted to be back. I am accompanied by Dr. Theodore Cooper, Acting Assistant Secretary for Health; Stephen Kurzman, Assistant Secretary for Legislation, and Stanley Thomas, Assistant Secretary for Human Development.

Mr. ROGERS. We welcome you gentlemen to the committee.

Secretary WEINBERGER. We thought these people would be able to answer your questions. I have a comparatively lengthy statement, Mr. Chairman, and it will cover in detail the reasons why the administration opposes the bill as passed last year and which is presently before the committee. I will also discuss some of the possibilities that we hope to develop with regard to the developmental disabilities bill which I will take up at the conclusion of this statement.

Mr. ROGERS. Certainly.

Secretary WEINBERGER. With your permission I will proceed and if at any time you have any questions, please feel free to interrupt me.

Mr. ROGERS. Thank you.

Secretary WEINBERGER. The "Health Revenue Sharing and Health Services Act of 1975," as H.R. 2954 is called, would continue and expand the state formula grant program under section 314(d) of the Public Health Service Act. It also provides for the revision and expansion of the community mental health program, the community health centers program, the migrant health program, and the family planning program.

It would also establish a National Commission for the Prevention and Control of Rape in the National Institute of Mental Health and create six new categorical activities, a commission for the control of epilepsy, another commission for the control of Huntington's Disease, a program for research and control of hemophilia, a program to develop and expand blood separation centers, a program of demonstration projects for home health services, and a commission to study mental health and illness of the elderly.

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H.R. 2954, as you said, Mr. Chairman, is identical to H.R. 14214, which was passed by the 93d Congress, but disapproved by the President on December 21, 1974.

GENERAL COMMENTS

Current economic and fiscal crises have necessitated that the President submit a revised 1975 budget request and a restrictive budget request for categorical and controllable health programs for fiscal year 1976, especially since even with the cost savings proposed, Federal expenditures for medicaid and medicare will be an estimated $22 billion in fiscal year 1976 as compared to $20.4 billion in fiscal year 1975, an increase of $1.6 billion.

Some may have asked why it is we always appear to be reducing certain programs. The answer, Mr. Chairman, is that among other things, our budget is 95 percent uncontrollable so when fiscal restraint is necessary, as it is this year, we have to look to the controllable programs. We note that the President's memorandum disapproving H.R. 14214 stated "H.R. 14214 conflicts with my strong commitment to the American taxpayers to hold Federal spending to essential purposes. The bill authorizes appropriations of more than $1 billion over my recommendations and I cannot, in good conscience, approve it. These appropriation authorizations are almost double the funding levels I have recommended for fiscal year 1975 and almost triple the levels I believe would be appropriated for 1976."

The President summed up his reasons for disapproval by stating that:

"Although the purposes of many of the programs authorized in this bill are certainly worthy, I just cannot approve this legislation because of its effect upon the economy through increased unwarranted Federal spending."

I might add, Mr. Chairman, that increased Federal spending contributes to inflation which hurts the people our Department serves more than any other group. Therefore, we feel a great responsibility for trying to control inflation as does the rest of the administration.

The authorizations in H.R. 2954 exceed the President's requested budget authority for 1975 by approximately $500 million and for 1976 by approximately $700 million.

Mr. ROGERS. May I just ask you to give us the figure at this time as to how these authorizations compare with the actual appropriations?

Secretary WEINBERGER. The actual appropriation—well, there wasn't any appropriation, Mr. Chairman. There was never an agreement on the authorization bill, so we are operating under a continuing resolution. The continuing resolution for 1974 is $621 million. The President's proposed budget for 1976 is $419 million, a difference of $184 million, and that is represented almost completely by the recommended 20-percent increase in non-Federal funding which the President has recommended as part of his budget proposal.

Mr. ROGERS. You say that these authorizations have exceeded the President's requested budget authority by approximately $500 million in 1975, $700 million in 1976. I was asking if you could give comparable figures as to how it compares with the actual moneys——

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Secretary WEINBERGER. Appropriated even though it is under continuing resolution.

Dr. COOPER. Right. My understanding, and correct me if I am wrong, is that the bill presently before you has authorizations in the same amount as the bill that went to the President.

Mr. ROGERS. Yes.

Dr. COOPER. And that was for over a billion dollars and the President's proposed budget is for $419 million.

Mr. ROGERS. And then what was the——

Dr. COOPER. That is for fiscal year 1976. Fiscal year 1975 is $603.6 million. The proposed budget for fiscal year 1976 is $419 million. H.R. 2954 calls for over a billion dollars.

Mr. ROGERS. Now what I am asking is what was actually appropriated or given to you by the Congress even though it may have been under a continuing resolution?

Secretary WEINBERGER. Well, we are to operate at the same level as the 1974 appropriations, Mr. Chairman, $621 million.

Mr. ROGERS. $621 million.

Secretary WEINBERGER. Yes.

Mr. ROGERS. For 1975.

Secretary WEINBERGER. Well, that was the 1974 appropriation, the continuing resolution authorizes us to spend at the same level for 1975. The President's revisions, however, would make it $603.6 million.

Mr. ROGERS. I understand. What I am saying is the bill authorizes how much for 1975?

Secretary WEINBERGER. The conference agreement authorizing over a billion dollars.

Mr. ROGERS. For what period of time?

Secretary WEINBERGER. For fiscal 1975.

Mr. ROGERS. For 1 year?

Secretary WEINBERGER. Yes.

Mr. ROGERS. All right. Now we had spending at what level, $621 million?

Secretary WEINBERGER. Yes. That is the authorized level. The President's revisions and deferrals, however, would take us down to $603.6 million.

Mr. ROGERS. Yes, I understand that, but I was asking what action Congress had taken in these programs.

Secretary WEINBERGER. The continuing resolution would be at the 1974 level, which was $621 million.

Mr. ROGERS. That is the figure I wanted.

Secretary WEINBERGER. Yes.

Mr. ROGERS. Thank you.

Secretary WEINBERGER. The fiscal 1976 budget that the President has submitted proposed that the direct delivery of health care through project grants emphasize cost sharing by grantees. This should assist in continuing the present program levels in the face of scarce Federal dollars. We therefore recommend against the excessive authorization levels set out in H.R. 2954 for migrants, family planning, community health centers, and community mental health centers, and recommend instead the authorizations in the President's budget.

It is important to point out, Mr. Chairman, that we are not talking here about the quality or the necessity for several of these programs.

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We are talking about the need for and the degree of Federal involvement and it is that which produces this $184 million difference which Dr. Cooper and I were just mentioning to you.

We believe that State and local governments and other sources should assume more responsibility and increase their contributions in support of these programs. As grantees increase their financial participation, they will have a greater incentive to review project needs in light of the financing of health services generally available under medicare and medicaid. We will assist the projects in every way we are able to obtain contributions from these and other third-party sources. We intend to require through changes in program regulations a 20-percent non-Federal match for project grant programs.

In addition, the non-Federal share requirement for Maternal and Child Health State formula grants would be increased under the proposals from 50 percent to 60 percent. A limited Federal role and increased reliance on the discretion and capabilities of State and local public and private sectors are indicated for these programs. This strategy reflects our conviction that not every worthwhile health program initiated by the Federal Government needs to remain the financial responsibility of the Federal Government indefinitely.

Moreover, the Department supports a policy to assure financial access to health care for all Americans on an equitable basis instead of the inequitable provision of health services manifested through narrow categorical grant programs to selected communities or for selected diseases. Medicare and medicaid are designed in part to accomplish these objectives and together will obligate over $22 billion in Federal dollars in 1976. States will spend an additional $6.9 billion in medicaid.

Mr. ROGERS. For medicaid the Federal Government is spending about $7 million.

Secretary WEINBERGER. Yes, I think that is roughly it.

Mr. ROGERS. Thank you.

Secretary WEINBERGER. While the intent of H.R. 2954 is worthwhile, several of the provisions of the bill cause us concern. Our principle concerns are the excessive authorizations contained in the bill and the expanded Federal role in current as well as in new programs. As I indicated, the levels far exceed the amounts in the President's budget to maintain the current level of services for community health centers, migrant health centers, and family planning.

In addition, the President has proposed, effective April 1, 1975, the termination of the State health formula grants supported under section 314(d) of the Public Health Service Act. The President's proposals for fiscal year 1975 and fiscal year 1976 included no grant awards for new community mental health centers, but allowed continuation and support the meaning of the Government's 8-year commitment, of the 626 community health centers already funded.

We are also concerned because the bill proposes that the Department initiate new programs in opposition to the President's request to the Congress for a 1-year moratorium on all new Federal program activities. Additionally, the detailed manner in which the bill specifically prescribes program activities would limit our management flexibility to administer the ongoing program effectively.

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Consequently, we believe it is necessary to have a general authority for supporting the development and operation of programs of community health services. Within a broad flexible authority, we believe we could continue to administer certain specific programs contained in H.R. 2954. We do not, however, support the detailed legislative and programmatic provisions of the bill, and this is, of course, fully consistent with the basic administration policy that the State and local governments know their priorities better than we do.

SPECIFIC COMMENTS

We certainly applaud the intent of H.R. 2954 to strengthen project management and accountability, to increase financial independence of the projects through emphasis on the development of fee schedules, third-party financing, collection mechanisms and reporting requirements. We also commend the efforts to increase accessibility, quality of services and to increase participation in the decisionmaking process by those being served by the projects. All of this represents very constructive efforts. These concerns, however, can best be handled administratively rather than by statutes which may well, because of their necessary rigidity, restrict us from the flexibility we believe is essential in certain situations. To the extent we have not already done so, we would attempt to incorporate such administrative controls for all health service programs.

The efforts at third-party collections is both useful and necessary. A lot of people have misunderstood the objective and thought it involved simply collecting more money from the beneficiaries whereas it involves an effort to get insurance funds from the companies to help support the public programs.

REPEAL OF SECTION 314(e)

The proposed bill would repeal section 314(e) of the PHS Act and substitute categorical authorities for programs administered under this section. In addition to the problems created by categorical provisions, the loss of this authority would restrict the capability of our Department to react to special health contingencies. In addition, the Department would lose the capability and authority to operate, for limited periods of time, special demonstration or health services delivery programs. This authority has been used in the past to continue programs to combat lead poisoning in children when this specific legislation had expired and for emergency rubella inoculation programs, a problem that came upon us suddenly and when we needed the flexibility to act promptly. Therefore, we would strongly oppose the proposed repeal of section 314(e) as a step in the wrong direction. That is, away from flexibility and toward more narrow categorization.

COMPREHENSIVE HEALTH FORMULA GRANTS 314(d)

Title 1 of the bill would amend section 314(d), the current program of comprehensive health formula grants to the States. To qualify for a grant, a State would be required to submit a plan in three parts: (1) An administrative part, (2) a public health service part, with an

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earmark of 22 percent for prevention and treatment of hypertension; and (3) a mental health service part.

Grants from this program have traditionally been awarded to States to assist them in providing public health services according to local priorities. These funds are used to support services traditionally the responsibility of the States and local governments.

The bill's authorizations of $160 million for fiscal year 1975 and $160 million for fiscal year 1976 are inconsistent with the President's revised 1975 budget which would terminate the program effective April 1, 1975. Additionally, in 1976 over $633 million will be available through other Federal health programs to help support many of the same kinds of activities now covered under the comprehensive health grants to States program.

FAMILY PLANNING

Title II of H.R. 2954 proposes to extend and amend title X of the PHS act dealing with family planning services at authorization levels of $150 million and $175 million for fiscal years 1975 and 1976, respectively. It would also provide specific authorization and research funding. Like the community health centers, the family planning projects are an example of a highly successful program effort. Organized family planning services are now available or accessible to women in over 95 percent of the Nation's counties. In fiscal year 1975 nearly 4 million women will revive family planning services through various DHEW-supported progams.

While the President's budget for the family planning services program is $100 million for fiscal year 1975 and $79.4 million for fiscal year 1976, reductions of Federal funding to these programs will be largely offset by increases in medicaid expenditures and from other sources to continue services to 4 million women in fiscal year 1976—the same level as in fiscal year 1975.

At present, over $40 million is expended by our Department for family planning-related research. This contrasts with the bill's provisions to increase the authorizations for research to $60 million and $75 million for fiscal year 1975 and fiscal year 1976 respectively. Most of this research is carried out by the National Institutes of Health which has sufficient authorization already for this purpose.

COMMUNITY MENTAL HEALTH CENTERS AND RAPE PREVENTION AND CONTROL

Title III of H.R. 2954 would completely revise and greatly expand the Community Mental Health Centers Act.

It would define a Community Mental Health Center as a legal entity through which comprehensive mental health services are provided principally to individuals residing in its catchment area.

Required services would include not only those currently mandated by the Department's regulations—inpatient services, outpatient services, partial hospitalization, emergency services and consultation services, but also specialized services for the mental health of children and of the elderly, assistance to courts and other public agencies in screening residents of the catchment areas to determine if they should be

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referred to a State mental health facility for inpatient treatment, followup care to catchment area residents discharged from a mental health facility, transitional halfway house services for mentally ill catchment area residents discharged from a mental health facility and provision, unless there is no need of it, of programs for the prevention and treatment of alcohol and drug abuse, and for the rehabilitation of abusers of alcohol and drugs.

The proposed amendments would replace the existing basic support structure of staffing grants with grants for the payment of centers' operating costs. All told, six new support mechanisms are proposed: Grants to assess the need of and to plan for new community mental health centers; grants for initial operations of new centers with a Federal share declining over 8 years from 80 to 25 percent (in poverty areas, the Federal share would decline from 90 to 30 percent); grants for consultation and education services, grants to enable present centers to convert to the proposed, expanded program, financial distress grants for up to 3 years to existing centers whose assistance has terminated because of statutory limits as to funding period which demonstrate that without continued support they would have to significantly reduce essential services; grants from allotments to States for the Federal share of projects to acquire, remodel, or lease facilities, and in poverty areas to construct new or expanded facilities.

For fiscal years 1975 and 1976, an additional $303 million for new grants would be authorized over the combined 1975 and 1976 budget requests of $359 million to honor the existing 8-year subsidy commitment.

Title III would also add to the Community Mental Health Center Act a new part dealing with rape prevention and control. It would establish within the National Institute of Mental Health a National Center for the Prevention and Control of Rape to conduct research into the legal, social, and medical aspects of rape prevention and control. This new program would have authorized appropriations of $10 million for each of 2 years.

There are a number of problems with this program in addition to its categorical nature. Inasmuch as the prevention and control of rape is in many respects, or obviously in all situations a criminal justice matter, it is unclear precisely why the Department should be mandated to establish a center or even what activities the proposed National Center would undertake to demonstrate how to prevent and control rapes. While some aspects of this crime are related to our mission, we see no sound programmatic basis for this Department to single it out from among the many forms of psychiatrically deviant behavior. With the existing activities and within research funding levels, we believe that the Department and the National Institute of Mental Health, in particular, can undertake in coordination with its overall behavioral research program an adequate investigation into the causes, treatment, and prevention of rape.

From the inception of the community mental health centers' program through fiscal year 1974, more than $1 billion have been awarded for the center's program and child mental health services and facilities. A total of 626 centers have been funded, of which 520 are operational in 1975.

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These centers are in all 50 States, the District of Columbia, Puerto Rico, and Guam. When in operation, the 626 centers will make services available to catchment areas containing about 93 million people, or about 44 percent of the population. In 11 States, the District of Columbia, the Virgin Islands, and Guam, over three-fourths of the population live within areas served by centers.

The President's budget for fiscal year 1976 requests over $160 million to honor continuation commitments to existing grantees. Overall, commitments to existing centers for the duration of their 8 years of grant support will cost the Federal Government about an additional $750 million. The Department believes that the delivery of community-based mental health care through the community mental health centers model has been amply demonstrated, that those centers that have operated efficiently and met community needs will be able to obtain sufficient State, local, and private moneys, patient fees, and third-party reimbursements to continue after their period of Federal support has ended, and that this program should now be absorbed by the regular health delivery system.

The medical and social services provided by CMHC's are similar to services generally available to eligible individuals under the Department's medicaid and social services program. The Federal Government will spend $8.7 billion in 1976 in addition to State and local expenditures of $7.7 billion for these programs.

It was the intent of the community mental health centers legislation that after 8 years of Federal subsidy every center would be financed by resources other than Federal grants. Those resources are varied. In 1972, the last year for which we have complete data, funds provided by the States equaled those provided by Federal staffing grants, with each contributing 30.7 percent of the Center's funds. Other significant sources of funds were receipts from services, including patient fees, insurance payments, and medicare and medicaid, 21 percent; local and county governments, 10.2 percent; construction grants, research, training and other Federal funds, 4.5 percent; and fundraising and all other sources, 3.1 percent.

State, local and third-party financing are available for the continuation of existing CMHC's and initiation of new CMHC's in those communities that regard this particular model of health care delivery appropriate for their needs.

As you know, we did not propose extension of the Community Mental Health Centers Act when it expired June 30, 1974, and we continue to oppose its extension now for the same reasons. Not because we don't think they are effective because we do, but we believe it is now time to shift responsibility—for developing and operating such facilities to State and local agencies which must ultimately bear the major responsibility for the direct provision of public health services of all kinds.

We believe that mental health treatment can properly be delivered most effectively in the communities from which the people requiring assistance come. That is still the basic need and a continuation beyond the 8 years' period of the Federal responsibility will turn the program into a Federal delivery system. This would not be nearly as effective or as helpful as community medical health centers run by and financed by community, State, local and private sources.

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In his December 21, 1974, memorandum of disapproval of the Health Revenue Sharing and Health Services Act, H.R. 14214, the President recognized the worth of its intent. But worthiness does not justify a vastly increased Federal role at this critical time for the economy. The Federal Government has fulfilled its appropriate role vis-a-vis community mental health services; it has underwritten the development of the CMHC concept.

Although the National Institute of Mental Health will not be involved in the direct financial support of community mental health centers, beyond that to which it is already committed, it will retain a strong leadership role in the stimulation and development of community-based mental health programs. Of particular importance will be its continuing contribution in technical assistance, consultation, resource development, and the dissemination of mental health knowledge.

MIGRANT HEALTH

Title IV of the bill would extend the migrant health program which provides needed services to migratory agricultural workers. This programs is presently delivering health services through approximately 105 projects with 355 service delivery sites in 37 States serving almost 400,000 migrants and seasonal farmworkers and their families; 42 percent of migrant agricultural workers work in 44 high-impact counties, all of which are served by migrant health projects. Every migrant high-impact county in the country is served by a project funded with Federal dollars.

During 1975, 390,000 persons will receive services involving approximately 640,000 patient visits. A uniform utilization and cost data reporting system was initiated in 1974 and is expected to provide projects with data which will provide the necessary financial management, evaluation, and planning tools to improve their ability to deliver services.

In cooperation with the Social Security Administration, Bureau of Health Insurance, a special demonstration project is underway to provide additional hospital care where needed to a group of migrant farmworkers and their families, even though they may move from State to State or county to county. This project is also gathering data on the utilization and cost of hospital services for use in further improvements in health services to the migrant population.

Although we plan to continue the program, we object to the proposed extension because it adds program specifications which could better be handled administratively. In addition, the bill would increase funding authorizations for this program to an unrealistic level, specifically $75 million for fiscal year 1975 and $80 million for fiscal year 1976, which the President's budget for the same periods recommends $24 million and $19 million, respectively.

COMMUNITY HEALTH CENTERS

I would now like to describe the operation of the program proposed for extension of title V of this bill. The community health centers program presently authorized by section 314(e) would be established under a separate new authority with increased authorization of $260 million for fiscal year 1975 and $280 million for fiscal year 1976,

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compared to the President's budget for the two periods of $200 million and $155.2 million, respectively. The proposed legislation also contains specifications for these centers which could limit program flexibility again.

This project grant program supports 157 ambulatory health care projects which provide primary health care and develop arrangements for specialty and inpatient care, particularly in areas where health care is scarce or nonexistent.

In 38 States, D.C. and Puerto Rico, through 127 neighborhood health centers, which include all of the projects initiated by the Office of Economic Opportunity and transferred to this Department over the past 4 fiscal years, about 1.3 million persons are receiving services.

These centers constitute important community health resources for persons who live in areas of high morbidity and mortality.

Currently there are 30 family health centers. These centers are primarily in rural communities in 26 States and the District of Columbia. In these centers, services are provided on either a fee-for-service and/or prepaid basis. It is estimated that the 30 centers will serve 105,000 people in 1975.

Since 1973, the Department has provided technical assistance to community health centers to improve overall management capability, including third-party collection procedures. Grantees have been assisted in developing cost accounting systems needed to collect third-party reimbursements and in correcting other management and fiscal problems, instruction and assistance in how they can improve their third-party collection procedures. This has helped them. It has helped them in developing cost accounting systems needed to collect third-party reimbursements and in correcting other management and fiscal problems. Frequently people involved in this are volunteers. We certainly appreciate their efforts, but it is helpful to have some technical assistance.

Title VI of H.R. 2954 calls for establishment of two temporary advisory commissions—a Commission for the Control of Epilepsy and Its Consequences and a Commission for the Control of Huntington's Disease and Its Consequences.

The commissions would be charged with studying the state of the art of medical and social management of epilepsy and Huntington's disease, respectively, investigating the roles of Federal, State, and private organizations in dealing with the diseases, developing a comprehensive national plan, and reporting their findings and conclusions to the President and the Congress.

Evidence about the nature of Huntington's disease is currently accumulating through the basic research program of the National Institute of Neurological Diseases and Stroke (NINDS). When solid leads concerning the disease are discovered, it will be appropriate to direct more specific research toward screening, prevention or therapeutic measures. Presently the state of knowledge about Huntington's disease is such that it would be premature and unproductive to convene a commission to develop a research plan.

Through various programs, $325 million is currently being spent by the Federal Government to help those afflicted with epilepsy. The funds are used for benefits, aid, rehabilitation, medical assistance, veterans care, and about $6 million is applied to specific research by

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the NINDS. A major area of that research is developing more effective, less toxic anticonvulsant drugs in order to increase the number of completely controlled cases.

As we have indicated in previous testimony before this committee, the Department does not believe that a statutorily established commission is an appropriate mechanism to deal with the issues raised by categorical diseases such as epilepsy and Huntington's disease.

The NINDS presently has access to expert professional and public advice in review of all its scientific programs, and, in the case of epilepsy, a special NIH Epilepsy Advisory Committee has been advising the Institute on its epilepsy program. In addition, the NINDS has been particularly active in fostering its contacts with voluntary agencies, including the Epilepsy Foundation and the many groups concerned with Huntington's disease.

The NINDS sponsored a meeting on January 16 of this year, at which Institute staff and representatives of the professional societies and voluntary agencies discussed the problem of potential fragmentation of the neurology area as exemplified by proposals to establish a variety of commissions.

Mr. ROGERS. May I interrupt? There has been a call to the floor for a record vote. If it meets with your approval, Mr. Secretary, we would recess for five minutes if we could—better say 10—for members to vote, and return as soon as possible if they can.

Secretary WEINBERGER. Thank you.

Mr. ROGERS. The committee stands in recess for 10 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will be in order, please. We will continue with the testimony of the Secretary.

Secretary WEINBERGER. Yes, Mr. Chairman, members of the committee. We were just speaking about the National Institute of Neurological Diseases and Stroke and their responsibility to support broadly based research and training of high quality.

These considerations, together with scientific opportunities and available resources, ultimately determine the scope and content of the Institute's programs. In our view, these concerns are being met within the ongoing NINDS programs and we oppose establishment of the commissions proposed in H.R. 2954.

I would also add, Mr. Chairman, that we oppose this legislation for another reason as well. The President's Biomedical Research Panel will, within the next year and a half, be carefully examining overall national health research priorities. The Panel has just been appointed by the President and will review, assess, identify, and make recommendations with respect to policy issues concerning the subject and content as well as the organization and operation of all biomedical and behavioral research conducted and supported by the National Institutes of Health.

Categorical disease commissions, as proposed in the bill, cannot help but usurp the responsibilities of this panel. I believe it important to have in hand the panel's recommendations which will be based on a comprehensive view of NIH organization and operations so that they can give an overall picture and make some overall recommendations for the proper role for the privately funded and Federal Government now and in the immediate future, and of course the private

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sector funding for research in the context of the Public Health Service before broadening the NIH mission or changing its organization in individual programs such as epilepsy or Huntington's disease.

Title VI also directs the Secretary to appoint a committee on the Mental Health and Illness of the Elderly and provides that the committee will study and report in 1 year on the mental health, research, training, and service needs of the elderly. We see no useful purpose in establishing by statute what is already part of the ongoing responsibility of the National Institute of Mental Health in ADAMHA, Alcohol, Drug Abuse and Mental Health and the newly formed National Institute on Aging.

Nor do we see any reason for singling out one group for such special attention. Multiplication of mandated special studies will, in the long run, undermine our efforts to maintain a balanced approach in our research, training, and service programs, and of course in an allocation of our scarce resources. Moreover, the specific responsibilities which the bill would assign to the new committee duplicate or overlap the responsibilities of three existing statutorily created entities. These are, (1) the National Advisory Council on Mental Health; (2) the Federal Council on the Aging, established by Public Law 93–29; and (3) the recently established National Institute on the Aging, mandated by Public Law 93–296, under which biomedical, social, and behavioral research will be conducted on the problems of the elderly.

Title VI would also provide grants for initial start-up of home health agencies, and for the training of home health service personnel. In 1974, there were 2,211 home health agencies—an average of over 40 per State—participating in medicare. We are unaware of any shortage of either agencies or personnel that might warrant new categorical grant programs to provide home health services.

Our Department is presently working on a report dealing with the entire issue of long-term care, including home health services, and it would be prudent to have the information from this report before establishing yet another categorical program.

With respect to the proposed comprehensive hemophilia diagnostic and treatment centers and the blood separation centers, we oppose these new programs as inconsistent with the President's request to delay new spending programs. Again, categorical attention to treatment fragments resources and deals inequitably with disease incidence.

In conclusion, Mr. Chairman, because of its excessive authorizations which, when totalled, exceed the President's fiscal year 1975 budget of $603.6 million by almost $500 million and his fiscal year 1976 budget of $419.1 million by over $700 million—because it would subsidize activities in selected communities rather than meeting the Department's broader objective of assuring financial access to quality health care to all Americans on an equitable basis, and because its categorical authorities are not consistent with the comprehensive health care concept, we strongly object to the enactment of H.R. 2954.

We urge instead enactment of the administration's bill which we are submitting to the Congress this week [see p. 180].

Before turning to developmental disabilities, I would like to say that we will be very glad to work with the committee to try to develop as rapidly as possible a new bill which can be signed. In that spirit of constructive assistance, let me suggest that we remove all of the prob-

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lems caused by these excessive authorizations and simply authorize such funds as are necessary.

I know there have been some problems with that in the past. I know some feel that this does not demonstrate to the degree they would like to demonstrate their commitment to the particular diseases, but it does solve a number of problems.

It would remove the difficulities caused by excessive authorizations. Nearly always those excessive authorizations arouse expectations which cannot be realized when the Appropriations Committees have considered and completed their work. It would be a sounder way from the point of view of public administration and the political approaches to the whole problem.

While there may have been some worries in the past that if such authorizations were voted, the Executive, whoever he might be—and it is the problem which Executives have faced and dealt with since the time of Thomas Jefferson—might not spend all of these funds.

That has been removed by the new Budget Impoundment Act. The President does not now have the authority his predecessors exercised and would, under the new procedure, not be able to impound appropriated funds.

So I would urge as strongly as possible that we remove this major point of contention by authorizing such funds as may be necessary.

Let us try to work out a bill that can be signed.

DEVELOPMENTAL DISABILITIES

Now, Mr. Chairman, if I might turn to developmental disabilities, which is the second subject before you, the extension of the developmental disabilities program, the authority for which, under the Developmental Disabilities Services and Facilities Construction Act, expired on June 30, 1974. As you know, Mr. Chairman, both the House and Senate passed widely differing bills to extend this program during the last Congress under the same number, H.R. 14215. The differences between the two versions were such that they could not be resolved in conference. This year, the same bills have been reintroduced as H.R. 2955 and S. 462, and the differences between them still remain.

Because the continuing resolution under which this program is currently being funded expires at the end of this month, I am sure you can understand our desire to see the impasse over the extension of this worthwhile program broken so that both we and the States can proceed with our planning freed from the present uncertainty.

I might say even an extension of the continuing resolution wouldn't really solve the basic uncertainties that are involved in funding levels.

Mr. ROGERS. I might mention, Mr. Secretary, that this will be done. We will continue the continuing resolution until authorizing legislation is enacted.

Secretary WEINBERGER. That is clearly better than nothing, Mr. Chairman.

Mr. ROGERS. It might even be better than that.

Secretary WEINBERGER. All right. We have taken a new look at our own position, contained in two bills introduced during the last Congress—H.R. 12892 and S. 3011, and have developed a new bill which, we feel, is an improvement that can be accepted by both the House and

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Senate. Our bill has been transmitted to the Speaker and the Vice President, and copies of it should be before the members of this subcommittee, and if not, will be shortly. [See p. 158.]

In addition, Mr. Chairman, over the last few months we have examined carefully the very complex question of how to insure that the care provided by institutions serving developmentally disabled persons neets certain necessary standards. I believe we would all agree that the standard of care provided in too many of our institutions today should be improved. The Senate has attempted to address this problem in title II of S. 462, as have several Members of the House in such bills as H.R. 687. We strongly disagree with the approach taken in these bills.

Our Department has undertaken over the past year the massive effort of establishing and enforcing standards for the 1,250 residential medical facilities funded under the medicaid program. It is our judgment that implementation of legislation such as title II of S. 462 would have the untoward effect of not only duplicating and slowing the efforts already underway, but in fact erasing the progress that has been made thus far. We believe that our present efforts constitute a good first step that should not be duplicated. Rather, we should be looking ahead to see how we can best build upon the foundation already established. In a few minutes I would like to discuss some of our ideas on this subject with you.

STATUS OF DEVELOPMENTAL DISABILITIES PROGRAM

First, however, I would like to describe briefly some of our current activities under the developmental disabilities program. As you may know, the developmental disabilities program was previously administered by the Division for Developmental Disabilities in the Rehabilitation Services Administration—RSA. When the Rehabilitation Services Administration was transferred at the beginning of this month from the Social and Rehabilitation Service to the Office for Human Development—the Assistant Secretary of that office, Mr. Thomas, is here today—then the Developmental Disabilities Division went with it.

It is our intention in the near future to establish a separate Office for Developmental Disabilities, with its Director reporting to the Assistant Secretary for Human Development.

The developmental disabilities program, as you know, is designed to achieve three basic purposes. The first is the development and improvement of planning capacity at State and local levels to utilize effectively the wide range of resources currently available to aid the developmentally disabled. This Department alone is providing this year an estimated $800 million in such assistance from such agencies as the Office of Education, the Social and Rehabilitation Service, the Office for Human Development, the Health Services Administration, and the National Institutes of Health, and even more assistance is made available by State and local agencies. One aim of this program, then, is to enhance the capability of State and local agencies to plan for the use of all these resources in a coordinated, effective manner.

The second basic purpose of the program is to serve as a catalyst to stimulate the expansion of services for developmentally disabled

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persons at the State and local level. The third purpose is the establishment of an integrated network within which services at the State and local level will be coordinated. In attempting to achieve these purposes, a major emphasis of the program is on the authority of the States to determine their own goals and the methods to achieve them. This flexibility has enabled the States to manage the program effectively.

STATE PROGRAMS

Fifty-five States and Territories have designated State planning and advisory councils and agencies to administer planning, services, and construction activities under this program. As I am sure you know, Mr. Chairman, a great many of the people devoting such time to the program are in the room today and we are certainly delighted to have them here, as I know the committee is.

Approximately $28 million, or 91 percent of the $30.8 million expended this fiscal year under part C of the act has gone directly to the States and Territories. The States have indicated, on the average, that they will use 73 percent of their funds for services, 25 percent for planning and administration, and 2 percent for construction.

A significant trend in the operation of the program has been the increased efforts by many States to deinstitutionalize developmentally disabled persons. North Carolina, Wisconsin, Washington, and California, in particular, have all emphasized this goal with success. It is generally agreed that returning the institutionalized individual to the community has in the majority of cases a good effect on his rehabilitation. It is the policy of HEW to encourage deinstitutionalization where such a program is consistent with the capacities of the individuals concerned and where the home community can provide alternative services. We plan to continue this policy in our administration of programs for the developmentally disabled.

UNIVERSITY-AFFILIATED FACILITIES FOR THE DEVELOPMENTALLY DISABLED

The program presently provides Federal support for interdisciplinary training in institutions of higher learning. It is similar to activities supported in the maternal and child health program. Grants may be made to cover the costs of administering and operating demonstration facilities and training programs for personnel needed to render specialized services to persons with developmental disabilities. This year $4,250,000 has been made available for training programs.

Among the professional disciplines trained in these facilities are medical personnel, dentists, nurses, speech and hearing therapists, nutritionists, physical therapists, occupational therapists, rehabilitation specialists, special educators, psychologists, social workers, and recreational specialists.

Each facility is encouraged to conduct a comprehensive program so that each discipline involved in the habilitation and rehabilitation of the developmentally disabled may be fully familiar with the contributions of the other disciplines.

ADMINISTRATION'S PROPOSED BILL

With this background before us, I would like to describe briefly our proposed bill. It is similar to H.R. 2955 in many respects, including the following.

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DEFINITION

Our draft bill would amend the current definition of "developmental disability" to include autism, as would the House bill.

CONSTRUCTION OF UNIVERSITY-AFFILIATED FACILITIES

Our bill would not include an authorization for grants for renovation and construction of university-affiliated facilities. These grants were needed in the original act to foster the initial construction of these facilities. However, since many such facilities now exist, this Federal assistance is no longer needed. Instead, we recommend that funds available for university-affiliated facilities be used for demonstration and training grants for such facilities.

FEDERAL APPROVAL OF CONSTRUCTION

The enclosed draft bill is similar to the House bill with respect to elimination of the requirement for Federal approval of construction projects under the State grant program. The deletion of this requirement is in accord with our objective of returning responsibility to State and local governments whenever it is appropriate to do so.

NATIONAL COUNCIL

The provisions relating to the National Council on Services and Facilities for the developmentally disabled and the State planning and advisory councils would embody current law rather than the expanded provisions contained in the Senate bill.

SPECIAL PROJECTS

Our bill would provide a special projects authority which would include the authority for the Secretary to fund projects of special national significance. Our bill would provide for a 30 percent set-aside of the special project funds of national significance as would the House bill.

The major differences between our proposed bill and the House bill are the following:

AUTHORIZATIONS

The authorizations for appropriations contained in our draft bill correspond to the amounts set forth in these programs in the President's budget for fiscal year 1976. These amounts are, for fiscal years 1975, 1976, and 1977 $30,875,000 for State formula grants, $18,500,000 for special project grants, and $4,250,000 for research and training in university-affiliated facilities.

EVALUATION

Our draft bill would require the Secretary of HEW to develop not later than February 1, 1977, a design for a comprehensive evaluation system to be implemented by the State in phases. Each State receiving funds under this act would be required to implement the first phase of this system not later than October 1, 1977. We believe that this pro-

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posal represents a realistic and workable approach to the establishment of a much-needed national system for the evaluation of agencies and facilities providing services to developmentally disabled persons.

DECLINING FEDERAL MATCH

As in the case of health services, we believe it is appropriate for State and local governments to assume an increasingly greater degree of responsibility for service programs that affect their citizens, and that they should progressively increase their share of support for these programs.

To this end, we are proposing that the Federal matching share for development disabilities be gradually reduced from 70 percent in 1975 to 60 percent in 1976 and 50 percent in 1977. Cosonant with the aim of inducing greater State and local involvement, the administration bill also proposes terminating Federal support for individual special projects after 3 years of initial assistance. This increased financial participation will give States and localities greater incentives to scrutinize these programs and evaluate their effectiveness.

QUALITY ASSURANCE

Now, Mr. Chairman, I would like to turn to the very complex subject of quality assurance in facilities providing care for developmentally disabled persons. The point I would like to emphasize for the subcommittee is that our Department is presently undertaking a far-reaching effort to upgrade the quality of care provided to developmentally disabled persons in medical or rehabilitative residential institutions. On January 17, 1974, we published regulations establishing extensive standards for Intermediate Care Facilities for the Mentally Retarded—ICF–MR's—and we are now engaged in the major task of implementing them. These standards, which we believe largely implement the same objectives as title II of the Senate bill, relate to habilitative services, medical care, fire safety, physical environment and sanitation. They aim to assuring that residents of ICF–MR's receive an array of services keyed to their individual needs so that they may reach their maximum potential. These regulations will have a substantial impact on the well-being of the many thousands of developmentally disabled persons who reside in such facilities.

The ICF–MR regulations, which are based on the recommendations of the Accreditation Council for Facilities for the Mentally Retarded of the Joint Commission on Accreditation of Hospitals, were issued under title XIX of the Social Security Act. Consequently, they apply to all ICF–MR's certified for medicaid reimbursement. Implementation of the standards must be completed by March 1977. This phase-in period will allow many facilities to complete the expensive and time-consuming renovations which the regulations will necessitate. Each intermediate care facility approved to participate in medicaid must, no later than March 1975, have a detailed plan for meeting the requirements by 1977. If it does not progress in accordance with that plan, it will be barred from continued participation in the medicaid program.

Our experience in developing and implementing these regulations indicates that the level of detail of the standards represent the limit

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that realistically can be expected of the network of facilities serving the developmentally disabled. While we recognize that the ICF–MR standards alone will not succeed in raising the quality of care in all our institutions serving the developmentally disabled, we believe that to go beyond these standards in the way that title II of S. 462 proposes to do would be to make unrealistic demands on the thousands of agencies and facilities involved.

Such demands could result in a major disruption in the delivery of services to the developmentally disabled and create considerable confusion and uncertainty for, and in many instances termination of services provided by individual facilities and agencies.

Last year, we prepared a rather detailed analysis of title II of the Senate bill, which is attached to the letter transmitting to the Congress our new bill to extend the Developmental Disabilities Act. That letter, with the attached paper, should be before the members of the subcommittee now, if not, we will get copies for you. While our objections to that title are described in detail in the paper, I would like to cite just a few examples of the disastrous results ensuing from enactment of that legislation.

1. Section 204 authorizes the Secretary to make grants to assist States in bringing publicly operated and federally assisted residential or community facilities and agencies into compliance with the title II standards. While the number of facilities affected by title II is unknown for the purposes of preparing cost estimates we have estimated that at least 6,000 facilities are involved. A conservative estimate of the amount needed by each residential institution over 5 years to bring itself into compliance with the title II standards would be $1 million.

Thus, at a minimum the cost of bringing each facility into compliance with these standards would be $6 billion. This total would be reduced to aproximately $1,250 billion if only residential facilities which provide medical services received the financial assistance; however, this lower figure does not take into account thousands of facilities providing personal care and thousands of community service agencies, all of which would be affected by title II.

2. Section 211 of S. 462 requires individual written habilitation plans to be developed and modified at "frequent" intervals on behalf of each developmentally disabled person who is residing in a residential facility, community facility, and agency to which the title II standards apply.

We estimate that the cost for an initial evaluation of an individual would be $400, based on the services of a four-person basic team working one half of a day. Quarterly evaluations would be an estimated $100 each. The first-year cost for the habilitation plan would therefore be an estimated $700 per person, or a total of $5.6 billion, which is just under the amount required to bring all the facilities in compliance.

This is based on an estimated population of 8 to 8.5 million persons. This estimate of the affected population is considered conservative; other estimates have placed the target population at 20 million.

Not only would the cost of section 211 be prohibitive, but it would require measurement in areas where assessment is difficult to make, such as affective and cognitive development. There are only a few personnel trained well enough to make the sort of assessments required under this section.

3. Section 212 would require that each developmentally disabled

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person served by a facility or agency be assigned a program coordinator responsible for implementation of the person's individual written habilitation plan. For an estimated population of 8 million persons, which we say is conservative, 1.3 million highly trained health personnel would have to be available to serve as program coordinators. Moreover, as I indicated earlier, these personnel would have to be exceptionally well trained in order to perform the functions required by title II. This number of highly trained personnel is simply not available.

Mr. Chairman, I think you can see that the resources in terms of manpower and money that would be needed to enable the many facilities and agencies affected by title II to comply with the requirement of that title are not available. I greatly fear that the result of placing such clearly unrealistic demands on these facilities would only result in their refusal to provide any care at all for developmentally disabled persons. Such a result would, in my opinion, be clearly undesirable and counter to the objectives that both the Congress and the administration share—improved care for these persons.

We believe that we should be looking to the next step to be taken beyond the existing ICF quality assurance program. It is our judgment that the next initiative in quality assurance needs to focus on the residents themselves, to insure that they are receiving and responding to effective programs of care that are helping them to develop and to reach their potential as fully as possible.

We refer to this approach as the outcome approach of quality assurance, wherein we seek to measure a facility's performance by the results it produces with its residents. While we have long been committed to such an outcome approach—indeed, this idea received considerable discussion in the Department at the time the ICF regulations were being developed—we have lacked the technological ability to implement it. However, recent developments in the developmental disabilities field, some of which occurred in projects sponsored by HEW hold promise that we can move in this direction. Unfortunately, technology will not allow us to adopt national outcome standards such as those proposed by part B of title II of S. 462, but another approach does constitute the next necessary step in our efforts to raise the standard of care for the developmentally disabled. We believe we should have authority to move in this direction as the approach is validated. We urge the prompt enactment of the administration's bill as an effective instrument for meeting the needs of the developmentally disabled population.

We certainly appreciate your great patience, Mr. Chairman, and members of the committee. We will be delighted to do our best to answer any questions you might have.

[Testimony resumes on p. 184.]

[The letter transmitting the administration's Developmental Disabilities Services and Construction Act, referred to, follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., February 19, 1975.

Hon. CARL ALBERT,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: Enclosed for the consideration of the Congress is a draft bill "To revise and extend the program authorized by the Developmental Disabilities Services and Construction Act."

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The most important purpose of this draft bill is to extend for three years the Developmental Disabilities program which, since its inception, has made a significant contribution in meeting the needs of the developmentally disabled.

One of the primary products of the Developmental Disabilities program has been to increase the planning capacity if State and local governments to utilize effectively all available resources to meet the needs of this population. The enclosed draft bill would continue that strategy and would increase the emphasis on developing effective means to reduce the dependency of the developmentally disabled. Under the program as it is currently operated and as we hope it would be continued under this legislation, Federal funds will serve as a catalyst to stimulate the growth of programs serving the developmentally disabled.

As you know, the Department submitted legislation during the last Congress—introduced as S. 3011 and H.R. 12892—to extend this program. Other bills were also introduced in both Houses and were finally passed, in differing form, by both the House and the Senate as H.R. 14215. However, that bill was never enacted, and the program is still operating under a continuing resolution. Both the House and Senate bills have been reintroduced as H.R. 2955 and S. 462, respectively.

The draft bill that we are proposing follows the format of title I of S. 462. However, as indicated in a letter which we sent to the conferees on December 11, 1974, on H.R. 14215 (a copy of which is enclosed), there are a number of features of the Senate bill which cause us serious concern. The following list indicates the major changes we are proposing for the program, as well as the major differences between our draft bill and the House and Senate bills:

1. Our bill would not include a requirement that an office of developmental disabilities be established in the Office of the Secretary. We agree with the Senate that the Developmental Disabilities program is more appropriately placed in the Office of the Assistant Secretary for Human Development, and, indeed, we have already placed it there and intend in the near future to establish a separate Office for Developmental Disabilities, with its Director reporting directly to the Assistant Secretary. Nonetheless, we continue to object strongly to the inflexibility of organizational mandates set in law, and we urge that the Congress refrain from including such a mandate in this bill.

2. Our draft bill would amend the current definition of "developmental disability" to include autism, as provided in the House bill, but not to include specific learning disabilities as the Senate bill would do. There is no clear category of persons who would be included within that term, and we object to broadening the coverage of this program to include such an unclearly defined category without being aware of the full implications of that action. Moreover, we feel that most persons who would fall within this category are already served by other Federally-aided programs such as the Education of the Handicapped Act.

3. Our bill would not include an authorization for grants for renovation and construction of university-affiliated facilities. These grants were needed in the original Act to foster the initial construction of these facilities. However, since many such facilities now exist, this Federal assistance is no longer needed. Moreover, this authorization has not been funded for the last few years. Therefore, we see no justification for continuing that authorization. Instead, we recommend that funds available for university-affiliated facilities be used for demonstration and training grants for such facilities.

4. The authority for grants to university-affiliated facilities would be similar to that contained in current law, except that the emphasis of such projects would be focused on interdisciplinary training programs and other demonstration training projects.

5. The authorization of appropriations contained in our draft bill would correspond to the amounts set forth for these programs in the President's budget for fiscal year 1976.

6. We are proposing that the Federal matching share for State grants under the Developmental Disabilities program be gradually reduced from seventy percent in 1975 to sixty percent in 1976 and fifty percent in 1977. We believe it is appropriate for State and local governments to assume an increasingly greater degree of responsibility for service programs that affect their citizens, and that they should progressively increase their share of support for these programs.

7. The provisions relating to the National Council on Services and Facilities for the developmentally disabled and the State planning and advisory councils

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would embody current law rather than the expanded provisions contained in the Senate bill.

8. The enclosed draft bill is similar to the House bill with respect to elimination of the requirement for Federal approval of construction projects under the State grant program. The deletion of this requirement is in accord with our objective of returning responsibility to State and local governments whenever it is appropriate to do so.

9. The draft bill would require the Secretary to issue regulations for the Developmental Disabilities program; however, because of the need to consult with interested parties and to issue a notice of proposed rulemaking before those regulations can be put into effect, no time limitation is specified for that process.

10. With regard to evaluation of services for the developmentally disabled, our draft bill would require the Secretary to develop not later than February 1, 1977, a design for a comprehensive evaluation system to be implemented by the States in phases. Each State receiving funds under this Act would be required to implement the first phase of that system not later than October 1, 1977. We believe that such an approach to evaluation is more realistic and effective than the unworkable requirement in the Senate bill for the development by the Secretary within eighteen months of an evaluation system and plan for implementation thereof which would be a model for State evaluation systems for all services delivered to persons with developmental disabilities.

11. Our bill would provide a special projects authority which would include authority for the Secretary to fund projects of special national significance. The ten percent set-aside for this purpose in the State grant portion of the Act would therefore be deleted. Consonant with the aim of inducing greater State and local involvement, the Administration bill proposes terminating Federal support for individual special projects after three years of initial assistance. This provision will give States and localities greater incentives to scrutinize these programs and evaluate their effectiveness.

As we indicated last year in our letter to the conferees on the subject of H.R. 14215, we have very serious concerns about the provisions contained in title II of the Senate version of that bill—the "bill of rights" for mentally retarded and other persons with developmental disabilities—which would establish very stringent standards for all residential and community facilities providing services to developmentally disabled persons. While we are in basic agreement with the thrust of that title, as indicated in the enclosed letter, we do not believe that the standards set forth in title II are achievable at the present time; nor are they the best means of improving the quality of care provided to persons in these facilities.

A more detailed analysis of our concerns with title II is contained in the paper which is annexed to our letter to the conferees. Although our bill does not incorporate a provision corresponding to title II, we are very concerned about the quality of care provided to developmentally disabled persons. Indeed, we believe that we have developed a basic approach to this problem which is not only more feasible than the approach in the Senate bill, but also comes closer to accomplishing the goals of the Senate bill.

We are advised by the Office of Management and Budget that enactment of this proposal would be in accord with the program of the President.

Sincerely,

CASPAR W. WEINBERGER,
Secretary.

Enclosures.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., December 11, 1974.

Hon. JACOB K. JAVITS,
Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR SENATOR JAVITS: This is to bring to your attention this Department's concern over several provisions in the Senate version of H.R. 14215 regarding developmental disabilities, which will soon be subject to Conference Committee action. This bill would provide for an extension of, and major revisions in, the program administered by this Department providing services to persons with developmental disabilities (i.e., mental retardation, epilepsy, cerebral palsy, and other neurological conditions), as well as establishing rigorous standards to be met by residential and community facilities providing services to such persons.

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Title I of the bill would revise and extend the Federal program for persons with developmental disabilities, the authority for which, under the Developmental Disabilities Services and Facilities Construction Act of 1970 (P.L. 91-517), expired June 30, 1974. This program provides grants directly to organizations conducting special demonstration projects as well as to the States on a formula basis. In general, we have been pleased with the operation of this program which has effectively served to coordinate and integrate the delivery of services to persons with developmental disabilities. The commitment of the Administration to the program is demonstrated in its bills, H.R. 12892 and S. 3011, which are very similar to the House version of H.R. 14215. However, some of the provisions in the Senate version cause us very serious concern. I would like to bring these problems to your attention and respectfully request your assistance in obtaining a saisfactory measure in Conference.

Briefly, the provisions in Title I of the Senate bill which are of concern to us are the following:

1. Section 4 would establish in the Office of the Secretary an Office of Developmental Disabilities. Presently, the Developmental Disabilities program is administered by the Division of Developmental Disabilities in the Rehabilitation Services Administration, which is part of the Social and Rehabilitation Service. While we agree that the time may have come for the Developmental Disabilities program to assume a more visible role as a focal point within the Department for persons with developmental disabilities, we object strongly to any organizational restrictions mandated by legislation. Such restrictions seriously limit the flexibility and management capability, not only of this Secretary, but of all future Secretaries.

2. Section 111 would increase the authorizations for State allotments from the current level of $32 million for FY 1974 to $50 million for FY 1975. The authorization would increase substantially over the next five years to a level of $110 million for FY 1979. In addition, the proposed special projects authority would authorize an appropriation of $17.5 million for FY 1975, gradually increasing to $27.5 million for FY 1979. Because of the clear need to restrain any increase in Federal outlays, we object to these excessive authorization levels in the Senate bill and would prefer instead that the bill authorize the appropriation of such sums as may be necessary.

3. Section 116 would continue the requirement in present law that the Secretary approve all construction grants awarded from funds allocated to States. We believe that Federal approval of construction grants is an unnecessarily costly step, in terms of time and money, in the construction of needed community facilities. For this reason, the Administration bill, as well as the bill passed by the House, would have removed the requirement for Federal approval of construction grants. Such a deletion of the requirement in present law is in accord with the Administration's objective of returning responsibility to the States and localities whenever it is appropriate to do so.

4. Section 119(a) would require the Secretary to publish final regulations to implement the new Act within ninety days of enactment. We agree that it is essential that regulations implementing the new Act be promulgated as swiftly as possible, and we fully intend to do so. However, the revisions in the Developmental Disabilities program contemplated in the Senate bill are significant and complex, and the promulgation of regulations to implement them will be a major undertaking.

It simply will not be possible to publish final regulations that give adequate and complete guidance to States and other concerned entities within ninety days. Because we appreciate the Senate's concern that the regulations be published in a timely fashion, we propose that an interim deadline of sixty days from enactment be set for the publication of proposed rulemaking, with a deadline of 180 days from enactment for the publication of final regulations.

5. Section 121 would require the Secretary to develop within eighteen months from enactment "an evaluation system and plan for implementation of such system which shall provide a model for the development of State evaluation systems for all services delivered within the States to persons with developmental disabilities." Even without the restrictive eighteen-month time limitation, the scope of the model system that would be required by this section is so broad, covering all services in each State affecting the developmentally disabled, as to make it extremely complex and difficult to develop. To accomplish the objective of this provision—the development of an evaluation capability in the State—through more feasible means, we recommend that the Secretary be re-

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quired to develop, by February 1, 1977, a design for a comprehensive evaluation system to be implemented by the States in phases. Each State receiving funds under this act would be required to implement the first phase of the system by October 1, 1977.

6. Section 122 would establish a new Special Project grant authority. The Senate bill also continues (under Section 112(e)) the separate authority for projects of national significance to be funded from a set-aside of up to 10% of the State-allotment funds. Apart from the disadvantages of maintaining two separate project grant authorities, we are opposed at this time to the increased outlays that could result from the additional authority for special projects under Section 122.

Title II of H.R. 14215, passed by the Senate on October 1, 1974, would establish rigorous standards to be met by residential and community facilities providing care for developmentally disabled persons. All Federal funds to any such facility which does not meet the Title II standards within five years of the enactment of H.R. 14215 would be terminated.

There is no doubt that Title II addresses an area of clear and urgent need. Conditions in facilities serving developmentally disabled persons have resulted in many cases in the delivery of inadequate services to such persons. Nevertheless, Title II as now drafted poses such major problems that we urge that Parts C and D be deleted and that Parts A and B be significantly amended along the lines suggested in the annexed paper, which was provided to committee staffs on October 24, 1974.

In summary, while we are generally sympathetic to the goals of the Senate bill, we feel that our recommendations would vastly improve it.

We are advised by the Office of Management and Budget that there is no objection to the presentation of these views from the standpoint of the Administration's program.

Sincerely,

CASPAR W. WEINBERGER, *Secretary.*

Attachment.

HEW COMMENTS ON TITLE II OF THE SENATE-PASSED VERSION OF H.R. 14215

Title II of H.R. 14215, passed by the Senate on October 1, 1974, would establish rigorous standards to be met by residential and community facilities providing care for developmentally disabled persons. All Federal funds to any such facility which does not meet the Title II standards within five years of the enactment of H.R. 14215 would be terminated.

There is no doubt that Title II addresses an area of clear and urgent need. Conditions in facilities serving developmentally disabled persons have resulted in many cases in the delivery of inadequate services to such persons. Nevertheless, Title II as now drafted poses such major problems that we urge that Parts C and D be deleted and that Parts A and B be significantly amended along the lines suggested below.

Our experience in developing and implementing the regulations establishing standards for Intermediate Care Facilities for the Mentally Retarded (ICF-MR's), published on January 17, 1974, indicates that they represent the limit to what realistically can be expected at this time of the networks of facilities serving the developmentally disabled. We believe that Title II, in going beyond the standards imposed in our ICF-MR regulations, would make unrealistic demands on the thousands of agencies and facilities which provide services to developmentally disabled persons and other community residents with similar needs. Such demands could result in a major disruption in the delivery of services to the developmentally disabled and create considerable confusion and uncertainty for, and in many cases termination of services provided by, individual facilities and agencies. Because of these concerns, we recommend that the standards and other requirements proposed in Title II be modified so as to incorporate the standards imposed by our ICF-MR regulations, and that they be made to apply only to ICF-MR's participating in the Medicaid program. We have indicated in the attached paper the provisions which we believe should be modified to effect these ends.

The Department is, of course, currently involved in a major effort to enforce the Federal ICF-MR standards, which we believe largely implement the same objectives as Title II of H.R. 14215. The ICF-MR standards relate to medical care, fire safety, physical environment and sanitation. They aim at improving

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the care and living conditions of residents of ICF–MR's and will have a substantial impact on the well-being of the many thousands of developmentally disabled persons who reside in ICF–MR's. Included in the ICF regulations, which are based on those proposed by the Accreditation Council for Facilities for the Mentally Retarded of the Joint Commission on Accreditation of Hospitals, are the following major requirements:

Physicians must evaluate ICF patients on admission to certify that ICF care is necessary and appropriate, and a treatment plan must be established for each patient.

Physicians must evaluate patient care and status regularly after admission.

Independent professional review of each patient's care must be carried out at least annually to assure that all patients are continuing to receive appropriate and necessary care.

ICF health services must be supervised by a fulltime Registered Nurse or a Licensed Practical Nurse.

ICF's must provide rehabilitative, health, and social services as needed, including organized activity programs.

ICF's for the mentally retarded must provide active treatment and a full range of professionally developed and supervised activities and therapies to promote capabilities for independent living and returning residents to the community.

The ICF–MR standards were issued under Title XIX of the Social Security Act. Consequently, they apply to all ICF–MR's certified for Medicaid reimbursement. Implementation of the standards must be completed by March 1977. This phase-in period will allow many facilities to complete the expensive and time-consuming renovations which the regulations will necessitate. Each intermediate care facility approved to participate in Medicaid must, no later than March 1975, have a detailed plan for meeting the requirements by 1977. If it does not progress in accordance with that plan it will be barred from continued participation in the Medicaid program.

Because the requirements in Title II are not related to those in the ICF–MR regulations or in any present law, they duplicate and conflict with the ICF–MR requirements. The enactment of Title II would therefore interfere with the considerable effort already underway to implement and comply with the Medicaid requirements. Moreover, Title II would have a significant impact on other aspects of the Medicaid program, which accounts for a significant share of the Federal financial assistance currently being spent on persons with developmental disabilities. The proposed legislation has not taken this impact into account.

We are concerned that a program impacting so heavily on the Medicaid program and on the operations of the Social Security Administration would not have received consideration by and approval of the Senate Finance Committee, which has jurisdiction over the legislation which affects such programs, or by the House Ways and Means Committee, which, in spite of adoption of the Hansen Report, still retains jurisdiction over the Social Security Administration.

Finally, we are particularly concerned with the inclusion of Parts C and D in Title II as required alternate standards to those under Part B. The inclusion of detailed requirements in statute will create difficulty in the event that new forms of service delivery necessitate changes. In addition, much of the language in the section is unenforceable because it is only admonitory in nature. Moreover, it appears to require that future JCAH standards, whatever they may be, will become applicable by virtue of these parts without further legislative or administrative action. This open-ended commitment to standards developed by a non-governmental body is a bad precedent in itself and totally unjustified by the need to improve conditions for the developmentally disabled.

In summary, the ICF Title XIX standards accomplish the objectives of this title within a shorter time frame through language which we feel can be enforced and, if necessary, defended in court. We strongly urge the deletion of Parts C and D because of their open-ended nature, their excessive detail, and their lack of enforceability. We urge amendment of Parts A and B to keep them within realistic limits and to make them apply only to ICF–MR's participating in Medicaid. The Department will have under constant review the opportunities for strengthening our regulations and extending their ambit to community facilities and will be happy to consult with the Congress as those opportunities become apparent.

The comments which follow provide recommended modifications for Parts A and B of Title II in line with the Department's proposal.

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TITLE II—PARTS A AND B

SECTION 201—DEFINITIONS

Summary

Section 201 includes definitions for terminology used in Title II.

Discussion

If the Department proposal to narrow the scope of Title II standards to ICF–MR's participating in the Medicaid program is adopted, many of the definitions in this section could be deleted or modified. Even in its present form, however, many of the definitions in this section are incomplete or vague and thus cannot provide useful guidance to facilities or individuals. For example, the definitions fail to include the terms "community agency," "community facility" and "program for community care," although these terms are critical in understanding Sections 204, 207 and 210. There are definitions of the terms "agency" and "community"; however, these are so broad that combining the two would lead to the inclusion of any program providing services to the developmentally disabled whether as part of the general population or as part of a special service group.

In addition, the term "program coordinator" is defined in such vague terms that it could include staff ranging from the unskilled to the highly skilled.

Department position

Delete all definitions which would not pertain to ICF–MR's participating in the Medicaid program.

Technical amendment

Define the term "program coordinator" to specify the degree of training required for individuals serving in that capacity.

SECTION 202—NATIONAL ADVISORY COUNCIL ON STANDARDS FOR RESIDENTIAL AND COMMUNITY FACILITIES FOR MENTALLY RETARDED AND OTHER PERSONS WITH DEVELOPMENTAL DISABILITIES

Summary

Section 202 establishes a National Advisory Council for Residential and Community Facilities which shall (1) advise the Secretary with respect to regulations promulgated by him for the implementation of the provisions of Title II, (2) study and evaluate the provisions of Title II to determine their effectiveness, (3) assist the Secretary in developing performance criteria to evaluate standards pursuant to Part B and Section 121 of S. 3378, and (4) develop recommendations for modifications in the standards established under Parts C and D of Title II.

Discussion

Section 202 creates a council separate and distinct from the National Council on Services and Facilities for the Developmentally Disabled proposed in Section 118 of the bill. Such a proliferation of advisory bodies impedes effective, coordinated action.

Cost impact of section 202

The administrative expenses for the council (travel, per diem, reproduction of reports, site visits, etc.) could range from $100,000 to $250,000. This does not include an estimated $60,000 in staff support.

Department position

Delete section and transfer functions of the proposed National Advisory Council to the National Council proposed by Section 118.

Technical amendment

None.

SECTION 203—ASSESSING COMPLIANCE WITH STANDARDS

Summary

Section 203 specifies a number of actions States must take (including submission of a State plan) to assure the Secretary that facility and agency plans to achieve compliance are being developed and implemented. The Secretary shall conduct an independent compliance survey and report his findings to the Congress.

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Discussion

The State plan required by Section 203 overlaps the extensive State plan required in Section 114 and also duplicates Title XIX requirements in some respects. The proliferation of State requirements, each slightly different, can only cause confusion.

Department position

Delete.

Technical amendment

None.

SECTION 204—GRANTS TO ASSIST COMPLIANCE

Summary

Section 204 authorizes the Secretary to make grants to assist States in bringing publicly operated and federally assisted residential or community facilities and agencies into compliance with the Title II standards.

Discussion

The cost impact of this section (with 75 percent Federal matching) would be significant (see below). In addition, this section includes no specific criteria to guide the Secretary in his awarding of grant funds. It also neglects to specify whether such funds are available only where other sources of financial support are unavailable.

This section would represent a sharp departure from present Federal policy with respect to the upgrading of facilities necessitated by the publication of Federal standards. Currently such upgrading is paid for in several ways: (1) by the State, if it is a State institution, (2) by the facility, if it is a private facility, and (3) by portions of Medicare and/or Medicaid reimbursements which are attributable to the cost of a facility's capital expenditures. We see no reason why such a departure from current policy is desirable or justifiable. The 75 percent FFP would benefit those facilities which are currently below standard. Facilities and agencies which have already spent a large sum in upgrading to meet Federal standards would, in effect, be disadvantaged.

Cost impact of section 204

A conservative estimate would be $1 million per residential institution over 5 years. While the number of facilities affected by Title II is unknown, for the purposes of preparing cost estimates we estimate that at least 6,000 facilities are involved. Thus, a minimum estimate of the cost of implementing Title II is $6 billion. This total would be reduced to approximately $1,250 billion if only residential facilities which provide medical services (facilities at the ICF level) received the financial assistance; however, this lower figure does not take into account thousands of facilities providing personal care and thousands of community service agencies, all of which would be affected by Title II.

Examples of the estimated cost of bringing individual residential (ICF level) facilities up to the ICF standards are as follows:

	Millions
Partlow, Ala. (construction only)	$22.5
Forest Haven, Md	8.5
Gracewood, Ga	2.0

Department position

Delete.

Technical amendment

None.

SECTION 205—MAINTENANCE OF EFFORT

Summary

Section 205 would permit "Federal assistance payments authorized under any Federal law" to "publicly operated or assisted facilities for the developmentally disabled only if" the facility provides evidence that such payments have not resulted in nor will result in any decrease in per capita State and local expenditures for services for the devolpmentally disabled which would otherwise be available to the facility. It would also require the submission of detailed expenditure reports by such facilities and the submission of an annuual Department report to Congress outlining the status of compliance with this provision.

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Discussion

The Department has no objection to the concept of maintenance of effort with respect to expenditures for the developmentally disabled. Such requirements are currently and have been long utilized in the Medicaid and other programs to assure that new Federal monies will augment and not replace current State expenditures and thereby improve the quality, scope and amount of services rendered.

We believe that the intent of Section 205 has been effectively met existing Title XIX law (Section 1905(d)) which requires States to maintain expenditures for ICF–MR's. Section 1905(d) (which was Section 299 of Public Law 92–603) expires as of January 1, 1975. The Senate Finance Committee Report on H.R. 1 (Public Law 92–603) makes clear that Congressional intent does not view perpetual maintenance of effort obligations of the States as desirable. We agree with the intent of the Senate Finance Committee Report on this subject.

There are several other problems with Section 205 as it is presently constructed:

(1) Section 205 specifies that the term "base year" means "the most recent fiscal year for which reliable fiscal data is available." This term is so lacking in specificity as to render enforcement of the provision meaningless.

(2) Section 205 assigns the responsibility for maintenance of effort to the individual facility. W believe it is administratively infeasible for a facility to be held responsble for assuring that State payments to the facility do not decrease. In addition, we believe it is more appropriate to assure that total State expenditures for a specified activity do not decrease than to tie State funds to specific facilities. In addition, we believe that the States should have flexibility in determining the allocation of their resources among the various facilities for the developmentally disabled and would therefore oppose any provision which would restrict State discretionary spending among such facilities.

(3) It is possible that Section 205 will not have its desired effect inasmuch as there is no sanction for States which fail to maintain total current expenditures for the developmentally disabled. Presumably, if a State or locality wished to discontinue or decrease funding for a particular facility such action would render that facility ineligible for any direct Federal assistance. However, it would not adversely affect any other facility in the State.

(4) Section 205 uses as a sanction "Federal assistance payments authorized under any Federal law". We believe this term is so broad in scope as to be administratively infeasible.

(5) Section 205 wouldfi we believe, establish an undesirable precedent in requiring the Department to review expenditure reports of every publicly assisted facility serving the developmentally disabled and to report to the Congress thereon.

(6) The major portion of developmental disability *service* funds currently available to the States is available under the Medicaid ICF–MR program; the developmental disabilities bill will not alter this situation. The Federal matching nature of the Medicaid program will tend to assure the continuance of State fiscal effort inasmuch as Federal funds are not available until State funds have been expended. Thus, we believe that maintenance of effort requirements are unnecessary with respect to institutional services for the developmentally disabled because the Medicaid program already provides sufficient incentive for States to finance care for the institutionalized developmentally disabled population. In addition, the ICF–MR program under Medicaid includes facilities which constitute the majority of facilities which are the target of Section 205; we believe it is unnecessary to go beyond this group of facilities to meet the objective of Section 205.

Departmental position

Oppose.

Technical amendment

None.

SECTION 206—WITHHOLDING OF GRANTS

Summary

Section 206(a) would authorize withholding of all Federal payments (indirect or direct) to any program of community care or residential facility for individuals with development disabilities unless it meets the Title II standards within 5 years.

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Section 206(b) would require the Social Security Administration to reserve and administer all funds to which any individual would otherwise be entitled to have paid on his behalf to any vendor of residential services of program of community care, public or private.

Discussion

Our principal concern with Section 206(a) is that it could result in a major disruption in the delivery of services to the developmentally disabled and to others in facilities which receive Federal reimbursement for services rendered. Such disruption would occcur, first, because Section 206(a) would create considerable confusion and uncertainty for both States and individual facilities and agencies which are currently in the midst of planning for and implementing the existing Federal ICF standards. We believe that States and facilities should not be further burdened with the task of enforcing additional standards until the successful completion of the ICF standard enforcement effort.

In addition, because Section 206(a) would apply to facilities receiving medicare and Medicaid reimbursement, it could create hardships for the nondevelopmentally disabled populations receiving services in such facilities. In effect, a facility treating a single patient with a developmental disability, which complied with Title XVIII–XIX standards but not the new standards to be promulgated under Title II of S. 3378, would lose Medicare and Medicaid funds for all patients. Such a cut-off of Federal funds would mean that the patients of facilities would no longer reside in such facilities unless alternative sources of funding could be found.

We believe that the withholding of all Federal funds from institutions and agencies not meeting standards in five years would represent an extreme measure. It would apply to so many facilities (schools, community mental health centers, etc.) and so many sources of Federal funds (e.g., even SSI benefits could be included in the scope of the provision) that it would create an overwhelming administrative burden. Normally, residential and community facilities and programs such as those under consideration in this title receive Federal funds from a variety of State and local, as well as Federal, agencies. Effective enforcement of the withholding of Federal funds, particularly enforcement with respect to funds paid indirectly as a result of revenue sharing, would require a massive monitoring and tracking effort, involving a great increase in Federal regional manpower.

The language of section 206(b) and of the Committee report is quite unclear concerning the responsibilities of the Social Security Administration, and section 206(b) is likely to create an administrative monstrosity. There appears to be no relationship between the administration of the earnings-related SS cash benefits program and the administration of funds to which an individual would be entitled to have paid on his behalf under a wide range of other Federal programs—including services programs such as Medicaid and vocational rehabilitation. Should the intent of section 206(b) have merely been that the SSA would determine a proper payee for funds withheld under section 206(a), it would seem to be much more reasonable to have the agency making the initial determination for payment of the funds withheld also determine the proper payee. SSA would be required to obtain information from the files of the various agencies before payment could be made of the funds withheld by these agencies.

Whatever responsibilities the SSA would be required to handle under section 206(b) would impair the operation of other SSA-administered programs, including the new SSI program and the Medicare program. We believe the House Ways and Means Committee and the Senate Finance Committee should be consulted before this provision is added to the conference agreement because both committees have indicated interest in any new responsibilities that might be imposed on the SSA.

Department position

206(a)—Do not oppose if (a) the standards promulgated pursuant to Title II were consistent with those promulgated by the Secretary for ICF–MR's, (b) such standards provided flexibility for the Secretary to develop and amend implementing regulations so as to keep pace with changing conditions in the developmental disability field, (c) their applicability be limited to ICF–MR's participating in the Medicaid program, and (d) the Federal fund cut-off penalty were limited to Medicaid funds.

206(b)—Delete.

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Technical amendment

None.

SECTION 207—EVALUATION AND PERFORMANCE CRITERIA

Summary

Section 207 requires the Secretary to develop an evaluation system and plan for implementation of such system designed to:

(1) assess the adequacy of all education and training, habilitation, rehabilitation, early childhood, diagnostic and evaluation services, or any other services or assistance under all laws administered by the Secretary; and

(2) develop specific criteria designed to provide objective measurement of the development progress of a developmentally disabled individual, which may be utilized by public agencies, residential facilities, and community based facilities and agencies to evaluate the effectiveness of the services provided to such individual.

Discussion

This section overlaps and/or conflicts with the responsibilities and activities established in Section 121 of Title I and establishes an overly broad mandate for evaluation of DHEW programs.

Section 121 mandates Federal development of a model State evaluation system for all programs within the State serving the developmentally disabled population which is virtually identical to the system described in Section 207, the only differences being that the Section 121 system is to be developed under the auspices of the National Council of Services and Facilities for the Developmentally Disabled and focuses upon a State rather than a national system.

Enactment of the Section 207 evaluation component would result in similar activities carried out by two separate bodies. This would create duplication of effort, different approaches to the same problem, and development of two information systems to meet each system's particular requirements.

Insofar as any national evaluation would be dependent upon the prior availability, accessibility, reliability and validity of State data, a State and national system should be developed coterminously under the same auspices. The national system should be phased in at appropriate times after initial State efforts have begun.

We support and accept the basic concepts introduced in Sections 121 and 207; specifically, (1) the value of Federal leadership in the development of an overall evaluation system concept, relevant methodologies with implementation guidelines, and Federally required standards; (2) the development of specific criteria designed to provide objective measurement of the developmental progress of persons with developmental disabilities, and (3) the potential utility of including in an evaluation system some of the recent developments under DHEW sponsorship related to individualized data systems. It will be especially useful to establish an initial coordinated Federal-State effort and system which can be built upon as capabilities for evaluation and the establishment of performance criteria advance.

While in agreement with the intent, we are concerned that th comprehensive evaluation of social programs is an extremely ambitious undertaking with severe limitations in the state of the art. Thus, it is necessary that evaluation methods be carefully assessed prior to Federal endorsement. Further, it is important that the real merits of the evaluation system, along with its potential for future growth, not be compromised by overambitious requirements for initial State implementation.

Thus, we interpret the legislative language as requiring the Department to assess the state of the art and design a system structure which will be feasible for States to implement and which will meet the above objectives as fully as an aggressive but responsible use of existing knowledge and methodology allow.

While we do not yet have an assessment of existing knowledge and methodology, we have the following impression of their status:

(1) The objective measurement of the development progress of persons with developmental disabilities is desirable and possible.

(2) The use of individualized data from habilitation plans as a basis for an evaluation system is probably technically feasible, but issues of cost and confidentality of data need thorough consideration prior to system design.

(3) Data can be developed on the receipt of services by developmentally disabled individuals which, on a statistical basis, could allow for useful evaluation

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of the impact of some services and service packages on the progress of developmentally disabled individuals.

(4) Deficiencies in the state of the art, coupled with practical restraints (e.g., cost, unavailability of control groups) will neither allow an initial system to assess cause and effect relationships between individual services and the progress of particular individuals nor allow the comprehensive evaluation of all services.

(5) The formal inclusion in the system of the development of a cost-benefit ratio of particular service alternatives is premature at best.

Department position

The Department recommends deletion of Section 207 and incorporation of its requirements in Section 121. We are preparing specific alternative proposals to Section 121, which will be submitted in a separate document.

Technical amendment

None.

SECTION 210—PERFORMANCE CRITERIA

Summary

Section 210 requires the Secretary to develop performance criteria for persons with developmental disabilities and minimum compliance levels for such criteria for all facilities and agencies providing services to persons with developmental disabilities. Such criteria shall be considered minimum standards under Title II.

Discussion

The intent of this section seems to be to use objective measures of the developmental progress of persons with developmental disabilities as a basis for establishing performance criteria by which individual facilities would be evaluated. We believe the establishment of such an evaluation system is desirable, but that it should be developed as part of the comprehensive evaluation system required under Section 121. In our proposed alternative to Section 121 (to be submitted separately) we will incorporate the objectives of Section 210.

Department position

Recommended deletion and incorporation of the objectives of section 210 into Section 121.

Technical amendment

None.

SECTION 211—INDIVIDUALIZED WRITTEN HABILITATION PLAN

Summary

Section 211 requires invidual written habilitation plans to be developed and modified at "frequent" intervals on behalf of each developmentally disabled person who is residing in a residential facility, community facility and agency to which Title II standards apply.

Discussion

We endorse the objective of an individual habilitation plan for every person with a developmental disability. However, we foresee problems with the smaller, non-medical facilities which would not have sufficient staff available to them to develop and implement habilitation plans for their residents/patients with developmental disabilities. The basic team required to develop an individualized habilitation plan would include a physician, psychologist, nurse and social worker. Ancillary personnel required as needed would include at least an apthalmologist, optometrist, audiologist, speech pathologist, occupational therapist, physical therapist, vocational rehabilitation specialist, neurologist, surgeon, X-ray technician, EEG technician and psychiatrist.

Considerable problems could ensue if the development of the habilitation plan requires the participation of a State agency representative. We believe it is unreasonable to expect a State agency to develop literally thousands of treatment plans. The approach of the ICF and Skilled Nursing Facility (SNF) regulations has been for the facility to develop the plans, although they are subject to independent professional review.

The requirements in subsection 211(d)(2) for assessment data would present implementation problems because some areas of measurement are difficult to assess (e.g., effective development, or cognitive development). In addition, insufficient trained personnel are available to attempt such assessments. Again, we would suggest that medical facilities would be in a better position to perform

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such assessments than non-medical facilities, which would generally not have available to them the services of psychiatrists or clinical psychologists. This comment also applies to subsection 211(e).

We feel that the performance criteria which the Secretary would be required to develop under Section 211(f) would necessarily drive from the measurement criteria to be developed under our proposed Section 121.

Plans for the patient who receives services from both the State vocational rehabilitation and developmental disability agencies should be coordinated, a requirement which the section does not suggest. The provision does not speak to which agency would have the lead in preparing the habilitation plan for a person with a developmental disability who is also receiving vocational rehabilitation services.

Cost impact of section 211

The cost for an initial evaluation would be an estimated $400, based on the services of a 4-man basic team working one-half day. Periodic (quarterly) evaluations would be an estimated $100 each. The first-year cost for habilitation plans would therefore be an estimated $700 per person, or $5.6 billion, based on an estimate of 8–8½ million persons. This estimate of the affected population is considered conservative, however; other estimates have placed the target population at closer to 20 million. The annual ongoing cost of the evaluations would be $3.2 billion.

Department position

Do not oppose if habilitation plans are limited to persons with developmental disabilities in ICF–MR's participating in Medicaid program and if coordination of DD and VR plans is required.

Technical amendment

The term "intervention" in subsection 221(d)(6) should be clarified because of its specific clinical connotations, which may be misinterpreted.

SECTION 212—PROGRAM COORDINATION

Summary

Section 212 requires that each developmentally disabled person served by an agency shall be assigned a program coordinator responsible for implementation of the person's individual written habilitation plan.

Discussion

While we endorse the objectives of this section, we believe they can be achieved at the present tim only by ICF–MR's participating in Medicaid rather than non-medical facilities or facilities which do treat the developmentally disabled. We would also oppose the detailed provisions relating to the program coordinator's function; these are generally unrealtistic in their broad scope and inappropriate for statutory language.

Department position

Do not oppose, if program coordinator requirements are applicable only to ICF–MR's participating in Medicaid.

Technical amendment

None.

SECTION 213—PROTECTIVE AND PERSONAL ADVOCACY

Summary

Section 213 would establish in each State a system of protection and personal advocacy for the developmentally disabled in that State.

Discussion

We object to this provision because it would create a new fair hearing system unrelated to current systems of due process safeguards. Furthermore, the section is so broadly drawn that it could be interpreted to authorize the State agency to overrule a Federal agency administering benefits or services to an individual.

A further problem with this section is its failure to distinguish clearly between those persons having an adjudicatory role and those having an advocacy role with respect to the treatment of persons with developmental disabilities. There must be a clear separation of such roles in order to avoid possible conflicts of interest.

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This system would also be extremely costly to implement (see below). It would require not only an ombudsman-type office, but an adjudicative arm also—one capable of producing a record which could be reviewed by a court. We would suggest an approach similar to that incorporated in the Vocational Rehabilitation Amendments which authorize demonstration projects for advocacy.

Cost impact of Section 213

A conservative estimate of the advocacy program, based on the experience with SRS demonstration projects, is $375,000/State or a total of $18,750,000 nationally. This does not include costs for an adjudicative arm.

Department position

Substitute authority for demonstration projects to test effectiveness of such systems.

Technical amendment

None.

SECTION 215—MINIMUM STANDARDS FOR USE WITH THE ALTERNATE PROCEDURE

Summary

Section 215 establishes additional standards for facilities and agencies using the Part B (Title II) standards.

Discussion

On October 3, the Department published final regulations (the Patient's Bill of Rights) which would require SNF's and ICF's to establish policies to ensure that certain rights are afforded to patients. These regulations give implicit recognition to the fact that patients' health and responsiveness to treatment are frequently linked to such rights as:

The right to be treated with dignity,
The right to be involved in decision-making about treatment, and
The right to maintain contact with the community.

The basic objectives of Section 215 are covered by the existing ICF regulations and the SNF Patient Bill of Rights; however, the requirements are not identical. Some sections (such as (2) and (9)) are unclear, and others (such as (7), (11), and (12)) would not be appropriate to apply uniformly to all facilities and agencies serving the developmentally disabled. Item (13) is one beyond the control of the facility; therefore, it is unfair to require the facility to conform to it unless the facility itself provides educational services. We see no reason for inclusion in this Title these criteria, which are already being implemented for the most part in medical facilities under the ICF and SNF standards. Facilities not falling under the jurisdiction of these standards would be generally unable to meet such standards, as discussed throughout this paper.

Department position

Delete.

Technical amendment

None.

A BILL TO revise and extend the program authorized by the Developmental Disabilities Services and Construction Act

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Developmentally Disabled Assistance Act of 1975".

TITLE I—GENERAL PROVISIONS

DECLARATION OF PURPOSE AND FEDERAL SHARE

SEC. 100. (a) The purpose of this Act is to improve and coordinate the provision of services to persons with developmental disabilities through (A) grants to assist the several States in developing and implementing a comprehensive and continuing plan for meeting the current and future needs of persons with developmental disabilities; (B) support of interdisciplinary training programs and training demonstration projects at institutions of higher education; and

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(C) the support of other activities which will contribute to improving the condition of persons with developmental disabilities.

(b) The Federal share with respect to any project assisted under title II of this Act may not exceed 70 percent of the necessary cost thereof as determined by the Secretary.

(c) The Federal share with respect to assistance under title III of this Act may not exceed 70 percent of the necessary cost thereof, as determined by the Secretary, for the fiscal year ending June 30, 1975, 60 per centum of such cost for the fiscal year ending June 30, 1976, and 50 per centum of such cost for the fiscal year ending September 30, 1977.

(d)(1) The non-Federal share of the cost of any project assisted under this Act shall be provided in cash or in kind, in accordance with rules generally applicable to grants provided by the Department of Health, Education, and Welfare.

(2) Payments of grants under this Act shall be made in advance or by way of reimbursement, and on such conditions as the Secretary may determine.

(3) For the purpose of determining the Federal share with respect to any State, expenditures by a political subdivision thereof or by nonprofit private agencies, organizations, and groups shall, subject to such limitations and conditions the Secretary may by regulation prescribe, be deemed to be expenditures by such State.

DEFINITIONS

SEC. 101. For purposes of this Act—

(1) "Construction" means the construction of new buildings, the acquisition, expansion, remodeling, alteration, and renovation of existing buildings, and initial equipment of any such buildings (including medical transportation facilities).

(2) "Cost of construction" means the amount necessary for the construction of a project, including architect's fees and the cost of the acquisition of land, but excluding the cost of offsite improvements.

(3) "Design for implementation" means a document prepared by the appropriate State agency or agencies outlining the implementation of the State plan as developed by the State planning council. The design for implementation shall include details on the methodology of implementation, priorities for spending, a detailed plan for the use of funds provided under this Act, specific objectives to be achieved, a listing of those programs and resources to be utilized, and a method for periodic evaluation of its effectiveness in meeting State plan objectives.

(4) "Developmental disability" means a disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition of an individual found by the Secretary to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, which disability originates before such individual attains age eighteen, which has continued or can be expected to continue indefinitely, and which constitutes a substantial handicap to such individual.

(5) "Institution of higher education" has the meaning given it in section 122(c) of the Education Amendments of 1972.

(6) "Nonprofit facility for persons with developmental disabilities", or "nonprofit private institution of higher learning" means a facility for persons with developmental disabilities, and an institution of higher learning which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

(7) "Nonprofit private agency or organization" means an agency or organization which is a nonprofit corporation or association or which is owned and operated by one or more of such corporations or associations.

(8) "Secretary" means the Secretary of Health, Education, and Welfare.

(9) "Services for persons with developmental disabilities" means specialized services or special adaptations of generic services directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with such a disability, and such term includes diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, training, education, sheltered employment, recreation, counseling of the individual with such disability and of his family, protective and other social and legal services, information and referral services, follow-along services, and

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transportation services necessary to assure delivery of services to persons with developmental disabilities.

(10) "State" includes the several States, Puerto Rico, Guam, American Samoa, the Virgin Islands, the Trust Territory of the Pacific Islands, and the District of Columbia.

(11) "Title" when used with reference to a site for a project, means a fee simple, or such other estate or interest (including a leasehold on which the annual rental does not exceed 4 percent of the value of the land) as the Secretary finds sufficient to assure for a period of not less than 50 years undisturbed use and possession for the purposes of construction and operation of the project.

AUDIT

SEC. 102. Each recipient of a grant or contract under this Act shall keep such records as the Secretary may prescribe, including records which fully disclose the amount and disposition by such repicient of the proceeds of such grant or contract, the total cost of the project or undertaking in connection with which such grant or contract is made or funds thereunder used, the amount of that portion of the cost of the project or undertaking supplied by other sources, and such records as will facilitate an effective audit. The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipient of any grant or contract under this Act which are pertinent to such grant or contract.

TITLE II—DEMONSTRATION AND TRAINING GRANTS FOR UNIVERSITY-AFFILIATED FACILITES

DEMONSTRATION AND TRAINING GRANTS

SEC. 201. (a) For the purposes of assisting institutions of higher education to contribute more effectively to the solution of complex health, education, and social problems of children and adults suffering from developmental disabilities, the Secretary may, in accordance with the provisions of this title, make grants to cover costs of administering interdisciplinary training programs and other demonstration training programs for personnel who are serving, or preparing to serve, persons with developmental disabilities. Such programs may be directed toward established disciplines as well as new kinds of training to meet critical shortages in the care of persons with developmental disabilities.

(b) For the purpose of making grants pursuant to this section, there are authorized to be appropriated for the fiscal year ending June 30, 1975, and for each of the two succeeding fiscal years, $4,250,000.

APPLICATIONS

SEC. 202. Applications for grants under this title may be approved by the Secretary, only if the applicant is a college or university operating a program of the type described in section 201(a), or is a public or nonprofit private agency or organization operating such a facility. In considering applications for such grants, the Secretary shall give priority to any application which shows that the applicant has made arrangements, in accordance with regulations of the Secretary, for a junior college or other community-based educational or health facility to participate in the programs for which the application is made.

MAINTENANCE OF EFFORT

SEC. 208. Applications for grants under this title may be approved by the Secretary only if the application contains or is supported by reasonable assurances that the grants will not result in any decrease in the level of State, local, and other non-Federal funds for services for persons with developmental disabilities and training of persons to provide such services which would (except for such grant) be available to the applicant, but that such grants will be used to supplement, and, to the extent practicable, to increase the level of such funds.

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TITLE III—GRANTS FOR PLANNING, PROVISION OF SERVICES, AND CONSTRUCTION AND OPERATION OF FACILITIES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

AUTHORIZATION OF APPROPRIATION

SEC. 301. For the purpose of making grants to carry out this title, there are authorized to be appropriated $30,875,000 for the fiscal year ending June 30, 1975, and for each of the two succeeding fiscal years.

STATE ALLOTMENTS

SEC. 302. (a)(1) From the sums appropriated pursuant to section 301 for each fiscal year, the several States shall be entitled to allotments determined, in accordance with regulations, on the basis of (A) the population, (B) the extent of need for services and facilities for persons with developmental disabilities, and (C) the financial need of the respective States; except that the allotment of any State (other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands) for any such fiscal year shall be not less than $200,000 and the allotment of the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands shall be not less than $50,000.

(2) In determining, for purposes of paragraph (1), the extent of need in any State for services and facilities for persons with developmental disabilities, the Secretary shall take into account the scope and extent of the services specified, pursuant to section 304(b), in the State plan of such State approved under this title.

(3) Sums allotted to a State for a fiscal year and designated by it for construction, renovation, or modernization which are unobligated at the end of such year shall remain available to such State for such purpose for the next fiscal year and for such year only, in addition to the sums allotted to such State for such fiscal year.

(b) Whenever a State plan is approved in accordance with section 304 which provides for participation of more than one State agency in administering or supervising the administration of designated portions of such plan, the State may apportion its allotment among such agencies in a manner which is reasonably related to the responsibilities assigned to such agencies in carrying out the purposes of this title, subject to the approval of the Secretary. Funds so apportioned to State agencies may be combined with other State or Federal funds authorized to be expended for other purposes, provided the purposes of this title will receive proportionate benefit from the combination.

(c) Whenever a State plan approved in accordance with section 304(c) provides for cooperative or joint effort between States or between or among agencies, public or private, in more than one State, portions of funds allotted to one or more such cooperating States or agencies may be combined in accordance with the agreements between the agencies and States involved.

(d) The amount of an allotment to a State for a fiscal year which the Secretary determines will not be required by the State during the period for which it is available for the purpose for which it is allotted shall be available for reallotment by the Secretary on such date or dates as he may fix (but not earlier than 30 days after he has published notice of his intention to make such reallotment in the Federal Register), to other States with respect to which such a determination has not been made, in proportion to the original allotments of such States for such fiscal year, but with such proportionate amount for any of such other States being reduced to the extent it exceeds the sum the Secretary estimates such State needs and will be able to use during such period; and the total of such reductions shall be similarly reallotted among the States whose proportionate amounts were not so reduced. Any amount so reallotted to a State for a fiscal year shall be deemed to be a part of its allotment under subsection (a) for such fiscal year.

(e) The Secretary shall administer grants under this title in accordance with policies used generally to administer grants throughout the Department of Health, Education, and Welfare.

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NATIONAL COUNCIL ON SERVICES AND FACILITIES FOR THE DEVELOPMENTALLY DISABLED

SEC. 303. (a) (1) The National Advisory Council on Services and Facilities for the Developmentally Disabled (hereinafter referred to as the "Council"), which was established pursuant to section 133 of the Developmental Disabilities Services and Facilities Construction Act, shall continue to exist for the period for which appropriations are authorized under this Act. The Council shall consist of twenty members, not otherwise in the regular full-time employ of the United States, to be appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive civil service.

(2) The Secretary shall from time to time designate one of the members of the Council to serve as Chairman thereof.

(3) The members of the Council shall be selected from leaders in the fields of service to the mentally retarded and other persons with developmental disabilities, including leaders in State or local government, in institutions of higher education, and in organizations representing consumers of such services. At least five members shall be representative of State or local public or nonprofit private agencies responsible for services to persons with developmental disabilities, and at least five shall be representative of the interests of consumers of such services.

(b) Each member of the Council shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his precedecessor was appointed shall be appointed for the remainder of such term.

(c) It shall be the duty and function of the Council to (1) advise the Secretary with respect to any regulations promulgated or proposed to be promulgated by him in the implementation of this title, and (2) study and evaluate programs authorized by this Act with a view of determining their effectiveness in carrying out the purposes for which they were established.

(d) The Council is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Council such secretarial, clerical, and other assistance and such statistical and other pertinent data prepared by or available to the Department of Health, Education, and Welfare as it may require to carry out such functions.

(e) Members of the Council, while attending meetings or conferences thereof or otherwise serving on the business of the Council, shall be entitled to receive compensation at rates fixed by the Secretary, but at rates not exceeding the daily equivalent of the rate provided for GS–18 of the General Schedule for each day of such service (including travel time), and, while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

STATE PLANS

SEC. 304. (a) For each fiscal year in which a State makes application to participate in programs under this title it shall develop, submit, and obtain the approval of the Secretary of an annual State plan which is a specific goal oriented plan, which shall include provisions designed to—

(1) reduce and eventually eliminate inappropriate institutional placement of persons with developmental disabilities;

(2) improve the quality of care, habilitation, and rehabilitation of persons with developmental disabilities for whom institutional care is appropriate;

(3) provide early screening, diagnosis, and evaluation of developmentally disabled infants and preschool children (including maternal care, developmental screening, home care, infant and preschool stimulation programs, and parent counseling and training);

(4) provide counseling, program coordination, follow-along services, and protective services on behalf of developmentally disabled adults;

(5) support the establishment of community programs as alternatives to institutionalization, designed to provide services for the care and habilitation of persons with development disabilities, which programs utilize, to the maximum extent feasible, the resources and personnel in related community programs to assure full coordination with such programs and to assure the provision of appropriate supplemental health, educational or social services for persons with developmental disabilities;

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(6) protect the human rights of all persons with developmental disabilities, especially those without familial protection; and

(7) provide for interdisciplinary intervention and training programs for multihandicapped individuals.

Such annual State plan shall be initially submitted within 180 days after the date of enactment of this Act.

(b) In order to be approved by the Secretary under this section, a State plan for the provision of services and facilities for persons with developmental disabilities shall—

(1) designate—

(A) a State planning and advisory council, which shall be responsible for submitting revisions of the State plan and transmitting such reports as may be required by the Secretary, and which shall include representatives of each of the principal State agencies and representatives of local agencies and nongovernment organizations and groups concerned with services for the developmentally disabled: *Provided*, That at least one-third of the membership of such council shall consist of representatives of consumers of such services;

(B) the State agency or agencies (except as provided in clause (C)) which shall administer and supervise the administration of the State plan, and if there is more than one such agency, the portion of such plan which each will administer (or the portion the administration of which each will supervise); and

(C) a single State agency as the sole agency for administering or supervising the administration of grants for construction, renovation, or modernization under the State plan;

(2) describe the quality, extent, and scope of services being provided or to be provided to meet the goals specified in subsection (a) of this section;

(3) describe (A) the quality, extent, and scope of services being provided, or to be provided, to persons with developmental disabilities under such other State plans for Federally assisted State programs as may be specified by the Secretary, which shall in any case include education for the handicapped, vocational rehabilitation, medical assistance, social services, maternal and child health, crippled children's services, and comprehensive health and mental health plans, and (B) how funds allotted to the State in accordance with section 302 will be used to complement and augment rather than duplicate or replace services and facilities for persons with developmental disabilities who are eligible for Federal assistance under such other State programs;

(4) provide for the maximum utilization of all available community resources including volunteers serving under the Domestic Volunteer Service Act of 1973 (87 Stat. 394) and other appropriate voluntary organizations;

(5) set forth policies and procedures for the expenditure of funds under the plan, which, in the judgment of the Secretary, are designed to assure effective continuing State planning, evaluation, and delivery of services (both public and private) for persons with developmental disabilities;

(6) contain assurances satisfactory to the Secretary that (A) the funds paid to the State under this title will be used to make a significant contribution toward strengthening services for persons with developmental disabilities in the various political subdivisions of the State in order to improve the quality, scope, and extent of such services; (B) part of such funds may be made available to other public or nonprofit private agencies, institutions, and organizations; (C) such funds will be used to supplement and, to the extent practicable, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided and not to supplant such non-Federal funds; and (D) there will be reasonable State financial participation in the cost of carrying out the State plan;

(7) provide that services and facilities furnished under the plan for persons with development disabilities will be in accordance with standards prescribed by regulations of the Secretary pursuant to this Act;

(8) provide such methods of administration, including methods relating to the establishment and maintenance of personnel standards and selection and advancement of personnel on a merit basis, as are found by the Secretary to be necessary for the proper and efficient operation of the plan (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods);

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(9) provide assurances that the State planning and advisory council is assigned adequate personnel in order to insure that such council has the capacity to fulfill its responsibilities in the areas of planning, resource development, and program evaluation;

(10) provide that the State planning and advisory council shall periodically, but not less often than annually, review and evaluate the State plan and submit appropriate modifications to the Secretary for his approval;

(11) provide that the State agencies designated pursuant to paragraph (1) of this subsection will make such reports, in such form and containing such information, as the Secretary or the State planning and advisory council may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of such reports;

(12) provide that special financial and technical assistance shall be given to areas of urban or rural poverty in providing services and facilities for persons with developmental disabilities who are residents of such areas;

(13) describe the methods to be used to assess the effectiveness and accomplishments of the State in meeting the needs of persons with developmental disabilities in the State;

(14) specify the maximum amount of, and the percentage of the State's allotment under section 302 for any year which is to be devoted to construction, renovation, or modernization of facilities, which percentage shall be not more than 10 percent of the State's allotment or such lesser percentage as the Secretary may from time to time prescribe;

(15) provide reasonable assurance that adequate financial support will be available to complete the construction of, and to maintain and operate when such construction is completed, any facility the construction of which is assisted by funds made available under this title;

(16) if Federal funds are allotted for construction, renovation, or modernization under this title, outline a program of construction, renovation, or modernization of facilities for the provision of services for persons with developmental disabilities which—

(A) is based on a Statewide inventory of existing facilities and survey of need;

(B) sets forth the relative need, determined in accordance with the regulations prescribed by the Secretary for the several projects included in the construction, renovation, or modernization program; and

(C) assigns prioprity to the construction, renovation, or modernization of projects, to the extent that financial resources available therefor and for maintenance and operation permit such priority, in the order of relative need, taking into account the requirement that any such construction, renovation, or modernization complies with any standards prescribed pursuant to the Architectural Barriers Act of 1968;

(17) provide for an opportunity for hearing before the State agency to every applicant for a construction, renovation, or modernization project;

(18) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursements of, and accounting for, funds paid to the State under this title in accordance with regulations the Secretary shall prescribe;

(19) provide for the implementation of an evaluation system compatible with the system developed under section 309 of this Act by October 1, 1977;

(20) provide, to the maximum extent feasible, an opportunity for prior review and comment by the State planning and advisory council of all States plans in the State which relate to programs affecting persons with developmental disabilities;

(21) provide that personnel assigned to the State planning and advisory council shall be solely responsible to such council;

(22) provide that all relevant information concerning any programs which may affect persons with developmental disabilities shall be made available by projects and State agencies to the State planning council; and

(23) contain such additional information and assurances as the Secretary may determine to be necessary to carry out the provisions and purpose of this part.

(c) The Secretary shall approve any State plan and any modification thereof which complies with the provisions of subsection (b) of this section. The Secretary shall not disapprove a State plan unless he has provided reasonable notice and opportunity for a hearing to the State.

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WITHHOLDING OF PAYMENTS

SEC. 305. (a) Whenever the Secretary, after reasonable notice and opportunity for hearing to a State planing and advisory council and a State agency or agencies designated pursuant to section 304(b)(1) finds—

(1) that any such State agency or agencies are not complying with the provisions required by section 304(b) to be included in the State plan, or with regulations of the Secretary;

(2) that any requirement set forth in an application submitted under section 304 and approved by the Secretary is not being or cannot be carried out with respect to the project for which such application was submitted; or

(3) that adequate funds are not being provided annually for the direct administration of the State plan,

the Secretary may forthwith notify such State council and State agency or agencies that no further payments will be made from allotments under this title for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph (1), (2), or (3) of this subsection as the Secretary may determine to be appropriate under the circumstances.

(b) Whenever the State planning and advisory council finds that a State agency administering funds pursuant to the implementation design is failing to comply with such design, the State planning and advisory council shall notify the Governor and the Secretary, who may provide notice, conduct a hearing, and withhold payments pursuant to subsection (a) of this section.

PAYMENTS TO THE STATES FOR PLANNING, ADMINISTRATION AND SERVICES

SEC. 306. From each State's allotment for a fiscal year under section 302, the State shall be paid the Federal share of its expenditures incurred during such year under its State plan approved under this title. Such payments shall be made from time to time in advance on the basis of estimates by the Secretary of the sums the State will expend under the State plan, except that such adjustments as may be necessary shall be made on account of previously made underpayments or overpayments under this section.

REGULATIONS

SEC. 307. (a) The Secretary shall prescribe general regulations applicable to all the States to carry out the purposes of this title.

(b)(1) Regulations promulgated by the Secretary may be waived upon approval of an application submitted by a State for a project to be completed by two or more political subdivisions or public or nonprofit private agencies, or by a combination thereof, which is consistent with applicable law and regulations promulgated by the Secretary for such purposes to provide services to persons with developmental disabilities by combining funds received from other Federal, State, or local programs to the extent that such regulations would without such waiver impede the implementation of such project. Such waivers shall be reviewed annually by the Secretary and issued on a case-by-case basis and for a specified period of time, but in no case longer than thirty-six months. Renewal of such waivers may be granted only after a full evaluation of the impact of such waivers by the Secretary.

(2) The Secretary shall publish in the Federal Register the fact that an application for waiver under paragraph (1) has been submitted by a State, and he shall not approve or disapprove such application for a period of not less than 60 nor more than 90 days after the date of such publication.

NONDUPLICATION

SEC. 308. (a) In determining the amount of any payment for the construction, renovation, or modernization of any facility under a State plan approved under this title, there shall be disregarded (1) any portion of the costs of such construction, renovation, or modernization which are financed by Federal funds provided under any provision of law other than this title, (2) the amount of any non-Federal funds provided under any provision of law other than this title, and (3) the amount of any non-Federal funds required to be expended as a condition of receipt of such Federal funds.

(b) In determining the amount of any State's Federal share of expenditures for planning, administration, and services incurred by it under a State plan

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approved under this title, there shall be disregarded (1) any portion of such expenditures which are financed by Federal funds provided under any provision of law other than this title, and (2) the amount of any non-Federal funds required to be expanded as a condition of receipt of such Federal funds.

EVALUATION OF DEVELOPMENTAL DISABILITIES SERVICES

SEC. 309. (a)(1) The Secretary, in consultation with the National Council, shall, by February 1, 1977, develop (A) a design of a comprehensive system for the evaluation of services provided to individuals with developmental disabilities and (B) a time-phased plan for the implementation by the States of such system which will specify a minimal evaluation system to be implemented by all States by October 1, 1977, and which will further specify phases of development leading to the establishment in each State of such comprehensive evaluation system. The comprehensive system shall provide guidelines and alternative methods for the development of State evaluation systems for Federally-supported services delivered within each State to individuals with developmental disabilities.

(2) Not later than February 1, 1977, the Secretary shall submit to the Congress a report on the evaluation system design developed pursuant to paragraph (1). Such report shall include an estimate of the costs to the Federal government and the States of developing and implementing such system.

(b) The Secretary, in consultation with the National Council, may make grants to, and enter into contracts with, public or private organizations or individuals to conduct feasibility studies to assist in developing the evaluation system required under subsection (a).

GRANTS FOR SPECIAL PROJECTS FOR SERVICES TO PERSONS WITH DEVELOPMENTAL DISABILITIES

SEC. 310. (a) For the purpose of making grants under this section for special projects and demonstrations (and research and evaluation connected therewith), there are authorized to be appropriated $18,500,000 for the fiscal year ending June 30, 1975, and for each of the two succeeding fiscal years.

(b)(1) The Secretary, after consultation with the National Council, shall make grants to States and public or nonprofit agencies and organizations to pay part or all of the cost of special projects and demonstrations (and research and evaluation in connection therewith) for (A) establishing programs which hold promise of expanding or otherwise improving services to persons with developmental disabilities (especially those who are disadvantaged or multihandicapped), and (B) for carrying out projects of special national significance including, but not limited to—

(i) demonstration projects for integrating services for the developmentally disabled population,

(ii) demonstration projects to coordinate and utilize all available community resources,

(iii) projects designed to improve the administration of, and the quality of care provided under, programs for individuals with developmental disabilities, and

(iv) projects to demonstrate new or improved techniques for the provision of services for such individuals.

(2) From the amount appropriated pursuant to subsection (a), the Secretary may reserve 30 per centum thereof for the purpose of making grants for projects described in subsection (b)(1)(B).

(3) Grants under this section may be used to support only the initial three years of any project or demonstration.

(c) A copy of each application for a grant under this section shall be submitted by the applicant to the appropriate State planning and advisory council simultaneously with submission to the Secretary. The Secretary shall not approve such an application until the State planning and advisory council has had an opportunity, for a period of at least thirty days, to review and make comments on the application to the Secretary.

(d) Projects, or a component of any project funded under this section, shall not be eligible for funding under section 304 of the Rehabilitation Act of 1973 or section 303(a)(2) of the Public Health Service Act.

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REPEAL

SEC. 311. Effective 90 days after the enactment of this Act, parts B and C of the Developmental Disabilities Services and Facilities Construction Act are repealed.

[The letter transmitting the administration's Health Services Amendments of 1975, referred to, follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., February 26, 1975.

HON. CARL ALBERT,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: Enclosed for the consideration of the Congress is a draft bill, "To amend the Public Health Service Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, the Drug Abuse Office and Treatment Act of 1972, the Social Security Act, to revise and extend programs of health services, and for other purposes." The bill would be cited as the "Health Services Amendments of 1975."

Title I of the enclosed bill would consolidate separate project grant structures containing separate appropriations authorizations and extend them through 1978. The activities are those designed (1) to assist in the prevention and treatment of alcoholism (parts C and E of the Community Mental Health Centers Act), and drug abuse (section 410 of the Drug Abuse Office and Treatment Act of 1972); (2) to provide health services for domestic agricultural migrants (section 310 of the Public Health Service Act); (3) to render services, disseminate information, and promote research in the field of family planning (title X of the Public Health Service Act); and (4) to develop and support selected health services programs (section 314(e) of the Public Health Service Act).

This consolidation is intended to enable us to simplify the administration of these activities—and thus to make available more funds for project activities instead of administrative expenses—and to give us needed flexibility to marshall resources for areas of greatest need.

To underscore our intention to continue the activities to be consolidated, the draft bill would specify these areas expressly. In addition, it would make explicit our authority to award grants under the consolidated provision for the operation of health centers and related facilities, including those formerly assisted under programs of the Office of Economic Opportunity which have now been transferred to the Department.

The consolidated provision would also authorize the use of project grants for amortization of principal, and payment of interest, on loans for facilities or to centers in existence prior to calendar year 1975 for the construction or acquisition of facilities used for program purposes, and for the payment of costs of minor remodeling.

Title I of the draft bill would establish a single advisory committee, the "National Advisory Council on Health Services", to advise on the administration of health services programs and to perform the functions now performed by the National Advisory Mental Health Council, and the National Council on Alcohol Abuse and Alcoholism. The new Council would also replace the National Migrant Health Advisory Committee and the Secretary's Advisory Committee on Population Affairs, both of which the Secretary created administratively.

The title would also repeal a requirement enacted by the Health Services Research and Evaluation and Health Statistics Act of 1974, over the Department's objections at the time, to require that not less than twenty-five percent of the annual appropriation for health service research, evaluation, and demonstration activities under section 304 or 305 of the Public Health Service Act be for activities directly undertaken by the Secretary. The repeal is necessary in order to avoid significant increases in Federal employment.

Title II of the draft bill would extend for fiscal years 1977 and 1978 the program of formula grants under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, and for fiscal years 1976, 1977, and 1978 the program of formula grants under the Drug Abuse Office and Treatment Act of 1972.

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Title III of the draft bill contains amendments to titles V and XIX of the Social Security Act. Section 301 would eliminate Federal matching for the provision of nonemergency dental services to adults under the Medicaid program. We believe these expenditures to be of a lower priority than other rapidly escalating medical costs reimbursed from Federal funds. Federal matching for children's preventive dental care, the most important phase of preventive dental care, would be continued for Medicaid eligible children under twenty-one.

Section 302 would lower the floor on the rate of Federal participation in State Medicaid programs from fifty percent to forty percent. The average Federal share would then be about fifty-one percent. The current formula, guaranteeing at least fifty percent matching, weighs the Federal participation disproportionately in favor of the richer States. Only the thirteen highest income States would be affected by this change. The distribution of the remaining Federal funds would be more closely related to the States' relative revenue producing capability as reflected by their average per capita income.

Section 303 would reduce the rate of Federal financial participation in State expenditures under the maternal and child health and crippled children's services program from fifty percent to forty percent. It would also repeal the supplemental allotments currently authorized for some States under that program. Increased State financial participation in activities funded through the maternal and child health and crippled children's services appropriation will promote a careful review of the need for the funding of these programs through narrow categorical programs in the light of the availability of Medicaid financing for the same services. Federal and State funding for the Medicaid program will amount to over $14 billion in 1976.

We recommend prompt and favorable consideration of this bill.

We are advised by the Office of Management and Budget that enactment of this proposed legislation would be in accord with the program of the President.

Sincerely,

CASPAR W. WEINBERGER,
Secretary.

Enclosure.

A BILL To amend the Public Health Service Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, the Drug Abuse Office and Treatment Act of 1972, and the Social Security Act, to revise and extend programs of health services, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Health Services Amendments of 1975".

TITLE I—HEALTH SERVICES PROJECT GRANTS; ADVISORY COUNCILS; INTRAMURAL RESEARCH

EXTENSION AND REVISION OF PROJECT GRANTS

SEC. 101. Effective with respect to fiscal years beginning after June 30, 1974, section 314(e) of the Public Health Service Act is amended to read as follows:

"(e)(1) There are authorized to be appropriated $463,000,000 for the fiscal year ending June 30, 1975, and $425,000,000 for the fiscal year ending June 30, 1976, and for each of the next two fiscal years, for grants to any public or nonprofit private entity to pay part of the cost of—

"(A) preventing or treating alcoholism and drug abuse;

"(B) providing or operating centers to make available comprehensive health services (as defined by the Secretary);

"(C) providing or operating health service clinics for domestic agricultural migratory workers or for projects in improving health care or conditions of these workers or their families, or to encourage and cooperate in programs to improve their health services or conditions, including the support of services to seasonal agricultural workers when it contributes to improving the health conditions of migratory workers;

"(D) providing services (including related training) in the field of family planning; or

"(E) providing services (including related training) to meet health needs of limited geographic scope or of specialized regional or national significance.

"(2) With respect to a facility or center, or portion thereof, used or to be used for a purpose enumerated in the preceding paragraph, the Secretary may pro-

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vide, upon such terms as he deems necessary to protect the financial interest of the United States, that a grant under this subsection shall be available to pay the cost (in addition to any cost for which it may otherwise be made available under that paragraph) of—

"(A) in the case of a facility or center in existence prior to January 1, 1975, amortizing the principal of, or paying the interest on, a loan for the facility's or center's acquisition, construction, expansion, alteration, or remodeling (including a facility or center acquired from, or constructed in connection with, any program or project transferred to the Secretary from the Office of Economic Opportunity), including architects' fees and the cost of acquiring land; or

"(B) its minor remodeling or minor alteration, including architects' fees."

CONSOLIDATION OF ADVISORY COUNCILS

SEC. 102. (a) There is enacted a new section 316 of the Public Health Service Act to read as follows:

"NATIONAL ADVISORY COUNCIL ON HEALTH SERVICES

"SEC. 316. (a) The Secretary shall appoint, without regard to the provisions of title 5 of the United States Code, governing appointments in the competitive service, and without regard to the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates, a permanent body to be known as the National Advisory Council on Health Services. The Council shall consist of the Secretary or his designee, who shall be the chairman, and not to exceed twenty members, not otherwise in the regular full-time employ of the United States, who are (1) leaders in health care administration or the provision of health services, or (2) representatives of consumers of health care. At least one-third of the appointed members shall be individuals representing the consumers of health care. Insofar as practicable, the members shall be appointed from different geographic areas of the United States and, in the aggregate, shall be representative of all areas within the United States in which health services are provided, or their provision assisted, under this Act.

"(b) Each appointed member of the Council shall hold office for such term as the Secretary shall prescribe.

"(c) Appointed members of the Council, while attending meetings or conferences thereof or otherwise serving on the business of the Council, shall be entitled to receive compensation at rates fixed by the Secretary, but at rates not exceeding the daily equivalent of the rate specified at the time of service for GS–18 of the General Schedule (as limited by section 5308 of title 5 of the United States Code), including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703(b) of title 5 of the United States Code for persons in the government service employed intermittently.

"(d) The Council shall advise the Secretary as to matters of policy arising with respect to the financing and delivery of health services under this Act."

(b)(1) Section 217(a) of the Public Health Service Act is amended—

(A) in the first sentence thereof, by striking out "the National Advisory Mental Health Council, the National Advisory Council on Alcohol Abuse and Alcoholism";

(B) in the second sentence thereof—

(i) by striking out "the National Advisory Mental Health Council, the National Advisory Council on Alcohol Abuse and Alcoholism, and", and

(ii) by striking out "psychiatric disorders, alcohol abuse and alcoholism, and dental diseases and conditions, respectively" and inserting "and dental diseases" in lieu thereof; and

(C) in the fourth sentence thereof—

(i) by striking out "(other than the members of the National Advisory Council on Alcohol Abuse and Alcoholism)";

(ii) by inserting "and" before "(2)"; and

(iii) by striking out "; and (3)" and the remainder of clause (3) preceding the period.

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(2) Section 217(b) of such Act is amended, in the second sentence thereof, by striking out "mental health, alcohol abuse and alcoholism,".

(3) Section 217(e) of such Act is repealed.

(4) Section 217 of such Act is further amended by striking out subsections (c) and (d) thereof.

(c)(1) Section 303(b) of such Act is amended by striking out "may be made only upon recommendation of the National Advisory Mental Health Council. Such grants".

(2) Section 303 of such Act is amended by adding a new subsection (c) to read as follows:

"(c) The National Advisory Council on Health Services shall advise the Secretary on matters of policy arising in the administration of this section."

(d) Section 329(e)(1)(E) of such Act is amended by striking out "National Advisory Council on Comprehensive Health Planning" and inserting "National Advisory Council on Health Services" in lieu thereof.

(e) Section 223 of the Community Mental Health Centers Act is amended by striking out ", after consultation with the National Advisory Mental Health Council (appointed pursuant to the Public Health Service Act),".

(f) Section 266 of such Act is repealed.

REPEAL OF REQUIREMENT THAT NOT LESS THAN 25 PER CENTUM OF HEALTH SERVICE RESEARCH, EVALUATION, AND DEMONSTRATION ACTIVITIES APPROPRIATION BE EXPENDED FOR DIRECT ACTIVITIES OF THE SECRETARY

SEC. 103. The second sentence of section 308(1)(1) is repealed.

TITLE II—EXTENSION OF ALCOHOLISM AND DRUG ABUSE FORMULA GRANTS

ALCOHOLISM

SEC. 201. Section 301 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 is amended (1) by striking out "and $80,000,000 for the fiscal year ending June 30, 1976," and (2) by inserting after "1975," the following: "and $46,000,000 for the fiscal year ending September 30, 1976, and for each of the next two fiscal years".

DRUG ABUSE

SEC. 202. Section 409 of the Drug Abuse Office and Treatment Act of 1972 is amended (1) by striking out "and" before "$45,000,000" and (2) by inserting after "1975," the following: "and $35,000,000 for the fiscal year ending June 30, 1976, and for each of the next two fiscal years".

TITLE III—NATIONAL AND CHILD HEALTH AND MEDICAID SERVICES

MODIFICATION OF FEDERAL FINANCIAL PARTICIPATION IN NATIONAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

SEC. 301. (a) Section 506(a) of the Social Security Act is amended by striking out "one-half" and inserting "forty per centum" in lieu thereof, effective with respect to payments under that section for amounts expended during quarters commencing after June 30, 1975.

(b) Section 516 of that Act is repealed, effective July 1, 1975.

SCOPE OF DENTAL SERVICES FOR WHICH FEDERAL MATCHING PAYMENTS WILL BE MADE UNDER STATE MEDICAL ASSISTANCE PROGRAMS

SEC. 302. (a) Paragraph (10) of subsection (a) of section 1905 of the Social Security Act is amended by inserting "for individuals under the age of 21" immediately after "dental services".

(b) The matter after clause (17) in subsection (a) of such section is amended by—

(1) striking out "or" at the end of clause (A);

(2) striking out the period at the end of clause (B) and inserting "; or" in lieu thereof; and

(3) inserting after clause (B) the following new clause:

"(C) any such payment with respect to dental services for any individual who is 21 years of age or older, other than emergency dental services (as

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defined in regulations prescribed by the Secretary), and oral surgical services and treatment related thereto which legally may be performed by a doctor of medicine or osteopathy or of dentistry."

(c) Clause (I) of section 1902(a)(10) of such Act is amended by inserting ", (10)," immediately after "paragraph (4)".

(d) The amendments made by this section shall be effective with respect to payments under section 1903 of the Social Security Act for amounts expended during calendar months after February 1975.

MINIMUM RATE OF FEDERAL FINANCIAL PARTICIPATION UNDER STATE MEDICAL ASSISTANCE PROGRAMS

SEC. 303. (a) The first sentence of section 1905(b) of the Social Security Act is amended by striking out "less than 50 per centum" and inserting "less than 40 per centum" in lieu thereof.

(b) The amendment made by this section shall be effective with respect to payments under section 1903 of the Social Security Act for amounts expended during calendar months after February 1975.

Mr. ROGERS. Thank you very much, Mr. Secretary, for your statement. We have a rule of the committee now that we call on members as they come to the committee meeting.

Secretary WEINBERGER. Part of the modification of seniority, Mr. Chairman.

Mr. ROGERS. We will proceed under the 5-minute rule first, allowing each member to question for 5 minutes and then proceed. Although I guess the rules have not been fully agreed upon, I think this part has been agreed upon.

Mr. HEINZ. By unanimous consent, Mr. Chairman.

Mr. ROGERS. I think it was, and I think under this arrangement Mr. Hefner of North Carolina was here first.

Mr. HEFNER. I only have one question referring to the proposal on page 32 and page 33, that the Federal matching share for developmental disabilities be gradually reduced from 70 percent in 1975 to 60 percent in 1976 and 50 percent in 1977. With the financial situation in many of the States, certainly in my State and I feel sure some of these other gentlemen's States and districts, what would happen to these programs if these States are not able even the first year to make these matching funds available.

Are we not responsible for seeing that some of these programs are implemented or do we just say that if the States can't come up with their share then we just drop the program?

Secretary WEINBERGER. Congressman Hefner, the proposal is as you have stated it, that we reduce the Federal match. This would require States to maintain programs at the increasing level that they have been funded over the years. We have gone from $34 million to $53 million in the past 4 years. There have to be other sources of funding. That is to say, some from State government, some from local government, some from private, quasi-private sectors, and some from third-party reimbursements.

The rationale is that the States have some problems, but they don't have the fiscal problems of the Federal Government at this time.

Another point to note is that these programs require for their ultimate effectiveness active and vigorous participation by the local communities and groups within them. Another point to bear in mind is that if there isn't some incentive to go after this additional source of funding, we may not get that degree of local interest, local support

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and the necessity to examine carefully on the part of State and local budget makers the degree of priority that should be assigned to these programs.

We in the Federal Government have had to make some very hard decisions. The selection of priorities involves not doing some of the things some people would like us to do. In making these decisions we have had to make some hard choices, and the States and local governments should do likewise.

Finally, it should be pointed out that Federal assistance to State and local governments has increased considerably and is now at the $56 billion level. This represents a $4¼ billion increase in 1976 over 1975.

General revenue sharing will continue to pump an excess of $6 billion a year into State and local government, is a positive source of funding, but it certainly need not be the only one.

In other words, we recognize that State and local governments clearly have fiscal problems, As one who was very closely associated with the State governmental operations for some time, I am perfectly aware of that.

I am also able to measure the degree of difficulty and problems that various governmental units are having. I can't think, however, of any governmental unit anywhere in the world that has the fiscal problems the U.S. Government has at the moment and the need to realistically and boldly meet them. This is what the President's budget does.

It does not require, in any sense, a reduction in efforts behind these programs. It does require some hard decisions and the assignment of priorities to maintain these programs.

Now, that is a very long answer to your question about one program. The reason I extended myself so is because that basic point runs through a number of the programs that we have discussed today, including one as important as developmentally disabled people.

It involves a whole raft of programs that I mentioned in the earlier part of this much too long statement.

Mr. HEFNER. I think my 5 minutes have elapsed, Mr. Chairman.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman. This has certainly been a rather comprehensive presentation you have given and I think it is quite worthwhile. I noticed in consideration of the bill H.R. 2954, the revenue-sharing aspects of this particular bill, this is really a new section, is it not, in the legislation?

Secretary WEINBERGER. Yes. There is an expansion of the State formula grant that is proposed under section 314(d). I would rather hesitate to call it a revenue-sharing approach. Congressman Carter, because the requirements and restrictions placed upon the States severely restrain them.

They would have to earmark 22 percent for hypertension, no less than 15 percent of the States allotment for mental health in addition to submitting an administrative part. The continuation of 314(e), which we discussed and proposed, would authorize a great deal more freedom and flexibility. This is the true hallmark of revenue sharing.

Mr. CARTER. Section 314(e) certainly would give more flexibility to you perhaps, but in that case the direction of this committee might very well be subverted.

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Secretary WEINBERGER. We would certainly hope not. It would give the States and local governments discretion on how to use the money. We would not expend anything under the 314(e) we are proposing. We would pass it down to States and localities and let them set their own priorities which again we feel they know better than we do.

Mr. CARTER. I haven't noticed that under your administration. Revenue sharing, of course, is accepted almost as money from Heaven by the States; is it not?

Secretary WEINBERGER. Yes, I think perhaps there may be some disagreement as to the source, but they do look on it as a very considerable and useful device.

Mr. CARTER. Something which the people themselves don't realize that they are paying for.

Secretary WEINBERGER. Well, I assume they realize we are all in this thing together, and though they may be citizens of the State, they are also citizens of the Federal Government and one way or another it is supported by dollars that they do not have to expend for their own purposes but taken by the Government.

Mr. CARTER. But actually that we in Congress are supposed to appropriate for which, in order to appropriate, we must provide taxation which in reality we do not do.

Secretary WEINBERGER. Well, the general revenue sharing program was funded without the requirement of additional Federal taxation.

Mr. CARTER. Yes.

Secretary WEINBERGER. It is a fact that several States have used these funds to bring about either a holding of the line or in some cases a reduction in the total tax load that the citizens has to bear. I doubt if the citizen is much concerned as to whether a portion of that tax load is colored one thing for State government or colored something for Federal Government.

Mr. CARTER. I am sure it is entirely different. If it comes from the Federal Government, then it is manna from Heaven, but if they see that tax bill from the State or local government, then they know that "I am paying this tax", and there is a great deal of resistance to it.

I say that not to disagree with you, sir, but to state it as I actually see it.

Secretary WEINBERGER. I think there are a lot of people who are aware that they have to pay Federal taxes, too.

Mr. CARTER. Yes, many of them are.

Secretary WEINBERGER. And I hear from several of them.

Mr. CARTER. But you know, when you really get in the crunch is when you have to vote for those taxes, which very few of us ever do. Actually, in the past 11 years we have only had two taxes of any import.

Secretary WEINBERGER. It is one of the reasons we are so anxious to shield anyone from that unpleasant necessity of having the deficit climb above $52 billion which we think is probably the amount that can be financed without new taxes.

Mr. CARTER. I certainly agree, but as I said, we had to vote for the two taxes which we have added in the past years. I regret it, but I felt as a responsible legislator it was necessary and I think that we must take a hard look at all of these programs. If we want to continue, then we must be willing to pay for them. Thank you, Mr. Chairman.

Mr. ROGERS. Thank you. Mr. Preyer, I believe you were next.

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Mr. PREYER. Thank you, Mr. Chairman, and may I say it is good to have you with us again, Mr. Secretary.

Secretary WEINBERGER. Thank you, sir.

Mr. PREYER. I don't know if this question has been asked when I have been absent. On page 4 concerning the 20 percent non-Federal match of project grants, I believe you say that you intend to require through changes in regulations a 20 percent non-Federal match.

Could you list for us specifically the programs you intend to do this for?

Secretary WEINBERGER. Well, there are a substantial number. Some would be family planning, migrants, community health centers, plus the maternal and child health program, which is not included in this bill, and this would be where we move from 50 to 60 percent, but basically it pertains to the project grants covered in this bill.

Mr. PREYER. Is there legislative authority for such a match requirement? We get into a problem here.

Secretary WEINBERGER. My understanding is that there is legislative authority for this. This is why we chose the phraseology, that we were advising the committee that the budget and the proposals of the administration indicate that we would be putting these changes into effect administratively for the project grant programs.

I believe that the maternal and child health formula grant requires a statutory change.

Mr. PREYER. What is the legislative authority?

Secretary WEINBERGER. As I understand it, it is the present act which we are continuing under the continuing resolution. Now, maybe Mr. Kurzman can add to that.

Mr. KURZMAN. We can give you the precise citations. As I understand it, however, most of these sections authorize the Secretary to set matching requirements for the States or a project-by-project basis. We don't set any matching by statute.

[The following information was received for the record:]

LEGISLATIVE AUTHORITY FOR MATERNAL AND CHILD HEALTH FORMULA GRANTS

The Social Security Act:
SEC. 503—Maternal and Child Health Funds.
SEC. 504—Crippled Children's Funds.
SEC. 502—Earmarks the amount of money that will be available for sections 503 and 504.
SEC. 501—Intent of section 502.

Mr. PREYER. I think that might be helpful to get that. It may be a problem of whether congressional intent is involved too, even if there is legislative authority.

For example, in the migrant health programs, I understand that congressional intent of that legislation was that there be no matching requirements. I don't know whether legislative authority would overrule that provision or not.

Secretary WEINBERGER. This is not to say anything that is given cannot at the same time be taken back. We do believe that the authority that we presently have under the act authorizes us to make changes in these formulas either upward or downward. The administration's budgetary proposals are based upon the assumptions that we can make these kinds of changes in the non-Federal matching requirements. This is one of the assumptions that brought us out to only a $53 billion deficit.

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Mr. PREYER. I would like to ask one other question in another area——

Secretary WEINBERGER. Maybe this would be useful. Dr. Cooper has some facts about current Federal matching.

Dr. COOPER. Yes. At the present time the project grants pay for about 25 to 30 percent of the community mental health program operating budget, 75 percent of the community health centers budget, 74 percent of the neighborhood health center budget, and 69 percent of the migrant health program clinic.

Mr. PREYER. I would like to ask one other question in the family planning area. This bill covers so many areas, I know everyone here has a lot of questions on different things. This is a general question. One of the most vexing and controversial subjects before the country today is the subject of abortion.

I think no matter how we stand on abortion, everyone would agree that it certainly ought to be the last resort and it is certainly not the primary means of family planning.

I think we can make a pretty good case that the high incidence of abortion is directly related to the unavailability of adequate family planning services. So that the question that occurs to me on your cuts in family planning is if we are interested in discouraging the use of abortion, is it really worth the price to cut family planning funds so drastically as you are?

Secretary WEINBERGER. Well, two points, Congressman Preyer. First of all, I agree with you. I have always felt abortion represents a failure of family planning and it isn't a part of the programs. It represents a confession that family planning has failed. Also, as I am sure you know, title X forbids the specific use of family planning funds for abortion.

Under medicaid, abortions can be authorized by States and funds are expended for that purpose. The important thing to point out is that our proposals, even though they involve reductions in some of the specific Federal funding for the title X program, contemplate an increase in the medicaid and social services funds, so that the same number of women, namely 4 million, will continue to receive family planning services through our departmentally supported programs.

I don't think the reductions in the specific Federal funding in any sense should be taken as connoting a reduction in the number of people served.

The number of people served, we believe, will remain the same. We also believe that this can best be done through medicaid and other sources and that the specific program can well be subjected to a reduction of Federal funding.

Mr. PREYER. Thank you.

Mr. CARTER. Would the gentleman yield?

Mr. PREYER. Surely.

Mr. CARTER. What about the rate now of births per family in the United States?

Secretary WEINBERGER. Well, the general rate of increase of the population at the moment, if I recall the figures correctly, is somewhere around 7½ percent a year.[1] It was 10 percent.

[1] EDITOR'S NOTE.—See correction of these figures in explanation of Secretary Weinberger on p. 201 of this hearing.

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Mr. CARTER. Per family it is 1.9. Actually that is really a little lower so far as family planning is concerned than the replacement rate; is that correct?

Secretary WEINBERGER. Well, there are different definitions of this, Congressman Carter. The population of the United States was increasing roughly at the rate of about 10 percent about 3 or 4 years ago. It is now down to something between 7 and 8 percent at the present time.

The family division of this I don't have specifically in mind. We are, I believe, a little above the replacement rate, right at or a little below zero population growth.

Dr. Hellman, who is our specialist on all population matters, is here and he can certainly give you the specific technical answers or we can put them in the record, whichever you prefer. But we have substantially reduced the rate of increase of America's population as we pointed out at Bucharest and at various other meetings.

In fact, it is one of the major problems with the Social Security system today. But, in any case, we have substantially reduced the rate of growth of the American population.

[The following information was received for the record:]

REPLACEMENT—LEVEL FERTILITY

Fertility is said to be at replacement when the total fertility rate equals 2,100. According to the U.S. vital statistics data, the total fertility rate fell to 1,896 in 1973 and to 1,862 in 1974. This means that if women continue to bear children at the age-specific rates observed in 1974, they would end their reproductive careers having born 1,862 children per 1,000 women. There is, of course, no guarantee that women will continue to bear children at the rates observed in 1974. The total fertility rate only tells what would happen if these rates continue.

Fertility rates below replacement do not necessarily mean that a country has achieved zero population growth since the current growth rate is influenced by the age structure of the population and immigration. While the total fertility rate for 1974 was the lowest ever recorded for the United States, the population grew by .75 percent or 1.6 million persons.

Mr. CARTER. I would certainly want to agree with the gentleman from North Carolina in that the family planning program we have had has been effective. I have got here 2.1 children per family is replacement. Anything below that is below zero population growth and it is 1.9, as I recall at the present time.

The other factor must be increased immigration or something of that nature. Thank you, Mr. Preyer.

Mr. PREYER. If the gentleman would yield back——

Secretary WEINBERGER. All of this great work we are doing is also increasing the length of life of each individual. I don't think the immigration rate has a significant effect on it at the moment, but we do have substantial improvement in the life expectancy. We are continuing to work for that, and obviously will continue to work for it.

Mr. PREYER. If the gentleman would yield back for 30 seconds, I agree the growth rate is declining and I am glad to see it, but I think on family planning we want to focus on the number of and the rate of unwanted children. That may be going up while the growth rate is actually going down.

Thank you, Mr. Secretary.

Mr. ROGERS. Mr. Heinz.

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Mr. HEINZ. Thank you, Mr. Chairman, and Mr. Secretary. I am glad to have you back before our subcommittee. I would like to talk with you for a moment about the community mental health center program. First of all, I would like to say that I think the committee appreciates your effort and all these efforts to try to make them as efficient and economical or as cost-effective as possible.

Clearly, when we have a situation where the budget is heading into progressively larger deficits, attention to management is greatly appreciated. Of course, it always remains our responsibility to make the priority decisions as to how the moneys which you spend would be allocated. But we are grateful for your assistance to us.

A couple of things you discussed regarding the mental health center program bothered me a little. Perhaps when you delivered the testimony you may have dropped out the word that particularly causes me a problem.

On page 10 you described the way the community health center program would include six new support mechanisms, and I hope we understand each other that actually there were at least two support mechanisms in the old bill, namely a grant program and a construction authorization, so that there you might be able to say that there were four new, two old. But, just so that we are all talking about the same thing, I would like to indicate what we have tried to do in the committee bill is make a distinction which the previous legislation didn't make between the grant for planning a center and the grant for operating a center.

As you must know, Mr. Secretary, because I know we have discussed the General Accounting audit report, one of the problems with the program was that centers received large chunks of money before they knew what they were going to do.

It was for this reason we split what was previously the operating grant program into two parts so that we could provide some seed money and therefore save money.

Similarly, I believe even the department testified in favor of financial distress grants. My memory may be wrong on that, but I have the feeling that you were favorable to financial distress grants last year. So I think there are some differences between us that are narrowing, if my memory serves correctly.

Now, I do understand that the testimony you are presenting here today is testimony that represents a Presidential and OMB—a White House position.

Secretary WEINBERGER. An administration position.

Mr. HEINZ. An administration position. May I ask whether the departmental position on the legislation we are discussing here, including the Community Mental Health Center, was any different—did the department favor or oppose anything that was different from what the administration is for?

Secretary WEINBERGER. There are no distinctions between administration and departmental policy, Mr. Congressman. They all merge together with the publication of the budget and state of the Union message and they are all part of the process of developing a policy.

This is the same situation where, for example, members of your staff might develop preliminary drafts for a speech at some occasion. Then you yourself make the final decision as to what is to be said.

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The testimony presented today is the administration policy. We have been quite consistent with respect to Community Mental Health Centers. We argued last year and this year for a termination of new starts and for completing the Federal commitment of 8 years that was in the initial act.

Actually, the initial act was five and later extended to eight. We argued for completing and honoring that Federal commitment, not for starting anything new, on the theory that we now have 626 of these centers; that we have a very large proportion of the public that requires services served by these Community Mental Health Centers; and that over an 8-year period, they should now be working toward a situation where the Federal Government does not pay for the operation or direct delivery of this service.

I believe this is practical and feasible. When I was in the California Legislature, long before there was a Federal Community Mental Health Act I was, I think it is reasonable and fair to say, partially instrumental in securing the enactment of an entirely State Community Mental Health Center bill. For that reason, I know not only about the tremendous value of these centers which is far superior to any large State mental institution, but I also know that it is entirely feasible to do without Federal assistance provided the community assign a high enough priority to it.

We don't secure that by simply continuing permanently 8-year commitments or starting more and more centers until we have covered 115 percent of the country or something of that kind.

Mr. HEINZ. I think, Mr. Secretary, you know that we aren't at 115 percent of the country. It is more like 1,500 areas of which 626 might be served by the end of 1975. It is always difficult for me to fully understand the description of a program which serves one-third of the United States as a demonstration program.

I am pleased that you agree, in spite of the fact that the programs can stand some improvement, that it has been a success, and I do hope we can work together to improve the program.

I suppose I do have some differences with you in terms of priority on community health centers. I think personally we can afford to continue to build them, although I must say I think we all have to recognize that there are a limited number of dollars around and maybe we could work out some kind of agreement between the committee and you on the rate at which we proceed because I think everybody realizes you can't build Rome in a day.

Secretary WEINBERGER. Well, or even in 12 or 15 years. We have 626 of the centers. They serve about 45 percent of the population, not a third. Eleven of the States where many of the critical problems occur, including the District of Columbia, they serve three-quarters of the population who live within the areas that are served by the Center. Again, I don't think what started out as an attempt to demonstrate the feasibility of a specific kind of technique should be considered an obligation of the Federal Government to demonstrate over and over again until we have demonstrated to the point that covers 100 percent of the population.

I think we have demonstrated that this is a very much better way to deal with mental illness than was formerly the case. I think we have amply demonstrated that it works very well. It is now time for

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the 626 centers to make provisions for eliminating or replacing the Federal funding over a very gradual 8-year period. Those areas where the local communities determine that more centers are necessary, would see the feasibility of funding them without the permanent continuation of Federal operative support.

Mr. HEINZ. Mr. Secretary, I think my time is about to expire, but I would like to enter for the record, if I may, Mr. Chairman, a question perhaps you could supply us an answer for the record.

The question is this: Some of my constituents recently informed me that family planning programs funded by the Department of HEW discriminate against natural family planning processes, at least that is the allegation.

Now my two questions for the Department are these: Does the Department have a policy which has the effect of discriminating against natural family planning processes, and by that we mean such things as the rhythm method of birth control; and secondly, do you believe and does the Department believe that all family planning techniques such as the techniques described as natural family planning processes ought to be made equally available to people so that all people can have full and free choice in family planning methods?

You don't have to answer that here because I am going to eat into somebody's else's time.

Secretary WEINBERGER. Let me briefly answer no and yes, and we will supply additional data too, but we do believe that those are the answers to the two questions you posed.

[The following information was received for the record:]

DHEW POLICY WITH REGARD TO NATURAL FAMILY PLANNING

The regulations for Public Health Service Act Title X project grants require projects to provide "for use of a broad range of medically approved methods of family planning including the rhythm method." Therefore, the Department does not discriminate against, but rather requires the inclusion of natural family planning methods among the broad range of medically approved methods which a project must offer. "Free-standing" natural family planning projects are not eligible for independent funding under the regulations since they do not offer the required broad range of methods. However, natural family planning providers have been funded as part of an umbrella grant, where the other required methods are available from other service providers also receiving funds through the umbrella grant, e.g., Pittsburgh and Wilkes-Barre, Pennsylvania.

Mr. HEINZ. Thank you, Mr. Chairman.

Mr. ROGERS. I think it might be well to clarify for the record, and particularly for new members who were not here when we wrote the Community Mental Health Centers Act, that it was not written as a demonstration program. It was written as a seed money program. In other words, to get communities to come in and start programs, to encourage them to do it, not just have a few demonstration projects.

In fact, the original goal was some 2,500, Mr. Secretary. That since has been modified to some 1,500, I believe. So I would beg to differ in the description of the community mental health centers program as a demonstration program.

It was never intended as just a demonstration program. It was a program where we would encourage and get things going and hopefully then the communities could continue after a certain time.

Secretary WEINBERGER. We believe that effective initially for 5 years, later extended to 8 years total authorization for the whole act, that

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it fitted within what could properly be called a demonstration program.

Mr. ROGERS. I happened to write the act, Mr. Secretary, and that was never our intention.

Secretary WEINBERGER. But it did have those limitations.

Mr. ROGERS. As a seed project; not as a demonstration. If you want to say we will demonstrate to every catchment area, if you want to term it in that fashion, I would have no argument. Perhaps we will demonstrate it in every catchment area. If you are willing to go along with that, I would agree.

Secretary WEINBERGER. No, that is what we are worried about.

Mr. ROGERS. I understand. But I tell you what the intention of the law is from those of us who wrote it. Mr. Symington?

Mr. SYMINGTON. Mr. Secretary, do you think those catchment areas which currently are not served should be served without any Federal input, merely on the basis of the States' experience?

Secretary WEINBERGER. I think it is mostly a matter of need. At this point it has not been demonstrated that every catchment area in the United States has the same requirement or same degree of requirement. As I have said too many times before, we believe that local needs are best ascertained by the local communities. If there is that need as perceived by the local communities, it will reflect itself in State funding exactly as it did in California long before there was any Federal act at all.

We believe this is a matter that can best be determined by local judgment. The Federal Government has indeed seeded or demonstrated or taken care of the many requirements of the problem, by funding 626 community mental health centers. In view of the current fiscal situation which are too well-known and do not need to be repeated here, it is time for local communities to decide their own priorities.

Mr. SYMINGTON. Therefore, you would think that to be the case whether it is a question of ongoing support for existing centers or starting new centers. In any case, do you think it is time for the Federal Government to withdraw support?

Secretary WEINBERGER. Well, along the schedule we have given, it isn't an abrupt withdrawal. It is an 8-year phasing out period. There has been ample notice given by the Congress itself that 8 years was the period of time for which funding could be expected.

So I would think that the answer to your question is yes. But, it shouldn't carry any implication that that is a very wrenching sort of schedule. It is a phased withdrawal and we are fully prepared to honor all the commitments we have made. It will cost three quarters of a billion dollars to honor that commitment. We fully expect to meet that.

Mr. SYMINGTON. I am sure we will learn how wrenching it is from the people who are involved.

Secretary WEINBERGER. And Dr. Cooper advises me that we will continue with technical assistance, consultation work, and a complete research program.

Mr. SYMINGTON. Turning to the question of family planning, you testified that we have reduced population growth to zero. By "we" you mean not the Federal Government, but the country?

Secretary WEINBERGER. Not I in some mysterious fashion. No; I don't like to assume responsibility for all of the things that have

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happened. The statistics as expressed by Congressman Carter, Dr. Hellman, and myself are all in general agreement.

Mr. SYMINGTON. Recently I read that, in the District of Columbia in the past year, legal abortions outnumbered live births. Could that be possible?

Secretary WEINBERGER. Well, as I say, I would hope not because it would seem to me that that represents quite a failure of the family planning, but Dr. Hellman carries figures around like that in his head.

Dr. HELLMAN. Yes; that is true.

Mr. SYMINGTON. So it is not only possible, which I guess but true?

Dr. HELLMAN. Some of these people come from outside the District.

Mr. SYMINGTON. Is there a ratio that you can give us on that?

Dr. HELLMAN. I could look it up for the record. I don't carry that in my head.

[The following information was received for the record:]

ABORTIONS AND LIVE BIRTHS IN THE DISTRICT OF COLUMBIA, CALENDAR YEAR 1973

According to officials of the District of Columbia Department of Human Resources, a total of 20,679 births were recorded in the District of Columbia during 1973. Of these births, 10,464 were births of District of Columbia residents. During 1973, a total of 40,812 abortions were performed in the District of Columbia. However, only 10,091 of these were abortions provided to District of Columbia residents. The remaining 30,721 abortions were provided to nonresidents of the District of Columbia. Therefore, the ratio was approximately one-to-one for District of Columbia residents although there were actually 373 fewer abortions than births to District of Columbia residents in 1973.

Mr. SYMINGTON. In that connection, about how many legal abortions were there in the country?

Dr. HELLMAN. About 800,000 in 1973; anticipated 900,000 in 1974.

Mr. SYMINGTON. If all of those abortions had been prevented, either by law or by some other form of persuasion, would there have been an increment of presumably just about that many people to the population?

Dr. HELLMAN. Provided all those women went to term; yes.

Secretary WEINBERGER. Some, of course, were therapeutic abortions.

Mr. ROGERS. May I interrupt just to say that this quorum call is a quorum that simply requires the first 100 to be present to answer. If they do not get the quorum, then they would ring a regular quorum so I don't think it is necessary for members to respond at this time.

Mr. SYMINGTON. Turning to the migrant health problem, where are most of the Federal funds spent, and for what kind of workers? Is your figure limited to agricultural workers in the Southwest?

Secretary WEINBERGER. Well, migrant health centers and services to the migrants. We are funding a new program that provides for hospitalization along the so-called eastern course of the migrant path and we have come up with some very interesting results.

Generally, they are used to fund the delivery of migrant health services by others, by State camps. There are a number, of course, in the Chairman's district. We had a difficult public health problem there a couple years ago with an outbreak of typhoid. We then brought in other elements of the Department to cope with the problem.

Mr. SYMINGTON. Are these migrants American citizens?

Secretary WEINBERGER. Well, we can't say that exclusively. Certainly a great many of them are, but there are some noncitizens legally

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in the country working at tasks which take them from place to place around the country.

Mr. SYMINGTON. Some of us are concerned about the availability to illegal immigrants of a whole panoply of American opportunities.

Secretary WEINBERGER. This is a serious problem, Congressman, and it runs through a great many other activities. We have recent court cases which require the full delivery of public assistance services to people illegally in this country. I am not aware of formal court tests on the migrant problem, but I would see very little way to distinguish a case that provided for public assistance delivery to persons illegally within the country.

Mr. SYMINGTON. Do you have any idea what portion of your budget may be diluted in this fashion?

Secretary WEINBERGER. With respect to migrants, no. I think we could probably get it through public assistance. We are delivering or funding the delivery of services to something like 400,000 migrants and seasonal farmworkers and their families each year and would keep that basic level. But we could certainly try to find that out for you. I believe it would be easier to find it out on public assistance programs. We will do our best to get it on migrants.

[The following statement was received for the record:]

Based on a survey of migrant health projects along the Mexican-American border, we are not able to find any projects which knowingly serve illegal aliens. These projects employ routine questioning and such verification as possible to determine the domestic migrant agricultural worker status.

Every patient must be registered before services are provided. The registration procedure entails determining work address, employer, period of employment, and State of legal residence. This is done for the purpose of determining eligibility for Medicaid or other third-party support and also helps to ensure that the program serves only domestic, agricultural, migrant workers.

Mr. SYMINGTON. Mr. Chairman, of the 400,000 migrants and their families, what is the average family size?

Secretary WEINBERGER. Two and a half.

Dr. COOPER. Four to five.

Mr. SYMINGTON. So we are talking about a large number of people.

Secretary WEINBERGER. I have to take issue with "diluted in this fashion." As long as the court says we have to do it, I suppose that it would be how much is included for this purpose.

Mr. SYMINGTON. Thank you.

Mr. ROGERS. Mr. Florio.

Mr. FLORIO. The appropriation for health services funded under the fiscal year 1974 continuing resolution is $621 million, is this amount correct?

Secretary WEINBERGER. Yes.

Mr. FLORIO. Now, if this same amount had been appropriated in 1975 there still would have been a reduction in health services because of inflation, but in fact you are only funding to the amount of $603 million; is that correct?

Secretary WEINBERGER. No. What we are doing, Congressman Florio, is we start with the basic level of $621 million which is provided by the continuing resolution.

The President has submitted certain revisions and deferrals to the Congress, which would reduce this figure by approximately $18 million. We await the congressional decisions on these matters. If they

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disagree with the President, then the $621 million would be spent. If they agree with the President, $603 million would be spent for fiscal 1975.

Mr. FLORIO. And the President's proposed budget for 1976 is $419 million?

Secretary WEINBERGER. And for 1976, $419 million.

Mr. FLORIO. A deficit therefore of $184 million from last year's spending?

Secretary WEINBERGER. I wouldn't call it a deficit. A reduction of Federal funding of $184 million which is approximately the 20 percent we have suggested that should be made up by non-Federal sources. Again, we emphasize that this is not a criticism of the programs. It is our opinion that the Federal role, in view of all of the well-known facts, requires some reduction.

Mr. FLORIO. When you say non-Federal funding you're talking about the States picking up a larger proportion.

Secretary WEINBERGER. Not completely. We have made substantial progress in encouraging third-party reimbursement. That nearly always means from medicare, medicaid, and private insurance. There is a rather surprising amount of private insurance money that would be available if these services were equipped to ask for it. We don't think the taxpayer's interests are served by allowing available private insurance funds to sit within the insurance company. Consequently, we have done our best and continue to try to emphasize methods by which people who operate many of these programs—and as I have said before, many times, they are volunteers—will be able to draw the available third-party funds.

So we believe it is quite realistic to ask for a 20-percent shift from Federal to non-Federal funding, and that that $184 million can well be made up by third-party or State sources.

Mr. FLORIO. In reference to the medicaid program are we not getting into a Catch-22 situation? Are we not switching from Federal to State payment? The administration is saying we are going to cut down on the Federal contribution to medicaid, is that not correct, Mr. Secretary?

Secretary WEINBERGER. No. For the eleven States best able to make an increased contribution we would ask for some increased contribution. What we are talking about in the medicaid program also is a half billion dollar increase, not a reduction, a half billion dollar increase. In a lot of those situations where the State's ability to pay is somewhat greater than the Federal Government's ability, we are asking that that be recognized.

Mr. FLORIO. The point I suppose I am driving at is that I really disagree with your basic premise that the Federal Government is in the worst financial shape of any governmental entity. We have had hard discussions with regard to my own State's economic programs, and I mentioned a $206 million deficit on a $2.8 billion budget, and my State does not have the authority for deficit spending. So for you to say the medicaid program should be cut in my State because we are better off just is not in accordance with reality.

Are you making any distinction with regard to this across-the-board generalization that we should shift things to the States because the States are better off, especially, when I can tell you some of the States are not better off. If you accept the justification for some of these pro-

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grams as you have indicated you did, I can authoritatively tell you that a State—at least one State, but maybe a number of other States—will not be able to provide for these services.

What is your response?

Secretary WEINBERGER. My response would be that you would only be able to provide for these services you are able to provide. You would have to readjust the priorities for total spending within the State. It depends entirely on the degree of willingness to face what are unquestionably difficult decisions for everybody as to the importance you attach to particular programs. We have done that in the Federal Government as we have had to. We would assume that that would have to be done now by some States.

I also think we want to keep this in proportion. The total additional State funding that is suggested, even if all of this were picked up by the State governments and not by any third party or private sources, which is not the fact, but even on that so-called worst case assumption, what we are talking about involves something on the order of about six-tenths of 1 percent of all of the States spending. It seems clear to me that within that kind of range and margin it is perfectly possible for States—even though I would be the first to agree with you, are not in splendid financial condition either—to readjust their priorities and pick up the additional amounts called for by the administration proposal.

Mr. FLORIO. I will conclude with one observation. You have mentioned general revenue sharing. I believe that in some of the urban areas in my State the program resulted in a net cutback, that is to say, the total cumulative amount for the categorical programs phased out was greater than the amounts received under revenue sharing. Thus, I don't think it is realistic to talk about the revenue sharing funds being able to be used to pick up some of these other costs.

Secretary WEINBERGER. It would be a unique situation if any State ended up with less total funding including revenue sharing. I know there were some proposals that some people felt looked that way, but to the best of my memory, none of these proposals of the Federal Government were adopted.

Mr. FLORIO. My information is to the contrary, particularly with regard to urban programs.

Secretary WEINBERGER. No. We have really never ended anything. The only partial success we had with those 312 proposals was one which involved a transfer of the Arctic Health Research Center from the Federal Government to the University of Alaska, and even that I believe was challenged in the closing days.

So I am not aware of any program in which the proposal to cut down on categorical funding, either because of or without reference to revenue sharing, was adopted.

Mr. ROGERS. Mr. Secretary, I might recall for you that we have just abolished the regional medical programs by your request to this Committee.

Secretary WEINBERGER. That is prospectively.

Mr. ROGERS. Well, it is in the law. We passed it. The President signed it.

Secretary WEINBERGER. I have no quarrel with that whatever.

Mr. ROGERS. That is a pretty good example, so we have tried to respond where we think priorities should be.

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Secretary WEINBERGER. Yes.

Mr. ROGERS. And we have also changed Hill-Burton.

Secretary WEINBERGER. Changed, but not——

Mr. ROGERS. Yes.

Secretary WEINBERGER. Yes, the funding requirements are there.

Mr. ROGERS. I think we have made significant changes in numbers of programs and I am sure we can go through quite a list.

Mr. FLORIO. I have nothing further.

Mr. ROGERS. All right. Mr. Scheuer.

Mr. SCHEUER. Thank you, Mr. Chairman. I would like to yield briefly to my colleague from Missouri.

Mr. SYMINGTON. Mr. Secretary, just following on a point raised by the gentleman from New Jersey; when you are assessing a State's ability to meet its requirements as a criteria for further Federal assistance, do you take into account whether or not the State has an income tax or the total taxes it raises? I think it is true that the gentleman's State has no income tax and I don't know how it does raise its funds, but would that be a relevant factor?

Secretary WEINBERGER. From the point of view of equity in a broad sense. I refrain from pointing out that New Jersey could easily do what everybody else has done, have an income tax.

Mr. SYMINGTON. That is what I wanted to know.

Secretary WEINBERGER. No, we have not tried to do that on any kind of individualized need basis. We recognize that a number of States have financial problems, but we don't think any of them have financial problems of the magnitude of the Federal Government; 95 percent of the budget that I worked with is uncontrollable; 75 percent of the total Federal budget is uncontrollable. Furthermore, there are enormous increased needs as, for example, roughly $18 billion for unemployment insurance that was not budgeted 2 years ago and a very large amount, something like $4 or $5 billion more for debt service because we didn't know about the interest rates at that time.

All of these things have amounted to create a situation which even if all of the President's cost savings proposals are adopted brings us out to a $52 billion deficit. On that basis I have every confidence that I am correct in saying that we are, therefore, somewhat proportionately less able to bear increased expenses than other governmental units.

Mr. SYMINGTON. And if we don't actually calibrate the taxes collected by a State from its citizens.

Secretary WEINBERGER. No. I think that is the State's business. It is fair to point out in that connection that their revenue sharing funds could be used to hold down or in some cases reduce taxes, and this is a perfectly fair decision.

We believe, and try to be consistent about it, that the State knows what it should do with money that is given to it. We don't think that we have any capability of saying that was wrong or that was right. It is what a State wanted to do.

Therefore, it is something we believe should be done. But we do point out that $6 billion in revenue sharing funds, $4½ billion in increased Federal aid to States, is an available source for States to use to help meet this six-tenths of 1 percent of total State spending that we are talking about.

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Mr. SYMINGTON. Thank you, Mr. Secretary. I yield back to Mr. Scheuer.

Mr. SCHEUER. Thank you, Mr. Symington.

Mr. Secretary, it is fine to have you here and if I am seemingly unhappy at some of your testimony, you will know that it is unhappiness with the corporate view and not the individual view.

Secretary WEINBERGER. Certainly. I have known you for a long time, Congressman, very favorably.

Mr. SCHEUER. I have admired your ability and intelligence and I only wish you were working for a different ball team. I would like to make a couple of initial points very briefly and then ask you a few questions. One gap I find in your testimony is the absence of any thrust to the reorganization of our health care delivery systems.

It seems to me that built into our health care systems now we have inordinate waste and misuse of money and resources and until we hone our surgeon's scalpel and take it to the very system itself, we may be saving millions with your program but we are wasting billions in a basically inefficient and frequently corrupt system.

You only have to read the newspapers of New York City to find out what is going on in our nursing home system. Let me read you a letter from the administrator of one of the nation's greatest hospitals in the New York area just a few days ago addressed to all his attending physicians.

In order to maintain our present level of quality and proceed to improve, we must insure that adequate financial resources are available. The only way this can be done is to continually maintain a high occupancy rate. We appreciate your cooperation to insure an adequate patient load to permit us to maintain a high level of care.

Now, the implications of that kind of a message are perfectly clear. We are taking people with sniffles and with sore toes and putting many in $150- and $200-a-day hospital beds. We are putting many in an institution that cost $150 a square foot to build and providing many with hotel services. It is absolutely outrageous.

I believe that a little bit of digging would find that this in addition to the nursing home situation, is a national scandal and I think perfectly basic structural reforms have to be made to our health service system to make it cost-effective to get people out of intensive care when home services can do the trick.

I don't know where your knowledge comes from, Mr. Secretary, but when you say on page 24 that you know of no shortage of either agencies or personnel that might warrant new categorical programs to provide home health services, I have to react in wonderment.

I can tell you that in New York City we are in desperate need of home health services and the lack of even minimum cost home health care services is what is filling our hospitals with $200-a-day patients who would be happier at home, who would be served with a fraction of the cost at home, and who would save the taxpayers a bundle of money if they were served at home. That is comment No. 1.

Secretary WEINBERGER. Would you want me to respond?

Mr. SCHEUER. Please.

Secretary WEINBERGER. Let me take up two or three points. First of all, with respect to the last point you made that we are unaware of either agencies or personnel that might warrant new categorical

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grant programs to provide home health services, we fully agree that the future lies in the provision of additional home health services. Our national health insurance bill provided for a much greater emphasis upon home health care.

I agree with you that there is much too great an emphasis on hospitalization caused by a distortion in most of the existing health insurance policies including medicare, which puts such a very specific requirement on hospitalization.

The letter you quoted from the hospital administrator is reminiscent of another similar problem which the Congress enacted a couple years ago whereby the Veterans' Administration is mandated to produce and maintain a certain level of occupancy which can only be done by going out and hauling people in off the street, whether they are ill or not. So we don't have to go as far afield as New York to correct that kind of situation.

One of the reasons that we are so anxious to avoid further categorization is that it does result in wasteful overlap, duplication, and a misplacement of a lot of the health dollars. We now for the first time have crossed the $100 billion mark in the cost of health services for the Nation as a whole, not just Government, but everybody. We do need a far more improved health delivery system, a system that relies much less on hospitalization, especially unnecessary hospitalization. These are some of the things we have proposed in the changes of medicare this year. We also have a health planning bill which this committee was instrumental in producing which I hope will lead us to some of the desirable results you talk about.

Mr. ROGERS. May I interrupt, Mr. Scheuer?

Mr. SCHEUER. Yes.

Mr. ROGERS. This is a second bell for a record vote. If we could go right there and come right back, take a 5-minute recess, and I think we can conclude this afternoon, Mr. Secretary.

Also, may I comment before we leave that I would hope while the Governors are here, some of your people might explain to them the details of the health planning bill. Some of them are not clear and they think that you have all of the power; you are not going to let them do anything. And I hope we can get that across to them that we have given them a great deal of power.

We tried to fashion it where the Governors would have real in-put, and if your people could make some effort while they are here, I think it could be helpful.

Secretary WEINBERGER. We certainly will do that. The ultimate answer to that is we never would have suggested and the President would have never signed the bill if it would have made such an unwise allocation of power.

Mr. ROGERS. Nor would this committee ever have approved it.

Mr. SCHEUER. I believe the Secretary is a man of great courage and if he is, I think the real testing point would be for him to meet a few of these Governors here and read to them the sentence on page 15 where he says, "It is now time to shift the responsibility for developing and operating such facilities to State and local agencies which must ultimately bear the major responsibility for the direct provision of public health services of all kinds."

Secretary WEINBERGER. Right.

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Mr. SCHEUER. I believe he has the guts to say that and I want to be around when it happens.

Mr. ROGERS. The committee stands in recess for 5 minutes.

[Brief recess.]

Mr. ROGERS. The subcommittee will come to order, please. I think the Secretary had one comment.

Secretary WEINBERGER. Yes, Mr. Chairman, an embarrassing but necessary correction on the population figures. That, of course is not a 10 percent rate of increase that we had up until recently. It was a 1 percent and it is not 7.5, it is 0.75. The briefing material which I had gotten firmly in mind casts it in the decimal point being the other way around, but I would certainly hope to nail it down. What we are now running is at a population rate that will double in 91 years, which makes it clear that it is 0.75, and I just wanted to point that out because otherwise, we would have pushed slightly past India and be climbing.

Mr. SCHEUER. You would have been about two or three times the Indian rate.

Mr. ROGERS. And you would have been supporting a larger family planning program, I am sure.

Secretary WEINBERGER. And that would have taken care of our social security problems too.

Mr. SCHEUER. Off the record.

[Discussion off the record.]

Mr. SCHEUER. Back on the record. OK, Mr. Secretary. I was going to say something about the problem, the challenge, the opportunity of family planning. I was glad to see significant support on the Republican side, and I am the sole surviving or resurviving Member of Congress who is an original supporter of that bill, along with Congressman Taft and Senator Tydings.

None of them are in those offices any more. Congressman Taft graduated to the other body, if I can use that verb. I remember with pleasure working with Dr. Hellman and I take pride and I am sure he takes pride in what we wrought. It is a popular program. It works. It is important to note that even though our population growth rate has approached zero, the effect of it won't be felt for about three-quarters of a century.

We will still be increasing our population. When we did have population growth that was uncomfortable, a lot of people felt this was the result of large rates of population growth among low-income minority families. The fact is, our great rate of population growth was due to middle class population growth, three quarters or 80 percent, something in that neighborhood, Dr. Hellman.

And so to pin responsibility on low-income minority groups was unfactual, harmful, and dangerous in a lot of ways. By the same criterion, the fact that we have substantially reduced our rate of population growth is an indication mostly that middle-class families are smaller, that middle-class young pepole are having smaller families.

It is not an indication that we have given all of the women in our country of childbearing years access to family planning and systems and equipment. We have made great strides toward your 5-year program, Mr. Secretary. We are serving almost 4 million women. I think in 1968 and 1969 when we were having hearings on the bill we thought

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there were about 5 million women in their child-bearing years who needed this help.

Now I think we compute that it is somewhere around 7½ million, so we are probably serving slightly over half of the population group to be served, but there are still a lot of women out there in their child-bearing years, probably upward of 3 million, who don't have access to family planning or materials and equipment.

It is my understanding that about 1,000 of the 3,000-odd counties in the United States do not have family planning programs. Now in your testimony you mentioned that 95 percent of the territory in our country is served. That conflicts with the figures as I know them. My knowledge may be out of date, I may very well be wrong, but as I understand it, there are approximately 1,000 counties where there is no systematic provision for family planning.

My question to you is—I am going to ask you several questions and you can sort of take a handle on all of them—why do we treat our success like we treat our failures? Family planning works. We have managed to create a perception in the minds of many young women in their child-bearing years that the optimum family size is not seven, eight, or nine, but it is two or three.

Why are we treating it like a failure? The family planning budget has remained constant at about $100 million for several years. There was a $10 million reduction last year. Inflation has cut another $10 million. It is very difficult for me to understand why you want to reduce it further. To say that cities and States can now handle this, to me is almost bizarre. In New York City we are firing cops. Our Governor in New York has devastated his Democratic constituency and his friends in New York City. And when he said the days of wine and roses are over, he really meant it and it went far beyond wine and roses.

It is conceivable to me that we could be cutting down on a program that has served so many people well, that has been so well designed and administered by your professionals, that has been so well received among the constituent groups, and that has such an incredibly high cost benefit factor.

Secretary WEINBERGER. To answer just as briefly as I can, because it is running quite late, there is no cut in the program. There is a shift in funding. We will still serve approximately 4 million people.

I think the statement in the testimony that there is organized family planning services available in over 95 percent of the Nation's counties is correct; I don't think there is any decimal point problem with that one. I do think that there is a lack of appreciation in some of your comments for the ability of nonfederally funded family planning services to exist. The educational work that has been done over the past few years, the number of different sources and private organizations and others from which this service is available, is on the increase. And I think that again it is a matter of relative priority. We can't be in the position if we are going to have any kind of control over inflation of simply increasing every single program that has a strong number of adherents.

We are not reducing this program. Some of the funding will be shifted. The same number of women will benefit as benefited in the past. This does not mean there will be fewer served because of infla-

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tion. We emphasize 4 million women served and will continue to have, and I think you overestimate it when you say there are 7½ million women of childbearing age who don't have access to or knowledge of this information.

I think you are assuming the only place they can get it is from a federally financed program, and we think that is wrong.

Mr. SCHEUER. What I am saying is a lot of women in previous years may have been able to get it. But in this devastated economy of ours they are no longer able to get it, and therefore you have an increase in your constituents.

Secretary WEINBERGER. First of all, I think that is a very temporary situation.

Mr. SCHEUER. Your President doesn't seem to think so. He has told us we are going to have 8 and 9 percent unemployment for a good many years ahead.

Secretary WEINBERGER. There have been differing estimates but the basic idea is that if we adopt the policies the President has proposed we will soon have a marked improvement in the economy. This will certainly eliminate even the possibility, which I don't believe exists now, for a number of people who might be in need of this service not being able to get it.

Mr. ROGERS. Thank you.

Mr. SCHEUER. May I ask just one more?

Mr. ROGERS. Let me shift over. Then we will come back. Dr. Carter, do you have any additional questions?

Mr. CARTER. Just one or two, Mr. Chairman, if it is all right.

With your permission, sir, I would like to recognize Dr. Elizabeth Boggs, who received the HEW Distinguished Service Award for service to the developmentally disabled. Could I ask her to stand with your permission?

Mr. ROGERS. Certainly. The committee is delighted to recognize Dr. Boggs. [Applause.]

Dr. BOGGS. Thank you very much, Mr. Chairman. It is a pleasure to work with this committee over the years and a pleasure to work with the Department in implementing the joint efforts of the Congress and the administration.

Mr. ROGERS. You have been a driving force to improve that legislation and I appreciate Dr. Carter bringing you to our attention, your presence here today.

Mr. CARTER. Just one other thing, Mr. Chairman. If you remember when the family planning bill came up, just a little explanation to that. It seemed that my good Catholic friends on the committee didn't want their names on it, and those who had large Catholic constituencies didn't want their names on it, so that the subcommittee voted since I was the original sponsor in the House to put my name on it and there it is today.

I strongly support it, not only here, but abroad. I think it is one of our greatest approaches to—well, assistance to the nations throughout the world if we can properly apply it.

Thank you.

Mr. ROGERS. Thank you.

Mr. SCHEUER. Mr. Secretary, I would like to ask you a question dealing with your relations to Congress. The Congress has made it clear

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time after time that we didn't intend that the family planning services project grant program be turned back to the States in effect to become a lump sum to State agency programs. Yet, for several years, HEW has been steadily transforming the family planning services project grant program into a system of block grants to the States.

I hope that you are going to instruct your regional offices as to the wishes of this committee and of the Congress that we have expressed time after time and tell them to cease and desist, and that you will cease and desist in your effort to change this program into a State agency program.

Secretary WEINBERGER. Well, Congressman, what we have tried to do, and I believe successfully, has been to assemble a number of different sources of funding so that States that wish to involve themselves in this program are able to do so.

The title X program has been observed and is continuing to be observed. We are also providing additional funds through medicaid for the family planning services.

I don't think we are ignoring any congressional intent.

Mr. SCHEUER. You tell us that you are going to put pressure on the medicaid people in title IV to reduce expenditures.

Secretary WEINBERGER. Well, we aren't telling them any specific areas to reduce. What we are trying to do is eliminate overutilization that deprives everybody, particularly the most needy, of these services. I don't think there is any public interest in seeing these States waste money. That is our only aim.

I am not conscious of any violation of congressional intent in this area whatever.

Mr. ROGERS. Thank you, Mr. Secretary. We don't have much time, so I will just ask a few questions, perhaps some to be submitted for the record.

I think you have given us the rationale and the thinking of the administration on the veto which was really what we wanted.

Mr. SCHEUER. We don't want the veto, do we, Mr. Chairman?

Mr. ROGERS. The rationale of the veto.

Mr. SCHEUER. Excuse me, Mr. Chairman.

Mr. ROGERS. So what we will do is look it over. Of course, I think it would be helpful for the record if you could characterize the major differences between the House bill, the Senate bill and any suggestions as to how differences might be appropriately resolved.

Secretary WEINBERGER. We would be delighted to do that.

Mr. ROGERS. We have some hesitancy in doing this. As you know, this committee has always stipulated a level of funding, because we think we ought to face up to it, let people know, rather than go through a charade of maybe getting nothing. So I think it is our feeling we probably would and we will look at that suggestion.

Let me ask you this concerning reimbursement to community mental health centers by SRS under the social services legislation. I think you have on your desk for decision a new proposed policy revision concerning appropriate reimbursement policy for such services.

Secretary WEINBERGER. We are pretty well completed on that. The social services regulations generally are before the Congress and approved and will take effect in October, absent some other change and that will finally bring some certainty into——

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Mr. ROGERS. Yes. If you will let us know what this is, then I would be interested in getting comment and you may want to expand on this for the record with regard to the provision in the Senate version of legislation on developmental disabilities regarding coverage of people suffering from specific learning disabilities.

Can you comment on that?

Secretary WEINBERGER. We will cover that. Generally we have felt that the developmental disabilities program should be primarily that. If you get into subjects that involve to a very considerable extent educational problems as opposed to health problems you diffuse and dilute the developmental disabilities program.

There are educational programs for the handicapped designed to reach these other things, but we will elaborate on that.

Mr. ROGERS. I think that would be helpful.

[The following information was received for the record:]

SENATE BILL'S COVERAGE OF SPECIFIC LEARNING DISABILITIES

With regard to the Senate bill's coverage of specific learning disabilities, we do not object to these changes provided that persons would still have to meet, in order to be covered under the Developmental Disabilities program, the three requirements listed in the definition: that the disability originate before age 18, that it can be expected to continue indefinitely, and that it constitutes a substantial handicap as newly and more explicitly defined in S. 462. We understand that under this definition those services which are provided under other programs, such as education, mental health, or vocational rehabilitation services, are not provided under this program. The approach we are proposing will limit the program to those now being served in order to maintain the sharp focus of this program on its legitimate target group and will prevent the program's resources from being unduly diffused over a wide range of individuals as a result of an otherwise vague definition.

Mr. ROGERS. May I ask you then as to the Departmental request for your programs in 1976; that is, what was the Departmental request vis-a-vis the OMB final decision?

Secretary WEINBERGER. I don't have that with me. We can certainly try to get it to the extent it is authorized to be transmitted. I can't recall. We will certainly get it.

[See Budget for FY 1976—Department request and President's budget for development disabilities, p. 207.]

Mr. ROGERS. Could you give me a ball park figure?

Secretary WEINBERGER. No, there were not so much significant differences in totals. There were some, of course. There always are, but there were most the specific allocations of particular portions of the total produced.

Mr. ROGERS. Yes, I understand there was a problem there that they wanted to specify line item amounts rather than giving you a total and letting the Department use its discretion as to allocation among line item authorities.

Secretary WEINBERGER. But to the extent that we can, we will try to give you that.

Mr. ROGERS. Is there any problem with letting the Congress know that?

Secretary WEINBERGER. There are some problems connected with it at given times during the budgetary process and frankly it has been changed since I used to be there. I don't know what it is, but to

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the extent that it is available to be transmitted to you, we will certainly try to do so.

Mr. ROGERS. Well, I presume we could call former Assistant Secretary Edwards and get it very easily, but as I recall he has commented that it was rather a significant reduction from the departmental request.

Secretary WEINBERGER. We have to look again at the timing. His memorandum served as a proposed draft appeal memorandum.

Mr. ROGERS. I understand that.

Secretary WEINBERGER. Yes, but then subsequent to that there were some changes made and we will certainly make every effort to get it. I don't think there will be problems with it.

Mr. ROGERS. It would be helpful for the committee to give in some context what the professional people within HEW who run the programs vis-a-vis the concerns and priorities of the accounting people in the Office of Management and Budget.

Secretary WEINBERGER. Well, it is a chap called the President of the United States who has overall responsibility for the entire Government.

Mr. ROGERS. I clearly understand that, Mr. Secretary.

Secretary WEINBERGER. Well, I think that——

Mr. ROGERS. And I know of the President's background in health as well, I served with him for 25 years.

Secretary WEINBERGER. But there is nothing in the budget or presentation I made this afternoon that contradicts what the President wants, to the best of my knowledge.

Mr. ROGERS. I don't deny that. I am not saying that you would present to us something he did not want. What I am saying is that I am not sure, that those wants were not directed solely by suggestions from the Office of Management and Budget without Department input.

Secretary WEINBERGER. We all had the oportunity to present our views to him and he took a much greater interest and personal involvement in the budget than any President within my memory.

Mr. ROGERS. What we are concerned with now is the Congress setting the priorities as we see them vis-a-vis what the Office of Management and Budget sees. It would be helpful in our setting of priorities to know what you as the Department and the professional health people thought was a reasonable approach, realizing the financial situation.

We understand there are some areas that we ought to look at for cutting and some economies, and this committee is willing to look at those areas. It would be helpful if you would let us have the departmental thinking in that appeals process.

Secretary WEINBERGER. We will do our best, sir.

Mr. SCHEUER. Could you give us also your thinking on any restructuring that you think would be helpful to save the kind of waste, the kind of misallocation——

Secretary WEINBERGER. Well, some of those would be before either this committee or the Ways and Means Committee with respect to our recommendations with respect to medicare and medicaid and there will be others, of course.

[The following information was received for the record:]

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BUDGET FOR FISCAL YEAR 1976—DEPARTMENT REQUEST AND PRESIDENT'S BUDGET FOR DEVELOPMENTAL DISABILITIES

Developmental Disabilities Budget	Fiscal year 1976— Department request	President's budget
State grants	$40,875,000	$30,875,000
Service projects	18,500,000	18,500,000
University affiliated facilities	4,250,000	4,250,000
Total	63,625,000	53,625,000

Mr. ROGERS. Thank you for your patience and we are sorry to have taken so long, but we are grateful to you and the committee stands adjourned until 10 o'clock tomorrow morning.

I did want to mention, Mr. Secretary, it would be helpful if we could have your prepared statements 24 hours before hearings. I know this is sometimes difficult. We are trying to give sufficient notice for hearings.

If you could encourage your people to get us those statements 24 hours in advance of testimony, this would be most helpful.

Secretary WEINBERGER. This is certainly something we will do. It is a point that I make at a different level than you have just made it, but we will do our best to get it to you.

Mr. ROGERS. Thank you.

Without objection, the Chair wishes to place in the record, as though read, a statement by the Honorable Larry J. Winn of Kansas.

STATEMENT OF HON. LARRY J. WINN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. WINN. Mr. Chairman and members of the subcommittee, I want to thank you for this opportunity to submit a statement in support of the Rape Prevention and Control Act.

Statistics show rape to be one of the most rapidly growing crimes in the United States today. And yet, rape is probably the least reported crime in our country, besides being one whose attacker is not likely to be punished. This low conviction rate and the rapidly increasing number of rapes makes it clear that our Nation's rape laws must be reexamined.

This is why I have cosponsored this bill to establish the National Center for the Prevention and Control of Rape. I am hopeful that the creation of a National Center would help develop a full understanding of the nature of the crime and its causes and effects; the impact and the threat of the crime on the victim, her family, and society; and the present methods of treating the victim and the accused.

Such an information center should go a long way toward assisting State and local officials in realizing the devastating psychological impact of rape on the victim and how law enforcement and health agencies have such a special responsibility in assisting the victim to cope with and overcome the massive psychic and emotional scars. Only then can we expect States and communities to develop more effective and more humane, victim-oriented procedures for dealing with the victim of rape.

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Since I cosponsored the Rape Prevention and Control Act, I have gained a new awareness of the crime of rape. I am confident that efforts at the Federal, State, and local levels will help curb the explosive rise of this terrible crime.

I would like to share with you statements [see attached] by Asa J. Steen, president of the Metropolitan Organization to Counter Sexual Assault in Kansas City, and Casey Eike, assistant to the Dean of Women at Kansas University and a member of the Lawrence Community/University of Kansas Rape Victim Support Service. The importance of community efforts such as those of these two groups in my district: Increasing public awareness, studying ways of prevention, and educating the public on the proper ways to deal with rape, cannot be stressed enough. The establishment of a National Center would be of tremendous assistance to local groups in helping them meet these goals.

Rape has no regard for age, class, or color. It is a crime forced upon women in every age group, in every socioeconomic class and in every ethnic group. Like many other crimes, it makes no sense, and is a violation of a woman's basic rights.

The Rape Prevention and Control Act symbolizes the recognition that our system of responding to rape is defective. It represents an important step toward re-examination on the national level of some of the commonly held attitudes about rape.

I am pleased that the subcommittee has held these hearings and look forward to favorable action by the full committee and passage by the House and Senate.

The time has come for the Congress to take action to remove the threat of rape from the lives of American women. The Rape Prevention and Control Act purports to do just that.

[Attachments inserted by Mr. Winn follow:]

ATTACHMENT I

The Metropolitan Organization to Counter Sexual Assault was formed to encourage the highest standards of treatment of rape victims through study and research of the multiple facets of the subject, to gain and disseminate information to be utilized in the prevention of rape and the treatment of rape victims, to foster high standards in the investigation and prosecution of rape cases and to encourage needed legislation to further these objectives.

There is a definite need to pursue these objectives on a national level. The passage of the House bill providing for the creation of a national center for the study of rape would provide positive emphasis in this area. Coordinated research, on a national level, is urgently needed. Progress in this area of endeaver is hampered by the lack of funds, to study the problem on a national scale.

This organization strongly favors such legislation and the membership will actively support these efforts.

SECTION I—HISTORY AND ORGANIZATION OF THE LAWRENCE COMMUNITY/UNIVERSITY OF KANSAS RAPE VICTIM SUPPORT SERVICE

In the Spring of 1971, a group of women, mostly students at the University of Kansas, came together over a particular issue. A woman friend was raped. For two years these women worked to provide a helping service for other victims of rape. A phone line was established and publicized, groups of women including victims of rape met to discuss the growing problem of attacks on women, and attempts were made to communicate concerns to the law enforcement agencies of the community. The project was successful in terms of the personal support provided to victims, but much less successful in establishing a workable relationship with the police. The experience served to heighten women's awareness of

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the magnitude of the problem and of the need for a community to provide a supportive service for victims of sexual assault.

Meanwhile, the City of Lawrence, Kansas was experiencing a marked increase in sex crimes. Percentages were running higher than the national percentage increases in crimes against persons, and specifically for forcible and attempted rapes. Citizens were hardly able to ignore this increased criminal activity. In 1972, on the university campus alone, there were 18 reported sex offenses, most of which were committed by the same suspect. The heightening widespread concern spurred additional women into action.

In the fall of 1973, several new women met with the originator of the initial rape victim service. These women included an Assistant to the Dean of Women, the Director of Headquarters, a drug and personal crisis center, the Director of the University Information Center, a 24 hour referral and information service, the Director of a Women's Residence Hall, the Director of Penn House, a low-income community help agency, and other community women. A new organization, the Lawrence Community/University of Kansas Rape Victim Support Service, was formed.

Because many of these women had already established working relationships with city, county, and campus officials, including law enforcement officers, the essential confidence relationships were easier to build. The cooperation of the city police, city detectives, campus police, county sheriff, and county attorney has only been surpassed by the dedication of the members of the Rape Victim Support Service. Thus evolved a highly effective and much needed community service.

SECTION II—ACTIVITIES AND PROJECTS OF THE LAWRENCE COMMUNITY/UNIVERSITY OF KANSAS RAPE VICTIM SUPPORT SERVICE

As a result of the growing concern about assaults against women in the Lawrence area, several projects have been launched.

I. Rape Prevention Slide Show

In the fall of 1973, the University of Kansas Dean of Women's Office and the Campus Security and Parking Department produced a rape prevention slide show entitled, "WOMEN TAKE WARNING." The slide show presented facts about assaults in the community and demonstrated simple precautionary measures, as well as self-defense techniques, useful to women in protecting themselves. The slide show, which is accompanied by a Rape Victim Support Service member and a self-defense instructor, has been presented extensively on the K.U. campus and the Lawrence community. Many requests have been received to present the program in other communities. The slide show program has proven itself a very effective educational tool.

II. Project Whistlestop

Another rape prevention project was begun in April of 1974 with the establishment of Project Whistleshop. This campus and community effort involved selling a silver whistle to women to wear as a sign of awareness of the need for self-protection, and to blow as a signal of distress. A publicity campaign was launched within the community to ensure public awareness and understanding of the project. Rape Victim Support Service members worked with other representatives of women's groups, University and city officials, campus and city police and attorneys, and the County Sheriff's office in effecting Project Whistlestop. Several thousand whistles were sold, and police records show a marked decrease in the number of assaults for the two month period following the initiation of Project Whistlestop, as compared to the corresponding time period the previous year.

III. Rape Victim Support Service

The Members of the Lawrence Community/University of Kansas Rape Victim Support Service has undertaken many other specific activities. In order to raise public awareness of the problem of assaults against women, we have participated in several radio programs on the subject and given information for newspaper articles. Staff members wrote a paper, "How To Start a Rape Victim Support Service," and compiled a paper on the legal aspects of the crime. We have talked with people from other communities about what we are doing and are interested in sponsoring a statewide conference on rape and rape victim support.

The staff of the Rape Victim Support Service makes a continuous effort to maintain communication within the group and to keep up to date on vital informa-

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tion. At the inception of the program, we made an effort to learn all possible ramifications of an assault, including police and hospital procedures, legal aspects, and social and psychological effects. We met with city and campus police, detectives, city and campus hospital personnel, the County Attorney, the County Sheriff, mental health workers, and the author of the Kansas Criminal Code. Since that time we have attended conferences on the subject, started regular data keeping from police files, and maintained several notebooks and files of all information and contacts we have collected. The staff meets weekly to share information and to outline future activities.

Establishing and maintaining a working relationship with agencies involved with rape victims has been a major concern. We have met with the Chief of Police and all of the city detectives, the County Sheriff, and all of his Deputies. Certain staff members meet weekly with campus police, and other staff members have regular communication with the County Attorney. One of our first actions was the establishment of a 24 hour phone referral through two 24 hour telephone hotlines. These hotlines can locate an available staff person any time of the day or night. We outlined our purpose, membership, and referral phone numbers on a three by five inch card which we had printed and distributed for all campus and city police to carry on their clipboards. We have developed a highly successful cooperative working relationship with the police. We participated in the campus police in-service training, helped set up communication between the Lawrence and Kansas City detective units, helped detectives locate assault victims for identification of a suspect, and have been allowed to do the initial questioning of a victim for police reports. One detective credited us with the increasing community cooperation with police in preventing and reporting all kinds of crime.

The most important thing we have done and the purpose behind our activities is the assistance of women who have been victims of rape and assault. Since our formation we have talked with approximately 25 victims of assault, 10 family members or close friends, and other involved individuals such as Resident Directors and Advisors. Of these cases, 13 are considered crisis intervention cases in which less than one week had elapsed since the attack. Other cases involved communicating with women who are still attempting to integrate an event which took place some time before.

Our services are available 24 hours a day by contacting one of the community or campus hot lines. Posters on campus and in the community publicize the service, and law enforcement officers inform victims about the service immediately following a complaint.

The Lawrence Community/University of Kansas Rape Victim Support Service strongly urges the adoption of the Rape Prevention and Control Act. The establishment of a National Center for the Prevention and Control of Rape will not only provide much needed assistance to citizens and law enforcement officials working with the crime of rape, but will aid general public awareness of the magnitude of the problem. Statistics from every part of the country will bear out the fact that the crime of rape is growing and permeates all segments of our society. The adoption of the Rape Prevention and Control Act will initiate much needed national action in order to bring a halt to this heinous crime.

Mr. ROGERS. The committee stands adjourned.

[The following statements and letters were received for the record:]

STATEMENT OF GOVERNOR HUGH L. CAREY OF NEW YORK

I appreciate having the opportunity to express my opinions concerning the Health Revenue Sharing, Health Services bill, H.R. 2954 before this committee.

As you know, Congressional authorization for the programs under this bill expired June 30, 1974 and the continuing resolution for continued funding expires February 28, 1975. I urge the Committee to give their immediate attention to the fate of Health Revenue Sharing and to the threats by the Administration to cut the health services budget by 20% and to rescind 314d funding. A letter received from H.E.W. on December 26, 1974 states the Agency's intention to recommend rescission of 314d funds for the fourth quarter.

Much is at stake here for New York State and the nation. Without this legislation, critical health services could not be delivered in the areas of Community Mental Health, Migrant health services, family planning and many others. In these times of dramatic fiscal problems it is a fallacy to believe that the State and local governments can assume the responsibility for developing and operat-

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ing public health services "of all kinds." Moreover, at a time when Congress is concerned about the rapidly increasing unemployment rate, it does not seem reasonable to cut authorizations that provide over 230 positions in New York State alone. The elimination of these positions would negate the efforts shown by Congress in the area of public service employment.

The termination of just the 314d funding would mean the elimination of the following programs:

1. Provision of Tuberculosis care in nine communities of New York where the incidence of this disease is the highest.
2. Surveillance and intervention regarding insect-borne diseases.
3. Provision of direct health sanitation services in communities not represented by county health departments, and direction and coordination of this activity, and public health nursing in other communities.
4. Health guidance services provided for our Indian Citizens residing on Reservations in New York State.
5. Central Departmental and Regional Office direction and coordination of Community Health Programs.
6. Provision of labor relation services.
7. Provision of regulatory activities in the area of milk and food production and distribution.

In addition, these eight programs would be substantially reduced:

1. Provision of adequate medical, nursing and special health manpower throughout New York State.
2. Consultation to localities regarding the operation and inspection of public water supplies and inspectional activities of these supplies through contract with the United States Geological Survey.
3. Physical therapy consultation to New York State hospitals.
4. Provision of professional and public education services.
5. Regulation of the sanitary aspects of migrant labor camps.
6. Regulation of the use of X-rays and ionizing and non-ionizing radiation sources for the protection of public health.
7. Conduct of Epidemiological studies in the area of cancer control.
8. Direction and coordination of the statewide emergency health services program.

In closing, I would like to emphasize my commitment to public health services programs. At a time of economic stress which we are experiencing today, these vital health programs should not be eliminated. In fact, they should not even be reduced.

Statement of the American Hospital Association

The American Hospital Association, which represents some 7,000 hospitals and other health care institutions (including most of the hospitals of the country; numerous extended and long-term care institutions; mental health facilities; hospital schools of nursing; and other organizations and institutions) and over 20,000 personal members, appreciates the opportunity to present recommendations in support of H.R. 2954, the Health Revenue Sharing and Health Services Act of 1975.

HEALTH REVENUE SHARING

Title I of H.R. 2954 would extend and amend Section 314(d) of the Public Health Service Act. The program of formula grants to the states for public health projects as authorized by Section 314(d) is part of the "Partnership for Health" program, and the American Hospital Association has supported this program from its inception. We continue to do so. We note that while H.R. 2954 drops the requirement of the existing program for state matching of the federal grant funds, it requires states to provide assurances satisfactory to the Secretary of HEW that federal funds will be used to make a significant contribution toward providing and strengthening public health services, and not to supplant non-federal funds. We believe such a requirement for maintenance of state effort is desirable. We recommend enactment of Title I of H.R. 2954 as introduced.

COMMUNITY MENTAL HEALTH CENTERS

The American Hospital Association strongly concurs with the intent of Title III of H.R. 2954 to extend the Community Mental Health Centers Program. The Association's House of Delegates has passed a formal resolution acknowledging

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that community mental health centers are "greatly contributing to the care of patients and the health of all Americans" and expressing concern about the Administration's reduced commitment to this program.

Information regarding the establishment of community mental health centers and their utilization indicates that these community-based programs not only have provided new and more accessible mental health services, but also have decreased the inappropriate use of institutional care in the treatment of patients with mental illnesses. Further, in many ways, the centers have served as prototypes for the development of new comprehensive health services organizations. They are mandated to develop broad programs of mental health services for populations of defined catchment areas, utilizing and coordinating existing resources and establishing linkages with other health and social service providers.

The Community Mental Health Centers Programs has been the principal force in the growth of comprehensive community-based care of the mentally ill, with increased emphasis on care outside of hospitals and deemphasis on long-term institutionalization. The program also constitutes a positive effort toward prevention of mental illness and disability. More care can be given to a larger number of people in this way, and more patients can be treated in or near their homes, thus enabling many to remain in the labor force as a result of the accessibility of ambulatory services. By thus maintaining more individuals as functioning members of society through early, locally available intervention, the cost of mental illness is offset to a substantial degree through decreased financial dependency of persons who develop psychiatric disabilities.

The 500 to 600 centers which have been provided assistance since the inception of the CMHC program ten years ago represent only about one-third of the goal of 1500 centers needed to serve the U.S. population. Of these, many that have received construction grants have not yet received staffing grants. Nearly half of the centers that have received construction grants, staffing grants, or both, are in designated poverty areas, and there can be no doubt that continued federal support is necessary for the maintenance and expansion of the Community Mental Health Centers Program.

The limitations and restrictions on coverage of community mental health services by third-party payors, including the federal government, are well known. A study of the sources of funds for operating federally-assisted community mental health centers shows that in 1972 only very limited support was provided through third-party payments. In fact, third-party payments provided only 17.1 percent of such funds, and almost half of these third-party payments came from Medicare and Medicaid. Approximately 4.0 percent of the funds for operating these centers came from direct patient fees, and 1.5 percent came from philanthropy. The remaining 77.4 percent of the total operating funds of the centers was provided by federal, state, or local governments and, as noted above, this does not include Medicare and Medicaid payments. The relatively small proportion of total receipts from private insurance and from Medicare and Medicaid is a reflection of both the limitations on coverage of mental health services referred to above, and the problems encountered by free-standing centers in becoming recognized as providers of service. These two factors have had a severe adverse impact on community mental health center services, notably services provided by nonphysician personnel, and on day or night hospitalization, as well as other innovative ways of providing care which hold promise for effective treatment of mental illnesses at a cost lower than is possible with more traditional approaches.

Operating Grants.—Under existing law, grants are made to assist in the establishment and initial staffing of community mental centers. These grants, awarded on a project basis, are intended to help meet the cost of professional and technical personnel employed by the centers. Such assistance is designed to help the centers initiate or expand mental health treatment programs over a multi-year period while new and permanent sources of financing are being developed. The federal share for these matching grants declines over the period of assistance at a rate related to whether the center is located in a poverty area.

There is great merit to the concept embodied in H.R. 2954 of providing operating grants in lieu of grants only for staffing. In 1972 operating costs of existing centers, exclusive of personnel costs, represented 34.8 percent of their total expenditures, compared with 22.1 percent in 1969. Therefore, the provision of operating grants would mean support for a broader range of activities and would allow the centers greater flexibility in developing programs most relevant to the needs of their communities. Such operating grants would also help existing centers to meet the additional specific requirements which H.R. 2954 calls for, such as pro-

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viding specialized services for children and the elderly and follow-up care for residents of their catchment areas who have been discharged from mental health facilities.

We strongly support the requirement for follow-up services for individuals who have been discharged from mental health facilities, and we recommend the strengthening of this requirement to include involvement of CMHC staff in the pre-discharge planning for individual patients on a direct contact basis before the patient leaves the mental health facility. Such linkage, together with a program of community residence and half-way house services, can be a major factor in ameliorating the national problem known as the "dumping syndrome."

Federal funds are needed both to assist in the establishment of new centers and for continued support of the operation of existing centers. Since the centers are intended to serve all residents of a catchment area, regardless of the patients' ability to pay, continued support will be needed until other forms of financing mental health services have been established on a national basis. Community mental health centers have experienced extreme difficulty in trying to obtain adequate financial support from other sources to supplement and replace CMHC funds. This was recognized by the Congress in the 1970 Amendments to the Community Mental Health Centers Act, which extended the period in which centers can received staffing grants and also provided a higher percentage of federal funds for centers in poverty areas.

Although it can be expected that, in time, coverage of mental illness by health insurance will improve, the withdrawal of federal funding not be predicated on a substitution of other financial resources that are hoped for but are not yet in place. In fact, it should be noted that attempts were made in 1974 to reduce mental health benefits in two federally financed programs—CHAMPUS and FEHB—which would have created a similar problem. We are pleased to note that H.R. 2954 allows up to eight years of operating grants for a center.

If, in considering applications for operating assistance under the Act, priority is accorded those applications which can clearly demonstrate the financial feasibility of operating a center without CMHC support in a relatively short time, some areas having a great need for health services of the type offered by community mental health centers will surely be precluded from participating. While we agree that concerted efforts should be made by the centers to seek out and utilize all other available funding sources, consideration of CMHC operating grant applications ought to be given in a manner that precludes a financial feasibility assurance requirement from becoming a barrier to approval of applications from high need areas with limited financial resources.

Additionally, payments for community-oriented preventive services which are not easily related to a specific patient cannot be expected from health insurance reimbursements for personal health services. The provisions of consultation and education services for health professionals, community agencies such as school systems, welfare agencies, courts, law enforcement agencies, public welfare agencies, and health services delivery organizations are fundamental to the prevention of mental illness and disability, and we are pleased to note the specific grant authorizations in H.R. 2954 for such services.

Financial Distress Grants.—We also support the provisions in the bill that would authorize financial distress grants for centers which already have received staffing grants under the CMHC program and which demonstrate that without further grants there is bound to be a significant reduction in the types or quality of services provided, or that the centers will be unable to provide the broader range of services called for in Title III of H.R. 2954. This is another important reason for continuing federal involvement in and support of the Community Mental Health Centers Program.

Facilities Assistance.—Under the existing CMHC program, construction grants are available to assist communities in establishing appropriate facilities for the delivery of comprehensive mental health services where none exist. The funds for construction grants are allocated to the states on the basis of need and population, with project sponsors providing matching funds. Approximately 387 centers have received such construction assistance since the beginning of the program. We urge approval of the provisions in H.R. 2954 that broaden the authority for facilities assistance and that emphasize the acquisition, remodeling or leasing of existing structures to serve as center facilities, rather than the construction of new facilities.

We also have noted with approval the emphasis in H.R. 2954 on the development by community mental health centers of effective procedures for evaluation,

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We cannot state too strongly our conviction in the requirement for program evaluation, and, further, believe that centers should be required to adopt sound management and accountability procedures and practices. The National Health Planning and Resources Development Act of 1974 is but one indicator that the day of public accountability has arrived—public accountability that will help assure program goal awareness, as well as cost containment.

The CMHC program is helping to bring more effective and humane care to mentally ill persons, including those unable to pay, and it is fostering coordination and cooperation among various agencies responsible for mental health care. These developments have, in turn, resulted in a decrease in services which overlap and an increase in the more efficient utilization of available resources. It would be counter-productive, and a serious error, not to provide for continuation and expansion of this program in Fiscal Year 1975 and beyond. Commitments already have been made by many states and communities for financial, physical, and human resources to match those expected through the program. As an example, one of our member hospitals which is affiliated with a community mental health center has informed us that facilities have been built with assistance of the CMHC construction grant funds and equipment has been purchased for use in providing a portion of the center's program. But if its approved staffing grant is not received, the center will be unable to deliver the scope and volume of services for which it has planned and prepared. Many other centers undoubtedly find themselves in similar binds.

The American Hospital Association recommends extension of the Community Mental Health Centers Program at the authorization levels contained in H.R. 2954.

RAPE PREVENTION AND CONTROL

The AHA commends the sponsors of H.R. 2954 for inclusion of provisions aimed at the prevention and control of rape.

Clearly, there is need for establishment of a center for research and for demonstration programs into the causes, consequences, prevention, treatment, and control of rape. The National Institute of Mental Health would seem to be an appropriate location for administration of such a program.

A number of hospital emergency departments have developed special programs of their own to assist rape victims both in the protection of their legal rights and in helping them with emotional problems resulting from assault. We would be pleased to furnish some additional information about such programs, if requested.

MIGRANT HEALTH SERVICES

The American Hospital Association strongly supports extension of the legislative authority for the Migrant Health Services program and an expansion of its scope.

The existing program for migrant health consists of project grants to public or private not-for-profit entities to provide access to health care services for migrant and seasonal farm workers and their families. Family health clinics have been established by many project sponsors for the provision of primary health services, and almost all of the services are for ambulatory patients.

Several unique aspects of the migrant health problem suggest the need for maintaining a distinct legislative authority for this program. First, migrant workers and their families, although extremely poor, often have great difficulty in obtaining local public health services. In fact, they frequently are ineligible for health care services that are available to other poor and near-poor individuals and families. Second, because of their high mobility, the beneficiaries of the program tend to be overlooked or ignored by state and local governments, and it is most unlikely that state governments under a non-categorical funding approach would accord appropriate priority to providing health services for migrant agricultural workers and their families.

The number of migrant and seasonal farm workers and their families is estimated to be approximately 3 million. While some 338,000 persons received ambulatory health care services under this program in 1973 through some 600,000 visits, there are no federally aided projects in a majority of the counties in the country that seasonally experience an influx of migrants. Funds for the migrant health program have never been sufficient to even approach meeting the health needs of migrant workers, and every year there are many approved projects for which funds are not available.

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Moreover, because of inadequate funding, existing migrant health projects are unable to allocate funds to cover the cost of hospitalization of beneficiaries. This is a major shortcoming of the program. The need for assistance for inpatient hospital care is well documented. Studies funded by HEW and OEO clearly indicate the grossly inadequate coverage of migrants by private insurance plans, Medicaid, or other public health programs. One recent study, funded by HEW, reached the following conclusion:

"Comprehensive health services without hospital access are simply not comprehensive. Relying on 'other sources' or 'local responsibility' resulted in limited hospitalization, critical delays, and numerous personal indignities."

HEW officials are aware of this problem and have expressed their concern before committees of the Congress. In August of 1972, for example, HEW acknowledged that fewer than 10 percent of the migrants nationwide had any hospital insurance coverage, and just last year the director of HEW's Comunity Health Service testified that very few migrants are covered by Medicaid. While we are encouraged that HEW recognizes this problem and supports demonstration programs aimed at solving it through prepaid capitation approaches, clearly more of these much needed hospitalization services could be provided if the legislation continues to specifically authorize such care and if the authorization and appropriation levels are substantially increased.

H.R. 2954 would extend the migrant health program and authorize increased funding for current expenditures. We support this categorical extension of the program and the increased authorization. We are pleased to note—as we strongly urged in our testimony last year—that the bill would permit migrant health centers to pay for hospital services, including inpatient care, where appropriate, and provides a separate authorization of $10 million per year for hospitalization. We believe such a provision is essential, and we commend the sponsors for its inclusion. In areas where there are no migrant health centers, and which are not high impact areas, H.R. 2954 provides support for certain specified benefits including primary care. Primary care in this provision should include needed hospital services, and we urge that this be spelled out in the bill by amending the proposed new section 401(c)(1)(B)(ii) to read as follows:

"(ii) for the provision of primary care *including hospital services as appropriate and feasible and other primary care as defined in regulations of the Secretary* for such workers and the members of their families;".

COMMUNITY HEALTH CENTERS

Title V of H.R. 2954 would add a new Section 330 to the Public Health Service Act to authorize the establishment and support of community health centers. Such centers have in the past been known as neighborhood health centers.

The American Hospital Association has supported the centers program and is convinced that federal support for them should continue. While it is desirable to have local sources of funds and third-party payments to take over the entire funding of these community or neighborhood health centers, the prospects for accomplishing such a goal are very dim. Medicaid and Medicare funds already are being utilized to pay for services in these centers—and certainly they should be utilized to the greatest extent possible—but Medicaid and Medicare do not meet the total needs of the individuals and families using the centers to obtain needed health care and services, nor do those programs provide adequate funds to keep the centers in operation. One such center in Chicago reports that grant funds support 78 percent of its budget. Even in New York City, where Medicaid eligibility is more liberal, one center nevertheless depends on grant funds for 45 to 50 percent of its support. Further, the Medicaid programs of some states do not cover the "medically indigent," many of whom often require and receive health services from community or neighborhood health centers. It also should be noted that the 1972 Amendments to the Social Security Act (P.L. 92-603) allow states to cut back on the level of services they provide under Medicaid. Therefore, to eliminate or reduce federal categorical assistance to such health centers would result in their greater dependence on other funding sources when those other sources are less and less available. It would undoubtedly close down some centers that serve the neediest individuals and families.

Finally, we are pleased to note that H.R. 2954 does not require a "self-sufficiency" principle to be applied in the consideration of applications by community health centers for grant funds. We wish to emphasize, however, that notwithstanding our objections to a rigid application of the "self-sufficiency" principle, we are in full agreement with the need for improved management of such

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health centers and the maximum utilization of third-party payments. H.R. 2954 makes adequate provision for efforts toward these goals.

HOME HEALTH SERVICES

The American Hospital Association is pleased to note the inclusion in H.R. 2954 of Section 602 which provides for a program to help establish and operate home health service agencies, and to train personnel to provide home health services.

For several years, since the mid-1950s, the American Hospital Association has worked cooperatively with the Public Health Service and private health organizations to encourage the development of home health care programs and adequate medical insurance coverage for such services. The Association's *Policy Statement on Provision of Health Services* calls for the inclusion of home health services as an important element in the continuum of the health services that should be provided. Our *Statement on the Role and Responsibilities of Hospitals in Home Care* likewise urges hospitals to develop home care programs to meet their proper responsibilities of serving patients wherever they may be.

Home health services are first and foremost of benefit to the patient and his family. At the same time, such programs have economic value to the community by freeing acute hospital beds and making possible more appropriate utilization of inpatient beds. We believe that any national health insurance legislation which Congress may eventually enact should include home care benefits. Further, we believe it will be necessary for the government to extend encouragement and assistance to hospitals for initiating and operating home health care programs as an extension of their in-hospital and outpatient services.

A home care program must not only provide high-quality care, but it must also provide or arrange for a level of care that is suitable to the changing needs of the individual patient. Levels of home care vary, depending on the medical needs of the individual. The levels can be designated as intensive, intermediate, and minimal.

The intensive level requires professional coordination of a range of services through an organizational structure administered by a qualified health care administrator and supervised by a qualified coordinator of professional and ancillary health services. A coordinated home care program is particularly well suited for rendering the intensive level of home care. This level can be the level of choice for the patient who requires multiple professional, diagnostic, therapeutic, and supportive services intermittently under professional supervision and coordination. Otherwise the patient would have to be cared for in a hospital or other institution. The care required is usually short-term.

The intermediate level generally applies to the patient whose illness, in terms of severity and complexity, requires fewer services than the intensive level, with appropriate professional coordination. The care required ranges from a few days to several months.

Finally, the minimal level, as dictated by the patient's condition, requires increased attention to supervision of the activities of daily living, to meal preparation, and to health aide services. It includes the supportive personal care services that are required by the patient who has a prolonged illness. The minimal level is particularly valuable for the isolated, infirm, confused, mentally impaired, or aged who are essentially homebound, incapable of leaving their home except with difficulty. In such cases the minimal level if care can forestall the need for institutional care, such as nursing home care. Appropriate use of supervised health aides for this level contributes to the effectiveness of professional manpower. The minimal level includes services provided by public health and visiting nurses for such purposes as maternal and child health, health promotion, communicable disease control, and other special health supervision programs.

During the last ten years, because of a lack of funds, hospitals have been discouraged from establishing hospital-based home care programs. There is an almost total lack of health insurance coverage for home health services in the private sector and severe restrictions on the Medicare/Medicaid home health care benefit, further complicated by conflicting interpretations and retroactive denials or reimbursement which have stood in the way of realization of home care benefits promised by those programs.

Where home health services do exist they are usually underfinanced, limited in their capacity to cover the needs of the people in their area who would

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benefit by such services, and frequently lack all the essential components to make them fully effective.

Some illnesses and some patients can be better and more economically treated at home rather than in a more expensive institutional setting. For all the above reasons the AHA feels a program of federal assistance along the lines proposed in H.R. 2954 merits your committee's approval.

The American Hospital Association strongly supports the important programs included in H.R. 2954, Mr. Chairman, and commends the Committee for the extensive consideration it gave these programs last year. We trust that the Committee will continue its support in these critical areas of national concern. We appreciate the opportunity to present the AHA's comments and recommendations to your Committee, and will be pleased to provide any additional information you and your Committee staff may request.

Statement of the American Medical Association

The American Medical Association appreciates this opportunity to present its views on these two legislative proposals. It was just one year ago that Association witnesses appeared before you in support of many of the programs which are now once again under consideration. While we are in support of the overall purposes and intents of H.R. 2954 and H.R. 2955, we would like to make specific comments on both of these proposals. With regard to H.R. 2954, the Health Revenue Sharing and Health Service Act, we offer the following comments.

TITLE I—HEALTH REVENUE SHARING

The American Medical Medical Association is again pleased to offer its support of Title I—Special Health Revenue Sharing Act of 1975, which amends the Public Health Service Act by extending Section 314(d), (relating to grants to States for comprehensive public health services), for two years. Section 314(d), first enacted in 1966, provides for block grants to States to assist them in maintaining adequate public health services. Grants to the States under this section are on a formula basis relative to the population and financial need in the State.

We support the provision of appropriate public health services. In our opinion, the formula grant provision contained in Section 314(d) ameliorate many of the difficulties that characterized the system of categorical grants which existed prior to enactment of that section. The block grants to the States can help overcome fragmentation of services and permit each state to meet its needs by establishing its own priorities.

We recommend adoption of Title I.

TITLE II—FAMILY PLANNING PROGRAMS

Title II, which is entitled "Family Planning and Population Research Act of 1975", extends for two years the present Act at generally the same level of funding. In addition, the bill amends the present Act to require the Secretary of HEW to define a low-income family in such a way as to insure that their economic status would not be a deterrent to participation in these programs. Also required would be an annual report, prepared by the Secretary, setting forth a plant for providing family planning services, undertaking population research, and training personnel. This report would be due as soon as practicable after the end of each fiscal year. We believe that these amendments are appropriate and should be supported, as should this Title of the legislation.

Even though it is recognized that goals sought under the legislation have been accomplished in substantial measure, in our view there still remains a need for the services provided by this program. One of the benefits of this program is to be found not just in birth rates or population growth statistics, but in infant mortality and morbidity figures. The knowledge which women have gained in understanding family planning principles and option results in healthier mothers and infants.

The primary source of birth control information has been, and will continue to be, the personal physician. However, there are still population groups for whom the services provided under the Act will continue to be a source of reliable information and counseling. If the progress which has been made is to be

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carried forward, these programs must continue to have necessary financial support.

We urge that Title II be adopted.

TITLE III—COMMUNITY MENTAL HEALTH CENTERS

This Title renews federal support of Community Mental Health Centers for two years, in recognition of a continuing national need and the demonstrated contribution of this program in meeting this need. The American Medical Association supports this legislaton, recognizing that it will strengthen and revitalize the delivery of mental health services on a community level.

The bill authorizes appropriations for operational assistance for a limited period of new community mental health centers, with diminishing federal assistance; grants for education and consultation services to existing centers; initiation and development grants to other agencies for mental health programs in poverty areas, particularly in inner city and rural communities; financial distress grants to existing centers which need federal funds to continue operating or to meet minimum standards of service; and grants for buying, leasing and renovating community mental health facilities and, in the case of poverty areas, for new construction. In addition, the bill sets forth the types of services to be provided by community mental health centers and the manner in which they are provided.

The original Community Mental Health Centers legislation provided for five essential services: inpatient care, outpatient care, day care, emergency services, and educational-consultation. To these Title III adds detoxification and referral for alcohol and drug abuse patients; screening of patients being considered for state hospitalization, and follow-up care for patients discharged from state hospitals. In addition, unless a facility is unable to provide such services or unless there is no need for them in the catchment area, the center must include comprehensive mental health programs for children and the elderly, as well as comprehensive prevention and treatment services for alcoholics and drug dependent persons.

These new requirements should go a long way toward filling existing gaps in service to patients and groups of patients whose needs in many communities apparently are not being met at the present time by centers or by other agencies. Also, by making such services available, centers will be better able to measure the extent of such needs, as well as to identify the particular problems of these segments of the population so that preventive, as well as remedial, programs can be properly shaped and executed. In this regard, however, it should be remembered that few centers are, or can become, all-inclusive self-contained units. In assuring each patient the wide range of services and continuity of care that his clinical needs require, the center must call upon the resources of other agencies in the community to weld a coordinated delivery system.

The requirement for a governing body that is representative of the catchment area should foster community involvement. Active and committed citizens who serve on a center's board of directors can do much to define community needs, to suggest methods of approaching various components of the community, and to explain the center's program and objectives to key groups and individuals. Such representation can become increasingly important as the federal share of operating costs declines from 75 to 15 percent over a five-year period (or from 90 to 15 percent over an 8-year period in poverty areas) and alternative sources of financing must be developed.

The provision that at least one-half of the governing body be non-providers of health care services, however, could result in a situation where all of them could be non-providers. We believe this provision should be amended to provide specifically for adequate provider representation.

Furthermore, the definition of provider of health care services should be changed. A "provider of health care services" is defined as "an individual who received (either or through his spouse) more than one-tenth of his gross annual income from fees or other compensation for the provision of health care services or from financial interests in entities engaged in the provision of health care services or in producing or supplying drugs or other articles for use in the provision of such services, or from both such compensation and such interests." Under this definition, for example, a person receiving just over 10% of his income from drug company stock dividends would qualify as a provider. "Providers", in our opinion, should be restricted to persons who are directly engaged as professionals in the delivery of health care.

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When we appeared before you last year in support of similar legislation, we were pleased that provision was made for the Secretary to evaluate programs under this Title. At that time, we recommended that provision be made to permit local community mental health centers to carry on evaluation studies at the community level. We are particularly pleased to note that the legislation now requires that centers undertake a program of continuing evaluation of the effectiveness of their programs in serving the needs of the residents of their catchment areas and for a review of the quality of the services provided by the centers. We believe that such an evaluation can form a sound basis on which a center can develop future plans to better serve the needs of the community.

With regard to grants for construction of centers, we noted in our previous testimony that such assistance was limited to catchment areas which included areas which had been designated as urban or rural poverty areas. The legislation before you alters that requirement to provide that funds for new construction would be available only in those areas where not less than 25 percent of the center's catchment area are members of low-income groups. While this would seem to be a broadening of this grant support, we would like to again point out that limited authority should be provided to meet a need in justifiable cases for such grants in other areas, where there is a demonstrable need for a physical facility but where no suitable existing structures are available for leasing, renovating or purchase. While this legislation seems to provide the Secretary with some discretionary authority, additional statutory direction and clarification would seem to be appropriate.

The legislation before you authorizes the establishment, within the National Institute of Mental Health, of a new administrative unit which would be known as the National Center for the Prevention and Control of Rape. The studies and investigations which are contemplated and the programs which are envisioned are laudatory. Most physicians would agree that rape is a serious and growing problem, and that increased efforts should be made to ascertain its cause, to ameliorate its effects, and to bring about its prevention. However, rape is a complex sociological problem with medical and psychological overtones. We believe that such important legislation should be considered separately and should not be included in the legislation which is now pending before you. Such separate legislation should be fully discussed and examined through the holding of public hearings. The committee should receive the maximum input in its legislative efforts to resolve this serious social problem. We recommend that this provision of Title III be severed from H.R. 2554 and be the subject of separate legislation and hearings.

We would again like to state our overall support, with the recommendations and modifications which have been stated above, of Title III and would urge its adoption.

TITLE IV—MIGRANT HEALTH CENTERS

When the AMA appeared before you last year in support of an increased effort to meet the health needs of the migrant agricultural workers, we pointed out that the social condition of the migrant agricultural worker is alarming and multifaceted. Various difficulties encountered by the migrant have an impact upon his health, and these conditions are aggravated by fluctuating work availability, language and cultural barriers and the rigors of migration itself. Exposed to vagaries of weather and crop conditions, the migrant is often unable to earn enough from seasonal employment to support his family at a decent standard. As a result of all of these pressures, the migrant worker is caught in a cycle of poverty which makes it difficult to improve his occupational skills or economic status. Moreover, his health may be directly jeopardized, thereby increasing and perpetuating his desperate condition.

In 1962, Congress recognized migrant problems with the passage of the Migrant Health Act. Under this legislation emphasis was placed on direct provision of outpatient services to migrants. At present, the Migrant Health Services Branch of the Department of HEW has contractual arrangements with a variety of quasi-governmental agencies, consumer groups, medical schools and medical societies to provide ambulatory services to migrants. Nationwide, there are now over 100 such migrant health projects attempting to serve approximately 1.5 million migrants and seasonal farm workers. The appropriations for migrant health care services have not matched the needs or fulfilled the mandate of the underlying legislation. Because of the scarcity of resources, HEW in the past has had to restrict funds exclusively to outpatient services. The AMA has on

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previous occasions commented favorably on the extension of migrant health grants and has urged that migrant health appropriations be increased.

When we testified a year ago, the emphasis of the legislation was the creation of migrant health centers. The legislation before you has broadened that emphasis by providing for the creation of migrant health centers as well as contracts or cooperative arrangements with other public or private entities to provide primary health services and such supplementary health services as are deemed necessary. This is a clear improvement in the legislation since it provides the program with substantially increased flexibility and should enable it to more quickly respond to the health care needs of specific migrant worker groups as these needs manifest themselves. We support this change in the legislation.

In reviewing the definitions, we note that the meaning of "primary health services" has been broadened under the section of preventive health services to include children's ear examinations, perinatal services, well child services, and family planning services. Preventive dental services have also been added as a primary health service. These are all beneficial changes in the program.

The definition of "supplemental health services" has been substantially broadened to now include, in addition to hospital services, home health services, rehabilitative services, and dental services, extended care facility services, vision services, allied health services, pharmaceutical services, therapeutic radiologic services, public health services, health education services, and services which promote and facilitate optimal use by the migrant worker of the services of this program. While this program expansion is laudatory in its concepts, it appears so open-ended as to make it virtually without internal limitations. Fully implemented in all its services and utilized fully by this population group, the program could be extremely expensive. We believe that some clarification is needed as to the extent of services which this program intends to provide. Such parameters would provide the guidance which is needed to realistically evaluate the program.

We are also concerned with the makeup of the governing board of the proposed migrant health centers. The bill requires that a majority of the governing body be selected from persons receiving services. This appears to overlook the transient character of the population. Whereas the governing body should have relative stability, its composition under the bill would consist of members of a highly mobile group. Accordingly, the mechanism for receiving and implementing the views of the patients should be restructured in the light of their needs and patterns of life.

A similar observation could be made concerning the National Advisory Council on Migrant Health which is created by this legislation. Of its 15 members, at least 12 must be from the governing boards of migrant health centers and of these, at least 9 must be individuals who are being served by a migrant health center. If this Council is to have any meaningful fulfillment of its statutory obligation to advise, consult with, and make recommendations to the Secretary on matters concerning the organization, operation, selection, and funding of migrant health centers, then a much more stable, cohesive and viable group is needed.

While many improvements have been made in the legislation since the last time we offered our views on migrant health care, we still do not believe that this is the method by which the health needs of the migrant agricultural worker can best be accommodated. As we previously testified in our appearance before this Subcommittee, a federally supported program utilizing voluntary health insurance coverage will provide the migrant worker the flexibility, mobility of benefits and the dignity of care which has been lacking to date in existing programs. The AMA has been developing the specifics of such a program for Congressional consideration. Such a voluntary health insurance program would better serve the interests of all in that the government would be getting the maximum benefit from its health care dollar since it would not be funding duplicative or underutilized health facilities.

We recommend that the present migrant health program be extended and that the Congress turn its attention to the development and implementation of a comprehensive private health insurance program for the migrant agricultural worker.

TITLE V—COMMUNITY HEALTH CENTERS

This Title amends the Public Health Service Act by adding a Section 330 which creates a new and formal program under which the Secretary of HEW is authorized to make grants to public and private non-profit entities to assist

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them in the establishment and initial operation of community health centers which will serve a medically underserved area or group. The centers would offer to all residents of the area it serves both primary health services and supplemental health services which exactly parallel those set out in Title IV for migrant health centers. This support of neighborhood or community health centers has been carried out in the past through the general authority for project grants for health services development of Section 314 (e) of the Public Health Service Act, as well as other authorizations.

It should be emphasized that the Association has a strong interest in the provision of health care to persons in shortage areas. Members of Association Committees on Community Health Care and Health Care of the Poor and Association staff have visited, studied, and reported on a number of these centers. One of the resulting observations is that neighborhood or community health centers provide health services to the poor which were not previously available. We believe that in some communities these centers should be supported. However, it is by no means clear that such centers are the ultimate solution to the problem of providing care in "medically underserved areas," or that the approach is so universally applicable that it should become the object of a Federal categorical grant program.

The Congress is well aware that categorical grant programs, once established, develop a life of their own, and a constituency, and are almost impossible to terminate. Even termination dates set forth in the original act, or language requiring the grantee to develop independence of Federal funding, can be, and usually are, later set aside or extended. Viewing the past history of categorical grant programs, it is only realistic to consider such programs from the outset as permanent additions to Federal health programs and a permanent competitor for expanded Federal funding. Until the establishment of such a federal program has been shown to be warranted, we urge against the creation of this specialized program, specifically and solely aimed at the development and operation of one particular type of health care delivery.

As we stated in our testimony last year, in these times of sharply increasing inflation and when so many other Congressional and Administration activities are aimed at limiting the cost of providing health care, the fact that the "cost-effectiveness" of neighborhood health centers has not been thoroughly explored in comparison with other delivery approaches is a further reason to question establishing this program. There is indeed some evidence that, regardless of other considerations, neighborhood health centers may not be the most economic method of delivering health care. A study published by HEW's Community Profile Data Center in October, 1972, on "The Cost of Standard Medical Services under Alternative Delivery Systems" concluded that, comparing the cost per visit for medical care in neighborhood health centers, prepaid medical groups, and solo practitioners' offices, the cost for care by the individual private physician was roughly half the other two. We do not consider this study necessarily conclusive, but before massive Federal funding—over half a billion dollars in two years—is committed to neighborhood health centers, more hard statistical data as to actual costs of delivery in comparison with results should be acquired.

We share with the Committee and the Congress a desire to respond responsibly to health care needs of medically underserved areas. In our opinion further development of the community health center approach to the delivery of health care for the poor should be included within general revenue sharing funds of the individual states. We would further urge that Congress seek a detailed up-to-date study of the cost effectiveness of the neighborhood health center approach to health care delivery before it authorizes any additional expansion of this approach.

For these reasons, we would urge that you delete Title V from this legislation and that you provide for a continuation of Section 314(e) of the Public Health Service Act.

TITLE VI—MISCELLANEOUS

Section 602 authorizes the Secretary of HEW to make grants to meet the initial costs of establishing and operating of public and non-profit private agencies which would provide home health services, as defined in Section 1861(o) of the Social Security Act, in areas in which home health services are not otherwise available. No grants could be used for the construction of facilities. We believe this to be a beneficial expansion of the Secretary's authority and should help to meet the needs of Medicare beneficiaries. Accordingly, we recommend your support of this proposed authority.

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Section 603 authorizes the Secretary of HEW to appoint a Committee on Mental Health and Illness of the Elderly to make a study and recommendations concerning the future needs for mental health facilities, manpower, research and training to meet the mental health care needs of elderly persons, the appropriate care of elderly persons who are in mental institutions or who have been discharged from such institutions, and proposals for implementing the recommendations of the 1971 White House Conference on Aging respecting the mental health of the elderly. This nine-member Committee would include at least one member in each of the fields of psychology, psychiatry, social science, social work, and nursing. The Committee would be disbanded 30 days after it had submitted its report. While the purposes of this Section are laudatory, we are of the opinion that the Secretary already has the authority to carry on the activities called for in this proposal. We recommend that this section be deleted.

Section 604 authorizes the Secretary to establish a temporary Commission for the Control of Epilepsy and Its Consequences. This Commission would conduct a comprehensive study of the level of medical and social management of epilepsy in the United States, and would investigate and make recommendations concerning the proper roles of federal and state governments and other agencies in the identification and treatment of epilepsy and its consequences. The Commission would be dissolved following the submission of its report. We believe that this Commission would be beneficial and we recommend support of this Commission.

Section 605 authorizes the Secretary to establish a temporary Commission for the Control of Huntington's Disease and Its Consequences patterned after the proposed Commission for the Control of Epilepsy outlined in Section 604. We would also urge support for this temporary Commission in the expectation that its report would add to the present understanding of Huntington's Disease.

Section 606 of H.R. 2954 amends Title XI of the Public Health Service Act by adding a Part D—Hemophilia Programs. Under this new authority, the Secretary of HEW could make grants to, and enter into contracts with, public and nonprofit private entities for the establishment of comprehensive hemophilia diagnostic and treatment centers. The Secretary would also be authorized to make grants to and enter into contracts with similar entities to develop and expand, within existing facilities, blood-separation centers to separate and make available for distribution blood components to providers of blood services and manufacturers of blood fractions. While we recognize the seriousness of hemophilia, there are already in operation a number of private programs which have been successful in meeting the special needs of this very small group. Present information indicates that there would seem to be no special need presently evident to justify these new federal programs. We recommend that this portion of the legislation be deleted.

This concludes our views on H.R. 2954. We would now like to briefly address ourselves to H.R. 2955—the Developmental Disabilities Amendments of 1975.

H.R. 2955

This legislation provides a two-year extension of existing programs for people with developmental disabilities with a total authorization of $192 million. The bill modifies the existing law by: Creating a new special project authority and raises the present 10 percent requirement to 30 percent of the state allotment for projects of special national significance; requiring that States spend a specified percentage of their allotment for programs for deinstitutionalization of persons with developmental disabilities inappropriately placed in institutions; eliminates the requirement for Federal approval of individual construction projects funded with state grant funds; adds autism specifically to the list of diseases covered by the program; and requires studies by the Secretary of HEW to determine the neurological diseases which should and should not be considered as developmental disabilities and the adequacy of services for persons with diseases not included.

The developmental disabilities program fills a very special need in providing comprehensive services for persons who are mentally retarded or have other developmental disabilities, and in funding research and demonstration projects in this field. As we pointed out in our testimony a year ago, we find lacking any provision for evaluating the effectiveness of this program. We would recommend that funds be specified for program evaluation both on the part of the Secretary and the local facility. With this recommendation, we would urge your support of H.R. 2955.

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This concludes the statement of the American Medical Association on H.R. 2954 and H.R. 2955. We respectfully request that our statement be made a part of the record of your hearing on this legislation.

STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION

H.R. 2954

The American Optometric Association supports the concepts contained in H.R. 2954, which if enacted will revise and extend programs of health revenue sharing and health services.

"Sight is one of man's greatest gifts. The preservation of that gift is one of his greatest challenges." So said the President of the United States in 1969.

But what exactly is the challenge?

The challenge is . . . more than ten million children need vision care. "Their future will only be as bright as we, the leaders of this generation, are able to make it by minimizing physical impairment or other handicaps to their health." Again, according to the President.

The challenge is . . . at least in families where the breadwinner is visually impaired (and uncorrected), the impairment itself is probably a factor contributing to the low income of the family.

The challenge is . . . up to 80% of delinquents observed in various studies had learning difficulties specifically in reading. Poor vision was found to be a contributing factor in 50% of these cases.

These challenges are particularly compelling for the low income families that are served by the programs covered in the bill before you. The rates for prevalence and degree of vision impairment of low income family members are considerably higher than corresponding rates for any other income group regardless of age.

These challenges present continuing challenges to the doctor of optometry, whose profession is the examination, diagnosis and treatment of conditions of the vision system.

With these challenges in mind, this Association would like to comment briefly on Titles IV (migrant health) and V (community health centers) of the bill.

TITLE IV—MIGRANT HEALTH

Optometrists are already involved in providing vision care to agricultural migrants and their families. We commend the Subcommittee for including children's eye examinations within the scope of primary health services and vision care for adults as a supplementary benefit. Inclusion of vision care will enhance the provision of this needed health service to this group, which is disadvantaged by income and mobility factors.

The American Optometric Association points with pride to the growing number of optometrists who are bringing vision care to migrant families. Programs in Idaho, Oregon and California have been particularly successful and often innovative. But programs such as this have only scratched the surface; a multitude of unmet needs remain.

It is a fact that persons from low income groups, such as migrant families, are most in need of vision care. In testimony before a special New York Department of Health hearing on vision care, Alden N. Haffner, O.D., Ph.D., Executive Director of the Optometric Center of New York, stated: "From the standpoint of his health . . . the person from the low income family is disadvantaged. Adequate evidence exists to detail that that person and that family have higher incidence of disability and disease than exhibited by the more socially advantaged family. Visual disability is no exception. Columbia University's Professor Charlotte Muller, a highly repected health researcher, found visual disability more than 400% higher in the poor family than in the family with an income of more than $7000. The irony of the situation and the melancholy truth are that the poor need more and better care, of all types, and can ill afford it . . ."

William C. Richardson, an instructor in hospital administration at the Graduate School of Business, University of Chicago, reported in the July, 1969 issue of Hospitals, the Journal of the American Hospital Association, that activity-limiting chronic visual impairments are eight times as prevalent among individuals with annual family incomes below $2000 compared with those from families with annual incomes of $7000 or more. His statement was based on the

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National Center for Health Statistics Publication, Series 10, Number 45, titled "Limitation of Activity and Mobility Due to Chronic Conditions, United States, July 1965–June 1966."

In its report on "Characteristics of Visually Impaired Persons," Series 10, Number 46, issued August, 1968, the National Center for Health Statistics concluded (page 7): "It is reasonable to assume that, at least in families where the major breadwinner is visually impaired, the impairment itself is probably a factor contributing to the low income."

Providing vision care to low income persons can be a major factor in improving their success in the classroom, their ability to earn a living, and their eventual removal from the welfare roles. It simply makes good sense to include vision care in the migrant health program.

To ensure that all available health care resources, including optometry, may be utilized in providing care under this program, we recommend that the Subcommittee add the following one-sentence paragraph to appear after § 310(b)(3)(K):

"Services included in (2) or (3) may be provided by such health care personnel including but not limited to dentists, optometrists, physicians and podiatrists, as are licensed by the respective states to provide such services."

TITLE V—COMMUNITY HEALTH CENTERS

We urge the Subcommittee to authorize continued appropriations for the operation of community health centers and to retain vision care for children and adults among the services to be provided by these centers. As is the case with migrant health programs, optometrists have been active in providing examination, diagnosis and treatment services for population groups served by these centers. Our Community Health Division recently identified optometric participation in health centers in such states as California, Connecticut, North Carolina, Utah, Washington, Alabama, Illinois, Kentucky, Massachusetts, Missouri, New York and Pennsylvania.

Inner-city children served by community health centers appear to have a higher incidence of learning disabilities, perceptual difficulties and developmental visual problems than do the more "advantaged" children in other parts of the city. At the same time, their parents suffer a higher incidence of functional vision problems which interfere with employability, job performance and the ability to share the same variety of experiences that are enjoyed by other Americans. Community health centers are playing a vital role in bringing needed health care services, including optometric care, to the residents of the inner city.

Title V of H.R. 2954 proposes that children's eye examinations be included as a preventive primary health service and, in effect, that vision services be offered as a supplementary health service for adults. We endorse the retention of these provisions. In addition, to ensure that all available health care resources, including optometry, may be utilized in community health centers, we urge the addition of the following single-sentence paragraph after § 330(b)(2)(K):

"Services included in (1) or (2) may be provided by such health care personnel, including but not limited to dentists, optometrists, physicians and podiatrists, as are licensed by the respective states to provide such services."

CONCLUSION

The challenge to preserve the vision of all Americans falls upon every citizen, young or old; but it falls particularly heavy upon those who have chosen to provide vision care services as a career. The American Optometric Association, which represents the profession that provides some 70% of the vision care services in our Nation, recognizes its responsibility to work with the Congress and Administration in meeting that challenge.

Therefore, we are pleased to support the concepts contained in H.R. 2954.

STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION

H.R. 2955

The Developmental Disabilities Services and Facilities Construction Act has served as a fine vehicle to aid those who truly need our help. H.R. 2955, the Developmental Disabilities Amendments of 1975, would extend this program and the American Optometric Association strongly supports passage of this bill.

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The Committee has done its work in this area diligently and we hope that the whole Congress will act swiftly on passage of H.R. 2955.

The role of vision to the developmentally disabled is a major one. The importance of vision to any child cannot be minimized. The National Eye Institute has stated that "vision is the most important of the senses, accounting for over 40% of all sensory input to the brain." Vision is involved in 80% of the learning process. Vision—good or bad—affects the education, the social adjustment, the very ability to succeed in life.

Vision problems are not outgrown, they only worsen with time. Despite this overwhelming importance, less than 10% of the children entering our schools have had the opportunity for a vision examination or vision screening.

Optometric services are one step in preventing the improper classification of a child as developmentally disabled, when indeed the problem is one of vision impairment. On the other hand, the child with a developmental disability needs to develop fully whatever senses or abilities are available to him.

The child himself will not know whether he is seeing as he should. Even the normal child cannot determine this. Vision is a learned process, beginning in the fetus and continuing through the early years of childhood. The child does not know how he is supposed to see, he has no basis of comparison.

Children can face a vairety of learning problems. Howard M. Coleman, O.D., M.Ed., and Sarah Taylor Dawson, M.A., relate some of these:

"Young children learn through the development of patterns—perceptual, behavioral, conceptual and combinations thereof. For the child who is lost in space there are no patterns. The world is a confusing, disorganized place filled with a bewildering mass of stimuli that constantly bombard him with incomplete and inaccurate information . . . The senses of the child—particularly the visual and the auditory senses—are amenable to learning (training) as an ongoing process in the life of the individual."

Mort Davis, O.D., of the College of Optometrists in Vision Development and leading optometrist in the field of child vision, explains that "there is a very delicate interplay between the information fed into the brain through the eyes and those adjustments of the eyes that feed information in most efficiently."

As vision affects learning, then, Dr. Davis further explains that "illness, stress, restricted or omitted experience in moving, all can adversely affect vision development."

In addition, "vision is more complex than other sense modalities and takes longer to develop fully. One consequence of this longer maturation period is that there is a greater probability of anomalies developing."

The Department of Health, Education and Welfare reports that "about 250,000 mentally retarded children of school age in our nation are functioning as best they can with uncorrected defects in vision. They very children who can least afford it may well be educationally short-changed because of the handicap poor vision imposes."

Another HEW report indicates at least one-tenth of children aged 6–11 (in noninstitutional settings) have eye muscle imbalance, disease conditions or other abnormalities in one or both eyes. This rate increases dramatically for those children with other handicaps.

The Michigan Health Department reported that vision screening of the mentally retarded revealed a vision problem incidence three times that of the normal child. A study of 103 children with impaired hearing indicated the 59% of those same children had some vision problem. A study of 98 4–10 year old children with cerebral palsy showed over 60% with ocular and/or refractive errors.

The American Optometric Association and the profession of optometry emphasize support for this program and for the bill before the Committee. Optometrists across the nation are participating in such programs. The Association is committed to provide comprehensive optometric care to all Americans and in so doing will continue and expand its work and concern for the developmentally disabled.

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

The American Psychiatric Association, which represents 22,000 of the 25,000 psychiatrists in the United States, urges the expeditious Congressional passage of H.R. 2954.

This association is especially interested in that portion of this bill which renews authorization for community mental health centers,

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The original goal of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 was to build a viable network of Community Mental Health Centers to provide mental health services across the country.

At this point in time, when the Administration has called a halt to federal funding for new starts, we have come only one-third of the way toward the conservative requirement of 1500 centers for this nation.

Officials of this Administration have stated that this program is a demonstration project, and that its success to date obviates the need for any further funding beyond the 8-year obligational period for existing centers. However, the inability of potential centers to become operational without federal funding disproves this theory. Moreover, many centers losing federal funding will not be able to continue services integral to them, such as emergency intervention, consultation and education, outpatient, and other services. The wide spectrum of mental health services envisaged as the operating model of such centers would not be financially feasible in many cases without federal support.

One of the dilemmas we would experience through the inability to complete the community mental health center network would be the creation of a vacuous situation in areas that will have phased out state mental hospitals, leaving few if any alternatives to treatment. Some areas are already experiencing such a crisis in the absence of community mental health centers or other facilities.

Termination of federal support would also leave an inequitable patchwork pattern of community mental health service availability around the nation—a development certainly not anticipated by the architects of the bill. Many areas with weaker funding capability though needing such services more than others have not been able to provide them.

Alternatives to federal support for centers have not sufficiently crystallized at this point so as not to inhibit future expansion of the centers' program. It does not appear that the states would be either able or willing to take up the slack.

H.R. 14214 which was pocket-vetoed by the President, provided a number of improvements in centers' operations, including an appropriate range of mandated services for children, the elderly, and alcohol and drug abuses. Centers must not be forced to retrogress in the provision of comprehensive services. They must be financially nurtured to provide such services.

Community mental health centers are part and parcel of the continuum of the mental health service system. They provide many services to the poor and near poor who suffer from mental and emotional illness, since mental health benefits in health insurance policies are still either nonexistent or extremely limited, and federal health programs still perpetuate discrimination in the treatment of mental illness.

As this association stated last year, we advocate that the Congress place a high priority on this piece of legislation, so that forward planning for the operation of new centers may proceed in a positive, dynamic manner. Also, those centers that have worked so conscientiously to build superior delivery systems should be permitted to operate in the same superior context.

It is vital that we do not become delayed by relatively minor details that impede the principal goal of the building and continuing work of the network.

STATEMENT OF THE NATIONAL ASSOCIATION FOR RETARDED CITIZENS

The National Association for Retarded Citizens is again pleased to have the opportunity to present this statement on the Developmental Disabilities Services and Facilities Construction Act. Our organization was very disheartened when this Committee and your counterparts in the Senate were not able to reach agreement in conference on your Developmental Disabilities bills at the end of the 93rd Congress. We are delighted and greatly encouraged, however, that you have seen fit to make the Developmental Disabilities legislation among the first to be considered in this new Congress.

It is difficult to comment on the provisions of H.R. 2955 without referring occasionally to the Senate Developmental Disabilities bill, S. 462. They differ greatly in certain aspects and, therefore, this statement contains comments on both bills.

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LENGTH OF EXTENSION OF THE LEGISLATION

The National Association for Retarded Citizens supports the Senate bill, which extends the Developmental Disabilities program for five years. We realize the House is attempting to systematize a schedule of health legislation on a three year cycle and that Developmental Disabilities would thus be scheduled for reconsideration in fiscal year 1977. This cycle can still be accomplished by extending the Developmental Disabilities legislation for five years.

If the legislation is extended for only two years, eight months of which have already passed, we will be working on another extension within a few months of enactment. The states should be given an honest opportunity to gear up and implement the many new provisions of the new bill. By the time regulations are final, the states would probably have less than one year to operate under the new provisions. We strongly support a most logical five year extension.

DEFINITION OF DEVELOPMENTAL DISABILITIES

Our organization endorses the definition contained in the House bill. We oppose the inclusion of learning disabilities in the definition of developmental disabilities, as contained in the Senate bill. We recognize the great need to provide services to the learning disabled population. The very term, "learning" disabled, however, connotes difficulty in the educational process. The vast majority of these children must be served through the public school system. We envision this need as an educational one, which should not be a Developmental Disabilities role except as the State Council reviews the special education state plan.

The National Association for Retarded Citizens has and will continue to support increased appropriations for programs for the learning disabled under the Education for the Handicapped Act.

In addition to the limitation on educational service needs, we feel that this disability category does not meet another criteria in the existing developmental disabilities definition, namely, that the disability "has continued or can be expected to continue indefinitely."

We also note that the Administration has chosen not to include the learning disabled in their Developmental Disabilities bill.

FEDERAL MATCHING

The National Association for Retarded Citizens strongly urges you to retain the 75% Federal matching requirement in the House bill. The Senate matching provision (70%) and the Administration's declining matching provisions would greatly inhibit and possibly prohibit states and provider agencies from participating in this worthwhile program. This is particularly true in these times of tight budgets.

BILL OF RIGHTS PROVISION

You are well aware of the provisions contained in the Senate bill (Title II) which would set standards for residential facilities and community agencies into law. Our organization has a deep commitment toward the purposes as stated in Title II of S. 462. The Policy Statements on Residential Services adopted by our Board of Directors in October 1968, addresses the issues of the denial of civil rights, unnecessary, inappropriate and prolonged institutionalization, the lack of maintaining standards and the need for alternative community care, all of which are found in Title II. To this end, the National Association for Retarded Citizens was a lead agency of the Accreditation Council for Facilities for the Mentally Retarded that developed the two sets of standards incorporated as Parts C and D of Title II.

It is our opinion, however, that locking these new, relatively untested standards into law is a serious mistake. These standards will need constant revision. To have to amend the Developmental Disabilities Act to accomplish this will be tedious and use up much of the Congress' valuable time. At the same time, we recognize the intent of this Title as very important.

We recommend adopting Part B of Title II in some revised form that will allow providers of service to the developmentally disabled, state agencies and the Federal Government to establish and implement quality assurance systems. In order for this to be accomplished, a reasonable timetable for compliance must be flexibly structured and most important, the Congress must authorize specific sums of money for residential and community-based facilities to be

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upgraded to achieve compliance and to the Secretary for developing such systems.

We urge the House of Representatives through this Committee not to enact Title II of the Senate bill into law.

AUTHORIZATIONS

Both House and Senate versions authorize the same amounts for the formula grants during the first two years ($50 million and $85 million). We strongly endorse these authorizations and encourage you to incorporate the Senate bill's authorization for three additional years to $95 million, $100 million and $110 million.

For purposes of funding the University Affiliated Facilities programs, we support the Senate authorizations of $20 million for each of five years.

We recommend the consolidated special project grants be authorized at $18.5 million for the first year, with an additional $2.5 million added each subsequent year.

CONSOLIDATED SPECIAL PROJECT GRANTS AND PROJECTS OF NATIONAL SIGNIFICANCE

The National Association for Retarded Citizens strongly encourages this Committee to enact the Special Project Grant provision in the House bill at the authorization level contained in our recommended authorizations.

We also endorse the purposes in the House bill which the special projects will meet. Additionally, we support the 80% set aside for projects of national significance in the special project authority.

Our organization hopes that the above recommendations will be helpful to your deliberations. The Developmental Disabilities program is a vital one that sets in place, at the State level, a meaningful planning mechanism designed to pull together Federal, state and local resources to maximize their effect on developmentally disabled citizens. In these hard economic times, maximum utilization of these resources should be utmost in our minds. We urge you to enact this legislation as rapidly as possible in order for the State Developmental Disabilities Councils to renew their activities and so that thousands of developmentally disabled persons can begin to receive desperately needed services.

This Committee is to be congratulated for its past efforts on behalf of the developmentally disabled citizens of our country, and we wish you well in this new session.

STATEMENT OF THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

This statement is presented on behalf of the National Council of Community Mental Health Centers (NCCMHC) representing 317 community mental health centers, most of which receive federal funding under the Community Mental Health Centers Act, and another 119 agencies which are developing CMHC programs or which have a direct interest in community mental health.

NCCMHC was extremely disheartened by the President's veto of HR 14214, not only because this action delays implementation of this important bill, but also because the President's statement showed a fundamental misunderstanding about the centers program, its achievements and the purposes of the proposed legislation.

The President vetoed the bill for two reasons: the cost of the legislation and the "more equitable and less restrictive" funding available to these programs through Medicare and Medicaid. Both of these statements reflect misunderstandings about the nature of the CMHC program and the services delivered.

First, on the question of alternative funding, the Administration has for the last several years attempted to phase out direct support for the initiation of CMHC programs on the grounds that other funding sources are available. These sources are Medicare, Medicaid, Titles IVA & VI of the Social Security Act (Social Services) and other federal third party payment programs, national health insurance, revenue sharing, state and local government funding, private insurance companies, and finally the patients themselves through fees for service.

The Administration has consistently ignored the facts, to wit:

We have no system of national health insurance and such a plan is now years away from enactment;

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Revenue sharing funds are not being used for health services to any great extent, and mental health programs receive only negligible support from these funds;

Medicare and Medicaid have legislative and administrative restrictions which severely limit reimbursements available to centers, and Medicaid eligibility requirements in many states preclude reimbursement for a very large percentage of poor families. As a result Medicare provided only 1.7% of the funds received by CMHCs in 1972 and Medicaid povided only 5.8%;

A recent ruling by HEW Secretary Weinberger, which requires CMHCs to deduct all federal grant monies before calculating their costs for purposes of reimbursement through the social services programs authorized by Titles IVA and VI of the Social Security Act, will in effect deny any substantial repayment to CMHCs for provision of such services to eligible individuals;

Private insurance policies generally discriminate against the less expensive outpatient care which is emphasized by centers, and coverage of mental health services under private policies is generally poor. As a result only 7.6% of revenues in 1972 came from such coverage.

CMHCs serve a population which is overwhelmingly poor—74% of center patients in 1972 had family incomes below $7,800.

State and local governments have recently been asked to assume a bigger and bigger burden of health and other social services spending as the federal government cuts back, and as a result, many are now seriously short of funds. It is doubtful if these agencies can continue to support their existing commitments to CMHCs, let alone substantially increase it.

Finally, it must be remembered that spending money to initiate and support CMHC programs frequently saves the taxpayers money in the long run. Early treatment and preventive programs can reduce the costs of care. Care provided through CMHCs, which emphasize outpatient, day care and other partial hospitalization programs, is less expensive than institutional care in a state hospital—the alternative for most CMHC patients. Untreated mental health patients cost society a great deal in time and money, as they drain the resources of police departments, courts, and welfare agencies, disrupt school programs and so on.

The authorizations in HR 14214 for CMHCs were not excessive. Indeed, for many of these grant programs, the authorizations were substantially lower than in the previous law. Moreover, the bill included very important provisions to Improve cost accountability in CMHCs and to encourage their maximum utilization of all available funding, with a view to becoming financially independent of federal operating grants as soon as possible.

Other revisions in Title III would have enabled CMHCs to improve their programs and strengthened the system of care, including the quality of care provided, the costs of that care, and the comprehensiveness, accessibility and acceptability of services, prior to the enactment of national health insurance. It is nothing short of ludicrous, not to say extravagant, to propose enactment of national health insurance without first attempting to bring some structure to the planning and development of health resources in this country. This Subcommittee, through the enactment of the National Health Planning and Resources Development Act of 1974 (PL 93-641) and the proposed health services and health manpower legislation, is proposing to set up the essential structure and bring about necessary changes in the health delivery system. The Administration, on the other hand, proposes no improvements in the system for health services delivery (as evidenced by budget cuts for CMHCs, neighborhood health centers, HMOs etc.), reduced support for manpower programs, and cuts in the PSRO budget. If national health insurance legislation is enacted without any of these necessary changes, the results will be rampant inflation in health care costs and great disillusionment among the public as the services they will be able to afford to purchase are just not accessible to them.

On the question of equity, the President claims that federal funding for health services should be channeled through Medicare and Medicaid because these services are "provided on the basis of national eligibility standards in Medicare and state eligibility standards in Medicaid". However, it is also important to remember that Medicare discriminates against individuals with mental illness, as opposed to other illnesses, and further emphasizes inpatient care over outpatient services for the mentally ill. In addition, Medicare requires care to be provided under the direct supervision of physicians, and as a result, many free standing centers with outreach services not staffed by physicians cannot collect reimbursements for services to the elderly.

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Medicaid, of course, discriminates drastically between residents of different states, both as to eligibility for services and the types of services to be covered. Only 36 states cover clinic services in their Medicaid plans (CMHCs can generally receive reimbursement under Medicaid only through this provision) and many of these limit services to the categorically needy only, while others specifically exclude mental health clinics from coverage.

Thus, families with the same income living in different states may be eligible for very different Medicaid coverage, ranging from nothing to substantial care, and in some states one family may be eligible for coverage while another with the same income is ineligible. This is not equity.

The costs of mental illness now run in the billions of dollar each year. If the federal government withdraws its support for community programs, the alternative for most of the over 1.5 million people now served by these centers each year would be the state mental hospital system. One way or another services for the mentally ill and emotionally disturbed must be provided. CMHCs have proved an effective and economical means to provide fully comprehensive care within the patient's community. To reduce federal expenditures in this area now is simply penny wise-pound foolish.

The President is rightly concerned over the relationship between federal spending and federal revenues. However, cutting back upon essential health services is not sound economics. It is even more inappropriate at this time to reduce our commitment to mental health care, as recent studies (particularly by Dr. M. Harvey Brenner, Johns Hopkins University)[1] show that the nation's economic health is a sure indication of its mental health. Economic recessions, or depressions, are the single most important source of fluctuations in mental hospital admissions or admission rates.

The conclusions of the Brenner study are already being proved correct in the current recession. Individual community mental health centers are reporting dramatic increases in demands for services. Over the last three months, many centers report increases ranging from 30–300%.

Moreover, the federal government is now spending millions of dollars to put people back to work in public service employment—yet by cutting back these essential services, the federal government is laying off many other workers. Health care is a service oriented industry—particularly community mental health care—and dollars spent on this program keep more people employed than dollars spent, for instance, to build highways. Thus before we cut federal spending, health and related services delivery programs should be given special attention.

We therefore urge early enactment of HR 2954 so that some appropriations—particularly for consultation and education and financial distress grants—can be made in FY 1975. The need for enactment of this bill is now urgent. Some 36 centers will receive their last federal staffing grant before June 30, 1975 and many of these will be forced to reduce or severely curtail services. A recent survey by NCCMHC showed that at least 12 of these centers would need further federal aid, if they are to continue to operate their current services (66% of those responding to the survey). Other centers, without exception, reported that increases in state and local government funds would provide sufficient monies for them to continue their programs without further federal assistance. A summary of this survey is attached for inclusion in the record.

It is interesting to note that services to be cut back or eliminated by the centers unable to replace lost federal dollars were generally consultation and education, outpatient, partial hospitalization and emergency services. Furthermore, most of these centers reported they would in the future be unable to serve patients who were unable to pay.

Thus the need for this legislation seems clear. Both the administration and the Congress envison enactment of national health insurance in the near future. Prior to that time, however, we cannot afford to let the existing system of delivery deteriorate. If we do, we will only find that it must be rebuilt if NHI is to be effective and not inflationary. The provisions of Title III of HR 2954 are designed to maintain and improve the system of care prior to enactment of NHI. They will also ensure a slow but steady expansion in the level of services available, at a time when substantial increases in demand for services are already evident and, judging by the state of the economy, can be expected to continue.

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[1] Mental Illness and the Economy, M. Harvey Brenner, Harvard University Press, 1973.

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Finally, we would like to strongly urge you not to reduce the authorizations in this bill nor to amend it in any way. By vetoing the bill after the adjournment of Congress, President Ford denied the 93rd Congress the opportunity to consider overriding his veto. Because the bill is so essential to the sound development of health services in this nation, and because the funding is not excessive by any means, the 94th Congress should be given the opportunity to express its will on this same bill. As far as CMHCs are concerned, the Administration's position is not that the authorizations in this bill are too high, it is that *any* authorization for centers is inappropriate. Thus reducing funding for centers will not make the bill more acceptable to the Administration, and it may result in damaging the program.

The CMHC program has been facing a highly uncertain future since President Nixon first proposed its termination in 1972. Yet demands from communities for new and expanded CMHCs (as indicated by the number of applications still pending for federal support: 52) remains strong. Unlike Medicaid, the CMHC program does not discriminate between individuals in different states—all states have at least one CMHC program; and unlike Medicare it does not discriminate against those with mental disabilities by restricting coverage for services. It is high time the federal government fulfilled its long-stated commitment of providing seed money to establish centers in all communities. This is equitable and economical—more importantly, however, it will bring quality mental health services within the reach of millions of Americans now effectively denied such care, at a time when demand for care is likely to reach an all time high.

MORRIS ASSOCIATES,
GOVERNMENTAL AFFAIRS CONSULTANTS,
Washington, D.C., January 28, 1975.

Re Effect of termination of Federal grants and alternative funding sources: Summary of NCCMHC survey.

To: NCCMHC members.
From: Chris Koyanagi.

In November 1974, NCCMHC surveyed the 36 centers which have federal staffing grants due to expire in FY 1975. A detailed summary of the 18 responses received is attached.

In brief, this survey indicates that about 30% of centers with grants expiring will be able to continue to operate without reducing the level of services provided and 60% will be forced to cut back services, often drastically, unless alternative federal funds become available (for many centers, approximately 10%, the funding picture is still unclear).

Those centers which do not need further aid from the federal government are relying almost exclusively on increases in state funding. While centers which report they cannot replace all of their federal funds are also anticipating increases in state support, the support for these centers falls short of the need. In some cases centers which need no further aid and centers in financial difficulty are located in the same state, indicating that the picture is far more complex than the commitment of the individual states to CMHCs.

Of the centers facing financial problems, a majority have been able to replace only half or less (often under 20%) of the amount previously provided through federal funds. As a result, these centers report serious cut backs in services. Almost all indicate their services will be substantially reduced with the greatest impact being felt in the consultation and education programs (in some cases these services will be eliminated entirely); outpatient services, partial hospitalization services and inpatient care. All centers report they will have to require that patients either pay for services—often raising their fee schedule—or have third party coverage. Such policies will tend to emphasize inpatient hospital care, since most private insurance policies and federal third party payment programs discriminate against less expensive outpatient care. These policies and programs also emphasize care under direct supervision of a physician, and this too will have an impact upon the centers operations and increase the cost of services.

Other services to be quite severely effected according to the survey are emergency services and specialized services in those instances where the center has obtained no alternative federal funding for specialized services. In many case, however, alternative federal funding has been obtained for children's programs and specialized programs for alcoholics and drug abusers.

Evaluation was also cited for significant reductions in one center, and two

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centers indicated they can absorb some of the cutback by reducing administrative and secretarial staff.

All the centers surveyed had either already received their last payment from the federal government, or will receive it within a very few months. Thus, these cut backs are already taking place: staff are being let go and patients turned away from some of these centers as a direct result of the phase out in their federal staffing grant.

The survey indicates that poverty centers appear to be in distress in greater proportion than their percentage in the surveyed centers would indicate. However, since the number of respondents was small, and the difference between the number of poverty centers in distress and the number which might be expected to be in distress judging by their percentage in the survey was not great, it would seem to be premature to conclude that poverty centers will find it harder to replace federal funding than nonpoverty centers.

All but one of the centers in distress indicated an interest in a federal financial distress grant, were these to be authorized. The amount of funds required to continue their programs are often modest—ranging from $40,000 and $65,000 up to $600,000 in the larger centers. On the average, the amount required is $250,000. (Note, this is the amount the centers feel they need for their programs, under proposed legislation they would be entitled to only part of this amount.)

NCCMHC Survey of Centers Losing Federal Grant Support Under Part B of CMHC Act in Fiscal Year 1975

In November, 1974, the National Council surveyed the 36 (24 poverty, 12 nonpoverty) centers which have federal staffing grants due to run out completely in FY 1975 with a view to determining:

how many of these centers might need continued federal assistance through a financial distress grant mechanism

where those centers which did not need further federal aid are obtaining their financial support

RESPONSES

Eighteen centers responded to the survey, half of those surveyed.[1] These responses showed that:

5 centers (28% of those responding; 2 poverty, 3 nonpoverty) need no further federal assistance

2 centers (11% of those responding; 1 poverty, 1 nonpoverty) may need further aid, but their financial situation is still uncertain

11 centers (61% of those responding; 8 poverty, 3 nonpoverty) will need further aid if their programs are to be continued at current levels

CENTERS NOT NEEDING FURTHER AID

Centers which report they do not need further federal assistance to continue their basic program funded eight years ago under a Part B grant include centers which have already received their final federal payment, as well as those with grants running out in early 1975. Date of expiration of these grants, and the amount of the last year's federal grant are shown below:

Grants run out:	*Amount of last year's grant award*
November 1974	$156,828
December 1974	646,818
February 1975	161,945
February 1975	60,000
July 1975	Unknown

Federal funds will be replaced almost exclusively by increases in state and local government funds:

Funds will be replaced by:	*Centers*
State and local government	3
State and local government as well as increases in 3d party collections	1
State government	1

[1] NCCMHC surveyed all 36 centers with expiring federal grants, those which are members of NCCMHC and those which are not. However, responses came generally from member centers (16 of the 18 responses).

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Thus for all five centers, increased state support is a primary factor in their ability to continue to operate their program. These five centers are located in five different states:

Massachusetts
New York
Pennsylvania
Colorado
Michigan

The cut off in federal funding is reported by these centers to be having no effect on the level of services they will provide in the community.

CENTERS UNCERTAIN OF THEIR FUTURE FUNDING

Two centers were unable to state whether or not they would be in financial difficulty as a result of termination in their federal staffing grant. Both centers were hoping for increases in support from state funds and other sources. These centers had grants running out within a few months of the survey date, for the following amounts:

Grant runs out:	*Amount of last year's grant award*
February 1975	$115,529
May 1975	65,000

Funds will be replaced by:

Uncertain—hopes for increases in state funding, has implemented new fee schedule and hopes for improved fee collections and third party reimbursements. (However, after repeated efforts the center has found it impossible to obtain Medicaid and Medicare)—1 center.

Hopes for increases in state and local government funds, and intends to increase fees—1 center.

These two centers are located in Michigan and North Dakota.

One of these centers reports that it expects to cut some services, and may lose one or two staff people. The funding picture for the other center is too uncertain for estimates of cut backs.

CENTERS FORCED TO CUT SERVICES

Eleven centers (61% of respondents) report that without further federal aid (which is not now available to them) they will be forced to reduce services, in some cases very substantially.

Many of these centers have already received their final payment through the federal staffing grant program and thus these cuts are not hypothetical, they are already being implemented. Others will be implemented shortly.

Grant runs out:	*Amount of last year's grant award*
August 1974	$200,000
September 1974	220,600
November 1974	600,000
December 1974	257,933
December 1974	50,680
December 1974	135,000
December 1974	203,000
January 1975	58,925
February 1975	600,000
July 1975	121,000
July 1975	442,547

While two of the centers had found no alternative source of funding, the remaining 9 centers intended to replace part of their lost federal funding through the following sources:

Funds will be replaced by:	*Number of centers citing this source*[1]
State government	5
Local government	3
Increased fee collections	6
Increased collections of 3d party payments[2]	4
Private contributions	1
No one	2

[1] These figures represent the number of centers which expect to collect funds from this source; some centers report they will collect funds from more than one such source and hence there are some duplications in these figures.

[2] Computer billing system for one center will pick up about $60,000–$90,000 per annum that had previously been "overlooked."

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The funds which these centers have been able to raise from other sources will generally replace less than half of the amount of federal dollars lost. However, three centers were unable at this time to accurately estimate what percentage of the federal grant would be replaced by these other funds:

Percentage of funds to be replaced:	Number of centers
Less than 20 percent	8
20–50 percent	1
50 percent	1
50–80 percent	3
Uncertain	3

As a result of the cut back in funding, most centers report their services will be substantially reduced:

Services will be:	*Number of centers*
Substantially reduced	7
Reduced a little	1
Held at approximately current levels	1
No response	2

Generally, the cutbacks in services will effect almost all aspects of the centers' programs. However, the degree of cut back in each service appears to differ quite substantially, as alternative funding for certain services (such as outpatient, consultation and education, and emergency services) are particularly hard to obtain. The number of centers reporting some cutbacks in various services is shown below (note this table does not indicate the degree to which each service would be reduced):

Services:	*Some cutback in this service*
Outpatient	8
Inpatient	7
Consultation and education	6
Emergency, crisis intervention teams	6
Partial hospitalization	8
Half-way house services	1
Special programs	5
For children	5
For elderly	1
For drug addicts	1
For alcoholics	1
Administration and secretarial support	2
Program evaluation	1
Outreach clinic	1

The following chart shows the degree to which each of these service areas will be reduced by these centers.

The service to be hardest hit appears to be consultation and education with two centers reporting complete elimination of these preventive services.

Many centers report most of their services will be cut back to provide care only for those who can pay. The result of this policy will be discrimination against outpatient care and partial hospitalization, since most third party payment mechanisms (including private insurance policies and federal Medicaid and Medicare programs) emphasize inpatient care. This is reflected in the estimates of cutbacks in outpatient and partial hospitalization services. Nonetheless, cutbacks in inpatient services are expected to be quite substantial in some centers.

Emergency services appear to be hit hard too, and here again emphasis will be placed on the patient's ability to pay, or his third party insurance coverage.

Fewer centers report cutbacks in half-way house and specialized programs: probably a reflection of the fact that these services are not provided by all CMHCs. In the area of special programs many centers indicated they will not need to cut back these services because of alternative federal funding obtained through Part F of the CMHC Act (for children's programs), and alcoholism and drug abuse funds obtained through Parts C & D of the CMHC Act and through other legislation. However, special programs for the elderly—which are rarely offered in centers and which cannot be funded through other sources—will be cut entirely by one center.

Finally two centers report they will be able to absorb some of the reduction in federal funds by reducing their administrative and secretarial staff.

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REDUCTIONS IN SERVICES CAUSED BY CUT OFFS IN FEDERAL FUNDING

Outpatient Services—8 centers report cutbacks, as follows:

1. 80 patient reduction per month
2. Will cut patient load; be unable to meet all needs
3. 3,000 sessions (per annum); 3 staff positions to be cut
4. Reduce patient load to those who can pay
5. Cut staff; reduction in patients
6. Raise fees substantially and effectively squeeze out lower and middle income group. Need to lay off 30–40% of staff
7. Staff cuts
8. Staff cuts and reduction in patients served

Consultation and Education Services—6 centers report cutbacks as follows:

1. All activity eliminated
2. 1,000 hours C&E work cut
3. Delete service
4. Raise fees substantially and effectively squeeze out lower and middle income group. Need to lay off 30–40% of staff
5. Must reduce
6. Staff cuts

Inpatient Services—7 centers report cutbacks as follows:

1. Will only be available on referral to private psychiatrists
2. 2,000 days of adult and adolescent hospitalisation eliminated
3. Will limit to those who can pay
4. Staff cuts and reduction in patients served
5. Raise fees substantially and effectively squeeze out lower and middle income group; need to lay off 30–40% of staff
6. Will not be able to continue
7. Staff cuts

Emergency Services, Crisis Intervention Teams, etc.—6 centers report cutbacks, as follows:

1. Will eliminate walk-in emergency service
2. 1,400 patient visits (children and adults) will have to be cut
3. Will be limited to those who can pay
4. Raise fees substantially and effectively squeeze out lower and middle income groups. Need to lay off 30–40% of staff
5. Very little emergency service will be provided
6. Staff cuts

Partial Hospitalisation—8 centers report cutbacks, as follows:

1. Budget reduced; program moved to less desirable quarters
2. Reduce staff by about one-third
3. 850 patient days (children) and 750 patient days (adult) cut
4. 1,500 sessions of day treatment and two staff members to be cut
5. Limited to those who can pay
6. Raise fees substantially and effectively squeeze out lower and middle income groups. Need to lay off 30–40% of staff
7. Will cut staff and patient load
8. Staff cuts and reduction in patients served

Half-Way House Service—One center reports cutbacks, as follows:

1. Raise fees substantially and effectively squeeze out lower and middle income groups. Need to lay off 30–40% of staff

Special programs—5 centers report cutbacks in special services for children, elderly, Alcoholics and/or Drug Addicts, as follows:

Children's Programs:

1. Support will be reduced and may result in smaller enrollment in special school for emotionally disturbed children.
2. 500 hours (including C&E for school and probation department and cutbacks in partial hospitalization)
3. 1,000 day treatment and 2 staff members to be cut from children and adolescent service

Programs for Elderly:

1. Program will be eliminated.

Programs for Alcoholics:

1. Cut back of 250 hours of consultation services.

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Programs for Drug Abusers:
1. 250 hours of consultation cutback
Administration and Secretarial Support—2 centers report cutbacks as follows:
1. Will eliminate many positions here (50%)
2. Will cut staff
Program Evaluation—1 center reports cutbacks, as follows:
1. 1,000 hours of evaluation time cut
Financial Distress Grants:

Ten of the eleven centers in distress reported that they would apply for federal financial distress grants, were these to become available.

The amounts which the centers feel they need for their programs are shown below (note, these are not the amounts which would be awarded under the proposed legislation—which restricts these grants to an amount equal to 90% of the percentage of costs for which the center was eligible in the last year of its staffing grant—but are the amounts the centers feel they would need to continue their current programs). The amounts required vary from a modest $40,000 up to $600,000. By and large these amounts are higher than the last federal grant awarded, reflecting increases in health care costs.

$240, 000
250, 000
[1] 40, 000
140, 000
175, 000
150, 000
450, 000
600, 000
65, 000
180, 000
600, 000
2, 840, 000

[1] This center does not intend to apply for a financial distress grant (see below).

The eleven centers in financial distress are located in eight states; two of these are states which will provide other centers with sufficient funding to continue to operate their program without further federal aid (New York and Pennsylvania):

Arkansas
California
New York
North Dakota
Pennsylvania
Texas
Washington
Wyoming

One center reported it will not apply for financial distress because:

"Our efforts to meet federal demands forced us into expansion beyond our ability to function. We will not repeat this mistake."

This comment highlights two issues which should be carefully considered by policy makers.

First, although federal funds for CMHCs may represent only a relatively small proportion of total spending (approximately one-third nationwide), these dollars are crucially important to the programs in that they ensure comprehensive services and adherence to national standards which might not otherwise be applied.

Secondly, if federal grants are set at too low a level, there is a serious danger of programs electing not to apply for federal funding because the requirements are too stiff and the dollars too low. Apparently, this one center feels the dollars in the financial distress grant are not enough to enable it to meet the federal requirements. Hopefully, this center is in a distinct minority, but this is something which needs to be watched over the next few years (assuming that legislation authorizing financial distress grants is enacted).

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STATEMENT OF THE NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES LEGISLATIVE COMMITTEE

The National Association of Home Health Agencies supports H.R. 1736 and the Home Health Services Section of H.R. 2954 that provides grants for expansion of Home Health Services and training of personnel to provide Home Health Services. We urge the Committee to retain this section in their bill.

In a speech to the American Association of Retired persons on January 20, 1975, Casper Weinberger, Secretary of HEW stated:

"It is becoming increasingly obvious that Government reimbursement programs are encouraging this warehousing of older Americans. Government reimburses more for institutional care than it does for care in the patient's own home. Because Home Health Services have been under-financed by Government. Programs like Medicare, Medicaid and Public Medical Assistance provide home health service benefits for only a narrow segment of the older population." "This is perhaps the major reason why people end up in institutions—it is the only way they can receive care for long term illnesses."

"Nursing homes are not cheap to build. Nor is care in them cheap; the cost of caring for a person in a nursing home now averages around $12,500 in New York City. For example, nursing homes cost the Medicaid system over $600 million annually in New York State. Taking into account current construction plans in that State, which call for a substantial increase in nursing home and similar beds over two years, nursing home Medicaid costs will soon exceed $1 billion in that State alone."

"Many of these additional beds would in all likelihood not be needed if adequate home care programs existed. And depending on the level of care needed, care of the elderly at home could be financed for between $3,000 and $9,000 a year."

"Today, home services do not exist on anywhere near the scale needed. Nor do we have the reimbursement mechanisms to meet the total need. Yet both economics and common humanity argue that we should have these home-care services."

In spite of the mounting evidence that Home Health Care would be both a cost effective and humane approach to providing needed care, the number of home health Medicare certified agencies dropped from 2,350 in 1970 to 2,247 in 1974 due to restrictive interpretation of the Medicare home health benefit and other funding problems. About half of the agencies provide only two types of services—nursing plus one other—instead of a full range of services. Hospital based home care programs, which often offer a wide range of services, have found the same problems in trying to expand as have the community-based agencies. Only 280 of a total of some 7,000 hospitals have such programs. In addition to expansion funds, training funds are needed—

To increase the availability of trained home-oriented paraprofessional personnel;

To provide business management training for Agency administrators; and

To provide continuing education for existing staff.

Demand for home care services by all age groups is expected to increase in the months and years ahead due to pending and recently enacted legislation. Home health services are included in the benefits which must be offered by HMOs under the Health Maintenance Organization and Resource Development Act and are included in the major national health insurance proposals as alternatives to institutionalization.

The Medicare, Medicaid Program does not provide an adequate reimbursement mechanism to create resources for development and expansion. Payments from these programs are made to certified Home Health Agencies only after services have been rendered and make no allowance in their formulas for development and expansion of Home Health Services. The service expansion funds would enable these existing Home Health Agencies to:

(*a*) Extend services into unserved areas

(*b*) Add homemaker/home health aide services and other services to existing home health agencies

(*c*) to expand the number of services an existing home health agency can provide.

(*d*) Improve the quality and cost-effectiveness of home health services; for example, improving staff productivity, developing a utilization review program, or an improved system of service documentation to reduce paperwork, etc.

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Many health education programs do not include a home health service field experience in their curriculum. We urge the Committee to require that all educational institutions receiving federal funds be required to include a home health service field experience in their curriculum.

Summary

The increasing costs of health care alone dictates that we need to provide ready access to Home Health Services for all Americans as an effective alternative to institutional care. This requires that funds be appropriated now to develop a supply of quality home health services that is capable of meeting the increased demand.

Therefore, we strongly urge you to retain the Home Health Services section in the Committee bill and include a requirement that all educational institutions training health professionals include a home health field experience in their curriculum.

Thank you for the opportunity to submit our views on this vital issue.

STATEMENT OF E. CLARKE ROSS, ASSISTANT DIRECTOR, GOVERNMENTAL ACTIVITIES, UNITED CEREBRAL PALSY ASSOCIATIONS, INC.

United Cerebral Palsy Associations, Inc. believes that the Developmental Disabilities legislation is absolutely essential to the eventual satisfactory programming for severely and multiply handicapped individuals. The present departmentalized delivery systems have for the most part chosen to ignore the severely and multiply handicapped and they relegate them in their thinking, planning, and service development to some pattern of institutionalized existence out of the mainstream of society.

The DD Act with its targeting of this population for planning and services, its mandate for coordinating service programs across department lines, and its involvement of consumers in the process of planning and decision-making has taken a giant step in helping our most severely disabled citizens move toward achieving their human and civil rights.

NEEDS FOR IMMEDIATE ENACTMENT

The foremost concern of UCPA related to the Developmental Disabilities legislation is that it be extended immediately.

The frustration and despair experienced by State Developmental Disabilities agencies and councils over last year's congressional deadlock has been highly detrimental to the operation of the program. The failure of Congress to enact a permanent extension, and the utilization of stop-gap measures such as continuing resolutions have had adverse effects on the administration of programs for the developmentally disabled within the states. The following are some of the areas that we have readily identified.

(1) It has greatly lowered staff-council morale.

(2) It has generated a reluctance by States to engage in any long term planning. This is the direct result of uncertainity over congressional priorities and emphasis. Minnesota is awaiting passage before issuing a new State plan.

(3) It has forced a delay in the appointment of new council members because of uncertainity over congressional requirements. Council composition is up in the air in North Dakota, Colorado, and Montana.

(4) It has postponed any new staffing of State agencies because of the obscurity in statutory requirements. Illinois is holding its approved regional staff positions open awaiting enactment of a DD extension bill. Minnesota DD staff are currently under temporary status for the same reason.

(5) Nationally, it has deferred necessary training programs because no new legislation exists. The Developmental Disabilities Technical Assistance System (DD/TAS) has planned a series of orientation sessions of new Council members on the changing focus of the DD program.

This has been delayed until the passage of an extension bill.

(6) It has created serious impasses in State government because of confusion over the proper placement and authority of both State DD councils and agencies. A permanent statutory base is a necessity in order to clarify the proper role of the DD program at the state level.

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UCPA recognizes that congressional differences over the legislation are substantial. However we feel it is imperative that Congress understand the very harmful effects this deadlock is causing at the State level and the disruptive influence it can have on the delivery of services to the Developmentally Disabled.

DEFINITION

UCPA certainly looks with favor on the addition of "autism" to the definition of developmental disability. We have always supported the broadest interpretation of the term "developmental disabilities" so long as efforts are targeted on the most severely and substantially handicapped individuals. Because of the necessity for interrelating DD programs with other state-federal programs such as social services, Medicaid, and Supplemental Security Income, it seemed wise to us to have all of these programs use the same definition for "disabled." UCP opted to support a slightly modified version of the definition used presently by the Social Security Administration. This definition was also recommended by the National Advisory Council for Developmental Disabilities:

> An individual is considered to be disabled "if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (or, in the case of a child under the age 18, if he suffers from any medically determinable physical or mental impairment of comparable severity.)"

UCPA is in agreement with the House Subcommittee on Public Health and Environment in not including "specific learning disability" in the definition. We firmly believe that the Developmental Disabilities legislation must be limited to those persons with severe learning disabilities namely those individuals with substantial disabilities requiring lifetime and comprehensive services. Part G of the Education of the Handicapped Act—Specific Learning Disabilities—offers educational opportunities to the less severely learning disabled. This legislation must be restricted to those individuals severely and multiply involved.

BILL OF RIGHTS: KEY ON QUALITY ASSURANCE

UCPA believes there must be a compromise reached on the exact provisions of the Bill of Rights for the Mentally Retarded and Other Individuals with Developmental Disabilities, Title II of the Senate extension bill. We believe in the necessity of a strong quality assurance mechanism but we are not wedded to locking the Joint Commission on Accreditation of Hospitals ACFMR standards into statute.

Last year, UCPA participated with several of her sister agencies on the Consortium Concerned with the Developmentally Disabled in drafting an alternative set of standards for Senate professional staff. These alternative standards were accepted and are contained in the Senate bill. UCPA believes they are an appropriate compromise to the existing deadlock over this issue. The alternative standards incorporate four general principles.

(1) Performance criteria by which the developmental process of a person with developmental disabilities may be measured.

(2) Individualized written habilitation plans for each person with a developmental disability.

(3) Designation of a program coordinator to assure a focal point for responsibility for the implementation of the individualized plan.

(4) Creation of a protective and personal advocacy system separate from the direct service agency.

Conclusion

USPA believes the Developmental Disabilities program is a meaningful and fundamental program for the nation's severely and multiply involved disabled persons. We believe the Congress has delayed too long its responsibility for enactment of a permanent and stable program which has proved its effectiveness. UCPA strongly recommends immediate passage of the legislation; the establishment of a functional, noncategorical definition targeted on the most severely and substantially disabled individuals; and a compromise on Title II which will guarantee quality assurance while maintaining flexibility at the service provider level.

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STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

The American Association of Retired Persons and the National Retired Teachers Association urge the Subcommittee on Public Health and Environment to favorably and expeditiously report the Health Revenue Sharing and Health Services Act of 1975 (H.R. 2954).

Our Associations' support of this legislation is predicated on the belief that even in these times of economic restraints, we can ill afford to be penny wise and pound foolish. The development of less costly alternatives to expensive institutional settings for medical treatment is a long range policy objective which we can no longer neglect if we are to cure the causes of short-run inflation in the health sector.

Specifically, H.R. 2954 incorporates three key legislative objectives of our Associations:

—We urge a federal grant and loan program to assist and encourage the development of home health agencies;

—We urge the enactment of a legislative requirement mandating community mental health centers to provide care for the elderly, and

—We urge the establishment of a Presidential Commission on Mental Illness and the Elderly American to develop a long range policy toward detection and treatment of mental illness.

Recognizing that many of the new members of the Subcommittee may not be fully aware of the rationale for these three policy stances and their subsequent translation into the legislative provisions of H.R. 2954, the following elaboration is offered:

HOME HEALTH

The demand for medical services is greater today than ever before, and the capacity of our nation's medical care system is being severely strained by these demands. There is a major need to refocus our health strategies to improve efficiency and insure optimum utilization of our scarce resources. Although we view no one approach as the panacea, neither should one course of action be discouraged. In this light, we believe that home health services may well be one of the more promising approaches to help resolve the complex problems hampering the efficient delivery of health care in our nation.

As the Senate Special Committee on Aging report on *Home Health Services* in the United States points out:

"The availability of comprehensive home health services in the United States could substantially affect the appropriate utilization of all health care resources. Such comprehensive services are not available at the present time. The potential of broad community-based home health programs capable of serving large population groups with varying and fluctuating needs has barely been demonstrated. Hospital-based programs are also in short supply and are not being developed in proportion to need. Focused upon short-term concentrated care, they do not have available in the community those services which can be extended to meet long-range need. Home health services, where they do exist, are under financed, limited in their capacity to cover the population in need and frequently lacking in essential components which might make them an effective resource."

We view Section 602 of H.R. 2954 as a viable incentive to stimulate home health care. Now, no mechanism exists for home health agencies to expand or for new ones to be established in communities without services. Home health agencies do not have sufficient funds to finance the expansion of services since their reimbursement barely covers operating costs. H.R. 2954 offers a plan of action to assist public and nonprofit home health agencies in extending their services to those in need as well as a structured grant program to initiate new home health agencies where none exists. Equally important, H.R. 2954 authorizes a much needed program for training home health personnel.

A review of home health services leads to the conclusion that they do not constitute a valid resource for the population which could make appropriate use of them. They are in short supply; they do not offer the comprehensive range of services required; they are limited in their capacity to provide for any significant volume of the population in need; and they have no geographic coverage. Where they do exist, the services are fragmented and are decreasing rather than expanding.

Turning to the elderly as a special consumer of home health services, we should look at a number of characteristics,

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First, up to 40% of the elderly have a chronic ailment that limits their abilities. This is a key point. We're speaking about a segment of the population that would need home health services, or some form of services. In testimony before the Senate Special Committee on Aging, Dr. Levine of the New York City Health Department pointed out that ambulation is the number one reason for elderly patients to be put into institutions. The second reason is mental incapacity. Obviously, if ambulation is one of the key reasons for institutionalization, it would appear logical that if you had home health services available, you would decrease the need to institutionalize the individual.

Second, we realize that the oldest segment of the aging population, those 75 and above, is the fastest growing percentage segment, given aging demographic characteristics. This is the segment of the aging population most prone to chronic disease and chronic ailments. Recognizing these growth patterns in the elderly would mean there probably would be a greater need for some form of home health services.

Third, we know the elderly have multiple illnesses and with the multiple illnesses—especially in chronic capacities—there is a greater need for some form of services.

Fourth, there are a number of social issues beyond the health spectrum—such as nutrition, isolation and boredom—which affect the elderly consumer. NIH did a study that pointed out a direct relationship between morbidity and boredom or pattern of daily concern in the environmental and economic areas.

Fifth, the elderly face almost insurmountable socio-economic problems. Insufficient income is a continual issue in the aging spectrum. With regard to housing, a Brandeis study pointed out that housing could be one of the major concerns in the lack of home health services because the older person with insufficient income cannot have, cannot maintain, a dwelling to live in. We've seen some positive changes within federal housing legislation that we now hope to see implemented, some day, by the Department of Housing and Urban Development.

Taken as a whole, all of these characteristics mean that the consumer is there. There are a number of individuals who need home care services.

MENTAL HEALTH

Both of our Associations' stances concerning mental health programs which were incorporated in H.R. 2954 are specific recommendations of the 1971 White House Conference on Aging.

With respect to the strengthening of requirements for community mental health centers to attend to the special needs of the elderly, it is important to reiterate the statement of Dr. Levine of the New York City Health Department before the Senate Special Committee on Aging: the second cited reason for institutionalization of the elderly is mental incapacity. Obviously, if we are to develop a health care system built upon quality economical care, then it is in the public interest to stimulate preventive screening and out-patient treatment of mental illness at the earliest stages. Specifically, it has been estimated that while people 65 years and over constitute 10% of the U.S. population, they comprise only 2% of the patients given outpatient mental health services but 22% of annual mental hospital admissions. This hardly indicates an optimization of our scarce resources.

The introduction of the paper on Mental Health Care of the Elderly prepared by the Committee on Aging of the Group for the Advancement of Psychiatry gives a feeling of the mental health issues:

"The mental health needs of the elderly have received some attention in recent years but the substantial additions of funds, personnel, and facilities to meet those needs have not been forthcoming. Medicare and Medicaid have helped; however, there are severe limitations and major defects in their provisions for mental health. The potential of comprehensive mental health programs—from home care to institutions—has not been realized. Rather, we find that older patients do not receive early and adequate care in the community but tend to be institutionalized in mental hospitals, nursing homes, and other care facilities with little likelihood of discharge. Furthermore, older patients are being increasingly pushed from inadequate mental institutions into other inadequate custodial facilities."

Research indicates a general correlation between age and psychopathology in general and depression in particular. Suicide, too, increases with age and attains its highest level in white males above age 65. Furthermore, as pointed out above, the complications of multiple illnesses, especially as a cause of chronic

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disability, are age-related and these conditions are directly related to the mental health of the person.

Pointing out these relationships, the handbook given to delegates of the 1971 White House Conference on Aging concluded that there were a number of specific gaps in the delivery of mental health services to the elderly. The enumerated problems were: (1) discontinuity and fragmentation of care, (2) inadequacies in residential and outpatient programs, (3) lack of adequate Medicare and Medicaid coverage, and (4) inadequate financial support for mental health programs. An evaluation of the present status of mental health care by our Associations indicates that the conclusions of the 1971 report remain unchanged. Efforts to instill a positive public program to meet mental health needs have failed. Initiatives have been frustrated by budgetary restraints, inadequate planning, competing priorities, administrative and regulatory red tape, and shameful neglect.

Writing recently in Newsweek, Shana Alexander, the noted syndicated columnist, educated her readers to the reality of mental health and the elderly:

". . . here in what I have called Kids' Country, we worship youth and prefer our old people to remain invisible, out of sight and out of mind. In all of Kids' Country there is not a single university or medical school chair of geriatric medicine nor any related chair in psychiatry. Less than 3 percent of National Institute of Mental Health funds are spent on geriatric problems. . . . The mental health of the elderly is an even gloomier uncharted sea. Depression and anxiety states are commonplace. People over 65 account for more suicides than any other age group. Twenty-five percent of total suicides is the usual figure given, but it is probably higher. Many such suicides can be classified as "rational" in the sense that as people grow older they have more and more to be depressed about. Continuing loss of loved ones, grief, increasing isolation, fear, and anxiety about doctors and disease, financial worry, and reluctance to see one's life savings dissipated on one's own prolonged demise are entirely realistic reasons to despair."

Our Associations can add little to this commentary except to confirm its content. There is a need to develop a national strategy to meet the mental health needs of older persons. These conditions must receive attention equal to that given the physical health needs. Our Associations believe that mental health needs of older Americans are not being met. The enactment of both Title III and Section 603 of H.R. 2954 is a necessity.

In closing, our Associations wish to reiterate the view that long range policy objectives which are cost-conscious should not be thwarted by short range economies. Our support of the home health and mental health amendments to H.R. 2954 are not only responsive to the identified health needs of older Americans but are predicated on the development of a full spectrum of health services within our nation. Our Associations are concerned that the elderly are not utilizing the kind of health services they probably need to the extent necessary, with the possible exception of acute inpatient hospital care. Despite increased social visibility and increased levels of public funding in their behalf, there is ample evidence to indicate that the aged, and particularly the chronically ill and disabled, have not been particularly successful in securing appropriate health services. The misallocation of resources has created the unfortunate circumstances of skewed attention to the acute episodic needs while the equally important chronic ailment needs have been neglected. H.R. 2954 offers a positive approach to developing those resources currently underutilized.

STATEMENT OF JOHN J. MCCARTHY, JR., M.D., PRESIDENT, BOARD OF DIRECTORS, NATURAL FAMILY PLANNING FEDERATION OF AMERICA, INC.

The Discrimination Being Perpetrated Against the Users of Natural Methods of Family Planning Under the Family Planning Services and Population Research Act of 1970

Because of an apparent misunderstanding of the intent of Congress, DHEW has perpetrated an interpretation of the Regulations regarding the implementation of the Family Planning Services and Population Research Act of 1970 which has prevented hundreds of thousands of women from receiving the family planning services they both need and want. The Congressional purpose was made very specific when it declared that the reason for the Act was "to assist in making comprehensive voluntary family planning services readily available to

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all persons desiring such services." Unfortunately, this purpose has not been fulfilled because of contradictory interpretation of the Regulation.

I. TWO SETS OF STANDARDS

DHEW has established two sets of standards for the provision of family planning. The first set of standards, applied to the providers of various types of artificial contraception, are so flexible as to allow over 90% of the funds to be used for these methods. The second set of standards have been drafted for the providers of the natural methods. These are so restrictive that it is almost impossible to secure funds under this Act.

A. Funding discrimination

When making inquiry to DHEW for a constituent concerned about the need for natural family planning services in Texas, Senator Tower received the following reply from Paul B. Batalden, M.D., Assistant Surgeon General, Director, Bureau of Community Health Services:

"The Title X Regulations published in the Federal Register on September 15, 1971, to implement the Act's program for the support for family planning service projects require, in part, that a family planning project to be eligible for support under the program of assistance established by the Act, must provide 'for use of a broad range of medically approved methods of family planning including the rhythm method.' Hence, an agency which provides instruction in the rhythm method of family planning but does not also make available other forms of family planning services cannot qualify as a grantee under Title X and the attendant regulations."

Subsequent correspondence with Carl Shultz, M.D., Director, Office of Population Affairs, DHEW attempted to point out that the proposal in question was submitted "to see that the existing legislation is carried out by providing the means whereby those seeking the natural methods of family planning may receive this service." The rationale submitted with the letter pointed out that "the regulation quoted by Dr. Batalden was, in fact, not being met in Region VI." No effort was made to rectify the lack of provision of "the rhythm method" in this Region nor were any steps taken to cut off the funds from these programs. This Region is not the exception, but the rule. Similar discrimination occurs in every Region. To date no official explanation has been received from the appropriate DHEW office regarding this one-sided interpretation of the Regulations, i.e., if you provide artificial contraception but not "the rhythm method" you can be a grantee, but if you provide the "rhythm method" but not artificial contraceptives you cannot.

In practical application this dual understanding of the Regulations has resulted in less than $350,000 being awarded for natural family planning services in FY74 while over $90,000,000 of Title X appropriations were invested in the provision of artificial contraception.

B. Quality assurance

Title X Regulations are very specific in their delineation of the minimum quality assurance standards that must be met by a project applicant. They require family planning medical services to "be performed under the direction of a physician with special training or experience in family planning" (59.5(a)(6)), that all project personnel be adequately prepared through "pre- and in-service training" (59.5(c)), that the provision of medical services related to family planning including physician's consultation, examination, prescription, continuing supervision, laboratory examinations, contraceptive supplies, and other necessary referral to other medical facilities when "medically indicated" (59.d), and that provision be made for "effective usage of contraceptive devices and practices." (59.5(p)). Additional sections outline other quality assurance aspects of the program.

On March 31, 1972 the National Center for Family Planning Services circulated an interim statement of standards entitled "Preferred Standards of Health Care in Family Planning Programs." Although never adopted as policy, they do reflect the dual standard applied to the two methods. For artificial contraceptives, a carefully spelled out program of prescription and follow-up is detailed. The natural methods are subsumed under diaphragm, foam, condom, rhythm with the statement—"Lack of patient acceptance is the only usual contraindication to the use of these methods." Further, regarding follow-up, the

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instructions read "Other methods: Other methods do not require a follow-up visit for medical review or examination prior to the required annual visit."

The natural methods require a very specific follow-up regime for the user. This follow-up requires a team approach in many instances of M.D., nurse, and teaching couple. At a minimum, the follow-up must be carried out by an R.N. or a carefully trained social worker. Perhaps the best illustration of the dual approach to quality care was the statement made by a Federal official on January 28, 1975 when it was pointed out that in a specific community natural family planning was not available. The reply was that the patient had only to write to the Regional Office of DHEW and information would be provided. In the event there were no providers in her area, "correspondence courses would be supplied."

Obviously, if members of the national staff of DHEW perceive that natural family planning can be handled by "correspondence courses," providers of care hold the same opinion. This complete disregard of the Regulations, but more importantly of people's lives and their freedom of choice, is appalling.

II. DIGNITY OF THE INDIVIDUAL

The intent of Congress as expressed in the original legislation and reflected in the Regulations by DHEW was to protect the dignity of the individual and to protect the right of choice. The Regulations deal with three main areas of patient safeguards—civil rights (59.5(a)(2)), individual dignity (59.5(a)(3)), and protection against "any coercion to receive services or to employ or not employ any particular method of family planning . . . (59.5(a)(8)).

Two major groups of potential users of the natural methods have been denied services. The first of these are low-income Catholic women who for moral reasons have chosen to follow the dictates of their consciences. In order to secure care, they must look for assistance from agencies providing services which are contrary to their religious beliefs. Although they would prefer to go to a Catholic hospital, for example, they cannot because the hospital cannot secure funding under the present interpretation of the Regulations. If they do request the natural methods, they are usually given a booklet on the failure of calendar rhythm or they are given the choice of artificial contraceptives or sterilization. To receive any service they are forced to choose between an outdated form of natural family planning and morally unacceptable means of family planning. In some instances requests for the natural methods are met with "you're kidding," or other sarcasm.

The second group of potential users are those who have been instructed by their physician to go off the pill or IUD. When they ask for help at the family planning clinics they find none. They cannot secure care unless it is a pill or some other medical means of contraceptive. When these alternatives have been exhausted, they are left without any method at all. On the other hand, natural family planning agencies which cannot for moral reasons refer a patient for other methods are denied the opportunity even to provide service to those seeking natural family planning methods. What further compounds the problem of obtaining natural family planning services is that the family planning clinics with no particular moral convictions deny natural family planning services by failure to make proper referrals to agencies offering such care. These agencies are not disciplined by DHEW. Yet when an agency providing natural family planning services indicates that they cannot make referrals because of moral conviction, they are denied funding.

Thus, not only are patients forced to violate their moral convictions, but agencies as well. The question must be raised on this dual type of interpretation. Why must an agency or individual be imposed upon because of religious or moral convictions while those without any apparent conviction can stand in violation of the Regulations? This has been brought to the attention of DHEW, but no known case or complaint has been followed up with a field visit or program evaluation.

III. PURPORTED LACK OF DEMAND FOR SERVICE

Potential providers are being continually told by DHEW that because there is no demand for natural family planning services no programs have been developed or likewise need to be funded. Yet, using DHEW's own demographic formula, over 900,000 low income Catholic women want and need natural family planning services. This number does not include many other groups that for medical reasons want a natural alternative. Although Congress has asked by legislation for the submission of a yearly update of a five year plan by DHEW on which to

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base its legislative action for the coming year, it has not been informed through this document as to the need for natural family planning services. Further, because no natural family planning services have been made available under this Title, the impression is given that people only request artificial contraceptives. Yet in the same time period as that for which the legislation has provided funding, over 200 natural family planning groups and agencies have sprung up in the United States to meet what the DHEW records would show as no demand. Only six of these agencies can be identified as receiving Title X funds. Of the six, two receive less than $20,000 a year, three less than $40,000, and one less than $80,000.

IV. THE RHYTHM METHOD

One additional concern must be shared in this document. The Regulations refer to the provision "of a broad range of medically approved methods of family planning including the rhythm method" (59.5(6)). Two specific problems are raised by the terminology. The first is that in the natural family planning field rhythm is a technical term used to define calendar rhythm. Although DHEW sought to choose a term to describe the natural methods, it could not have picked a worse designation. Calendar rhythm is an outdated prototype of the natural methods, has had limited success, and in the minds of many is associated with a high rate of user failure. The second problem is more serious. Because the term has developed such negative associations, most family planning programs refuse to provide this type of service. In addition, they do not offer the other methods of natural family planning because they have not received information, in-service training, or education in the effective methods of natural family planning. The term "rhythm" has so stereotyped a particular result that a blind spot has developed which DHEW has not sought to eliminate.

Summary

The obvious misunderstanding of the natural methods by DHEW has led to a double standard of project funding on quality and patient care. It has in fact prevented the intent of Congress from being carried out. Specific legislation is called for which will allow the over 900,000 low income women who want to use the natural methods to receive subsidized quality care.

STATEMENT OF MRS. MARJORIE GUTHRIE, PRESIDENT AND FOUNDER, AND RICHARD BRANAGHAN, EXECUTIVE DIRECTOR, COMMITTEE TO COMBAT HUNTINGTON'S DISEASE

NEEDED: A NATIONAL COMMISSION ON HUNTINGTON'S DISEASE

Chairman Rogers and members of the subcommittee, we deeply appreciate the opportunity to testify on behalf of the need to establish a National Commission. I am Richard Branaghan, Executive Director of the Committee to Combat Huntington's Disease. With me is Marjorie Guthrie, President and Founder of the Committee, whose husband, Woody Guthrie, was one of the finest balladiers and entertainers in the nation prior to the time he fell victim to Huntington's Disease.

Woody Guthrie also gave this country a song, "This Land is Your Land, This Land is My Land . . ." which, in a sense, has become a national anthem for young people throughout our country. He was recognized by the U.S. Department of Interior on April 6, 1966, by being awarded the Conservation Service Award. The Honorable Stewart Udall, then Secretary of the Interior, stated in a letter accompanying the award: "In conjunction with this award, we are also naming a Bonneville Power Administration Station in your honor. It will be known hereafter as the Woody Guthrie Substation in honor of the fine work you have done to make our people aware of their heritage and their land".

Marjorie Guthrie began work to assure that research and care programs would be developed to prevent and cure Huntington's disease and founded the Committee to Combat Huntington's Disease.

Mr. Chairman, I would like to give you some information about the legislative situation regarding Huntington's disease, as well as insert a background statement on the disease published as part of the 1974 Reserve Program Report of the National Institute of Neurological Diseases and Stroke. Marjorie Guthrie will then tell you about the impact of the disease itself, and how little has been done to find a cause and cure.

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At the end of last year, President Ford vetoed the Health Revenue Sharing and Health Services Act of 1974, which contained a provision which had been agreed to by the Senate-House conference on the bill, which was worded as follows:

"COMMISSION FOR CONTROL OF HUNTINGTON'S DISEASE

"SEC. 605. (a) The Secretary of Health, Education, and Welfare shall establish a temporary commission to be known as the Commission for the Control of Huntington's Disease and Its Consequences (hereinafter referred to in this section as the "Commission").

(b) It shall be the duty of the Commission to—

(1) make a comprehensive study of the state of the art of medical and social management of Huntingtons disease in the United States;

(2) investigate and make recommendations concerning the proper roles of Federal and State governments and national and local public and private agencies in research, prevention, identification, treatment, and rehabilitation of persons with Huntington's disease;

(3) develop a comprehensive national plan for the control of Huntington's disease and its consequences based on the most thorough, complete, and accurate data and information available on the disorder; and

(4) transmit to the President and the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House of Representatives, not later than one year after the date of enactment of this Act, a report detailing the findings and conclusions of the Commission, together with recommendations for legislation and appropriations, as it deems advisable.

(c)(1) The Commission shall be composed of nine members to be appointed by the Secretary of Health, Education, and Welfare. Such members shall be persons, including consumers of health services, who, by reason of experience or training in the medical, social, or educational aspects of Huntington's disease, are especially qualified to serve on such Commission.

(2) The Secretary shall designate one of the members of the Commission to serve as Chairman and one to serve as Vice Chairman. Vacancies shall be filled in the same manner in which the original appointments were made. Any vacancy in the Commission shall not affect its powers.

(3) Any member of the Commission who is otherwise employed by the Federal Government shall serve without compensation in addition to that received in his regular employment, but shall be entitled to reimbursement for travel, subsistence, and other necessary expenses incurred by him in the performance of his duties on the Commission.

(4) Members of the Commission, other than those referred to in paragraph (3), shall receive compensation at rates, not to exceed the daily equivalent of the annual rate in effect for grade GS-18 of the General Schedule, for each day (including traveltime) they are engaged in the performance of their duties and, while so serving away from their homes or regular places of business, each member shall be allowed travel expenses, including per diem in lieu of subsistence in the same manner as is authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

(d) The Commission shall cease to exist thirty days after the submission of the final report required by subsection (b)(4)."

We must, however, express a concern that the legislative language appearing in the bill would not serve the purpose intended. Simply put, there is no authorization for appropriations in the language. Thus, there really is no way for the Commission to become operative. There will be no staff, no money to pay for consultants or members of the Commission, and no money for studies.

The bill, then, must contain language including the following elements:

(*a*) authorization for the Secretary of HEW to carry out the functions of the Commission, including hiring staff, and making grants and contracts;

(*b*) language indicating that such sums as necessary may be appropriated to carry out the functions of the Commission.

This provision would be very helpful to all those concerned with Huntington's Disease. Of course, we had been hopeful earlier that the amendment to the Senate-passed bill, sponsored by Senator Clark of Iowa, and which had 21 cosponsors, would be agreed to by the House. Because we had no opportunity to appear before your subcommittee, inasmuch as the bill immediately went to conference after Senate passage, we could not make the case before you for acceptance.

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We realize the severe economic situation today would mitigate against passage of that full amendment, and we are aware of the arguments of your committee against its approval at this time. We feel certain, however, that if the proposal for the Commission is agreed to by this committee, as it was before in the House-Senate conference, and if the bill is signed by the President, that the commission's findings will give the compelling evidence to assure the interest and action of the Congress on the larger program.

So that the members of the Congress will be able to learn more about Huntington's Disease, I insert now the NINDS statement.

Special Report: Huntington's Disease

Huntington's disease is a hereditary disorder characterized by a combination of physical and mental symptoms, either of which may appear before the other. Often, however, the physical symptoms come first, and usually between the ages of 35 and 40, by which time the individual may have passed the disorder on to several children.

Early symptoms may be confused with fidgety nervousness. The uncontrollable chorea may show itself as abnormal involuntary movements, such as jerking, twisting and spasms of the muscles of the face, tongue, neck, trunk, arms, and legs. As symptoms become more severe, the patient may have trouble swallowing and may be unable to speak.

Huntington's disease also may begin with distressing personality changes, such as indifference, dullness, irritability, poor judgment, loss of memory, and carelessness about personal looks and habits. Outbursts of violence may occur, alternating with periods of short-lived depression. In later stages the patient may become profoundly demented.

Huntington's disease is passed on through an autosomal dominant gene, which means that each offspring of an affected person has a 50 percent risk of having the disease. Males and females and all ethnic groups may be affected.

If a person does not show symptoms by age 35, the probability of his having the disease diminishes with each succeeding year. In very rare instances, however, individuals over 70 years old have been known to develop the Hungtington's disease symptoms.

Prevalence

Because of its hereditary nature and categorication as a "mental" disease, families have hidden its existence for centuries and it is almost impossible to assess accurately statistics regarding the prevalence of Huntington's disease in the United States.

A review of a number of studies on the prevalence of Huntington's disease in various world populations indicates a fairly uniform distribution which would mean that about 10,000 to 14,000 Americans have Huntington's disease symptoms. However, since the establishment of the Committee to Combat Huntington's Disease (CCHD), incoming letters, phone calls, and personal contacts have led the CCHD to believe that three to four times this number may have been the Huntingdon's disease gene and either have Huntinton's disease symptoms or will eventually develop symptoms.

Diagnosis

There is, as yet, no means to test and identify persons with Huntington's disease before symptoms become apparent. The diagnosis of Huntington's disease is usually based on the clinical findings of dementia, and chorea, and positive family history. The insidious onset of involuntary movements is unlike most other forms of chorea and can aid in the identification of the disease.

Early detection

Early detection of Huntington's disease may be helped by knowledge of the family history and the expected age of onset from that in older siblings. Investigators report that the mothers of some large chroeic families may be able to sense which children will develop the disease, and later events prove them to be correct.

Advances in diagnosis

Preliminary findings from several federally supported laboratories have sparked the hope that a test for the early detection of Huntington's disease is near.

In one collaborative study investigators have described a predictive test based on the observation that the drug levodopa aggravates choreiform move-

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ments in patients with Huntington's disease and might bring out undetected chorea in asymptomatic victims. When the effects of oral levodopa were compared in offsprings of choreics and controls, the children of choreics developed facial twitches and involuntary movements while controls remained unaffected. It has not yet been proved that indivdiuals developing chorea with this test will develop the disease later, nor that those in whom the test is negative may not develop it in time. The National Institutes of Health is presently supporting research to investigate the effectiveness of such a test. If this predictive test proves reliable, it should be of considerable value in eliminating the disease. Attempts are now being made to refine the L-dopa test to find biochemical changes that occur without concomitant physical symptoms.

Other preliminary reports indicate that it may eventually be possible to detect Huntington's disease using less drastic approaches. National Institute of Neurological Diseases and Stroke (NINDS) grantee scientists in California have found that a certain type of cell (fibroblasts) taken from pateints with Huntington's disease and cultured in the laboratory do not survive as long as cells from normal individuals cultured under the same conditions. This difference in cell life span may be useful in identifying Huntington's disease very early in presymptomatic victims. It is also hoped that such a test, if successfully developed, could be extended to intrauterine tests to detect Huntington's disease in the fetus.

While the development of a test to identify carriers before symptoms occurred would, of course, be of considerable value in genetic counseling, the question has been raised by a recent NINDS survey whether individuals who risk developing the disease would choose to know if they carry the defective gene. In the study 23 percent of the high-risk respondents—those under age 45 with a Huntington's disease parent—indicated that they might refuse to take a simple and safe predictive screening test if one is developed.

Cause

Until now the nature of Huntington's disease has been poorly understood. However, a recent report from a group of Canadian researchers may change this status. They found that the brains of patients who had died of Huntington's disease were deficient in a compound called gamma-aminobutyric acid or GABA. It is believed that GABA inhibits neural transmission in the brain and that a deficiency might produce the symptoms characteristic of Huntington's disease.

Support for this hypothesis recently came from a group of English scientists who reported a reduction in the activity of an enzyme (GAD or glutamic-acid-decarboxylase) in the brains of Huntingtons disease victims. The reduced activity of this enzyme which is involved in the production of GABA indicates that certain GABA-containing nerve cells in the brain are malfunctioning.

Treatment

It is hoped that these exciting leads into the biochemical nature of Huntington's disease will pave the way for the development of a successful treatment. Until now the treatment for Huntington's disease was directed toward improving the involuntary movements of the patients. Presently a number of laboratories are directing their studies toward the evaluation of GABA as a therapeutic agent and correction of what appears to be the basic biochemical abnormality of Huntington's disease.

In one promising pilot study, two of seven Huntington's disease patients given large doses of GABA has shown striking improvement, one patient has shown moderate improvement, and the remaining four have remained unchanged.

At the National Institute of Mental Health, scientists have synthesized a compound similar to GABA, but which may pass through the blood-brain barrier and enter the brain more readily than GABA. It is hoped that this agent will help "correct" the GABA deficiency and improve the patients' condition.

Research

The Department is presently supporting several types of research through the National Institutes of Health and the National Institute of Mental Health of the Alcohol, Drug Abuse, and Mental Health Administration, aimed at finding the cause, cure, and treatment of Huntington's disease and at disseminating information materials relating to it.

The NINDS funds seven regular research grants, a portion of a Program Project and Categorical Clinical Research Centers, and two collaborative studies at $416,000.

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Other research studies relating directly to Huntington's disease include six General Clinical Research Centers, funded by the Division of Research Resources at $78,787, and a portion of two Program Projects and Categorical Clinical Research Centers funded by the National Institute of Arthritis, Metabolism, and Digestive Diseases, and by the National Institute of Child Health and Human Development at $35,000.

In addition to these programs relating directly to Huntington's disease, the NINDS has an extensive program of basic research funded at $13,475,000, which is important in understanding the nervous system and the disorders which interrupt its normal functioning.

The Institute works closely with the Committee to Combat Huntington's Disease (CCHD), a voluntary health organization that encourages research in Huntington's disease. The CCHD plays a vital role in disseminating information about the disease and in providing psychological support for members of families affected with Huntington's disease. The Institute also has prepared a pamphlet for the public describing Huntington's disease and outlining current research which gives hope for the future. In writing the pamphlet, NINDS worked closely with CCHD. (End of text of pamphlet.)

May I now introduce Marjorie Guthrie to you.

Mr. Chairman, and members of the subcommittee, I am Marjorie Guthrie, President and Founder of the Committee to Combat Huntington's Disease. Huntington's disease has a long and tragic history. There is evidence that as long ago as the early 1600's families suffered with a strange disorder which was passed from one generation to another. The "victim" looked peculiar as he moved with twitching and uncontrolled jerks. There were facial grimaces and tongue movements . . . and as the deterioration continued, as it was believed that these persons were "tortured souls", "possessed by the devil", and "witches!". They were ostracized . . . even burned at the stake in New England.

Who were these strange people who had lived productive lives in the community for 30 or 40 years, bore healthy children, were good church going people and now became irritable—sometimes violent—persons? As they struggled to walk down the road, frequently they were taunted . . . "too much to drink!", "can't keep himself together!", "look at his clothes all falling off!". And when the frightened victim realized his physical deterioration, he perhaps remembered that this is what he saw happen to one of his parents; he ran away to hide—or even commit suicide. The families were ashamed of the victim and lived in fear that one day this could happen to other members of the family.

We know today, that these victims were suffering from Huntington's (chorea) disease. One group came to the United States from England, another from Holland. Both groups multiplied . . . spreading out across the country until today there are HD families living in every state of the nation.

1872, Dr. George Huntington, who had seen these families as he travelled with his father and grandfather, both physicians, wrote:

"The hereditary chorea . . . is confined to certain and fortunately a few families, and has been transmitted to them, an heirloom from generations away back in the dim past. It is spoken of by those in whose brain the seeds of the disease are known to exist, with a kind of horror, and not at all alluded to except through dire necessity, when it is mentioned as "that disorder" . . . When either or both parties have shown manifestation of the disease . . . one or more of the offspring almost invariably suffer from the disease, if they live to adult age; but if by any chance these children go through life without it, the thread is broken, and the grandchildren or great grandchildren of the original shakers may rest assured that they are free from the disease."

Today "that disorder" continues to multiply and haunt every member of an HD family. What was once called a rare disorder has now become known as the "not-so rare, rare disease" of the nervous system . . . with full penetration. Not only is the patient suffering . . . but all family members are acutely aware that they are potential victims all their lives. Our Committee is searching nationwide for these sufferers, and because we know now that there are also children with Huntington's disease who are often misdiagnosed as epileptics or schizophrenics. And while Dr. Huntington described one kind of Huntington's we know now that there are various forms of expression, even within the same family. For example, because a 4 year old child was diagnosed as having the illness, we were able to trace 80 additional "at-risk" members in this one family. In a family of 12 children, in upstate New York, 4 children have already been diagnosed as patients with HD.

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Let me go back a bit . . . and tell you HOW I learned these facts. When I met my husband, Woody Guthrie, he had already made his first recordings and was writing the story of his life . . . his autobiography. He would write by hand during the day and when I returned from my rehearsals as a member of the Martha Graham Dance Company, he would read what he had written and I would type the days work. One day, he wrote about his mother's illness. He described the sadness that seemed to overcome her as the family suffered a series of financial losses, and the death of his sister from fire at the age of 12 as their home burned to the ground. Often his mother would disappear only to be found hiding out in the local movie house. People talked about Nora Belle Guthrie as she staggered down the street, clothes all in disarray. And when she became angry and irritable, Woody wrote that she "threw" the dishes across the room and overturned the furniture. Papa had threatened to take her to the "insane asylum" so the children would straighten up the house before Papa returned. But as she deteriorated the day came when she was committed to the Norman State Hospital of Oklahoma, where she died.

Of course, I know now that what Woody had written about his mother was what a child saw. His mother did not throw dishes . . . but probably was trying to drink or eat and the involuntary movement jerked the dishes out of reach. She overturned the furniture because her staggered walk could not control her body movements.

As Woody read and I typed, I began to wonder . . . and I asked him if he could get sick like his Mama, and did he know what was the matter with her. He told me, "Oh no, Mama had Huntington's Chorea and only females can get this kind of sickness!" And we went on working.

I remember going to a local library . . . read a few words . . . but felt reassured that he would not have to worry when we have our children, just as Woody had said. Years later after being hospitalized several times . . . after being diagnosed an alcoholic . . . after threatening suicide . . . Woody was admitted to Bellevue Hospital in New York City. He was examined and was confined for several weeks in the locked psychiatric ward for observation. I came to visit regularly and then one day he surprised me. He called on the phone and said that the doctor told him to go home. I called the doctor in charge of his ward and questioned him. I will never forget his reply. He said, "Your husband is a very sick man, and we don't know what to do with him!" I remember, I answered . . . "And what do you think I am going to do with him?" My children were then just 2, 3, and 4 years old.

After leaving Bellevue Woody continued to deteriorate. Eventually, we came crying to Brooklyn State Hospital, begging for some determination of his illness. None came. Eventually, it was recommended that he receive shock therapy and while waiting for an available bed, a young doctor made the diagnosis of Huntington's Chorea. We were both stunned. Impossible! Only females get Huntington's! We were wrong and we know now that both men and women can have HD.

Woody was hospitalized over a period of 15 years . . . the usual expectancy. When he could no longer walk he was tied into his wheelchair. When he could no longer speak, we made three cards—YES, NO, ?—and he would answer my questions by "hitting" the card. I learned that he did not feel pain. I fed him when he was hungry or thirsty. I would wheel the chair out to the terrace when he answered that he would like to see the sky or trees again. When I was unsure of his answers because the movement became so uncontrolled, I began to use "eye blinks" . . . one or two to mean "yes" or "no". When the doctor asked me if I thought my husband really understood what I was saying, I asked him to stand with me and see the expression on Woody's face as he smiled back or indicated through his eyes the reality that this was a whole man . . . living inside the prison of his body . . . and NOT a mental patient! A man who could think and dream and remember and feel—with special needs—but unable to tell anybody anything! This was the tragedy of Huntington's!

I had been told many times that there was nothing to be done. I heard the words "hopeless" and "helpless" over and over again. I worried about my children. What could I tell them? What was wrong with Daddy? How could I tell them that they too might suffer the way he did? And then . . . I woke up out of my nightmare. I told Woody, "If you could tell me in some way about what is happening to you, maybe we could tell the doctor. We could get him interested in trying to help." This was the beginning of doing something.

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I realized then that doing something made me feel better and there must be others who felt as I did. With help from Dr. John Whittier who had already transferred Woody to Creedmoor Hospital, I began to read the scientific literature. Dr. Whittier and I talked and he helped me to understand what was happening and just a few months before Woody died we started the committee to combat Huntington's disease. We did not use the name chorea because there was already evidence that not every patient has the chorea like movements (children often are stiff) and the Huntington gene with its various forms needed a more encompassing name. Huntington's is a disease.

I learned that no one knows how many families are affected with HD. And to support the theory that it was more widespread than anyone believed, especially because of the uniqueness of it being "hidden" for so many generations. . . . I began to travel to look for HD families. I visited patients at home, at meetings, in hospitals. I found some, but we believe that the facts are still unknown. Our Committee has a mailing list today of over 10,000 names of families who have written to us for information. Half of them have identified themselves as members of an HD family. Some have requested that information be sent with no identifying return name or address. Others have asked that information be sent to "my friend". With our limited resources, we believe that we have just touched the tip of the iceberg!

We keep a careful count and try to document the information that our families hesitantly share with us. For every letter that we receive about an individual, we learn that we are "unearthing" not just one HD patient but perhaps 5 or 20, or as in the child, where we found 80 others, who are or might be affected with HD. We know from prominent physicians that because the picture has been so devastating many doctors withhold the diagnosis of HD even though the diagnosis has been confirmed. Yes, some doctors feel that since they have nothing to offer the patient it is best to "say nothing". Those of us who are aware of recent advances in medicine feel that the disease MUST be openly discussed in order to encourage research. Dr. George Paulson states, "The statistics would be better if we had a sure treatment and everyone had a cure to gain in exchange for reporting the disease!"

One surprising statistic that is available—In a survey of all 168 VA Hospitals, we have located almost 500 known identified HD patients—costing an estimated $6 to $10 million dollars a year for their care. Since few physicians have seen or recognized a case of HD and because of the secrecy surrounding this disorder we can be sure that even within the VA the statistics are misleading. This is one of the major unique reasons why we need a special commission on Huntington's Disease. We have the task of identifying and educating not only the HD families but also supplying new information to physicians, the social workers, and all the other health professionals who might come in contact with an HD family, or a family that "appears" to be an HD family with no family history available.

As the disease progresses many families disintegrate. Patients have been deserted. Children are sent out for adoption because there is no one at home to care for them . . . sometimes with and sometimes without the family background. The financial burdens on the family are disastrous. Suicide is not uncommon. Recently in the Los Angeles Times, December 29, 1974, there appeared an article entitled The Poignant Anatomy of a Suicide. This young man jumped to his death and left a note that said, "Gentlemen: Please contact my attorney." The article stated:

"Franklin had, or worse yet, thought he had Huntington's Disease (HD). He had watched his father die two years ago from HD, a genetic disorder so terrible his mother called the death 'a blessing'. To a man like Franklin who appeared to be in control of any situation, who more than a half dozen friends described as 'calm, self-composed', such suffering would be unthinkable. The puzzler is, did he really have the disease? Or only the terror of it? The tragedy beyond his death is the possibility he may have passed the potential for HD to his daughter. Now, how will she know?"

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The cost in suffering can not be measured, but the cost to society for the care of the HD patient and his family needs to be surveyed. We believe that with proper care and a better understanding of the course of the disease, more patients might live at home and become less of a burden to themselves and their families if we had better medication to control the involuntary movement. It will take RESEARCH and experimentation to find these drugs.

Our families are offering tissue, blood, spinal fluid . . . themselves to investigators. There is every reason to believe that, as in many other genetic disorders, we might someday find the key to early diagnosis or intra-uterine diagnosis. CCHD has pointed the way. We have located HD families not only in every state but have organized them so that they can be available to scientific investigators. We now have 50 chapters as well as affiliates in England, Scotland, Austria, Canada and recently we started the Huntington Liga in Belgium.

Many scientists agree that the two great frontiers of research today are the study of man's brain and his genes. I quote from a recent review in the Lancet of the first complete text book devoted to this disorder: "One cannot escape the feeling that this disease of Huntington's Chorea is a key one and its final solution will have wide implications in brain research." HD has significant relationships with the aging process, with Parkinsonism, multiple sclerosis, muscular dystrophy, myasthenia gravis, and many other similar genetic and neurological disorders.

We believe sincerely that our common effort in support of basic research pertaining to the human brain and the study of genes has helped to bring about a new surge of interest in an area of research hitherto almost completely neglected.

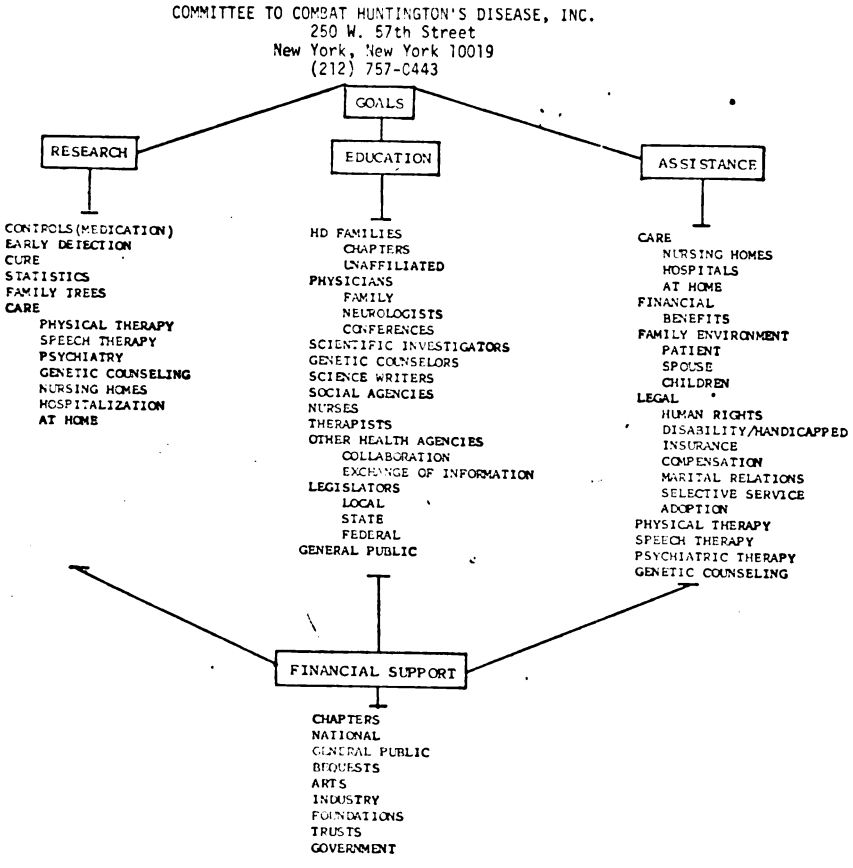
We want to continue that effort, however, we feel that we must not neglect those areas of research that could bring some measure of hope to the HD families. It will take a special Commission to plan the attack against HD. We need this special task force to work out the short-range plan and the long-range plan against this disease. We need to establish scientific methods for identification, early detection and the control of HD. And then we will need to establish a network of cooperating centers for the clinical research and proper care facilities for all who are affected. One of the responsibilities of the Commission must be to examine and establish guidelines as to what proper care should be for the HD patient and his family. Dr. Andre Barbeau, an active research investigator in this field, has explained that, "this disease can be easily defined and characterized, as opposed to heart disease, which may have hundreds of causes" and thus research may be specific and direct . . . and may open the door to relieve the suffering of millions of Americans who are living with these major genetic, neurological cripplers.

CCHD can no longer carry the burden alone. We believe that a commission on Huntington's disease could help elucidate, evaluate, and coordinate the kind of questions that might lead to some of the answers.

I ask your permission to insert the attached chart, which explains our goals in research, education, and assistance to the victims of this disease.

Thank you very much for your attention.

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Statement of the National Hemophilia Foundation

Mr. Chairman and members of the Subcommittee: The National Hemophilia Foundation[1] is pleased to state its views on the legislation now before the Subcommittee on Public Health and the Environment, The Health Revenue Sharing and Health Services Act of 1975. Over the past several years we have dealt with a number of the members of this committee, and always have been pleased with the openness and receptiveness of the members and their staffs about the difficulties experienced by the hemophiliacs in this country.

In particular, Mr. Chairman, we are pleased and grateful that you decided to include in the bill you introduced, and upon which these hearings are held, those sections of the bill concerning hemophilia which were in the bill passed last year by the House and the Senate and which was vetoed by the President in the closing days of the last Congress. Needless to say, that veto was a bitter disappointment to the hemophiliacs of this nation.

Last year we were hopeful that the House members of this subcommittee who attended the Senate-House conference on the bill would have been able to accept the Senate-passed version of the bill, which contained three provisions, including comprehensive treatment centers and blood separation facility aid, as well as a

[1] The National Hemophilia Foundation, located at 25 West 39th Street, New York, New York 10018, is a voluntary, non-profit health agency, and the only national organization concerned with the disease of Hemophilia. The Foundation is an active member of the National Health Council, and furnishes reports to the National Information Bureau. It maintains an active liaison with the American National Red Cross and other organizations that are concerned with assuring an adequate, safe, and reasonably priced supply of blood and blood products to those who require it. The foundation is also a member of the Ad Hoc Committee to establish an American Blood Commission. For further information contact Mr. George Theobald, Executive Director,

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program permitting entitlement to full health care to all hemophiliacs across the nation. We can understand why the subcommittee members here who attended that conference could not accept the full amendment, inasmuch as you did not have the opportunity to have hearings on the issues, and because of the economic stringencies which were already becoming obvious in late fall of last year. We also understand that because you are looking forward to hearings on National Health Insurance as well as the Heart, Blood Vessel, Lung, and Blood Act, which comes up for renewal this year, you preferred not to handle the issue of comprehensive entitlement at that time. Needless to say, we look forward to testifying before you on both those bills in the near future. Consequently, at this time we will confine our remarks to the issues present in your bill, dealing with the comprehensive treatment centers and the blood separation facilities.

Mr. Chairman, there are almost 100,000 hemophiliacs in this country, 25,000 of whom are severely or moderately affected. (A recent study, funded by the National Heart and Lung Institute, verifies that number.) They all suffer a genetic disorder of the blood, in which the clotting factor is either partially or completely missing—this disorder is commonly known as the "bleeders' disease". *It is important that this committee understand that hemophiliacs are unique among chronic disease victims because they are not born crippled and can be spared the physical pain usually associated with the disease if financial conditions allow them continuous access to the missing clotting factor, which must be derived from human blood for both emergency and prophylactic use.* Without this ongoing treatment, the hemophilic unnecessarily becomes a burden to himself, his family, and to society. Without the treatment the hemophiliac is literally, during bleeding episodes, and after, crippled by his own blood, due to the bleeding which takes place in the joints and tissues, destroying them.

Now, however, a "medical miracle" can take place whenever we desire it and can pay for it—a "medical miracle" which has taken place because of the research supported by the legislative activities of this very committee. Scientific advances have provided us with materials capable of correcting this disorder by replacing the missing clotting factor. Bleeding usually can be checked with transfusions of the "clotting factor" concentrates, or with transfusions of part or whole blood, or plasma. Due to the very nature of the disease, while the patient is fully dependent upon the availability of the product, this availability and use is not alone enough to insure that the hemophiliac remain in the mainstream of a productive society. Adequate treatment of the disease mandates a comprehensive care approach, to heal the ravages of the past lack of care, as well as social and psychological injuries to the family and loved one. This comprehensive approach must utilize the services of hematologists, orthopedic specialists, dentists, psychiatrists, social service and vocations specialists. For it is only by utilizing adequate diagnostic and treatment facilities that the hemophiliac can be assured of receiving the vitally necessary care that he requires in order to play his full role in society. It should be noted that such treatment programs in the comprehensive care centers can be of enormous benefit for those with other bleeding disorders as well, as they can serve as models for facilities which can properly screen, diagnose, and give expert care in the diseases of the blood.

While there are presently approximately 67 existing treatment centers in 27 states, in the great majority of cases they are insufficiently comprehensive in their treatment. There is also a continuing need for such facilities in areas which are partially or wholly lacking in diagnostic and treatment facilities. Such centers could also serve as a resource for providers of health care who are in outlying areas and who do not have access to services offered by a comprehensive care center. It should also be noted that in such centers, it is important that programs be offered for the training of both professionals and paraprofessionals in hemophilia research, diagnosis, and treatment.

Besides the delivery system of health care for hemophiliacs, there is need of improvement in the processing of the blood and blood products upon which they depend. We all know that this subcommittee is deeply concerned about blood and its distribution, as well as its separation into products which can be used by those who are critically ill from many diseases. We know that this vital and precious national resource is squandered at a rate, unnecessarily, which is greater than almost any other of our resources. Almost 30% of all blood drawn in this country is literally "poured down the drain" because whole fresh blood, if not used, becomes outdated within 21 days.

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At present, our nation cannot meet the ever-increasing demands for blood. One reason is that blood is not broken down into its components as a routine activity, so that one unit of blood could serve many patients. The components, including blood cells, platelets, white blood cells, AHF rich plasma, and Factors VIII nd IX, can now be separated out for most advantageous use far more easily than in the recent past, and the rapidly evolving technology promises us even more inexpensive and efficient separation than in the past, and the proper use of these components will lead to less waste and better cost-effectiveness in health care delivery.

Although on the one hand, less than a third of all blood collected in the United States is broken down into its component parts; on the other hand, the demand for blood and blood products is rapidly increasing.

The National Hemophilia Foundation strongly urges this subcommittee to retain the provisions of this bill calling for grants to establish appropriate treatment centers and assist blood separation facilities.

We also like to point out to the subcommittee, that while the two provisions above are very important to all hemophiliacs, the critically important section of the Senate-passed bill calling for entitlement to comprehensive care including payment for the clotting factor, was deleted in the House-Senate conference last year.

Perhaps some members of this committee do not know that hemophilia is the most expensive chronic disease in the United States today. The problem of the hemophiliac is that he and his family are presented a chronic catastrophic expense, an overwhelming year-in year-out financial burden. For example, replacement therapy alone *averages* from $4,000 to $6,000 per year, and in some instances has reached as much as $26,000 per year. At the appropriate time, Mr. Chairman, the National Hemophilia Foundation will appear before you again to develop these views further.

We appreciate the time you take to study this statement, and will be pleased to answer any questions you may have.

STATEMENT OF RANDY V. ENGEL, EXECUTIVE DIRECTOR, U.S. COALITION FOR LIFE, AND ALSO IN BEHALF OF PEOPLE CONCERNED FOR THE UNBORN CHILD

Chairman Rogers and Members of the Subcommittee on Health and Environment: I am Randy Engel, Executive Director of the United States Coalition for Life, Export, Pennsylvania (Pittsburgh), a national and international research agency specializing in governmental population control programs and policies. As such we have a substantial interest in the activities of this Subcommittee to which Congress refers much of its Family Planning and Population Control legislation.

At the request of Mrs. Mary Winter, Vice President of People Concerned for the Unborn Child (formerly Women Concerned for the Unborn Child), I am also entering this testimony on behalf of PCUC, Pennsylvania's oldest and most active pro-life agency.

My remarks today will be directly primarily at Title II. Section B. of H.R. 2691—The Family Planning Services and Population Research Act of 1975. (Identical sections appear in H.R. 2133, and H.R. 2954.)

Let this record clearly show that this written testimony is being entered *under protest*—in lieu of the fact that the Subcommittee and its Chairman, Rep. Paul Rogers has seen fit to limit its "public hearings" on this and other sections of the Health Revenue Sharing package to the testimony of the Administration witness of Mr. Casper W. Weinberger, Secretary of Health, Education, and Welfare on February 19 and 20, 1975. Of the more than 88 pages of testimony only about one page of testimony was given over to family planning programs and an overall general financial statement relating to such federally sponsored programs.

Having been denied seating by this Subcommittee last February on H.R. 14214, the Health Revenue Sharing Bill (Title III—The Family Planning and Population Research Act of 1973), we again, one year later are denied an opportunity to testify in opposition to Title II Section B.—The Family Planning Services and Population Research Act of 1975—a one-half billion dollar, two year federal program of both prevention by means of contraceptive, sterilization and abortion.

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This refusal to permit the U.S. Coalition for Life to testify has been compounded by the erroneous statements of Subcommittee Chairman, Mr. Rogers and the Subcommittee Staff who have upon questioning by other Congressmen have denied the fact that as early as November of 1973, the Coalition had contacted the Clerk of the Subcommittee in order to insure a seat at the Family Planning hearings which were scheduled to begin soon after the 1974 session of Congress reconvened.

I quote from the attached letter of Rep. Moorhead of Pennsylvania to a Pittsburgh constitutent regarding Chairman Rogers' reply to Coalition charges of hearing bias, . . . they (the Subcommittee Staff) received no correspondence nor were they ever contacted by any pro-life group or persons prior to the close of the hearings, with the exception of the U.S. Catholic Conference."

I will take this opportunity to enter into the official record of this hearings therefore, two letters from the Subcommittee on Health and Environment—one letter directed to me as the Director of the U.S. Coalition for Life dated November 5, 1973 and the second letter directly to me personally at my home address dated November 1, 1973. Please note that Clerk Williamson states that the Subcommittee hearings on Family Planning will probably be carried over to the 1974 session and that I would be notified of the hearing schedule when the Subcommittee would consider the various Family Planning bills.

Additionally, Mr. John Short and Bill Devlin of Life Lobby, L.I., N.Y. spoke personally with Mr. Rogers on January 22, 1974 and expressed interest in testifying at the Subcommittee hearings on Family Planning. Yet neither Life Lobby or the U.S. Coalition for Life were ever invited to testify despite their obvious interest in doing so on Family Planning bills.

Chairman of the full Committee on Interstate and Foreign Commerce on August 12, 1974 speaking on behalf of the Health Revenue Sharing Bill—H.R. 14214 on the House floor thus stated ". . . In the intervening year the Committee has studied these programs in depth and *held hearings* on their extension which revealed *unanimous support* for them, except in some cases on the part of the Administration." (emphasis added). See the Congressional Record for August 12, 1974 beginning on page H. H8030 for the House views on H.R. 14214.

Obviously Rep. Staggers did not read the Coalition written testimony in opposition to the Family Planning section of H.R. 14214 or if he did, he did not consider the lengthy testimony to be seriously considered as part of the general hearing process. This is one reason the U.S. Coalition for Life puts such emphasis on the opportunity to testify orally before the Subcommittee.

In addition to our opposition to H.R. 2691, Title II. Section B. on the grounds of biased previous hearings and inadequate current hearings limited to Administration spokesmen, we oppose the manner in which the architects of the bill have piggybacked the Family Planning section of the measure on to the Nurses Training bill. It is obvious in light of the current exposure of abuses within federally funded Family Planning programs that supporters of this segment of H.R. 2691 feel it will be easier to push the Family Planning title through as part of a total health package than as a separate bill, the type of which Rep. Tim Lee Carter has already introduced. Apparently, little consideration has beeen given to those nurses, hospital administrators and other medical personnel from religious institutions, i.e. affiliated with religious institutions of many denominations, who cannot in conscience support the entire bill because of the Family Planning section.

FAMILY PLANNING ABUSES

Those members of the Subcommittee and full Committee who have read our previous written testimony in opposition to H.R. 14214 will recall that we listed a litany of anti-life abuses and violations of the original Tydings Bill, i.e. the Family Planning Services and Population Research Act of 1970.

Coalition charged that federal funds under Title X of the Public Health Service Act were being used to promote abortion, to carry out abortion research, to corrupt the morals of minors, to fund fertility control experimentation among the poor, primarily clinic patients, the underwriting of abortion research of national and international drug firms such as the Upjohn Company, the misuse of confidential family planning and other government data, the invasion of marital privacy by federal employees, the promotion of population control research designed to modify citizens' fertility control patterns, and anti-life indoctrination of the young via so called programs of "population education".

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The Coalition stands by these charges today. As a matter of fact there are many more recent events highlighting these abuses than there were one year ago. And above all, highlighting the need for an unbiased joint Congressional investigation of federal Family Planning abuses carried out under Title X as well as many other titles and other federal Family Planning programs—both domestic and foreign.

We find it incredible that certain members of this Subcommittee wish to go for another two years without such an investigation.

In addition to the attachments mentioned with regard to Subcommittee staff and Coaliion requests to testify on Family Planning measures, I am attaching a variety of articles on some of these current abuses of Title X funds under the Tydings Bill of 1970.

Included in these attachments are the following articles: [1]

"The Pill, Planned Parenthood, a Minor and Death," the story of a sixteen year old minor who died 49 days after being given a subscription for birth control pills at a P.P. center without the knowledge or consent of her parents.

"Sterilization Without Informed Consent," selections from the Public Citizen Inc. exposé of contraceptive sterilization of clinic and other patients without full knowledge and consent of the patient.

"Medicaid Abortion Fraud"—The illegal overpayment of MEDICAID funds for abortions. (Title XIX).

"The Farce of Abortion Counseling"—How Planned Parenthood and its allies such as Clergy Counseling conduct their "abortion counseling" programs complete with maps to the nearest abortion mill.

"The Strange Case of Birth Control Czar Dr. Joseph Beasley and the Nonexistent Mobile Birth Control Clinics of the Louisiana Family Planning (Health) Foundation." The case of Dr. Beasley should be of special interest to Rep. Bingham of the U.S. House of Representatives who during the August debate on H.R. 14214 used Dr. Beasley's program as an example of a Family Planning success story.

Conclusion.—On information provided to the Subcommittee and Full Committee of the Interstate and Foreign Commerce of the House at this and other written testimony, I thereby request that the Committee move to strike the entire Family Planning section that is Title II Part B. of H.R. 2691 and that Rep. Rogers announce the opening of fair and open hearings on federal Family Planning programs.

As this Subcommittee is aware, Title II Section B. of H.R. 2691 is simply an authorization bill to refund the original Tydings Bill. Perhaps it is time that Congress consider the phasing out of the Tydings Bill which has proven to be an anti-life $2,250,000,000 boondoggle.

We realize that such action will deprive Planned Parenthood personnel of the funds to continue the standard of living to which they have become accustomed and other anti-life groups, of their financial base. On the other hand such deprivation can be justified on the basis that other American citizens, the blind, the handicapped, the uneducated, the poor in general will have access to federal funds released by the folding of the many anti-life programs covered under Title X. (PHSA).

I trust that such hearings will be called in the very near future.

Thank you.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C., November 5, 1973.

Mr. RANDY ENGEL,
Director, U.S. Coalition for Life, 165 Hills Church Road,
Export, Pa.

DEAR MR. ENGEL: Thank you for your letter of October 29 requesting information concerning H.R. 6021 and H.R. 6139.

As of this time no hearings have been scheduled on either of these bills. We will let you know when they are scheduled.

Thank you for writing.

Sincerely yours,

LEE S. HYDE, M.D.,
Professional Staff Member.

[1] May be found in the committee files.

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CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C., November 1, 1973.

Mr. R. V. ENGEL,
Route 3, Export, Pa.

DEAR MR. ENGEL: This will acknowledge your postal card of October 26, 1973, inquiring as to whether any hearings will be held this year on H.R. 3381, to expand and improve the family planning services of the Federal Government.

Early this year this Committee held hearings on legislation to extend for one year, until June 30, 1974, twelve expiring health programs under the Public Health Service Act, of which family planning and population research was one. That legislation has been enacted into Public Law 93-45. For this reason I do not believe the Committee will consider H.R. 3381 or similar bills this year. At this time there is no projected program as to what health legislation may be considered in the second session of the Congress, however, in view of your interest I have had you listed to be notified at such time as this bill may be scheduled for action in 1974.

Sincerely yours,

W. E. WILLIAMSON,
Clerk.

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SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT, HON. PAUL G. ROGERS (FLA.), CHAIRMAN

PUBLIC HEARINGS

Time: 10:00 a.m., Thursday, February 21, 1974, room 2322.
Subject: H.R. 11511 (Rogers, Fla.) and H.R. 11845 (Rogers, Fla., et al.), Special Health Revenue Sharing Act of 1973.

WITNESSES

Hon. George E. Brown, Jr., Member of Congress from California.
Hon. Pierre S. duPont, Member of Congress from Delaware.

Panel of Family Planning

Joseph D. Tydings, national co-chairman, Population Crisis Committee, Danzansky & Dickey, 1120 Connecticut Avenue NW., Washington, D.C.

Frederick S. Jaffe, vice president, Planned Parenthood-World Population, 515 Madison Avenue, New York, N.Y.

Mr. Russell H. Richardson, president, National Family Planning Forum, State Office Building, room 417, Atlanta, Ga.

Louise Tyrer, M.D., director, Family Planning Program, American College of Obstetricians & Gynecologists, 79 West Monroe Street, Chicago, Ill.

Sheldon Segal, M.D., vice president and director of biomedical division, Population Council, 245 Park Avenue, New York, N.Y.

Thomas L. Hall, M.D., acting director of Carolina Population Center, University of North Carolina, University Square, room 405, Chapel Hill, N.C.

William Little, M.D., Department of Obstetrics and Gynecology, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex.

Judy Senderwick, president; Joyce Tarnow, southern vice president, Zero Population Growth, 1346 Connecticut Avenue NW., Washington, D.C.

Rev. Msgr. James T. McHugh, director, Family Life Division, U.S. Catholic United Methodist Church, 100 Maryland Avenue NE., Washington, D.C.

A. Dudley Ward, general secretary, Board of Church and Society of the United Methodist Church, 100 Maryland Avenue NE., Washington, D.C.

Representative of Women's Lobby, Inc., 1345 G Street SE., Washington, D.C.

Hon. Ronald Dellums, Member of Congress from California.

Hon. Yvonne B. Burke, Member of Congress from California.

National Conference on Developmental Disabilities: Jennifer L. Howse, Ph. D., director, developmental disabilities section, Division of Retardation, State of Florida, 1311 Winewood Office Plaza, Tallahassee, Fla. Accompanied by Allen Cohen, director, Developmental Disabilities, State of Virginia: Mrs. Bernetta Barrett, chairperson, Developmental Disabilities, State Planning and Advisory Council, State of Illinois; Jack Leathe, director, Developmental Disabilities, State of Texas; Clell Hemphill, director, Developmental Disabilities Program, State of Iowa.

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[Mailgram, Feb. 27, 1974]

Representative HARLEY STAGGERS,
Washington, D.C.

During 6 days of hearings on Family Planning Bill 11511 by the sub-committee on Environment and Public Health shared by Representative Rogers a litany of anti-life spokesman were invited to testify to the total exclusion of citizens pro-life groups some of which were on the register of committee clerk Williamson to be notified of hearings on any Family Planning Bill for the sub-committee we ask your support for holding the hearing record open for two weeks and ask that written testimony of pro-life groups and accompanying documentation be accepted in full and inserted into the official records.

RANDY ENGEL,
U.S. Coalition for Life,
Export, Pa.

* * *

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., March 29, 1974.

Re H.R. 11511.

MS. JOAN PORTMAN,
83 Semicir Street,
Pittsburgh, Pa.

DEAR MS. PORTMAN: Thank you for your communication asking that Congressman Paul Rogers, Chairman of the Subcommittee on Public Health and Environment, of the Committee on Interstate and Foreign Commerce, hold open the record of hearings in order that additional statements might be submitted.

In an effort to be helpful I have contacted Congressman Rogers and he has indicated that he has written several individuals advising them that:

"I have been advised by my Subcommittee staff that they received no correspondence nor were they contacted by any pro-life groups or persons prior to the close of hearings, with the exception of the U.S. Catholic Conference. I can assure you that had they been contacted by pro-life groups wishing to testify, those groups would have been scheduled.

"Although the hearings record generally closes ten days after the conclusion of hearings, I have extended this deadline to March 15th so that the Subcommittee may have as much information as possible on these important measures."

I have also been advised that the hearings are now being finalized for printing but that if statements are received within the next week that every effort will be made to try to include them in the record.

It is good of you to write and I hope you will feel free to continue to communicate with me regarding matters before the Congress of interest to you.

Sincerely yours,

WILLIAM S. MOORHEAD, M.C.

* * *

FEBRUARY 18, 1975.

From: U.S. Coalition for Life, Export, Pa.
To: Committee on Interstate and Foreign Commerce, Committee Clerk, Chief of Staff, Washington, D.C.
Subject: H.R. 2691, nurses training and other purposes.

SIRS: Our agency considers H.R. 2691 to be of critical importance. We therefore request that our agency be notified by phone or letter when public hearings will be held on the Nurses Training and Health Revenue Sharing Bill. Further that we be given ample opportunity at the hearing to discuss our agency's views on this and any other similar measure.

RANDY ENGEL, *Director.*

* * *

From: U.S. Coalition for Life, 165 Hills Church, Export, Pa.
To: Chief of Staff Committee Clerk, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.
Subject: 1975 Family Planning Act.

SIRS: Our agency wishes to present oral testimony on H.R. 2133—the 1975 Family Planning Bill and any other similar measures in this area. According to Rep. Dent no hearings are yet scheduled. Please notify us when hearings will begin either by phone or by letter. We trust that you will notify us in time to

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make out-of-state flight schedules and at the same time that HEW-Office of Population Affairs and such agencies as Planned Parenthood are notified lest we run into problems of last year in which pro-life representation at Rep. Rodger's hearings were insufficient.

Reply requested.

Thank you.

RANDY ENGEL, *Director.*

COMMENTS OF THE HONORABLE PAUL G. ROGERS ON THE STATEMENT OF THE UNITED STATES COALITION FOR LIFE

The preceding statement of the U.S. Coalition for Life, which has been included as submitted to the Committee, makes several charges and observations which deserve comment. The Coalition was concerned that they were not extended an opportunity to testify orally on the Title X provisions of this legislation. No public witnesses were invited to present oral testimony on any provisions of this measure, because the measure was identical to one which was thoroughly considered in the 93rd Congress. The Coalition is the only organization of which I am aware that found this to be objectionable.

The Coalition should be aware that the law is very clear as to the design and content of programs funded under Title X of the Public Health Service Act. None of the funds appropriated under Title X may be used in programs where abortion is a method of family planning. This provision would not merely prohibit the use of such funds for the performance of abortions but would prohibit the support of any program in which abortion counseling or abortion referral services are offered. Title X further provides that the acceptance of family planning services shall be voluntary and unconditional.

The difficult issue of the appropriate design and content of Federally funded family planning programs in our society is one with which I have long struggled. The seriousness and complexity of this issue is not reflected in, nor the debate on it enhanced by, testimony such as this.

STATEMENT OF MAHARISHI INTERNATIONAL UNIVERSITY

Mr. Chairman and Members of the Subcommittee: Previous testimony before this committee reviewed the World Plan which was established in 1972 to provide a worldwide system for the teaching of Transcendental Meditation (TM) and the Science of Creative Intelligence (SCI). The World Plan, which has opened approximately 400 learning centers in the U.S., was discussed as a successful model for community health programs. We would like to draw to the attention of this committee the steps implemented this year to expand the programs of the World Plan through the acquisition of residential teaching facilities.

A. NEIGHBORHOOD CENTERS

On January 1, 1972, Maharishi Mahesh Yogi inaugurated a World Plan to establish one Science of Creative Intelligence teaching center for each one million population; within a year's time, the required 200 centers for the U.S. were in operation. An additional 200 satellite centers have been opened to provide further convenient service to the entire population. These centers teach Transcendental Meditation (TM) and the Science of Creative Intelligence (SCI), and offer an increasingly broadened follow-up program.

The effectiveness of TM and SCI as therapeutic modalities in certain problem areas of physical and mental health has been evaluated by over 300 scientific research projects in 18 countries, and has been summarized in previous testimony. Several extensive articles have appeared this year which review the use of Transcendental Meditation as an adjunct to current psycho-therapeutic modalities. Psychiatrists in Connecticut, New Jersey and California have cautioned that the observed clinical effectiveness of TM may necessitate the immediate training of several thousand TM/SCI teachers as health care paraprofessionals. To meet this growing demand, SCI teachers are currently attending special advanced teacher training courses for work in rehabilitation areas. Each local center by the end of this year will have at least one teacher specially trained in SCI/TM rehabilitation skills.

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Essentially, World Plan Centers correspond to out-patient treatment facilities; they are staffed to handle inquiries and provide initial instruction and follow-up maintentnce. Dr. Harold Bloomfield of San Diego, California, noted that many of his patients were finding their needs met by the local World Plan Center, leaving him the time and energy to devote to those institutionalized patients, far more in need of his personal attention.

B. RESIDENTIAL FACILITIES

A vital aspect of the World Plan is the establishment of a forest academy for each major World Plan Center. These facilities of 100–200 bed capacity will be located in secluded country settings. They will offier in-residence courses of two days to three months duration, and will be structured to provide both indepth intellectual analysis and greater experiential value of SCI. Similiar facilities will handle the specific requirements of rehabilitation and health care.

Academies for the World Plan have been acquired in northern and southern California and in New York state. The New York Academy for SCI has facilities for 500 and houses, as well, a complete video production studio and a press capable of producing course material for all the North American World Plan Centers.

Last fall, Maharishi International University (MIU) purchased a central campus in Fairfield, Iowa, capable of comfortably housing 2,000 students. The resident faculty and professional staff of MIU provide the expertize necessary to structure programs for the areas in need of qualified SCI teacher para-professionals.

The demand for TM/SCI projects in drug and alcohol abuse programs and in correctional institutions presently exceeds the qualified personnel available to initial full-scale programs. A demand from mental hospitals is anticipated that will require a doubling of the present 5,000 SCI teachers in the United States. The academies and central campus have been purchased, thus far, without the use of external funds and are economically self-supporting. However, in order to meet current demands for expansion, outside support will be necessary.

C. RECOMMENDATIONS AND CONCLUSIONS

In light of the scientific evidence from the 300 TM research projects, the desirability to employ TM as a technique to counteract developmental disabilities is obvious. Furthermore, the structure of the World Plan is consistent with the aims of this government to provide the most effective and convenient health care services to all its citizens. In terms of the range of services offered, the health concerns encompassed and the efficiency of operation and maintenance of these World Plan facilities, they serve as a model for successful treatment centers. It is hoped, therefore, that Federal funds will be made available paricularly for the immediate acquisition and/or construction of more World Plan residential facilities.

Details concerning the operation of World Plan facilities and the special training programs currently offered can be obtained by writing Maharishi International University, Fairfield, Iowa 52556. For information on World Plan centers located in over 60 countries, and on residential faciilties presently operating in England, Germany, France, Switzerland and India, contact the World Plan Executive Council, Hotel Kulm, CH6446 Seelisburg, Switzerland. For information on current scientilc research on TM/SCI in health and rehabilitation, contact the International Center for Scientific Research, World Plan National Headquarters, 1015 Gayley Avenue, Los Angeles, California 90024.

EPILEPSY FOUNDATION OF AMERICA,
Washington, D.C., February 18, 1975.

HON. PAUL G. ROGERS,
U.S. House of Representatives,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: We have been notified of the hearings to be held this week on the Developmental Disabilities Service Act (H.R. 2955). It is our hope that the new bill will receive the support needed to continue the good work that has been initiated by the original DD Act.

Attached is a statement made by James MacDonald Watson, M.D., that clearly delineates the position of the Epilepsy Foundation of America.

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In addition we have also enclosed a copy of testimony given by Jack McAllister, which demonstrates clearly what DD legislation has done in the State of Florida, as just one example of the need and worth of DD efforts.

Your consideration in this matter is deeply appreciated.

Most sincerely,

LEONARD G. PERLMAN, D.Ed.,
Associate Executive Director,
Government Liaison and Program Development.

ENCLOSURES

STATEMENT OF JAMES MACDONALD WATSON, M.D., ON BEHALF OF EPILEPSY FOUNDATION OF AMERICA

Mr. Chairman, Members of the Committee, on behalf of Epilepsy Foundation of America and the approximately four million Americans with convulsive disorders, let me express our appreciation for this opportunity to present our views to you. It is indeed an honor.

At the risk of appearing mawkish, permit me the opportunity to initially speak to a rather provincial point: that of the gratitude of our organization and its volunteers and afflicted constituencies for so promptly acting on a proposal to extend the first public law in recent history to attempt to provide a modicum of service to a profoundly needed population.

Thirty-five years ago, we had centers for the care, treatment and habilitation of persons with epilepsy. Then a new medication—diphenylhydantoin, usually known as dilantin—was developed for control of convulsive seizures. We thought that solved the problem, so we eliminated the centers, or "epileptic colonies." Our action, however, was premature; we then discovered that about half of our patients could not achieve complete seizure control. It is to this half, the severely handicapped, that the Developmental Disabilities Services and Facilities Construction Act addresses itself. Programs authorized by DD have served a high percentage of this two million. It is the *only* public law providing specific services to do so.

That it has been effective is exemplified, for instance, by our San Antonio, Texas, Epilepsy Association. Stimulated by a $14,000 DD grant—a small enough sum—this brand new voluntary association moved from virtually no services to a cooperative agreement with a community hospital from which it was able to obtain space and resources for financial assistance, mental health and employment counseling services. It developed a public relations department through which its new activities are promoted, formed a speaker's bureau, and introduced a teacher information program, School Alert, to the community. Today, an average of 60 persons attend monthly organized meetings and a number of patients have received the benefits of professional counseling designed specifically for their needs.

With the increased resources provided by yet a smaller DD grant of only $10,200, the Louisiana Epilepsy Association was able to expand its case load from 300 to an average of 1,200 in a nine-month period. Counseling services were added for parents and teenagers; and the development of a system of public information exhibits, media packages and a speaker's bureau were made possible. Building on the base provided by DD, and using its volunteer initiative, this chapter was also able to obtain an additional $23,225 to provide a gas liquid chromotography unit in its community hospital. Of the first forty epilepsy patients to have blood serum levels of anti-convulsants analyzed by this method, ten were determined to require an adjustment of medication.

I could go one with examples to document the needs and the progress this legislation has made toward the solution of the needs, but my point in summary is that this program has served to provide help to countless hundreds of people who have for 35 years lacked access to an understanding counselor's ear, a job, a method of determining what kinds and how much medication they require, and protection of the "inalienable" rights of a constitutional person in our society.

My second point requires a brief review of the historical base of S. 427. From its inception 10 years ago when its purposes were to (1) stimulate the development of a network of facilities for service delivery to the mentally retarded; (2) develop needed manpower; and (3) encourage research into the problems of mental retardation, the program has grown. Initial staffing grants for community mental retardation facilities were added in 1967, as well as provisions for construction of facilities for major programs of interdisciplinary training of mental

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retardation medical and allied manpower. In 1970, when it became apparent that a great deal of effort was being expended in programs for the mentally retarded, with a total dollar figure of $606,970,000 in HEW alone, the legislation was wisely expanded to include services to persons with epilepsy and cerebral palsy—other neurological handicaps with a need indeed as great.

This expansion brought new emphases: (1) the marriage of several neurological disorders; (2) concentration on the most severely handicapped; and (3) stress on accessing existent community resources and facilities.

This continued expansion proved the health of the concepts; but as with all maturation processes, growing pains are beginning to be felt. While we are yet only three years into the new philosophy—with insufficient time to have adequately evaluated its propriety and progress—attempts to fertilize it perhaps too much are being made by various interest groups and organizations.

This is a danger we must avoid. Too many government programs have forgotten their mission; too many have strayed from the path leading to the original goals established; and as a result, too many have not been successful—indeed are being phased out. DD must not go this way. Let us, then keep it—essentially as it is.

With the wide discrepancies between authorizations and appropritaions for DD, the minimal sums it is likely to secure *can* help develop innovative attacks on a set of neurological problems. It *can* provide much assistance to an underserved, brain damaged population. It *cannot*—without massive injections of money—also attempt to service groups which are no less needy, but which may receive their own tailor-made services through crippled children's programs, mental health programs, maternal and child health services, handicapped education programs, services for the blind, the deaf, and many others.

Those concerned with Developmental Disabilities need to remember its mission: to serve the neurologically handicapped. It needs to grow—but not too far, too fast. It needs to assess the validity of its yet new concept. It needs to retain its well-considered emphasis on those in our society who most need its services. And it needs time to adjust to its new clothes.

In short, the Developmental Disabilities Services and Facilities Construction Act is needed—and essentially just as it is.

Mr. Chairman, Members of the Committee, I thank you.

* * *

STATEMENT[1] OF JACK MCALLISTER, DIRECTOR, DIVISION OF RETARDATION, DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, STATE OF FLORIDA

Mr. Chairman and members of the Subcommittee, it is with a great deal of pleasure that I have the opportunity to emphasize the intense need to support the Bill bfeore you which calls for a *National Commission on Epilepsy*. I am Jack McAllister, Director of the Division of Retardation in the Department of Health and Rehabilitation Services for the State of Florida.

I would like at this time to describe some of the events taking place in behalf of persons with epilepsy in Florida. As the Honorable Chairman of this Subcommittee (Paul Rogers) was the sponsor of the Developmental Disabilities legislation in 1970, you will be pleased to know of the inroads established as a direct result of this mandate.

For example, the combined efforts of the Florida Epilepsy Foundation, Florida's Department of Health and Rehabilitative Services Division of Retardation, Developmental Disabilities Advisory Council and significant action by Governor Ruben Askew, have resulted in two years of exemplary action planning and specific steps to coordinate existing resources, identify areas of unmet needs and crystallize the State's responsibility for services to persons with epilepsy.

In July, 1972, a Developmental Disabilities Planning Grant was awarded to the Florida Epilepsy Foundation which provided the vehicle for an intensive, Statewide planning effort which culminated in a *Five-Year Action Plan*.

A copy of the finished *Five-Year Action Plan for Epilepsy* was presented to each State agency in Florida. This Plan was identified as capable of providing services to persons with epilepsy. A majority of the agencies were represented on the Developmental Disabilities Council (DD) and, therefore, had been involved early in the planning.

Progress to date in the implementation of the *Five-Year Plan for Epilepsy* has moved along rather well for this long ignored problem area and thus far, this

[1] Presented at the hearing before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce on H.R. 13405, August 12, 1974.

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long-range Plan has proven highly productive in terms of progress for persons with epilepsy. For the Plan serves as a blueprint for bringing about beneficial administrative actions as well as a sound base-line documentation for framing future legislation.

Allow me to list but a few of the recommendations, in the various areas:

In *Medicine*, blood level analyses should reach more of the general public throughout Florida who are medically indigent as a screening and diagnostic procedure.

In *Education*, legislation should be enacted to provide a program of school health services with primary emphasis on having a nursing aide available in every school trained to provide improved first aid for the child with grand mal convulsions.

In the area of *Transportation*, documentation was completed on sound administrative procedures to be used in licensing drivers with epilepsy and other disabilities. These results confirm the need for legislative action to avoid possible discrimination.

In the *Administrative* realm, consideration is being given to change of the name and responsibility of the Division of Retardation to be consistent with Developmental Disabilities, thereby focusing on not just one disability group, but on the population described in the mandate.

While many other pertinent recommendations were made in areas such as legal problems; day care; employment and recreation; I would now like to describe a few visible positive steps which have just recently taken place.

For example, the Florida State Legislature has appropriated $562,500 to provide a State-wide system of information and referral, social work services, and the provision of neurological assessment for the needy.

In the area of *Employment*, legislation was enacted to provide subsidization by the State of around $500,000 to sheltered workshops who served the substantially handicapped developmentally disabled, *including the person with epilepsy*. These funds should serve as an incentive to workshops to give greater attention to these persons.

In addition, the State Vocational Rehabilitation Agency has assigned one counselor to serve in each of the State's 16 regions. Those assigned will be receiving intensive training in epilepsy rehabilitation during September of this year and work closely with the Epilepsy Foundations throughout the State.

Also of significance is the fact that blood level analyses of anticonvulsant medication was to be completed on all institutionalized clients of the Department of Health and Rehabilitative Services within this year to upgrade medical care in all State institutions.

This is but a sampling of the progress derived to date from the *Action Plan*. A Plan which served as a blueprint for bringing about beneficial administrative actions as well as a sound base-line documentation for framing needed legislation. We highly recommend that a similar long-range action plan be developed for the nation—and for this reason, urge your consideration of the Bill before you calling for a National Commission on the Epilepsies.

The Five Year Action Plan for Epilepsy in Florida has proved to be highly successful, and I feel strongly that the establishment of a National Advisory Commission to develop a National Plan for the Control of Epilepsy and its Consequences will prove highly successful for the Nation.

AMERICAN HEART ASSOCIATION,
New York, N.Y., February 20, 1975.

Re Health Revenue Sharing and Health Services Act of 1975.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN ROGERS: We estimate that 22,340,000 Americans have some elevation of blood pressure (hypertension). Approximately half of those with hypertension, however, do not know they have it, and surveys of various population groups indicate that only 10 to 20 percent of hypertensives are currently receiving treatment.

Increased funding from public sources is certainly necessary to correct this imbalance. For this reason, addition of health revenue sharing money to the

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effort to control high blood pressure could be extremely valuable. On the other hand, we believe that legislation of this kind should be more specific about areas of support, in recognition of immediate needs and priorities.

In our estimation the first priority is to determine the most cost-effective way to provide hypertension control services on a community-wide basis. Therefore, we suggest that a significant portion of newly authorized funds should be earmarked for demonstration projects. A requirement would be that heart associations, local health departments and local professional and academic groups participate in the design and implementation of such demonstration projects. In addition to screening for high blood pressure, these projects would also have to include a mechanism for referral and follow-up, to insure treatment of detected hypertensives. Other minimum components would be: 1) low-cost or free treatment and/or prescription drugs for those who cannot afford medical attention and who do not qualify for other forms of medical assistance, and 2) public, patient and professional education for the community to be served.

It is our belief that without direction of this sort, the funds proposed may not be used in the most effective way. We would be pleased to provide more details about necessary demonstration projects on request.

Respectfully,

ELLIOTT RAPAPORT, M.D.,
President.

THE NATIONAL CANCER FOUNDATION, INC.,
New York, N.Y., February 20, 1975.

Hon. PAUL ROGERS,
Chairman, House Health Subcommittee,
Rayburn Office Building,
Washington, D.C.

DEAR SIR: We understand that the Subcommittee on Health is planning hearings to receive testimony relevant to several health-related bills which have been reintroduced this year.

Since we will not be able to appear at the hearings, we are taking this opportunity to register our support of the home health services provisions (Sec. 262) of H.R. 2954–S. 66, the Health Revenue Sharing and Health Services Act.

Cancer Care, Inc., the service arm of the National Cancer Foundation, has for over 27 years provided comprehensive social services to advanced cancer patients and their families. Our testimony before the House Ways and Means Committee and our research study, *The Impact, Costs and Consequences of Catastrophic Illness on Patients and Families* (both of which are enclosed) attest to the urgent need for services which provide care in the home when illness strikes.

Since we are keenly aware of the uneven distribution of home health agencies throughout the country, we therefore applaud measures that would begin to remedy this situation.

Sincerely,

MARJORIE K. HERRMANN,
Mrs. John A. Hermann.
President.

IRENE G. BUCKLEY,
Executive Director.

Enclosures:
#1 NCF Statement on NHI
#2 Research Study, *The Impact* . . ., may be found in committee files.

STATEMENT ON NATIONAL HEALTH INSURANCE LEGISLATION WITH EMPHASIS ON PROVISIONS FOR COVERAGE OF LONG-TERM CATASTROPHIC ILLNESS

Testimony by Irene G. Buckley, Executive Director, on Behalf of the National Cancer Foundation, Inc. and Cancer Care, Inc. Before the Committee on Ways and Means, U.S. House of Representatives, Friday, June 14, 1974.

Mr. Chairman and members of the Committee: My name is Irene G. Buckley, Executive Director of the National Cancer Foundation and its service arm, Cancer Care, Inc.

We appreciate the opportunity to express our views on that part of National Health Insurance with which these agencies are directly involved.

This statement is, therefore, chiefly but not entirely concerned with those aspects of National Health Insurance which relate to catastrophic illness.

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NATURE OF THE AGENCY'S SERVICE

Cancer Care, Inc. is a unique service agency in the health care field. Its purpose is to help patients and families cope with multifaceted problems of caring for an advanced cancer patient at home. These patients have usually been dismissed from further intensive in-patient hospital care. They must return home, enter a nursing home or other extended care facility, or make some special arrangements. Most patients want to return home, if possible.

It is usually at the point of the patient's imminent return home that referral is made to Cancer Care, Inc., often by the social service department of the hospital.

Providing adequate and appropriate care for a seriously ill patient at home is itself a problem. Maintaining an orderly household with normal family relationships and a positive emotional environment may be even more difficult.

Household management is more complicated when there are children, when a parent is the patient and other adult members of the family must work. These heavy responsibilities often fall on persons who are unfamiliar with helping resources in the community, and who are worried over costs which have strained or drained family financial resources. There is, above all, the emotional stress of day and night contact with a family member who is seriously ill and often in great pain.

A staff member of Cancer Care, Inc. helps the responsible member of the family work out a feasible plan for care at home taking into account such factors as the family constellation, financial situation, condition of the patient, and prognosis of the physician. The agency then arranges whatever assistance is needed in carrying out the plan, making a budget, and helping to secure the special services needed. If necessary some portion of the cost is borne by the agency.

BASIS FOR OPINIONS AND RECOMMENDATIONS EXPRESSED IN TESTIMONY EXPERIENCE AND RESEARCH

I would, therefore, stress that the opinions and recommendations expressed here about catastrophic illness coverage as part of a plan for national insurance coverage are based on 27 years of intimate day-to-day contact with advanced (usually terminal) cancer patients being cared for at home.

This experience is further buttressed by an in-depth study of a selected number of client families in which the patient had died within the preceding 16 months.

A copy of the study report entitled, "The Impact, Costs and Consequences of Catastrophic Illness on Patients and Families,"[1] has been provided for each member of the Committee.

The study gathered data in the five general areas of:

1. Income and composition of the family
2. Duration of the illness from onset to death
3. Total costs of the illness, by category
4. Sources of funds to pay the costs of the illness, by category
5. Hardships, other than financial, related to the illness

This social research is a revelation of what it means to total families to have a member stricken with a severe, irreversible illness. It shows that middle-income families can be reduced to poverty in less than two years.

Catastrophic illness means catastrophic costs—which most families are unable to pay.

Participants in the study were self-maintaining families with middle to low incomes, who are covered by private medical insurance and who are responsible income producers—accustomed to and expecting to pay their bills. The question, "Why must catastrophic illness bankrupt the middle-class family?" deserves an answer.

The purpose of the research was to document facts on behalf of the families faced with catastrophic illness defined by our agency as "An illness that the patient and his family are not able to cope with, using the attitudes, machinery, and resources normally available. Such an illness has no apparent satisfactory conclusion, and can lead to the exhaustion of both the patient's and family's emotional and financial resources, or to the patient's death."

Some of the major findings of the study will be cited in this testimony to support the agency's views on those provisions of National Health Insurance bills under consideration, pertinent to catastrophic coverage.

[1] *The Impact, Costs and Consequences of Catastrophic Illness on Patients and Families*, Cancer Care, Inc. of the National Cancer Foundation, Inc., New York, N.Y. March, 1973.

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The National Cancer Foundation and Cancer Care, Inc. believe that adequate insurance coverage is the only means by which most American families can meet the devastating costs of longterm catastrophic illness.

Some form of medical insurance was the main source of funds for most families in our study. Only 3% of the study group were without any form of medical insurance. The *median* picture of these families showed that illness-related costs amounted to $19,054, the median annual income available to pay these costs was $8,000, and the median medical insurance payments were an insufficient $5,000—a $14,000 gap! Can you picture being faced with medical bills amounting to two or three times your annual income? Note that in addition, the expenses for food, clothes and shelter for the family that had to be paid out of this same income. The 115 families (448 people) in the study expended almost 2½ million dollars just to sustain and care for their family members who were dying from advanced cancer. This did not include the voluntary dollars contributed for professional social work services which all these families received.

INADEQUACY OF CURRENT HEALTH INSURANCE COVERAGE

Total illness-related costs over $10,000 were incurred by 84% of the study families but only 39% received medical insurance payments of that amount or more. Specific examples indcated the inadequacy of most insurance coverage. One family with an income of $11,000 had medical costs of $43,000. About one-half was paid by Blue Cross/Blue Shield and a special health policy. But a family loan of $12,000 was required to pay the additional costs.

In another case, illness lasting nine months cost $15,675. About one-quarter was paid by health insurance. Those without adequate insurance used savings, cashed in life insurance policies, mortgage property, took out bank loans, and utilized so much current income for medical bills that the family could have only bare necessities. The father of several children with a normally sufficient income was obliged to use $15,000 of his savings, borrow substantial amounts, and was left with nearly $8,000 in unpaid bills at the end of his wife's illness covering more than five years. He stated that insurance paid $12,000 for hospital bills, but they amounted to $20,000. His doctor's bills amounted to another $20,000.

Sometimes, when Cancer Care is trying to help the family work out a budget, unpaid bills for patient care and running the household are brought to the office in shopping bags.

Catastrophic illness coverage should be an integral part of a comprehensive plan for national health insurance. It should not be a separate and individual program.

NEED OF HEALTH INSURANCE FOR THE ENTIRE FAMILY AND EVERY FAMILY

The agency takes a strong position on this point for the following reasons:

> Our experience indicates that health insurance is needed for the entire family and for every family. Ability to secure and pay for adequate medical care in the early stages may prevent serious trouble later. The agency's study also revealed a surprising number of multiple health problems. The patient may have several diseases at the same time, for example, diabetes and heart disease in addition to cancer. Also, in many of the cases there were other health problems in the family at the same time.
>
> A husband had a coronary one month after his wife became ill with cancer. He was unable to work for five months, and only then for shorter hours and less pay. A wife suffered a coronary after the first two years of her husband's illness. In a family of four adults, in a short space of time one died, one became seriously ill with cancer, another had a serious back ailment, and the fourth "fell apart" from fatigue and tension and required psychiatric care.
>
> One woman suffered recurrence of psychiatric problems when her husband became ill with cancer.

The recurring instances of need for psychiatric help for the patient and family members, particularly children; and the reports of neglect of dental care further illustrate the need for a genuinely comprehensive insurance coverage for preventive care as well as illness.

There is also a danger that catastrophic illness insurance might be considered a substitute for a comprehensive plan to meet the health needs of all persons.

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INADEQUACIES OF A DISEASE-BY-DISEASE APPROACH

We believe that a "disease-by-disease" categorical approach, oriented to catastrophic illness insurance (such as the coverage recently provided to patients with severe kidney diseases), is unsound, impractical and uneconomical. Cancer Care provides a disease oriented service. We believe, however, that the overall impact of the many illnesses appropriately described as catastrophic are apt to be similar in kind and degree regardless of the disease. Furthermore, the competition for securing insurance coverage among disease oriented agencies would be wasteful in money, time, energy, and emotion. Also it is obviously unfair as a national policy to give preferential benefits based on the nature of an illness suffered by an individual.

On making catastrophic illness coverage an *option* in a National Health Insurance plan would inevitably result in uneven coverage, with many families unwisely preferring to take the risk of a costly illness rather than pay the additional premium. Too many people, in good health, tend to consider catastrophic illness as happening to other people, but not to themselves. For other individuals the possibility of a long, expensive illness and the fear of not being able to pay for it results in a constant underlying anxiety and a lifetime, spent in accumulating savings "for a rainy day," often at the sacrifice of education of children and other essentials of life.

FINANCIAL ADVANTAGES OF SPREADING COSTS OVER THE TOTAL POPULATION

In the long run, combining coverage of catastrophic illness with the normal amount of illness experienced by individuals is said by some authorities to be sound financially. We lay no claim to expertise in medical economics. However, we have been apprized of expert opinion that spreading the large expenditures of catastrophic illness suffered by a relatively small number of people over the total population will make the cost of such insurance feasible.

Jerome Pollack, Professor of Economics of Medical Care, and Associate Dean for Medical Care Planning, Harvard Medical School, speaking at a Cancer Care, Inc. Symposium, suggested that although individual costs of catastrophic illness are great, they are not incurred by a large proportion of the population, and that if included as part of a National Health progrma (which would also presumably lower the incidence of catastrophic illness through better methods of prevention and medical treatment) would not add so greatly to the total cost of the program as to make this kind of coverage prohibitive.

In conclusion, he said, in discussing National Insurance for catastrophic illness: "We will be required to expand risk sharing to ease and even the burden . . . . Our coverage has tended to address itself not to the truly catastrophic but rather to the median section of loss . . . . The additional cost of extending protection to cover the truly catastrophic illness is minimal."

We, therefore, urge the Congress, in planning for health insurance for the nation, to consider the needs of the total population. Even if it must be implemented in stages, let the master plan be comprehensive and all inclusive.

We find that legislative proposals for national health insurance submitted to the Congress so far, do not meet adequately the costs or cover the services apt to be required for long-term catastrophic illness.

Catastrophic illness insurance cannot be merely an extension of coverage for the usual hazards of sickness and accident. There are special factors causing or accompanying catastrophic illness which must be fully studied and understood in making provision for this type of coverage.

There are many such factors which appear to have bene overlooked in framing the catastrophic illness sections of national health insurance proposals, but were clearly revealed in Cancer Care, Inc.'s study. Three of these are duration of the illness; the age and family position of the patient; and the family income in relation to the size of the family.

Duration of Illness

In one-fifth of the cases studied by Cancer Care, Inc., the illness lasted less than a year; in nearly one-fourth of the cases, it lasted four years or more. A few patients in Cancer Care, Inc.'s caseload have been ill for as long as ten years. In most situations, the costs, financial as well as physical and emotional, are cumulative.

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Age and Family Position of the Patient

The ages of patients at death ranged from six to 89. The median age was 60. Nearly one-third were over 70. Most of these were elderly couples or persons living alone. Often they had used their Medicare lifetime reserve for hospital care, and the limited number of home visits were inadequate for their needs. Their resources were slightly above the eligibility line for Medicaid. They were sometimes afraid of "not dying soon enough." For example, an elderly couple living on $3,100 a year incurred $35,000 in medical bills after the husband contracted cancer. They exhausted their life savings, sold their house and tapped every other resource of income to pay the bills. After spending $26,000, they were finally penniless and qualified for Medicaid, which picked up $8,500.

Nearly ⅘ were in the age range from 30–64, the most active years when family responsibilities are greatest. More than one-fourth were heads of households and chief wage earners. The family income usually stopped entirely or was greatly reduced when the wage earner became ill. In some cases inability to work meant also cancellation of health insurance carried by the employer.

In nearly half the cases, the wife of the wage earner was the patient. This situation usually calls for someone to assume household duties. Other family members—husbands, mothers, mothers-in-law, sisters, adult daughters, frequently with families of their own to care for—try to fill the gap.

Many times the breadwinner must stay home from work to care for the children, care for and transport the patient for treatment. The hiring of helping persons in a home eventually becomes a necessity, not anticipated, planned and seldom covered by insurance.

As patients become progressively incapacitated and unable to care for themselves, family members are pushed to their perimeters of perseverance. They are simply unable to cope.

More than one-half of these families in the study lost part or all of their income as a direct result of the catastrophic illness, either through the patient's inability to continue to work, or because another family member had to stop, or cut back, on his job to take care of the patient.

Family Income Related To Size and Age of Family Members

Income during the year before the death of the family member showed this group to be in the middle and lower income brackets. More than one-fourth had incomes of under $5,000 and only 15 percent were in the $15,000 and over bracket.

About one in ten were one-member families, usually widowed and living alone.

There were a number of large families of 5–7 members, but size of family bore little relation to income. On the whole, these families were barely able to survive on their incomes. In families with young children, emotional, psychiatric, and adjustment problems were most frequently experienced. There were difficulties in maintaining positive mental health in the face of the stresses brought on by the fact of advanced cancer in a close family member. A large majority of families found it necessary to cut back on usual expenses for food, clothing, and health care of other family members. Other families used money that had been allocated for further education, or travel or little luxuries to provide for patient needs.

The findings of the study and the day-to-day experience of the Cancer Care, Inc. staff show the effects on family members in contact with a critically ill person plus the need for stringent economy are often "devastating."

Children become frightened and confused. Children who have been very close their parents are reluctant and need to be prodded to even enter the sickroom.

They become confused by changes in personality, frightened by physical deterioration, withdrawn and insecure about their own lives and relations with other people.

In many cases, children's schoolwork suffers. Formerly good students make failing grades. Some refused to go to school at all. Confusion and difficulty in concentration while studying sometimes precipitates actual deterioration in schoolwork. Others become recluses.

Numbers of teen-agers require psychotherapy. One boy refused to finish high school after his mother's death and remained in his room day and night. He moved from his home and his father arranged for psychiatric treatment for him. A teen-age girl had to be in a psychiatric hospital for a year after her mother died. The illness had lasted nine years—most of the daughter's life.

Nearly 2,500 children lived in the homes of patients served by Cancer Care, Inc. last year.

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Among adults the most common results were utter fatigue and frustration.

A woman wrote of being "at her writ's end," needing to work but unable to, her weight reduced to 85 pounds, having stayed up to care for a relative for months from 4:30 p.m. to 8:30 a.m., after the medical homemaker was dismissed for the night.

Care for one patient required change in life plans for four people in the family. The husband took a night job on weekends to add to his income. A daughter who had worked full time and gone to college three nights a week dropped the courses. Another daughter spent full time at college and worked on weekends. The patient's mother, who had health problems of her own, stayed to help out. The patient expected the family to spend all free time at home. Calls from the patient, extra laundry and housework resulted in constant fatigue and family tensions mounted.

Elderly people often had special problems of coping, both personal and financial. A husband, aged 74, still employed, reluctantly gave up his job to care for his wife, and used savings to pay for the medical expense.

An elderly woman started to work full time, with the help of a medical homemaker to care for her husband. However, she had to retire before she became eligible for a company pension and her husband's union pension stopped with his death. She was left with Social Security of $154.80 a month, living in an apartment for which rent was $157.00 a month. She reported unpaid bills owing to six doctors.

In the fiscal year 1978, patients aged 65 and over comprised 47 percent of Cancer Care, Inc.'s caseload.

We are in principle opposed to payment of deductible and co-insurance as part of a national health insurance plan. In cases of long-term catastrophic illness these payments are impractical, imposing unjustifiable and often impossible financial burden on the patient and his family. The burden is compounded by the potentially long duration of the illness and the fact that the patient is very often either the principal wage earner or the wife and mother.

We are aware that the costs of a system of national health services available to every citizen must of necessity be paid for by the citizens, whether by greater Social Security, a separate health payroll tax, part payments of insurance costs, or direct payment to vendors by individuals. In our opinion the payment of deductibles and co-insurance is a complicating factor, adding to administrative costs. In some borderline cases of poverty and near-poverty such payments may tend to discourage persons from seeking the medical help they need but cannot afford. These payments up to the annual amounts required by the current proposals before catastrophic coverage takes effect, we find too great a financial burden for the families which Cancer Care, Inc. is involved. The payment of 10 percent of income or annual expenditures of $1,000 to $5,000 may not seem impossible amounts for a single year, but if the illness continues year after year, cumulative effects may cause severe financial burden.

We therefore request that the three factors mentioned above, namely the duration of illness, family position of the patient, and family composition as related to family income be taken into account before requiring premium payments, deductibles and co-insurance payments in cases of catastrophic illness.

Coverage for post hospital care in most of the proposed plans is woefully inadequate for long-term illness. Either the services required for care of a seriously (often terminally) ill person are not included under insurance coverage, or are so limited in amount as to provide only token payments.

HOSPITAL AND DOCTOR BILLS EVEN WHEN INSURED WITHOUT LIMIT ARE NOT ENOUGH

They are, of course, large items in catastrophic costs. They were reported as major cost items by every family in the Cancer Care study. Hospital costs ranged from under $2,500 to over $30,000; doctors' and surgeons' bills from $200 to over $5,000. Overall these expenses amounted to nearly two-thirds of the total costs directly attributable to the services required for care of these patients. Some, but not all, of the plans introduced in Congress call for unlimited coverage of these two items, and are believed to provide catastrophic coverage. However, there are great variations as to what the proportion of total cost is payment for doctor and hospital.

In one of our cases the total cost of the illness was reported as $13,783, of which doctor and hospital were responsible for $5,472. Other expenses amounted to 8,311. In another case, doctor and hospital costs of $4,000 amounted to less than a third of total costs of $12,230. In yet another case, total care for an illness

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lasting 8 years cost $30,588, of which only $4,000 were due to doctor and hospital costs. In an illness covering an extended period, relatively small proportion of the time is apt to be spent in a hospital. Patients are usually dismissed when they no longer benefit by hospital care. It is important for framers of health insurance legislation to understand that patients may be discharged from the hospital when they are still very ill indeed. They are often terminal patients who literally go home to die.

CARE IN AN EXTENDED CARE FACILITY OR IN THE HOME

The inadequacy of the provisions for care outside the hospital can best be understood by analyzing the range of services received by a patient in a hospital. In addition to doctor, nurse service, laboratory and therapy of various kinds, the patient receives food (purchased, prepared and served) shelter (with daily cleaning and linen change), bathing and grooming, laundry, transportation (by wheel chair if necessary). A social worker is usually available. A bedside library, and small errand service are often available. After the hospital stay, most of these services are still necessary, and if the patient cannot do them for himself, they must be provided or somehow secured.

While the four usual costs were anticipated—doctor, hospital, drugs and burial, at least 23 other services usually not anticipated and not covered by insurance are: medical homemaker, housekeeper, home attendant, nurse, domestic, social worker, equipment, laboratory tests, patient transportation, special treatment, other patient care, food for home help, blood transfusions, patient laundry, dentist, special diets, special clothing, psychiatric treatment, dwelling modifications, nursing home, child care, ext. care facility, patient personal care.

If necessary items for care in the hospital are covered by hospital insurance, though they are not usually labeled "health" services, the question may logically be raised as to why the services essential for adequate care of a catastrophically ill person cannot be covered after he leaves the hospital.

These unanticipated items for care in the home may run into very high costs. For example, if the wife and homemaker is the patient, a substitute for family care and housekeeping must be provided at considerable cost. So far this kind of service has not been included as a legitimate medical expense in any National Health Insurance plan. Since household workers are now covered under a minimum wage, 8 hours a day coverage for a housekeeper would cost nearly $6,000 a year. A trained homemaker-home health aide for 4 hours a day would cost about the same amount.

Among the costs for such items to families studied, one family paid $19,800 for skilled help at home during a period of 8 years and 5 months; another paid $8,688, for a housekeeper and homemaker for 8 years; drugs cost $1,700, and psychiatric care and counseling cost $1,250.

Care in a nursing home when included in benefits is covered for periods of 30 to 120 days per year. If continuous care is required, the total cost soon becomes prohibitive for the average family. The only alternative would seem to be care in the home. But home care services too are limited as to specific services such as registered nurse, home health aide, speech or physical therapist, in some cases, a social worker. Moreover, the number of home visits is also limited. Usually only a total of 100 visits per year, or in one plan, 200 visits are covered by insurance, plus co-insurance.

We believe that under national health insurance, plans for catastrophic illness must include provisions which are sufficiently flexible to meet the patient's individual needs, depending on the nature of care required and the stage of the illness.

Care in the home as well as in a hospital or other health facility should be included.

We believe that social services should be an integral part of such care. The nature of home care service should be planned in relation to the changing needs of the patient and the capacity of the family to provide for such needs.

Plans for care may be made and periodically reviewed by an appropriate agency or a professional team which might include some or all of the following: physician, psychiatrist, nurse, social worker and therapist. Those services deemed essential by such a team to the well-being of the patient should be covered in any national health insurance act.

As indicated at the outset of this statement, Cancer Care, Inc. program provides a direct service to the patient being cared for at home and to their families. The agency provides social work counseling to help advanced cancer pa-

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tients and family members cope with the emotional trauma of the disease, and financial planning and assistance when needed to help pay for the costs of home care. The service program is geared to individual patient and family need according to a financial and service plan worked out by the agency with responsible family members. One important feature in each plan is flexibility to provide the special service needed according to changing needs of the patient over a period of time. A trained nurse is provided for when needed. But nurses are not and should not be employed when the real need is for a housekeeper.

Within a 50-mile radius of New York City, in 1973, Cancer Care, Inc. spent over two million dollars for services on behalf of advanced cancer patients and their families, including social work counseling, planning and information, financial aid, social research and professional education and training.

Of this total, over $936,000 was dispensed to help families pay for 600,000 hours of services needed for home care. Among services provided were homemaker-home health aides, 414,000 hours; housekeepers and domestics, 120,000 hours; attendants, 30,000; and nurses, 24,000 hours.

We realize that the variety of services utilized and the flexibility with which they are used is not easy to incorporate into a federal law. Our Board of Trustees believes that the principles are sound and that they can be incorporated into a system of planning and service which will reflect the variety of health care needs for service.

The position statement of the Board of Trustees of the National Cancer Foundation, Inc. and Cancer Care, Inc. on Catastrophic Illness Insurance As a Part of Comprehensive Insurance, ends with these words: "In addition to the care by a physician and medical treatment prescribed by him, and the social work counseling, services in the home may need to include any or all of the following among a variety of services: homemaker-home health aides, appropriate household or other help, child care; nursing care; transportation; and provisions of wheel chair or other sick-room equipment."

We hope the legislators who have given so much thought to planning for National Health Insurance programs will be willing to think further about the special needs of those who suffer from long-term catastrophic illness.

We are well aware of the urgent need many families feel for the financial relief which they might get from a national health insurance plan passed by this session of Congress. However, we cannot recommend the passage of any bill which does not meet the realities of the costs of long-term catastrophic illness.

We stand ready to give any assistance possible in further consideration of the points we have raised in our testimony today, to aid members of this committee or individual sponsors of national health insurance legislation.

AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES,
Washington, D.C., February 20, 1975.

Hon. PAUL ROGERS,
Chairman, Subcommittee on Public Health and Environment,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: The American Federation of State, County, and Municipal Employees, AFL–CIO, represents over 700,000 public employees across the country, 200,000 of whom work in the health field. Of these 200,000 members, about 80,000 work in mental health institutions. We are vitally concerned, therefore, about the health legislation which the Subcommittee on Public Health and Environment is considering.

During the past two years, AFSCME has conducted a series of Health Institutes around the country involving almost 2,000 health workers and focusing on the trend toward the deinstitutionalization of mental health care. We have learned that, for the most part, patients are being dumped out of state institutions with little or no follow-up care; that institutions are being closed while no alternative facilities exist to accommodate the patients; that no regard is being given to the fate of experienced health personnel working in institutions; and that no thought is being given to the economic impact on communities where institutions slated for closing are located. Since so little have been said about the problems of deinstitutionalization, we have prepared a report detailing our findings. It is attached for your information.[1]

[1] "Out of their beds and into the streets," by Henry Santiestevan and published by the AFSCME. This publication may be found in the committee files.

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The Health Revenue Sharing and Health Services Act of 1975 (H.R. 2954) and the Developmental Disabilities Amendments of 1975 (H.R. 2955) go a long way toward recognizing some of these problems. However, we urge you to incorporate the attached language into these bills in order to improve institutional care, achieve a balanced system of care, and provide community facilities, where appropriate. We believe these amendments would accomplish this goal and minimize any hardships to patients, employees, and the community.

We would appreciate your favorable consideration of these matters which are of great concern to the members of this union. If you would like any additional information or assistance, do not hesitate to call either Margie Siegel (452–4850) or Nanine Meiklejohn (452–4848) our Legislative Representatives.

Sincerely,

MARTIN GLEASON,
Director, Department of Legislation.

Attachment.

AFSCME'S RECOMMENDED AMENDMENTS TO THE HEALTH REVENUE SHARING AND HEALTH SERVICES ACT H.R. 2954

Employee Protections

Deinstitutionalization can mean the wholesale closure of state mental institutions or, at least, cutbacks in institutional staff. A public policy which encourages a change in the method of delivering public services without guaranteeing to the affected employees protections related to their employment status would not be responsible.

The quality of mental health care would be adversely affected under these circumstances. Quality care cannot be provided in an atmosphere of uncertainty and fear among mental health employees in state institutions likely to be affected by deinstitutionalization. Also, at a time of shortages in direct care personnel, it would be folly to lose the services and skill of experienced health workers.

For these reasons, we recommend the following amendment, which is intended to minimize employee hardships and to provide some continuity in employment and in health care. Similar language appears in the Urban Mass Transportation Act, and the Juvenile Justice and Delinquency Prevention Act. (New language is italicized throughout.)

SEC. 102(d)(3)(C)—After subsection (iii) on page 7, between lines 16 and 17 insert a new subsection (iv) as follows:

"*(iii) provide that fair and equitable arrangements are made, as determined by the Secretary of Labor, to protect the interests of employees affected by assistance under this Act. Such protective arrangements shall include, without being limited to, such provisions as may be necessary for—*

I. the preservation of rights, privileges, and benefits (including continuation of pension rights and benefits) under existing collective bargaining agreements or otherwise;

II. the continuation of collective bargaining rights;

III. the protection of individual employees against a worsening of their positions with respect to their employment;

IV. assurances of employment to employees of any State or political subdivision thereof who will be affected by any program funded in whole or in part under provisions of this Act, with first priority for employment in community facilities being given to employees of state institutions who become employed as a result of the shift from institutional to community care; and

V. training or retraining programs, including a planned program for career development and advancement for all categories of personnel.

Renumber old subsections iv and v appropriately.

Using the same rationale, we also urge an additional amendment. The amendment recognizes that work in community centers may require different skills, and, therefore it calls for training and retraining.

SEC. 206(b)(2)—On page 35, between lines 7 and 8, insert a new subsection (H) to read as follows:

"(H) *the adaquacy of arrangements of the applicant for transfer of personnel as well as patients from state institutions serving the catchment area, to be accomplished, where necessary, by means of training and upgrading programs;*"

Renumber old subsection (H) accordingly.

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H.R. 2954 provides that services at community centers may be provided "through appropriate arrangements with health professionals and others in the catchment area". This implies the purchase of services from private providers. We believe such activity should be kept to a minimum and that it should certainly not be used to displace currently employed workers. We recommend the addition of the following phase:

SEC. 201(b)(2)—Amend the second sentence of this subsection on page 19, line 4:

"The center's services (A) may be provided at the center of satellite centers through the staff of the center or through appropriate arrangements with health professionals and others in the center's catchment area; *Provided that no employees will lose their jobs because of contracting out or purchase of services,*"

Continuity in Patient Care

H.R. 2954 contains a good planning mechanism and strong requirements intended to guarantee continuity in patient care and to achieve a balance of institutional and community-based mental health care. These requirements would be reinforced by the following additions:

1. SEC. 102(d)(3)(C) (page 7, line 14)—Amend Subsection (iii) on page 7 line 14:

"(iii) include a detailed plan designed to eliminate inappropriate placement of persons with mental health problems in institutions: *Provided that provision is made for adequate safeguards that no public institution will be closed and that no patients requiring continued care will be released until alternative facilities providing quality care are operating;* and to improve the quality of care for those with mental health problems for whom institutional care is appropriate;"

2. SEC. 201(b)(2)—Amend the first sentence of this subsection on (page 18, lines 23 and 24)

"The provision of comprehensive mental health services through a center shall be coordinated with the provision of services by other health and social services agencies in the center's catchment area *and with state institutions serving the same catchment area* to insure that persons *needing services* or receiving services through the center have access to all such health and social services as they may require."

AFSCME's RECOMMENDED AMENDMENTS TO THE DEVELOPMENTAL DISABILITIES AMENDMENTS OF 1975 H.R. 2955

Employee Protections

Deinstitutionalization of care for the developmentally disabled involves the same kind of dislocation of institutional employees and possible negative consequences for the quality of patient care described in connection with the deinstitutionalization of mental health care. For this reason, we urge that H.R. 2955 be amended to include employee protection language. As with H.R. 2954, this amendment is designed to insure that employees will not be adversely affected by any restructuring of the mode of delivery of services. The amendment also recognizes the need for retraining building on skills already acquired. Again, there is adequate precedence for this language in other laws, including the Urban Mass Transportation Act and the Juvenile Justice and Delinquency Prevention Act. (All new language is italicized.)

SEC. 5(b)—On page 8, line 3 substitute "*(22)*" for "(21)". On page 9, line 4 delete 'and."' Add a new subsection (21) between lines 4 and 5 on page 9 to read as follows:

"*(21) provide that fair and equitable arrangements are made, as determined by the Secretary of Labor, to protect the interests of employees affected by assistance under this Act. Such protective arrangements shall include, without being limited to, such provisions as may be necessary for—*

A. the preservation of rights, privileges, and benefits (including continuation of pension rights and benefits) under existing collective bargaining agreements or otherwise;

B. the continuation of collective bargaining rights;

C. the protection of individual employees against a worsening of their positions with respect to their employment;

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D. assurances of employment to employees of any State or political subdivision thereof who will be affected by any program funded in whole or in part under provisions of this Act, with first priority for employment in community facilities being given to employees of state institutions who become unemployed as a result of the shift from institutional to community care; and

E. training or retraining programs, including a planned program for career development and advancement for all categories of personnel;"

Continuity in Patient Care

Like the Health Revenue Sharing bill, the Developmental Disabilities Amendments establish a dual goal of eliminating inappropriate placement in institutions and of improving the quality of care for persons for whom institutionalization is appropriate. To strengthen this dual focus, to improve state planning processes, and to guarantee that patients will not merely be released without any provision for follow up care, we recommend the following amendment:

SEC. 5(b)—Amend this subsection on Page 9, line 2:

"(20) contain a plan designed to eliminate inappropriate placement in institutions of persons with developmental disabilities: *Provided that provision is made for adequate safeguards that no public institution will be closed and that no patient requiring continued care will be released until alternative facilities providing quality care are operating;* and to improve the quality of care and the state of surroundings of persons for whom institutional care is appropriate; and"

Finally, we hope that the Committee Report on this bill will strike more of a balance between deinstitutionalization and upgrading instituitonal care than did last year's report on an identical bill. Otherwise, all the money in the set-aside from the state allocations for deinstitutionalization and upgrading institutions may be used for deinstitutionalization alone. There is a clear need for a dual system of care; the Committee Report should point out that a fair share of the set-aside be used to improve institutions since there always will be a need for some institutional care.

THE NATIONAL EASTER SEAL SOCIETY
FOR CRIPPLED CHILDREN AND ADULTS,
Chicago, Ill., February 21, 1975.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on Health and the Environment,
House of Representatives,
Rayburn House Office Building,
Washington, D.C.

DEAR CHAIRMAN ROGERS: Enclosed you will find a statement of the National Easter Seal Society for Crippled Children and Adults which, together with this letter, we request be included in the record regarding your consideration of the Developmental Disabilities legislation.

The statement reflects our deep concern about the Developmental Disabilities Act and our support for it. The major point stressed in this statement is the need to clarify the definition of developmental disabilities so that it would relate to functional capacity and not specific types of impairments. We believe that the bill under consideration still poses some of the problems inherent in the bill proposed last year. The focus of our definition is on behavioral deficits resulting from a physical or mental condition which substantially interfere with an individual's ability to acquire normal skills and knowledge and to engage in competitive employment or manage his own affairs. We believe that attempts to list specific types of impairments can never fully reflect the basic intention of this law which is to provide services to better enable every disabled individual unable to acquire normal skills and knowledge to become more independent and self-sufficient. We believe that our definition as set forth in this statement and mentioned above lends itself much more readily to the establishment of a program responsive to the basic goals of the legislation.

We would also like to take this opportunity to indicate to the Subcommittee the importance of community-based care and services in the field of developmental disabilities.

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As you know, the National Easter Seal Society operates about 250 outpatient centers serving about 238,000 physically handicapped children and adults, a substantial number of whom are developmentally disabled. We believe that resources such as our centers need to be further developed so that parents of disabled children and disabled individuals have more choices with regard to the placement of disabled people.

We appreciate the opportunity to submit the accompanying statement and this letter and we will be glad to be of assistance to the Subcommittee as it considers this very important legislation. We commend you and the other Members of the Subcommittee for your dedication to this program and to the disabled in thiscountry.

Sincerely,

EDWARD J. DRAKE, *President.*

NATIONAL EASTER SEAL SOCIETY FOR CRIPPLED AND ADULTS POSITION ON DEVELOPMENTAL DISABILITIES LEGISLATION

The nationwide Easter Seal Society has a direct interest in proposals under consideration in Congress to modify the Developmental Disabilities Act. With few exceptions our affiliated societies are a major provider of the wide range of diversified services which may be supported under the Act in order to meet the lifetime needs of developmentally disabled persons.

From a perspective developed during 53 years of providing direct services to physically handicapped persons and their families, we have reviewed Public Laws 88–164, 91–517 and 93–45.

The Developmental Disabilities Act stems from Public Law 88–164, the first national commitment to promote the welfare of the mentally retarded. With the passage of the Developmental Disabilities Act in 1970, significant and important changes were made, the most important being the addition of the concept of services.

Definition

As presently written the Act has good intentions but it could have disastrous effects. It has set the welfare of one handicapped child against the other; one parent against the other; one organiaztion against the other. If we have learned anything, it is that the gains we have made in promoting legislation and in obtaining appropriations, have all been made because we have worked together in the attainment of a common cause.

The controversy over the Act lies in the definition of developmental disabilities and its interpretation upon which implementation of the law rests. The broadening of the definition to include cerebral palsy, epilepsy, and other neurological conditions requiring treatment similar to that needed by mentally retarded persons was a remarkably important move. It is unfortunate that in defining developmental disabilities, three diagnostic conditions were listed and that other developmental disabilities were lumped together under the phrase, "other neurological conditions". Specifying the three conditions has resulted in implementing this Act with undue emphasis on mental retardation, epilepsy and cerebral palsy to the detriment of services to other developmentally disabled children and adults. Although the definition was not intended to limit benefits to the three disorders, and because of ambiguity in the wording, in actual practice it excludes services to most other developmentally disabled persons.

The National Easter Seal Society could support the definition that was proposed by the National Advisory Council on Services and Facilities for the Developmentally Disabled, namely:

> "Developmentally Disabled means a disability which 1) is attributable to medically determinable physical or mental impairment; 2) originates before the individual attains age 18 and has continued or can be expected to continue indefinitely; 3) constitutes a severe handicap to substantial gainful activity (or in the case of a child under 18, a handicap of comparable severity)."

This definition would eliminate mention of the three diagnostic conditions and focus on the most substantially handicapped.

We would be willing to settle for the definition of the Council rather than further fractionate the forces concerned with the welfare of handicapped persons.

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If, however, the House Committee were to explore a more comprehensive definition, we would suggest the following:

> "a Developmentally Disabled person is one with a physical or mental condition, originating before age 18 which has continued or can be expected to continue during the life of the individual, *and which leads (or has led) to functional deficits which substantially* interfere with the individual's ability to acquire normal skills and knowledge, to engage in competitive employment, or to manage his own affairs without public assistance."

Such a definition does not make reference to a "medically determinable" impairment or to a category of individuals. These are not oversights for we believe it is only through an analysis of one's functioning ability that we can determine whether or not he is disabled in contrast to his having a physical handicap. The person who makes the determination should be experienced in the remediation of such disabilities. The concept in this definition is based upon functioning ability rather than upon etiology.

Other Considerations

The original Developmental Disabilities Act did not give guidance to the functions of the State Planning and Advisory Councils on the Developmentally Disabled. This has caused confusion in some States and has prevented these councils from performing in an effective way. We are aware of the problems some Easter Seal Societies have experienced in attempting to work with State Councils for the Developmentally Disabled. It would be useful if the amended legislation could provide more guidance about functions of these Councils.

The National Easter Seal Society wants to go on record as recognizing the Developmental Disabilities Act as a very important piece of legislation. It is our belief that the Act could be strengthened by clarifying the definition. We would like to see a differentiation between that which is a physical condition and that which constitutes a handicap. We would like to see the focus on services and not on diagnostic categories. We would like to see services available to any person with a substantial handicap originating before age 18 who needs such services. We would like to see as much Federal money as possible funneled into these programs so that the impaired in our society need not be permanently handicapped.

NATIONAL ASSOCIATION OF COUNTIES,
Washington, D.C., February 22, 1975.

Hon. PAUL ROGERS,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROGERS: On behalf of the National Association of Counties (NACo), I take this opportunity to present the views of NACo on H.R. 2954, the "Health Revenue Sharing and Health Services Act of 1975."

As you know, Mr. Chairman, the programs authorized by H.R. 2954 are carried out by a majority of county health agencies across this country.

We supported similar legislation last year (H.R. 11511). We also urged President Ford not to pocket veto the bill when it passed Congress.

Again, we support passage of the health revenue sharing bill. Our reasons for support are clearly outlined in NACo's testimony before your Subcommittee last year.[1]

We do, however, have one major concern. This concern deals with Section 314(d)(6)(A) of Title I of H.R. 2954. (See page 9 of the bill.)

The 314(d) program, although under-funded since its inception, was the early proto-type of special revenue sharing or block grant seen now in the Comprehensive Employment and Training Act (CETA), the recently enacted Community Development Act and the Law Enforcement Assistance Act (LEAA). Both forms of revenue sharing consolidate separate categorical project grant programs in manpower, criminal justice and housing into general purpose programs. They have allowed locally elected officials a sufficient amount of flexibility and certainty of funding from year to year to able them to use federal funds to the best advantage.

[1] See p. 513 of "National Health Services and Health Revenue Sharing," Pt. 1, Serial No. 93-86, hearings before the Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, 93d Congress.

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Earmarking 22 percent of the 314(d) revenue sharing funds for hypertension programs seems to us a retrenchment to the categorical approach to local program funding. We endorse and applaud the Congress, for authorizing funds to treat hypertension. However, these funds should be authorized under a separate title of H.R. 2954 or under other titles of the PHS Act.

Mr. Chairman, again we want to point out how strongly we endorse your efforts to insure that health service programs authorized under H.R. 2954 continue to receive legislative support.

Sincerely yours,

JACK WALSH,
Supervisor,
San Diego County, Calif.,
and Chairman,
NACo Health and Education Steering Committee.

[Whereupon, at 5 :30 p.m., the subcommittee adjourned.]

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AMTRAK AUTHORIZATION

HEARINGS

BEFORE THE

SUBCOMMITTEE ON TRANSPORTATION AND COMMERCE

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

ON

H.R. 3282

A BILL TO AMEND THE RAIL PASSENGER SERVICE ACT OF 1970 TO AUTHORIZE ADDITIONAL APPROPRIATIONS

AND

H.R. 4718

A BILL TO AMEND THE RAIL PASSENGER SERVICE ACT TO PROVIDE FINANCIAL ASSISTANCE TO THE NATIONAL RAILROAD PASSENGER CORPORATION, AND FOR OTHER PURPOSES

MARCH 11 AND 13, 1975

Serial No. 94–5

Printed for the use of the
Committee on Interstate and Foreign Commerce

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AMTRAK AUTHORIZATION

TUESDAY, MARCH 11, 1975

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON TRANSPORTATION AND COMMERCE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2218, Rayburn House Office Building, Hon. Fred B. Rooney (chairman) presiding.

Mr. ROONEY. We are opening hearings today on several bills designed to improve the operations of the National Railroad Passenger Corporation.

H.R. 3282 is a bill requested by the administration. It would supply Amtrak with $63 million in Federal grants as an emergency supplemental authorization for the current fiscal year. We are told that Amtrak will run out money by mid-April without additional Federal funds.

The second bill is one I have introduced, which would combine the emergency assistance with fiscal year 1976 authorizations.

This bill would authorize $63 million for the remainder of fiscal year 1975, $350 million for fiscal year 1976, and an additional $105 million for 3 months in 1976 reflecting the July–August–September period, which conforms with the new Government fiscal year.

In addition, the legislation authorizes $125 million in new loan authority for Amtrak for new equipment and facilities.

This total new authorization—of both loans and grants—is $643 million.

In addition, the legislation freezes the basic system and experimental routes for an additional fiscal year.

We had hoped that we would have had the opportunity this year to undertake a major review of Amtrak operations. In May, Amtrak will have been operating most of the Nation's intercity rail passenger service for 4 years. It is time Congress took a long hard look at its progress.

Unfortunately, the committee will have to devote most of its time this year to the problems associated with the Northeast rail situation. I can promise you that next year we will embark on a major review of Amtrak.

It is because of the time problems that I am recommending to the subcommittee that we consider the emergency supplemental request and the fiscal year 1976 authorization as one package rather than two separate bills. We have five other authorization bills to work on, and a number of other important items in addition to the Northeast rail legislation which need our attention.

Without objection, the text of H.R. 3283 and H.R. 4718 will be printed at this point in the record:

[Testimony resumes on p. 13.]

[Text of H.R. 3283 and H.R. 4718 follows:]

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94TH CONGRESS
1ST SESSION

H. R. 3282

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 19, 1975

Mr. STAGGERS (for himself and Mr. DEVINE) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Rail Passenger Service Act of 1970 to authorize additional appropriations.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Rail Passenger Service Act as amended (45 U.S.C. 501) is amended by striking out "$534,300,000" in section 601 (a) and inserting in lieu thereof "$597,300,000".

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94TH CONGRESS
1ST SESSION

H. R. 4718

IN THE HOUSE OF REPRESENTATIVES

MARCH 12, 1975

Mr. STAGGERS (for himself and Mr. DEVINE) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Rail Passenger Service Act to provide financial assistance to the National Railroad Passenger Corporation, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Amtrak Improvement Act of 1975".

DECLARATION OF POLICY

Whereas it was the original intention of the Congress in the Rail Passenger Service Act to inaugurate a national system of intercity rail passenger services operated by the National Railroad Passenger Corporation; and

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94TH CONGRESS
1ST SESSION

H. R. 3282

IN THE HOUSE OF REPRESENTATIVES

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H. R. 4718

IN THE HOUSE OF REPRESENTATIVES

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Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Amtrak Improvement Act of 1975".

DECLARATION OF POLICY

Whereas it was the original intention of the Congress in the Rail Passenger Service Act to inaugurate a national system of intercity rail passenger services operated by the National Railroad Passenger Corporation; and

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Whereas that Corporation has been established and has undergone four years of development as a national transportation entity; and

Whereas it is in the interests of the Nation to introduce the proper measure of commitment to the provision of intercity rail passenger service over the next several years in order to encourage and permit the Corporation to improve its financial and operational performance and the quality of service it provides;

The Congress finds that it is essential to the national interest to provide a sufficient multiyear Federal financial commitment for the provision of such services; to enhance the effectiveness of the program of State-initiated intercity rail passenger services; and, to establish clearly the authorities and responsibilities of the Corporation for the management of its affairs.

SEC. 2. Section 102 of the Rail Passenger Service Act (45 U.S.C. 502) is amended by amending the definition of basic system to read as follows: "'Basic system' means the system of intercity rail passenger service designated by the Secretary as the 'basic system' prior to the enactment of this definition or the service provided by the Corporation pursuant to section 403 (a) (as that section was in effect prior to the enactment of this definition (and as revised pursuant to section 403 (a) and (c) of this Act.".

SEC. 3. Section 303 (b) of such Act (45 U.S.C. 543) is amended by adding the following sentence: "The Board of Directors of the Corporation has, among others, the fol-

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lowing responsibilities in the development and promotion of intercity rail passenger service:

"(i) responsibility for approving the Corporation's annual operating and capital plan consistent with the provisions of this Act, and the guidelines issued by the Secretary pursuant to this Act;

"(ii) responsibility for approving deletions, additions and changes of service consistent with section 403 of this Act; and

"(iii) responsibility for approving the Corporation's annual report to Congress pursuant to section 308 of this Act.".

SEC. 4. Section 303(d) of such Act is amended by inserting immediately after the third sentence the following: "This limitation upon compensation shall not apply, however, in the event the Board determines with respect to a particular position or positions that a higher level of compensation is necessary and is not higher than the general level of compensation paid officers of railroads in positions of comparable responsibility.".

SEC. 5. Section 306(a)(3) of such Act (45 U.S.C. 546(a)(3)) is amended by deleting ", except as otherwise provided in this Act,".

SEC. 6. Section 308 of such Act is amended by (a) in the first sentence of subsection (b), striking the words "by

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February 15 of" and by inserting a new sentence immediately after that first sentence as follows: "Until 1977, the report shall be due by February 15; thereafter, it shall be due by February 1 and the reporting period shall be the preceding Federal fiscal year.".

(b) By deleting subsection (c) and substituting the following:

"(c) The Secretary and the Commission shall transmit to the President and to the Congress each calendar year reports on the effectiveness of the Corporation in carrying out the purposes set forth in section 101 of this Act. Beginning in 1976, the Secretary's report on the Corporation shall be made part of the Department's annual report to Congress. The report of the Commission will be due on March 15.".

SEC. 7. Section 403 of such Act (45 U.S.C. 563) is amended by (a) changing the title of such section to "CONTINUATION OF SERVICE" and (b) by deleting subsection (a) and inserting the following in substitution:

"(a) The Corporation may add routes or delete routes or required service of the basic system but only in accordance with this subsection and with a plan approved pursuant to section 601 of this Act. Within one hundred and eighty days of the enactment of this subsection the Board of Directors shall establish procedures by which the Corporation may

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add routes or delete routes and required services of the basic system. The procedures must be submitted to the Secretary, and the Secretary shall approve the procedures within sixty days of receipt unless he finds that they are not adequate in terms of procedure and do not provide for adequate public notice, opportunity for an informal public hearing, publication of the final decision, and transmittal of that decision to the Secretary, the Congress, and the Interstate Commerce Commission.".

SEC. 8. Section 403 (b) of such Act (45 U.S.C. 563 (b)) is amended by (a) inserting a "(1)" immediately after the "(b)", by inserting in the first sentence the word "intercity" before the words "rail passenger service", and by deleting the second sentence and inserting the following in substitution: "The Corporation shall institute such service under a two-year, renewable agreement if the State, regional, or local agency agrees to reimburse the Corporation for 50 per centum of total operating losses and associated capital costs of such service if that service can be provided within the resources available for service under this subsection and if that service is consistent with the following requirements:

"(A) The State or agency must make an adequate assurance to the Corporation that it has sufficient re-

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sources to meet its share of the costs of such service for at least two years; and

"(B) The State or agency has conducted a market analysis acceptable to the Corporation to insure that there is adequate demand to warrant service.";

(b) adding the following paragraphs:

"(2) If more than one application is made for service and all applications are consistent with the requirements of this subsection, but all the applications cannot be accepted within the available resources, the Board of Directors shall decide in its discretion which application or applications best serve the public interest and can be provided within the available resources, except that a proposal for State support of a service dropped from the basic system will be given preference.

"(3) The Board of Directors shall establish the basis for determining the total costs and total revenue of the service provided pursuant to this subsection.".

SEC. 9. Section 403(c) of such Act (45 U.S.C. 563(c)) is deleted and the following is inserted in substitution:

"(c) Service on all experimental routes designated by the Secretary pursuant to section 403(c) (as that subsection was in effect on the date before the enactment of the Amtrak Improvement Act of 1975) shall cease two years

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after that service was initiated, unless the Corporation finds that it has attracted sufficient patronage to serve the public convenience and necessity. If such service is continued, it shall become part of the basic system subject to subsection (a). Funds authorized in section 601 for the basic system may also be used for experimental routes regardless of whether such routes are made part of the basic system.".

SEC. 10. Section 404 of such Act (45 U.S.C. 564) is amended by deleting subsection (b) and by inserting the following in substitution:

"(b) Any route or required service may be discontinued or changed by the Corporation pursuant to section 403 (a) of this Act, notwithstanding section 13a of the Interstate Commerce Act, provided that at least thirty days' notice of any change or discontinuance of service is sent by mail by the Corporation to the Governor of each State in which the train in question operates. If any Governor responds to such notice, the Board shall review such comments before taking final action pursuant to section 403 (a) of this Act.".

SEC. 11. Section 601 of such Act (45 U.S.C. 601) is amended by (a) in the first sentence of subsection (a), striking "$534,300,000" and inserting "$597,300,000" in substitution and by inserting "through fiscal year 1975"

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immediately after the words "subsequent fiscal years" and by (b) adding the following new subsection:

"(c) There are authorized to be appropriated to the Secretary for the benefit of the Corporation the following sums:

"(i) for the payment of operating expenses for the basic system and operating and capital expenses of service provided pursuant to 403(b), $315,000,000 in fiscal year 1976; $95,000,000 for the period July 1, 1976, to September 30, 1976 (hereinafter referred to in this section as the 'transition period'); $320,000,000 in fiscal year 1977; $325,000,000 in fiscal year 1978; and $330,000,000 in fiscal year 1979. Of the foregoing amounts, the maximum authorized for service provided pursuant to section 403(b) is as follows: $25,000,000 in fiscal year 1976; $7,000,000 for the transition period; $30,000,000 in fiscal year 1977; $35,000,000 in fiscal year 1978; and $40,000,000 in fiscal year 1979.

"(ii) for the payment of capital expenditures of the basic system: $110,000,000 in fiscal year 1976; $25,000,000 for the transition period; $110,000,000 in fiscal 1977; $110,000,000 in fiscal year 1978; and $110,000,000 in fiscal year 1979.

"(iii) Such sums as are necessary for the payment of increased operating costs of the basic system of the

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Corporation due to inflation calculated in the following manner: Annually, beginning in fiscal year 1976, the total cost impact on the Corporation resulting from inflation for operating the basic system shall be calculated by the Secretary, using the Corporation's total costs during the preceding fiscal year as a base, and based nationally established cost indices for (a) labor, (b) fuel, and (c) materials. The Secretary shall publish his procedures for making these calculations in the Federal Register for comment. The Corporation shall submit such data as the Secretary deems necessary to assist him in making these calculations. The Corporation shall be entitled to an additional annual authorization for operating the basic system for any fiscal year or period calculated as follows:

$$\text{"Total cost impact of inflation for the current fiscal year or period} \times \frac{\text{Federal operating grant for preceding year}}{\text{total Corporation costs for preceding year}} = \text{additional authorization.}$$

"(c) (1) Funds appropriated pursuant to this authorization shall be made available to the Secretary during the fiscal years for which appropriated and shall remain available until expended.

"(2) Within one hundred and eighty days of the enactment of this subsection, the Secretary shall issue, and from time to time amend as he deems necessary, guidelines for

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establishing sound budgetary and planning procedures for the Corporation. Such guidelines shall address the following:

"(A) Financial and operating data to be included in the Corporation's capital and operating plan required under this subsection;

"(B) Date for submission of the plan;

"(C) Accounting, contracting, and other administrative and statutory requirements regarding the use and expenditure of funds disbursed pursuant to this Act;

"(D) Procedures for considering major deviations from the annual plan proposed subsequent to the time the plan was approved by the Secretary.

"(3) The Board of Directors of the Corporation shall thereafter submit to the Secretary an annual plan of proposed operating and capital expenditures, and the Secretary shall approve such a plan, based on such information as he may require within the guidelines, if it can be executed within the projected resources available to the Corporation. The Secretary shall thereafter pay to the Corporation such sums as are appropriated and are consistent with the approved plan.".

SEC. 12. Section 602 of such Act (45 U.S.C. 602) is amended by deleting subsections (h) and (i).

SEC. 13. Section 801 of such Act (45 U.S.C. 641) is amended by deleting subsections (a) and (b) and by insert-

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ing the following in substitution: "The Commission shall, at least one time each year, make such recommendations to the Corporation and the Congress as it determines are necessary to provide adequate service for quality intercity passenger rail service.".

SEC. 14. Section 305 of such Act (45 U.S.C. 545) is amended by striking subsection (h) and inserting the following in substitution:

"(h) The Secretary of the Treasury shall establish and maintain, in cooperation with the Corporation, customs inspection procedures for trains operated in international intercity rail passenger service that, consistent with the effective enforcement of the customs and related laws, will be convenient for passengers and will result in the most rapid possible transit between embarkation and debarkation points of such service.".

Mr. ROONEY. Our first witness today is the Honorable Asaph Hall, Acting Administrator of the Federal Railroad Administration within the Department of Transportation.

Mr. Hall, if you will identify your colleagues, you may proceed.

STATEMENT OF ASAPH HALL, ACTING ADMINISTRATOR, FEDERAL RAILROAD ADMINISTRATION, DEPARTMENT OF TRANSPORTATION, ACCOMPANIED BY RALPH MUELLER, ACTING DIRECTOR, PLANNING AND BUDGET DEVELOPMENT; AND WILLIAM LOFTUS, ACTING ASSOCIATE ADMINISTRATOR FOR FISCAL ASSISTANCE

Mr. HALL. Thank you, Mr. Chairman.

On my right, I would introduce Mr. Ralph Mueller, Acting Director of Planning and Budget Development and on my left, Mr. William Loftus, Acting Associate Administrator for Fiscal Assistance.

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Mr. Chairman and members of the committee, I appreciate this opportunity to appear before you today to discuss the urgent need for additional authorizations for fiscal year 1975 as well as to discuss the administration's proposals to deal with Amtrak's requirements in future years.

FISCAL YEAR 1975 REQUIREMENTS

Mr. Chairman, in June 1974, Amtrak estimated its gross operating deficit for fiscal year 1975 at about $150 million. Based on this estimate, the Amtrak Improvement Act of 1974 included an additional authorization of $200 million under section 601(a) of the Rail Passenger Service Act. However, fiscal year 1975 has been a year of extreme difficulty for Amtrak in forecasting its revenues and costs. The economic recession, changing travel patterns, and the high rate of inflation have had a severe impact on the entire railroad industry including Amtrak. Because of the higher costs for wages and fuel and the additional cost of adding service due to increased demand, Amtrak revised its estimated deficit in September 1974 to a level of $238.2 million. At that time, Amtrak indicated that this revised estimate did not include certain contingency costs which, as they occurred, would raise the deficit even higher. These contingencies included the impact of inflation costs during the remainder of fiscal year 1975, the financial impact of new incentive performance contracts between Amtrak and the operating railroads, and a proposed program for overhauling passenger cars.

Certain of these contingency costs have now occurred and Amtrak currently estimates its operating deficit for the current fiscal year at $325 million including depreciation.

A total of $247.1 million in appropriated funds and noncash deductions is currently available to meet this anticipated deficit leaving a total cash deficit of $77.9 million for the remainder of this fiscal year. Of this deficit, $14.9 million can be met through the use of existing authorizations under section 601(a) of the act. The remaining $63 million, however, will require additional authorizations. Mr. Chairman, I have attached to my prepared statement a table [see p. 23] which relates Amtrak's total fiscal year 1975 deficit to the requirement for and additional $63 million in new authorizations. Amtrak estimates that its presently available resources, including the $14.9 million available under current authorizations, are not adequate to carry the corporation through April of this year. Therefore, to avoid a drastic curtailment or even cessation of rail passenger service, the additional authorization of $63 million and the full supplemental appropriation of $77.9 million will be required by mid-April. The only other alternative would be to reduce costs through temporary cessation of some or all of the mandatory service which Amtrak must now provide, which would be inconsistent with the service requirements established in the act.

Mr. Chairman, I would like to underscore the immediacy and urgency of Amtrak's fiscal year 1975 requirements. Authorizing an appropriation legislation is urgently needed to avaid curtailment or stoppage of service.

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AMTRAK'S LONG-TERM REQUIREMENTS

Mr. Chairman, I would now like to turn to the future of intercity rail passenger service and the need we perceive for Amtrak to be directed toward the development of a dynamic rail passenger system that performs an essential transportation function and continues to justify a strong Federal commitment. The Department has been concerned with the continued rise in Amtrak costs, a relatively uncontrollable situation which is exemplified by what this committee is confronted with today in respect to fiscal year 1975 funding. Our goal in developing the administration's legislative approach has been to create the basis for a financially stable, efficient service-oriented Amtrak. To achieve this goal, the legislation which we propose has the following objectives:

1. To establish a long-term and firm commitment of Federal support to intercity rail passenger services;
2. To place responsibility for the development and promotion of efficient intercity rail passenger service within Amtrak and to permit the Amtrak system to change consistent with transportation demand and available resources; and
3. To provide a more efficient mechanism for States or groups of States to initiate intercity rail passenger service in conjunction with Amtrak.

LONG-TERM FUNDING

Since the inception of service by Amtrak on May 1, 1971, the development and promotion of rail passenger service has been hampered by the failure of a long-term authorization. Amtrak has not had a firm, long-term funding commitment by the Congress or the executive branch on which it could develop its long-range operating and capital plans. The uncertainties inherent in an annual authorization process have resulted for the most part in piecemeal, short-term planning. At the same time, both the Congress and the executive branch have had to deal with a rising and relatively uncontrollable deficit which, as we discussed earlier, requires an immediate additional authorization in fiscal year 1975. We believe the annual authorization process is neither productive nor constructive of sound financial planning or cost estimation and controls by the Corporation.

The Corporation has made progress toward fulfilling the original intent of the act. A national rail passenger system is in place. New equipment is now entering the system, and the consumer will have this year the choice of rail transportation in all major markets. Now that this initial phase is completed, a more permanent basis of providing Federal support to the Corporation is needed as the basis for continued development and improvement of the system.

The administration proposes a 4-year authorization in excess of $2 billion to meet Amtrak's operating and capital requirements during this period.

Mr. Chairman, may I add at this point, I have attached to my statement a copy of the Administration's proposed bill entitled, "Amtrak Improvement Act of 1975" [1] and a section by section

[1] H.R. 4718 was introduced on March 12, 1975. See p. 3, this hearing for text of bill.

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analysis of the bill for the committee's reference [see p. 22]. These authorizations are calculated based on data submitted by Amtrak to permit Amtrak to continue the level of service the corporation currently plans for fiscal year 1976. It envisions no major restructuring of service for the next 3 years—through fiscal year 1979. The level or mix of service provided during the period could be changed by Amtrak to the extent additional revenues are generated by traffic growth, fare changes, cost savings, and economies achieved by putting new equipment in service and by other management improvements.

Specifically, the administration proposes an authorization of $315 million for fiscal year 1976, rising to $330 million by 1979, to provide for Amtrak's operating expenses. The authorization also includes $95 million for operating expenses during the fiscal year 1976 transition quarter. The fiscal year 1976 amount is based on Amtrak's estimate to continue all current services during that year. In addition to this basic funding commitment, the administration's bill recognizes that Amtrak is subjected to inflationary pressures over which the Corporation has little or no control. In order to accommodate the cost impact of inflation, the Administration's bill would provide a mechanism through which the annual authorization is increased to meet a share of the inflationary costs that occurred during that year. The Government's share of the calculated annual inflation costs would be directly related to the percent of the Corporation's total costs funded by Federal grants. The concept of sharing the burden of inflation between the Government and the Corporation results from the fact that the Corporation's revenues cover only about half of its expenses. Therefore, it would be unreasonable to expect the Corporation to generate through the fare box the full costs of inflation arising from its total cost base. For fiscal year 1976, the total authorization and appropriation for operations contained in the President's budget is $350 million, which allows for $35 million to cover increased deficits due to inflation.

To date, Amtrak's capital program has been funded through federally guaranteed loans. At the end of this fiscal year, approximately $860 million of such guaranteed loans will be obligated. Our projections indicate that the Corporation will be unable to repay this debt. It is neither practical nor fiscally responsible, therefore, to continue to use this as a method of financing Amtrak's capital program. Furthermore, debt servicing of these guaranteed loans is becoming an increasing burden to the Corporation as outstanding loans and interest rates have increased over the past 2 to 3 years. For example, Amtrak now estimates interest costs on its outstanding debt at $38.8 million in fiscal year 1976.

In order to meet Amtrak's urgent needs for equipment, motive power, and other capital requirements—including spot improvements on the existing rights-of-way necessary for their use by passenger service—the administrations' proposed bill also includes $110 million in grant funds for each year during the 4-year authorization period, plus an additional $25 million for the transition quarter.

I should emphasize that this amount does not provide for major passenger-related improvements on rail right-of-way which have

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heavy freight use. We have specifically excluded such funding from our proposal for several reasons:

First, the Regional Rail Reorganization Act of 1973 requires the Department to initiate a program to improve rail passenger service on the northeast corridor where it is the predominant service. We are in the final stages of completing our planning studies on the corridor. The results of these studies will provide for both the executive branch and the Congress a basis for considering the most appropriate means to improve service on the corridor. In the interim, the Department and Amtrak this year are jointly implementing track and roadbed upgrading and maintenance programs totaling $40 million, with $25 million already appropriated under recent amendment to the Regional Rail Reorganization Act and $15 million of Amtrak loan authority. These programs will allow work on the corridor to continue through fiscal year 1976.

Second, we believe that passenger-related right-of-way improvements on freight lines must be accomplished in conjunction with overall improvements related to freight service. The final system plan of the U.S. Railway Association for restructuring the Northeast and Midwest railroads will provide a basis for considering right-of-way improvements in this section of the country.

Third, we are in the midst of examining how the rail right-of-way improvement question can be best addressed for the entire railroad industry. We expect to submit further proposals to the Congress on this critical matter during the remainder of the session, and therefore, we do not believe the extremely complex issue of freight and passenger rail right-of-way improvements should be addressed simply in the context of Amtrak legislation.

As a final element of our proposed 4-year authorization, we are investigating the appropriateness of the initiation of a program for the orderly retirement of the Corporation's existing debt. The interest burden of the Corporation is growing and, as I indicated earlier, there is no hope that the Corporation will ever be able to retire the debt.

I have attached to my statement a table which summarizes the authorizations included in our proposal [see p. 23].

An issue related to the retirement of the Corporation's debt is the appropriateness of the presence of private sector equity stockholders on the Amtrak Board. This issue needs to be addressed. The administration is therefore considering the most appropriate methods by which the Corporation can acquire the outstanding common stock of Amtrak now held by four railroads.

Mr. Chairman, in the aggregate, we firmly believe a commitment by the administration and the Congress to a 4-year program as I have outlined will provide a sound and very necessary basis upon which Amtrak can develop and improve the Nation's system of intercity rail passenger service. It will provide a basis for developing long-term plans and will set aside whatever uncertainties there have been of the Federal commitment to rail passenger service.

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AMTRAK RESPONSIBILITY AND ACCOUNTABILITY

I would now like to address the other major element of my proposal, that of Amtrak's responsibility and accountability.

For long-term financing of rail passenger service to be effective in establishing a basis for developing and promoting intercity passenger service, a second element is essential and inseparable. Amtrak must have the necessary flexibility and management discretion to implement such a program. At present the responsibility for the promotion of intercity passenger service is fragmented. The ICC has the responsibility for determining quality of service standards as well as authority to approve or disapprove the discontinuance of routes. The Department of Transportation has authority to assure the prudent use of Federal funds through the issuance of guidelines applicable to expenditures of funds for operations and capital. The Congress has mandated that routes and service be continued for specific periods of time regardless of the need or utility.

The end result of this diffusion of authority has been to reduce the Corporation's ability to manage its affairs in pursuit of the commonly agreed objective; namely, to foster intercity passenger service based on sound transportation decisions.

The time has come when we must recognize that regulatory and political control over Amtrak's management flexibility in offering service are counterproductive. The decision process must be more clearly and solidly vested in the entity responsible for providing the transportation service—Amtrak.

It is important to note that the Directors of the Corporation, except for the three railroads which are on the Board because they are common stockholders, are appointed by the President with the advice and consent of the Senate. We believe this is the appropriate time to clearly establish the responsibilities which the Board of Directors is expected to exercise in implementing the act and fulfilling its public obligations. Toward that end the administration's bill clearly establishes the responsibility of the Board of Directors and places on the Board certain responsibilities currently vested in the ICC and the Secretary of Transportation.

The administration bill would make the Board responsible for developing an annual operating and capital plan which can be executed within the resources authorized by this act. The Board would be required to take the steps necessary to raise revenues, cut costs, or alter service patterns and levels to insure that the plan can be executed within available resources. This should introduce greater management discipline into the execution of the Corporation's affairs and will obviate the need for supplemental appropriations such as we are faced with in fiscal year 1975. The Secretary of Transportation would be required to review the annual plan for operating and capital expenditures. He would be authorized to disapprove it only on a finding that the plan, taken as a whole, cannot be executed within the projected resources available to the Corporation.

In line with our proposal to vest responsibility in the Board of Directors, we propose that the Board be given the flexibility to add, delete, or alter routes and required service without using the procedures of section 13(a) of the Interstate Commerce Act. Our proposal

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would vest this responsibility exclusively within the Board of Directors. However, the Board would be required to establish a systematic procedure including a process of soliciting public views in making these decisions. The procedures adopted by the Board for adding, deleting, or altering routes and required service would be subject to approval by the Secretary to insure that the procedures fully protect the right of the public to have a fair and orderly process for reaching these decisions. The Board would be required to formally notify the affected States, other interested parties, the ICC, the Secretary, and the Congress on its decisions and the basis on which the decisions were reached.

Mr. Chairman, we recognize that this is a sharp departure from current procedures. However, we believe the foundation of Amtrak's ultimate success is management flexibility to develop rail passenger service based on transportation, economic, and environmental considerations rather than a rigid regulatory process or political considerations.

We believe that the resource commitment of which I spoke earlier is sufficient to continue all existing Amtrak service in fiscal year 1976 and to continue most, if not all, service thereafter, should Amtrak desire to do so. We do not foresee a major restructuring of the Amtrak system. We do, however, believe that the prudent use of this authority by the Corporation will result in a system of Amtrak service that is more productive from transportation, economic, and environmental considerations, as well as from a fiscal standpoint.

In line with this important policy, we recommend the modification of section 801 of the act which now authorizes the ICC to establish adequacy of service standards. We believe that prescriptive standards by the Commission are inconsistent with the policy of placing all responsibility within the Board. We propose that the Commission have an oversight role and be required to review, at least once each year, the results of Amtrak operations and to make recommendations to the Corporation, the Congress, and the Secretary on those actions required to provide improved service on the intercity rail passenger system.

We believe there provisions will strike a proper balance between those responsibilities which should be vested in Amtrak and those which must be retained by the ICC and the Secretary. The Secretary through his participation on the Board of the Corporation and through general oversight of the operating and capital plan, will insure that the Amtrak program is supportive of national transportation objectives. Further, we believe that the ICC in an oversight role can be far more effective than in its current role of attempting to regulate and enforce service standards.

Finally, Mr. Chairman, we recommend, consistent with placing full responsibility within the Board, that the current statutory limitations on the salaries which can be paid to Amtrak corporate officers be removed. We have found that the ceiling is a severe restriction in recruiting top management talent. The Corporation must be able to compete effectively in the job market and that requires that it be permitted to offer salaries equal to those that prevail in the private sector. An artificial salary ceiling is an unnecessary and, indeed, an unproductive limitation. It follows the old axiom of being penny wise and pound foolish.

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STATE SUPPORTED SERVICES

The response of certain States to the provision under section 403(b) of the act for initiation of State-supported services has been encouraging. Congress decision to recognize the needs of State and local agencies for intercity rail passenger service to meet the particular and unique requirements of a local or regional market has proven to be a wise one. We are convinced, therefore, that these provisions can be made even more effective by establishing a new Federal-State relationship.

To encourage wider and broader use of the existing authority we recommend that the requirement that a State or local agency agree to reimburse Amtrak for two-thirds of the deficit associated with a service be reduced to 50 percent. Further, we propose that all related capital costs, including stations, be shared on a 50-50 basis. Our proposed amendments to section 403(b) would permit a State or local agency to contract with Amtrak on a 2-year, renewable basis for the initiation of service which met its particular transportation requirements. The administrations' proposal would provide that within Amtrak's total annual authorization for operating expenses, up to $25 million would be available in fiscal year 1976 for State supported intercity services, including associated capital costs. This amount would rise to $40 million by fiscal year 1979.

Given the increasing flexibility the Corporation will have to redesign existing or initiate new service, as well as the enhanced ability of the States to seek the initiation of service under section 403(b), we recommend the deletion of section 403(c) which mandates the initiation of at least one experimental route each year. The initiation of any new or experimental service should be left to the discretion of the Board. All existing 403(c) service would be continued as now provided under the act.

CONCLUSION

Finally, I want to address a point which, while not included in our legislative proposals, will need further consideration. This is the issue of whether contracts are compensatory of the costs incurred by railroads for providing service to Amtrak. This has been a source of much controversy and has most recently been raised by the U.S. Railway Association in its preliminary system plan. It is the Department's view on this matter that we cannot expect rail freight shippers to subsidize rail passenger service. We agree with the statement in the USRA plan that there is a need to establish arrangements that fully and equitably compensate freight and passenger organizations for the services they provide to each other.

In summary, Mr. Chairman, the administration proposes:

1. More than $2 billion over the next 4 years in Federal funding for continuation and improvement of intercity rail passenger services.

2. Strengthening the role of the Amtrak Board of Directors to make key financial and operating decisions free of arbitrary regulatory and political controls.

3. Providing 50 percent Federal funds for State-supported intercity rail services.

Mr. Chairman, it is my sincere hope that the committee will give full and careful consideration to our proposals. We are most sensitive

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to the fact that we are seeking early consideration of additional authorizations for fiscal year 1975 and at the same time proposing significant changes in the legislative policies and programs that will govern Amtrak over the next 4 years. We hope that the committee can find it possible to deal quickly with the additional fiscal year 1975 authorization required to continue Amtrak service without disruption. Other parties will need an opportunity to study our longer range proposals and advise the committee of their views. Whatever course the committee chooses, we will be most willing to work closely with you and the staff.

We believe the basic concepts expressed in our proposals are equally applicable to a shorter time frame bill of 1 or 2 years.

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

[The attachments referred to follow:]

Section-by-Section Analysis of H.R. 4718

[See text of bill on p. 3.]

Sec. 1.—Title: "The Amtrak Improvement Act of 1975"

Sec. 2.—Amends the definition of basic system to include those routes already designated by the Secretary as experimental routes and any route now operated under the present section 403(a) but not yet part of the basic system.

Sec. 3.—Lists specific responsibilities of the Board of Directors, in addition to their existing general corporate responsibilities.

Sec. 4.—Removes the present salary limit for coporate officers if the Board determines that a higher salary is necessary and is not higher than the salary level paid to officers performing comparable duties for other railroads.

Sec. 5.—Makes a technical amendment to the Act made necessary by the amendment in Section 10 of this Act.

Sec. 6.—(*a*) Changes the date for submission of the Corporation's report and designates the fiscal year as the period to be addressed in the report, beginning in 1977. (*b*) Allows the Secretary to submit his report on the Corporation as part of his annual departmental report.

Sec. 7.—Amends section 403 to provide a new mechanism for adding routes or deleting routes and required service. The Corporation is given the ability to change the basic system as long as it follows an appropriate public hearing process and as long as the change is consistent with the annual plan submitted to the Secretary and is within the resources appropriated by the Congress.

Sec. 8.—This section amends section 403(b) which provides for state or agency initiated intercity rail passenger service. This amendment lowers the percentage that states or agencies must pay to 50 percent (from the present 66⅔ percent) of the capital costs and operating losses of the service and provides for a two-year renewable contract between Amtrak and the state or agency. The Board of Directors would determine the basis for determining the total costs and revenues attributable to the service. Two new conditions for this service are introduced: (1) the state or agency must provide adequate assurance that it has the resources for two years operation of the requested service; and (2) the state or agency must provide the Corporation with an appropriate market analysis of the requested service. If multiple applications are made for service and they cannot all be provided within the available resources, the Board is given the discretion to choose which service best suits the public interest, except that a service dropped from the basic system would be given preference.

Sec. 9.—This section terminates the authority to designate new experimental routes by striking the present section 403(c). The proposed section, however, would continue service on routes already designated for a period of two years from the initiation of service. At the end of that time, the Corporation would be given the discretion to determine if those experimental routes became part of the basic system on the same criteria as are now in the present section 403(c).

Sec. 10.—Consistent with the purpose of this bill to provide greater flexibility to the Board to manage the affairs of the Corporation, this section strikes the present section 404 which requires the Corporation to go to the Interstate Com-

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merce Commission before discontinuing a route or required service. This section (and the proposed revisions to sections 403(a) and 601), however, ensures that such a change will be done in a systematic manner with proper public involvement. The proposed revision to section 403 (a) requires a public procedure, approved by the Secretary, which must include an informal public hearing, preceded by adequate public notice. In addition, this section requires that an additional prior notice and opportunity to comment be provided to the Governor of any state which may be affected by a proposed change before the Board may take final action. Finally, all changes must be consistent with the resources made available to the Corporation.

Sec. 11.—This section amends section 601 to provide a long-term, four year authorization for the program and a mechanism for approving the Corporation's annual plan by the Secretary. Specifically, subsection (a) provides an additional authorization of $63,000,000 for fiscal 1975. Subsection (b) provides a four year authorization, totaling more than $2 billion. Of this amount, specific maximum amounts are allocated for service under section 403(b) (up to $130 million); for capital expenditures ($465 million);

To account for possible inflation, an additional amount is authorized to be calculated by the Secretary each fiscal year. The Secretary will make this calculation to offset inflated operating costs based on nationally recognized price indices for labor, fuel, and materials. The additional authorization is intended to offset only the Federal Government's fair share of inflation—consistent with its percentage contribution to the Corporation's operating budget—and thereby to encourage the Corporation to take some measures internally to offset inflation. Therefore, the total cost impact from inflation as calculated by the Secretary is multiplied by a fraction, the numerator of which is the prior year's federal operating grant and the denominator of which is the total Corporate costs. The product of this calculation would equal the additional authorization. For example, if the Secretary calculates that the total cost increase from inflation is $20 million and if the operating grant for the prior year were $315 million and the total costs for the prior year were $630 million, the additional authorization would equal $10 million, calculated:

$$\$20 \text{ million} \times \frac{\$315}{\$630} = \$10 \text{ million}$$

The four year commitment of funds and the specific provision for possible inflation will provide the Corporation a sound basis for planning its future. At the same time, the funds authorized in this section are intended to cover the full federal share of operations. The basic thrust of this bill is to give the Corporation more flexibility, but at the same time to put a definite ceiling on the amount of the federal authorization.

Subsection (c) provides the mechanism for ensuring that this ceiling is not breached. Each year the Corporation must present a plan to the Secretary for his approval. The Secretary is required to establish procedural guidelines for the plan, to include: the data to be included in the plan, the date for submitting the plan, the procedures for amending the plan, and such other procedural matters as relate to the expenditure of Federal funds. The Secretary must approve the plan if the plan is within the resources available from the authorization and projected revenue and if sufficient data, as established by the guildeines, is made available to him.

Sec. 12.—This section terminates the authority of the Secretary to issue guidelines since the amendment to section 601 will determine the scope of Secretarial review.

Sec. 13.—This section amends section 801 to revise the Interstate Commerce Commission's role in determining service standards to one of oversight. Again, this change is consistent with the other amendments to give the Board of Directors flexibility to make basic management decisions as long as the Board stays within the budget authorization.

NOTE.—There is also being submitted an amendment to section 305(h) to clarify the responsibilities of the Secretary of the Treasury with respect to customs inspections on Amtrak's international services.

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Reconciliation of fiscal year 1975 deficit to additional request for authorizations

	Millions
Total fiscal year 1975 Amtrak deficit	$325.0
Less—	
Noncash items (depreciation)	13.8
1-time saving from change in railroad billings	20.0
Funds carried forward from fiscal year 1974	13.0
Fiscal year 1975 deficit requiring appropriations	278.2
Less current authorizations:	
Carryover from prior years	15.2
Enacted for fiscal year 1975	200.0
Additional authorization required	63.0

PROPOSED AUTHORIZATION AMOUNT

[In millions of dollars]

	Fiscal year—		Transition quarter	Fiscal year—			Total
	1975	1976		1977	1978	1979	
Operating grants	63	[1] 315	95	320	325	330	1,448
Section 403(b) limitation included above		(25)	(7)	(30)	(35)	(40)	(137)
Inflation	[2]	[2]	[2]	[2]	[2]	[2]	[2]
Capital grants		110	25	110	110	110	465
Total excluding inflation	63	425	120	430	435	440	1,913

[1] $350,000,000 included in President's fiscal year 1976 budget submission includes $35,000,000 to cover increased deficits due to inflation.
[2] Such amounts as determined by the Secretary.

Mr. ROONEY. Thank you very much, Mr. Hall, for that very concise statement.

I am a bit pessimistic about whether or not Congress will pass a 4-year authorization—$2.1 billion authorization. This country is presently faced with a possible deficit of $52 billion in the 94th Congress, and I doubt whether or not we can sell to the Congress the 4-year authorization proposal.

Why does it have to be 4 years? Why can't it be 1 year? Why can't Congress take a look at it in fiscal year 1977?

Mr. HALL. Mr. Chairman, I think it is our feeling that 4 years is not a magic number. We have looked at that in really two contexts.

One, we would like to see an appropriate time frame of Federal commitment set up so that the Corporation will have a reasonable time to review its own plan, recognizing that much of the work the Corporation has to do in terms of bringing on new equipment, planning the route structure, and making changes in the service, requires considerable leadtime.

It was our feeling to the extent possible both the executive branch and the Congress should try to set up a reasonable time frame for commitment so that the management of Amtrak would not be constantly coming back annually, or actually less than annually, to get the necessary financing to carry out their plans.

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That was one reason. I think the second reason we came up with a 4-year period is that Amtrak has been operating now for almost 4 years. This has been a period of great strain in terms of the management's trying to get really a new system put in place, picking up from a very poor system that was inherited from the railroad industry. We feel that now Amtrak has reached a point where, because of investments that have been made during the initial 4-year period, new equipment will be coming on line in the system during about the next 4 years. The 4-year time frame amounts to a phase 2 for Amtrak, during which it will consolidate the improvements that have been developed during the first 4 years. Thus, Amtrak, for the first time, in our opinion, now will have an opportunity to test the market using the new and better techniques that have been developed. We felt that, therefore, the 4-year time frame was somewhat analogous to the initial 4-year period and picked it for that reason.

I would hasten to say, Mr. Chairman, I think the important point in our proposal is not the 4 years or 3 years or 2 years but rather the concepts that we have tried to express in terms of two points.

First, the commitment on the part of the Federal Government to support Amtrak at a level which will allow continued service and at, we think, a very responsible level of support.

Secondly, the commitment to, or the authority given to, the Amtrak Board and management to put in one place the management of the system, the decisionmaking process which heretofore has been scattered throughout all of these agencies I mentioned.

This would place full responsibility and accountability where it belongs, on Amtrak, for doing a good job. Because of the situation in the last 4 years, it has been hard to do that, and there has developed somewhat of a finger-pointing exercise.

Mr. ROONEY. If we give you a 4-year authorization, do you think that you might discontinue some of these unprofitable, long-haul routes?

Mr. HALL. Well, of course, under our proposal, that would be up to the Board, principally, to determine where changes in either the route structure or service levels are called for.

I think it is our feeling that the authorization levels we envision in this bill would not require any, as I mentioned, any massive change in service.

We do think that Amtrak's Board and management should be able to look at their route structure and determine where service should be increased or decreased; we should give them that flexibility.

Mr. ROONEY. I don't think we could go to the floor with that word "emergency." Every time anyone testifies before our committee, it seems to be an emergency. This committee recently authorized emergency legislation of $347 million to the Northeast Railroad.

You say you do have $15.2 million in authorized funds. If these funds are appropriated, how far will it carry Amtrak?

Mr. HALL. It is my understanding that would not be sufficient to carry them through the middle of April. There are several large payments due toward the middle of April to the railroads, and that money is just not sufficient to cover those payments.

Mr. ROONEY. Do you have any contingency plans?

Mr. HALL. We have been talking with Amtrak management about how additional cost savings could be brought about. I think it is our

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feeling that the only significant cost savings would be as a result of either stopping certain services or severely curtailing certain services.

Amtrak has done, I think, a very commendable job since last fall of recognizing the situation that has come about this year and trying to cut costs as best they can. We don't see that there is too much more they can do to reduce the level of overhead; it comes down to a matter of trying to get direct service costs reduced.

Mr. Loftus advised me that there have been cases in the past where the railroad payments have been delayed. I suppose that is certainly one opportunity that, if Congress were moving toward legislation, and it didn't quite come about on the day that the bill was due, that the railroads might be willing to accept delay. It is not appropriate to do that in our minds. We would not like to see that happen, but I guess that is the last possible way to avert a shutdown.

Mr. ROONEY. I have several other questions, but I do not want to ask them now, but later, and I recognize the gentleman from New Jersey, Mr. Florio.

Mr. FLORIO. Thank you, Mr. Chairman, I have two questions in regard to the last point you talked about in terms of expenditures and difficulties you anticipate in meeting these expenditures. Do you have some breakdown of expenditures which would be attributed to the maintenance of rails and rights-of-way?

I ask you in view of the fact new legislation is pending, designed to exclude the Government from taking over rights-of-way, I am wondering if that legislation should be considered and enacted, and what relief would be provided by enactment?

Mr. HALL. You are talking about the rail industry as a whole, as opposed to Amtrak?

Mr. FLORIO. Yes.

Mr. HALL. As I mentioned earlier in my statement, we are definitely concerned with that problem. The administration—in fact, last year both Congress and the administration were addressing the Surface Transportation Act which had as one of its features, $2 billion worth of federally guaranteed loans, which would have been—in our mind—made principally available for upgrading the tracks and other fixed facilities.

We will be coming forward very shortly to the Congress with an updated proposal based on the general principles int he Surface Transportation Act which will address the track rehabilitation problem. I think that it is fair to say that it is not a simple solution. It is our opinion that taking over the tracks—if you will, nationalization of the tracks—is not the answer to the problem. In fact, it may produce more problems than currently exist.

Mr. FLORIO. What do you prefer?

Mr. HALL. We would prefer to see a restructuring of the Nation's rail system take place, based principally on plans that can be developed by the private sector railroads, rather than set up a nationwide central planning activity for the entire route structure. We think that can take place. There are many good railroads in this country, solvent railroads who have the ability to invest money in their track and fixed facilities. We think we can adapt some legislation to allow them even more incentive and ability to do that.

What we are really concerned with, what most of us tend to think about, is not the good railroads, but about the bankrupt and marginal

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carriers who do not have cash to invest in their fixed plant. It is those railroads we would like to give the ability to work out, if you will, joint trackage and joint operating agreements with other railroads, so that rather than rebuilding every line in the country, we can aim the Government funding and assistance toward rebuilding those major lines which can be used by more than one carrier, perhaps, and in a sense shrink the mainline system which has to be held at a very high degree of maintenance to something more reasonable than it is now. We think it can be done through various incentives and criteria that could be set up under a federally sponsored loan program to the railroads, themselves.

We don't think you have to go so far as to charge the taxpayer for buying up all of the miles of roadbeds and trackage in this country and then rehabilitating them on taxpayers' funds. We think it can be done in a private sector context where the money can eventually be repaid and the taxpayers will not be out many billions of dollars.

Mr. FLORIO. My question was how much of your operating expenses are attributable to maintenance of roads and rights-of-way.

Mr. HALL. I see, in the total industry?

Mr. FLORIO. With regard to Amtrak.

Mr. HALL. No; I don't, with regard to Amtrak.

Mr. FLORIO. Thank you, Mr. Chairman.

Mr. ROONEY. Do you actually believe the railroads can become solvent in this country?

Mr. HALL. I definitely think they can become solvent, given the right environment in which to operate. In fact, I would back-up 1 minute and say most of the railroad industry is solvent. Only the ones that we continuously deal with are not, and I think we tend to look at the bad side almost exclusively.

When you look at the 61 class I railroads in the country, there are only eight now in bankruptcy and probably half a dozen more in the marginal category.

Mr. ROONEY. Mr. Skubitz and Mr. Florio attended a 3-hour briefing the other day by a prominent railroad expert and he indicated to us that every railroad in this country will be bankrupt within the next 15 years.

Mr. HALL. I would say, under the current regulatory environment and under the current inability of rail management to gain access to the capital market, I am not sure I would disagree.

On the other hand, if we and the Congress take the initiative this year and give the railroad industry an ability to manage, through an improvement in the regulatory climate—and much of t is has already been discussed at length last year by the Congress—and also along the lines of, as I was saying, giving the industry access to capital investment, I don't think that has to be the case.

Mr. FLORIO. A gentleman was here last week from the freight carriers. The point he made was that the railroad system of this country is so interdependent and interlocked that one could not effectively say that one railroad was good and one was bad. He maintained that they were all bad to different degrees. None seem to be in a financially stable position.

Mr. HALL. I certainly wouldn't argue that their financial position couldn't be improved considerably. I would agree.

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Mr. FLORIO. The point I wanted to raise, as a last point, was one that was formerly brought up in the meeting with the Freight Carriers. They believe, as do you, that a greater degree of deregulation would make for a healthier railway system. However, the reason the railroads decided to come under a quasi-Government controlled system was because they were having financial problems which they themselves caused, in many ways, through abuses of their finances. The freight carriers argue that the strong competition by other modes of transportation, such as trucking and inland waterways, will keep them honest. There is a different situation with regard to passenger carriers, for the most part. You do not have the same pressures for competition. Therefore, do you believe that greater deregulation of passenger rails will insure no abuses? By abuses, I mean arbitrary discontinuances of lines purely on the basis of profit as opposed to social concern or other economic concern.

Mr. HALL. I think on the passenger side, what you have to compare is rail passenger service against airplane passenger service, against bus passenger service. I would suggest that standing where we are today, that rail passenger service is certainly much less competitive than either the bus or airplane service. I think that is proven by statistics on ridership.

It would be our hope that by giving Amtrak more direct responsibility for improving their system, in other words, by not subjecting them to rigid regulatory controls, that the system would improve, pricing decisions could be made, service decisions could be made more quickly and more responsive to the market in an attempt to improve the competitive situation of rail passenger service.

I think, if anything, rail passenger service is in a much worse competitive situation than rail freight service.

Mr. FLORIO. Thank you, Mr. Chairman.

Mr. ROONEY. I recognize the gentleman from Kansas, Mr. Skubitz.

Mr. SKUBITZ. Thank you, Mr. Chairman.

Mr. Hall, when did the administration get this bill?

Mr. HALL. We finally worked on it all weekend, Mr. Skubitz, and got it cleared yesterday by the administration.

Mr. SKUBITZ. We have been in session since January and the administration has looked forward and knew, even last January, we were going to have a deficit and you were going to have to come down here. You mean to tell me you wait until the day before we have a meeting to present a bill of this nature to this committee?

Mr. HALL. Well, there were two subjects that we were dealing with. One is the immediate problem of the deficit, which I believe was submitted some time ago. This particular bill we have been working on, Mr. Skubitz, since last fall in terms of trying to develop a conceptual approach that the administration asked us to propose. We had it pretty well laid out, but the actual drafting of the language is a tedious process.

Mr. SKUBITZ. Well, it is not fair, to the committee and Congress, to come down here the night before the meeting and hand us a bill like this and expect us to digest the bill and ask you questions about it. This is what I am objecting to.

I think you folks are in trouble down there. You have a plan that should be submitted to us so we can have an opportunity to review it,

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discuss it with our people, and intelligently question you about your program. I don't think we are in a position, really, to do that today.

Mr. HALL. I do definitely agree with that.

Mr. SKUBITZ. I can understand a railroad or an airline coming down the night before and clouding the issue up by saying, "Brother, if we don't have it tomorrow, we are going to lock them up." However, I wouldn't want the administration, the Government or any branch to come here and treat the other branch like that. Am I unfair in this?

Mr. HALL. Not at all, sir. I believe what I tried to say at the end of my statement is it would be our hope, recognizing this is a very recent submission and it contains many, many very drastic changes, which I am sure you want to review, that the committee could find time this session to address these changes and not perhaps try to completely couple the long-term commitment that we are suggesting with Amtrak with the immediate problem we are faced with.

Mr. SKUBITZ. My whole point is this, Mr. Hall: You say we will have a chance to review this proposal. What I would like to do is review it with you.

Mr. HALL. I am at your service.

Mr. SKUBITZ. This means either we need another meeting before we get into the whole matter or we take only the testimony submitted today and go ahead and design our own program.

Now, there are a lot of questions I would like to ask. I don't feel I am really in a position to ask them, because I have not had an opportunity to read the various provisions of the proposal.

One provision you bring out is the 4-year program. Now I have been around this place a long time, not as a Congressman, but on Capitol Hill. It has always been the policy of any administration to come down and say: "We would like to have a 4-year program so we can develop a package which we can look forward to. But, we can't do it in one year."

Now, if you have something to sell and you can come down and justify what you have done in the past and present your proposal, you can have a 4-year or you can have a 10-year program. But I don't think it wise for the legislative branch to authorize programs for 4 years which amount to what—a hunting license from there on. All you have to do is duck the authorizing committee and go to the Appropriations Committee, which does not know what it is all about anyway, and say, "They authorized this amount of money and we have to have it." Then, the committee looks at the total amount of money it has to spend and says, "Boy, we can't give you but x amount of dollars."

The agencies have played a nice game and asked for a lot more than they need so when the Appropriations Committee cuts them down they get at least what they hoped to get in the beginning. That is my feeling anyway.

So I am a little skeptical, as is the chairman of the subcommittee, about these 4-year programs. I would like to visit with you again, and I would like to ask you what was done last year to justify giving you more money next year.

Now, you spoke of "the economic recession changing the travel patterns throughout the country." I assume it did, but I am wondering did it benefit Amtrak? I mean, did it affect air transportation and use

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of private automobiles and even the bus companies? Did they lose business and did you pick it up?

Mr. HALL. The fact is that all modes have lost business, including Amtrak.

Mr. SKUBITZ. Including Amtrak.

Mr. ROONEY. Will you yield?

Mr. SKUBITZ. Yes.

Mr. ROONEY. Didn't you have the greatest year in 1974 as far as passengers?

Mr. HALL. As far as passengers, and I think Mr. Reistrup can address it, but if you look at the chart for 1974 of ridership, it was high in the first 6 months when there was a gasoline shortage and it began to fall off and at the end of last year and at the beginning of this year it is lower than before.

Mr. SKUBITZ. Was the decline because of gasoline availability or because the ride was lousy and riders didn't go back the second time?

Mr. HALL. You may address that to Mr. Reistrup.

Mr. SKUBITZ. Mr. Hall, taking the ridership, let me ask you this question: Under present Amtrak operations, doesn't the addition or the use by more riders actually cause you to go further into debt?

Mr. HALL. That is the way it is working right now, sir.

Mr. SKUBITZ. And for the future you think it looks bright 4 years from now; is that it?

Mr. HALL. No; I think the approach that Amtrak has laid out is that they are planning to bring new equipment on the system.

Mr. SKUBITZ. I am glad you brought new equipment on.

Mr. HALL. They will have higher density seating and obtain more revenue per unit cost and that, plus additional improvements in efficiency, will tend to move its ratio back to what we say.

Mr. SKUBITZ. The equipment, what kind of new equipment?

Mr. HALL. There are a combination of types. The largest number are single-level, low-level cars which are basically called Metroshells, and they have an outside appearance of a Metroliner, but not a self-powered configuration of a Metroliner car.

Mr. SKUBITZ. Will they still have the insides of a 1914 model?

Mr. HALL. No; these are new cars.

Mr. SKUBITZ. Where are you getting them?

Mr. HALL. The Budd Co. has the contract.

Mr. SKUBITZ. And you purchased those in France?

Mr. HALL. No, sir. Those you referred to are turbine trains, which is another type.

Mr. SKUBITZ. How many did you purchase?

Mr. HALL. There are a total of 13 train sets and each contains 5 cars.

Mr. SKUBITZ. Have you more on order at the present time?

Mr. HALL. That is the extent of the order.

Mr. SKUBITZ. That would be 13 trains?

Mr. HALL. Thirteen full trains; that is right.

Mr. SKUBITZ. And how many in each group?

Mr. HALL. There are five cars per train.

Mr. SKUBITZ. I have ridden similar trains, but I have not ridden one since you purchased it here. My question is this: "What good are new trains on a passenger line today—a train that has the competency

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to go 120 miles an hour on a 10-mile-an-hour track?" I mean, what benefit comes to the public from that sort of thing?

Mr. HALL. The track problem is very definitely there. There is no argument about that, Mr. Skubitz. As I mentioned in my testimony, we believe that the solution to the track problem should be looked at from the standpoint of both freight and passengers, because the freight trains are going 10 miles an hour also, which is not good.

We think, for the most part, Amtrak's operations will be operated over freight routes which will be upgraded over the next few years.

Mr. SKUBITZ. Then, we are never going to be able to really have fast rail transportation if we have to depend upon the type of track which will carry freight; is this correct?

Mr. HALL. We need to upgrade the tracks before the service meets the standards that you are speaking of, that is correct.

Mr. SKUBITZ. What do you do about maintenance today? How does Amtrak fit into the maintenance of roadbeds?

Mr. HALL. I believe I should defer that question to Amtrak itself. It is handled under their contractual relationship through the individual railroads, for the most part.

Mr. SKUBITZ. Is Amtrak going to testify today?

Mr. ROONEY. Yes.

Mr. SKUBITZ. Another point that you speak of is, I believe your words were, "it was not proper to raise the rates to the using public," is that right. Instead, that you want grants in order to keep the price down. Is that correct?

Mr. HALL. No; let me restate what we have in mind.

We believe that to the extent possible the impact of inflation should be covered by increased rates. However, in the case of Amtrak, whose revenues are roughtly one-half of their costs, it is in our mind unfair to expect the corporation to recover the total cost of inflation of a very large cost base when it has the ability to collect only about half of those costs the revenue side.

So what we proposed here is that the corporation basically pick up its portion, which is as much as it can get through revenues, and that the remainder of the proportion be picked up through this inflation formula that we have in our bill.

Mr. SKUBITZ. Well, now, I may be a little bit old fashioned, but I was under the impression that we were going to get this thing on a profitable basis someday. However, you don't hold out any light that the public should always be subsidized, instead, for using these different routes, such as in New Jersey?

Mr. HALL. I would say, sitting here today, in the foreseeable future, I see no future in which Amtrak will be profitable.

Mr. SKUBITZ. If you don't see any, what effect will it have on the airlines and buses if we subsidize the railroads? Will the buslines come in next and say, "Hey, you are subsidizing those fellows, what about us?"

Mr. HALL. I think this is definitely a matter of public policy on how the individual modes of travel are treated, Mr. Skubitz. I believe it is fair to say that both Congress and the executive branch, particularly in our new proposal, are saying that "we do believe that it is a matter of public policy that intercity rail passenger service should be subsidized during the immediate future."

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Mr. SKUBITZ. I don't buy that. I tell you that right now. You spoke of the Board's salary and that seemed to bother you a little bit. You feel that paying a higher salary is going to get you better-type men, "a penny saved is a penny earned," or something like that. I forget what it was. Why do you think this is true? Does experience with what we have had in the past prove the point to you?

Mr. HALL. No, sir, I wouldn't say that. It is just that as Amtrak continues to operate, it must be in a position to be able to attract the best people into its management. That is not to say that the people now in its management are not the best people, but it does say it is very difficult to get those people to come into management.

I think our Department's position is very definitely that Amtrak should be able to be competitive from a salary standpoint with its private sector counterparts; that is, the railroad industry. And in order to continue to be able to attract the kind of people that we need to decrease the deficit and get Amtrak going back toward the "black", we need to be able to pay a few more thousand dollars to get the best people to come in and do it.

Mr. SKUBITZ. I am glad you say that because I think we have pretty good fellows in the Amtrak group now. I didn't think salary was the real cause of it. When I look at some of the railroads and see what they pay presidents and the boards of directors and what-have-you, and then I note that about all they did was run them into the red and gripe about the Government not helping them, I wonder whether salary was the main point.

Mr. HASTINGS. Would you yield?

Mr. SKUBITZ. Yes.

Mr. HASTINGS. Do you think if we raise some of the salaries high enough we might be able to get some turnover?

Mr. SKUBITZ. Maybe they are keeping our salaries down so they won't attract better Congressmen.

One other question, Mr. Hall. The reason I object to this 4-year program is that I look at the chart you submitted to us today that proposes the amount, you speak of operational grant section 403(b). Grants go from $63,000 to $300,000 to $320,000, to $325,000 and $390,000, which means total grants are, up to fiscal 1979, $1,048,000. That is the makeup deficit, isn't it?

Mr. HALL. Yes.

Mr. SKUBITZ. What is the basis for that?

Mr. HALL. That is based on Amtrak's estimate during fiscal 1976, what their deficit will be during 1976 to operate all services currently on the route system. We have projected that on into the future and we have added in the line below which says, "inflation to pick up the increment of cost impact on inflation" to cover any increase in that regard that may have occurred.

Mr. SKUBITZ. To me, to go a little further with that, the $315 million for fiscal 1976, what operational grants are you talking about? I mean, what is going to cause that sort of deficit in 1976?

Mr. HALL. Well, Mr. Riestrup, I think in his statement, will address some of the details on what is involved in that deficit. Basically, it is made up of the excess of payments for service over what they take in in revenues. Much of it is. There is also an inflation increment on the cost side and ther is the cost of new services that will be provided in 1976, already initiated, but annualized for 1976.

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There is just the inability at this point in time for Amtrak to completely cover in the revenue side its costs. There is no way that Amtrak has been able to determine that it could raise fares enough to do that because if you raise them too high you lose ridership.

Mr. SKUBITZ. I think it would give the President a little bit more money if he could bring the losses down and let fares go up to some extent.

Mr. HALL. We hope that will happen and we agree.

Mr. SKUBITZ. One other point. You spoke of two things that caused your deficit: Wages and energy. What wage increases were given in the last year?

Mr. HALL. Well, Amtrak operates using railroad personnel who are covered by the National Bargaining Agreements that are entered into by the rail industry.

Mr. SKUBITZ. That is what or why I am asking the question.

Mr. HALL. There was a 10-percent increase just agreed to retroactive to January 1 and another 5-percent increase effective October 1, of this year, and another 4 percent in calendar 1976, and another 4 percent in calendar 1977, under the agreements just reached, plus a cost-of-living increase.

Mr. SKUBITZ. Wait a minute. You are not counting 1977's in on this 1975 deficit, are you?

Mr. HALL. What I was speaking to is the agreement that has been agreed to, and 3-year agreement, under the rail industry, those costs will begin to appear in the fiscal year that the wage increases go into effect.

Mr. SKUBITZ. Mr. Chairman, there are other questions I would like to ask.

Mr. ROONEY. I was about to invoke the 25-minute rule.

Mr. SKUBITZ. We have our authority on railroads here, Mr. Adams, so I will yield.

Mr. ROONEY. I recognize the gentleman from Illinois, Mr. Metcalfe.

Mr. METCALFE. Thank you, Mr. Chairman.

I would like to ask Mr. Hall, when you enter into a contract with other railroads, can you identify the actual cost to the railroads for the use of the various parts of the system, I mean, for instance, how mush is allocated for railroads and how much is allocated for terminals and how much is allocated for stations? How do you break down this allocation?

Mr. HALL. If I may, Mr. Metcalfe, I would like to defer a detailed answer of that question to Mr. Reistrup from Amtrak since the department does not get directly involved in the negotiation of the contracts with the railroads. I would say this, however, during the past year Amtrak has moved away from its original contract relationship with the railroads which were a cost reimbursable plus fixed fee type of contracts, management-fee-type contracts, to a contract which does define a base cost, picking up the element you have mentioned, plus an incentive payment for better performance, above standard performance. So there is a cost base plus an incentive payment to the railroads on most of the contracts now which, in effect, gives them additional payments for being on time, for having equipment available, and so forth.

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We believe that is the appropriate way to go, because it puts the incentive where it belongs, on the operating railroads to do a better job.

I would ask or suggest that you might ask Mr. Reistrup if he could provide any more details on the cost base. I simply do not have that information.

Mr. METCALFE. Let me raise this question: When you enter into these contracts, you have a general idea as to what is specified in these contracts; do you not?

Mr. HALL. That is correct.

Mr. METCALFE. And it relates to these three, so you have general knowledge, but you are suggesting that Mr. Reistrup answer those questions specifically?

Mr. HALL. Yes. They are built up on those basic cost elements.

Mr. METCALFE. Can you explain the reason for entering into incentive contracts with the railroads after having contracted to them the costs; that is, the actual and allocated plus the 7 percent profit?

Mr. HALL. Under the new contractual arrangements, the only base is the cost base and the rest is an incentive payment which was arrived at on the basis that under the old contracts there was no way that Amtrak really had any control over the railroads on meeting certain performance criteria, such as on-time performance.

They have now been able to write into their contracts for the railroads a specified level of performance and if they fall below that there is a penalty and if they exceed it there is an incentive, except that penalties can never be greater than incentives. The only area where there is an additional profit or return on investment capitalization at the moment, that I am aware of, has to do with the Northeast corridor operations of the Penn Central Railroad.

In that case, Amtrak had agreed in concept with the Penn Central and this is not approved by the reorganization court judge as yet. However, there is an agreed-upon contract which would provide a 1-percent-a-month return on investment or $1 million, I beg your pardon, a $1 million return on investment for the use of the Northeast corridor from Washington to Boston because that is predominantly a passenger corridor, not a freight service corridor.

That is the only contract that I am aware of that has that particular provision.

Mr. METCALFE. I have one more question to ask you.

Why can't we expect clean cars and good services when we pay cost plus 7 percent profits? Why must we pay the incentive contract?

Mr. HALL. Well, I think that goes back to the basic concept of an incentive contract and why Amtrak has moved to that away from the strictly cost reimbursable plus a percentage contract.

Under the incentives, the railroad must meet a certain minimum standard and if it falls below it, it runs the risk of losing money. If it could exceed that, it gets more money, so there is a built-in incentive to improve service.

As you look at the actual results over the past few months for those railroads operating under an incentive provision, I think you will find that the ontime performance has improved tremendously. I believe,

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perhaps Mr. Reistrup could address this in more detail, but the cleanliness, availability of cars, has also improved. I think we are seeing the results of moving toward that.

Mr. METCALFE. Thank you very much, Mr. Chairman.

Mr. ROONEY. I recognize the gentleman from New York, Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman.

Mr. Hall, I am a newcomer to this Transportation and Commerce Subcommittee although I have been on the full committee for three terms. I start out in the enviable position of not having any prejudice against Amtrak in its operation, and a great deal of interest in learning about it, not involving any prejudice.

Do I understand you base this thing over and above the request for supplemental authorization, now that if you can be removed from some of the regulatory functioning devices, as I see them and some political judgments of the Congress, you could perceivably operate this railroad a little better than you do today?

Mr. HALL. We believe so.

Mr. HASTINGS. And in the quest for, if not operating profitably, at least reducing the rate you have lost, you said corporation revenue only covered one-half of the expense?

Mr. HALL. Yes.

Mr. HASTINGS. And that is your goal and, if not, and I am sure it would not be operated profitably, but you admit that is probably not obtainable but with the kind of changes you are recommending you could perhaps reduce the operation expense relative to your expense?

Mr. HALL. We would hope so.

Mr. HASTINGS. That is admirable and I certainly have no argument against that kind of goal.

On the question for your authorization, I hate to take issue with you; there are only two members on the minority on this subcommittee and I hate to see us divided, but I am not so concerned about your authorization being stretched beyond 1 year. I don't know—you indicated for 4—but it is not magic and I suppose it would require getting Congress tuned in to the operating board in order for us to grant that kind of authorization.

Isn't that essentially what you would have to be offering to us?

Mr. HALL. Yes, sir. I think in all of the conceptual approaches we have taken here, we are placing principal responsibility on the Board of Directors of Amtrak to maintain the type of public responsibility that we think is required for a Corporation of the nature of Amtrak.

We think the Board is capable of doing that. It is a Presidentially appointed board. I would suggest that the Congress always has the ability to conduct oversight hearings at any time when you do not think the Board is conducting itself properly, and I would argue, also, that the annual appropriations process does give a pretty good filter through which any actual funding would have to take place.

So I think there is a considerable amount of control that would remain even if there were a long-term authorization.

Mr. HASTINGS. I hope that we could. I hope the subcommittee and full committee and Congress develop that kind of confidence that you could operate with the goals in mind we discussed.

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There was a bill that Congressman Heinz and myself and Mr. Skubitz introduced this morning relating now to improvement of the roadbeds, and I don't know if you had a chance to take a look at it, which would combine the public service employment aspects together with a need for the railroads to improve, and both, of course, passenger and rail, and we talked about an authorization of $500 million in this fiscal year, $1 million in 1976, $1 billion in 1977.

Knowing you have not taken a look, I can't ask you to comment on the concept, but the concept of that type of thing I would appreciate if I could have a comment.

Mr. HALL. Yes, sir, and in fact in the Department, we have been looking at that same tying together of the problem of unemployment and the problem of trying to rebuild the Nation's rail lines. We, I think it is fair to say, think that is an idea that has very much merit. We, I believe, have talked to some of the staff people on that and have generally considered that it is a workable program, that in fact we can put people to work very quickly this year to help rebuild the railroads, principally the tracks, which is what I think we are talking about, and it is a proposal that can be coordinated with both rail management and rail labor.

There are some obvious problems of "how you determine where the people are going to be placed and what lines would be rebuilt."

Mr. HASTINGS. I think we have the Secretary to make those kinds of determinations.

Mr. ROONEY. Will you yield?

Mr. HASTINGS. I will certainly yield to the chairman.

Mr. ROONEY. Are you advocating the Congress give $2.5 billion to the stockholders of some of these profitable railroads just to build up maintenance of their trackage?

Mr. HALL. No; I have not gone that far.

Mr. ROONEY. That is what you said. You said you endorsed the concept.

Mr. HALL. I said the concept of trying to put people to work to rebuild the railroad.

Mr. HASTINGS. I believe in putting them to work on public projects but not to work for private industry.

If you yield, my statement, I believe, if you understood carefully that is not the intent of the bill. As a matter of fact, there are several sections that prohibit the kind of transfer to private stockholders that you alluded to, and we can discuss it when we get it before the subcommittee and the hearings I mentioned, but that is not the intent, as I say, of this point.

One other suggestion, you changed the cost-sharing formula to State services 75–25 and 50–59; and what are you anticipating, a further involvement of States in that 50–50 concept?

Mr. HALL. Yes, sir. I think our objective in this section of the bill would be to encourage the States where they believe they have a unique need for what you might term regional or local intercity passenger service, that we give the States some additional ability to participate in that problem or that prospect.

Mr. HASTINGS. How much involvement have you found with 75–25?

Mr. HALL. Well, the current level is fairly small. I believe the latest number I have is that the Federal share of State-supported service is

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running about $5 to $7 million at this point. That is mostly operating deficit, and there is very little capital cost included in that.

It has been done without much formality and without any general plan either on the part of State or Amtrak for initiating such services. As applications come in, they are reviewed on an individual basis.

Mr. HASTINGS. I thank you. I think I have some doubt that most States have fiscal ability now to be able to respond even 50–50, and under the Reorganization Act, you know, the title IV is 70–30, and I don't find too many States showing a great deal of interest. Maybe they are exercising other options, hopefully, but it would seem the States have also taken the position these matters ought to be under Federal rather than on an individually shared basis.

Mr. HALL. I would say Mr. Hastings, that two good examples, however, of I think very good State cooperation have been the State of New York and the State of Michigan who have come forward and in fact initiated services with Amtrak. We would like to see more of the kind of innovative planning which those States have done.

Mr. ROONEY. Mr. Adams, the gentleman from Washington.

Mr. ADAMS. Thank you, Mr. Chairman.

Gentlemen, I was not of the opinion there were any problems in the United States worse than the problems of the railroads until I arrived on the Budget Committee; now I find you are running about dead even. In connection with that particular point, I certainly am going to support and I have discussed it with the chairman, 27-month authorization, because I think that we must get out in front in the budget process. That means that we need to have an authorization passed by the committee and by the Congress for fiscal year 1976, the transitional quarter, and fiscal year 1977, because the statute requires we do this before May 15 of next year. So at least to that point I certainly agree with you, we don't want to get our feet tangled up in trying to authorize something at the last moment.

Now, the second item, and going to the subject of the right-of-way and roadbeds, I agree with the comments of the chairman and I will be discussing with other members of the committee the introduction of possible legislation particularly in the Northeast, where we are trying to create a viable system for the Government to have an involvement in the roadbeds. I do not think we can put this money into the bankrupt estate. Perhaps we ought to be doing it through a Government corporation, but our problem in the past has been we did not wish to pay off all of the bondholders but gave a fair market value for everyone. If we can arrange some kind of transfer into a Government corporation of the roadbeds subject to the presently existing mortgages, the Government would then charge user charges to both privately owned carriers and to Amtrak, then we might be in a position of assisting it with the use of Federal jobs in that area.

We understand from the report of the U.S. Railroad Association that they have considerable doubts that they can maintain a capital program and modernization program in the Northeast corridor project, which is, as I understand it, is projected to be run by Amtrak or to be turned over for high-speed rail service unless there is some assistance for the capital program. In other words, that the new corporations there cannot handle this.

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Then I would ask you, Mr. Reistrup, in your contract arrangement, to please explain to me this arrangement you have for the Northeast corridor, this contract arrangement with the trustees. What is being proposed on what kind of return on investment?

Mr. REISTRUP. Do you wish I respond now?

Mr. ADAMS. Are you going to testify?

Mr. REISTRUP. Yes.

Mr. ADAMS. I will withhold that. I thought you had testified already, because I had your statement. I apologize, and I have several questions about how much we should pay for a negative investment up there. I realize we should pay for costs and so on, but when you have something that is already bankrupt, I have grave question as to how much we should be putting into it.

Also, in terms of the authorization for more than 1 year, in the Amtrak Improvement Act of 1974, we authorized a $25 million program to convert some historic rail terminals into intermodal terminals. The Administration has requested $500,000 for 1976.

Does this program need a new authorization beyond fiscal year 1976? Should we go with a longer term authorization for those additional fiscal years?

Mr. HALL. I believe it does, Mr. Adams.

Mr. ADAMS. Is it in your proposed bill that you have attached or will it have to be added?

Mr. HALL. We have not included it as a specific line item.

Mr. ADAMS. Does it need to be included as a line item? I need to know because I have not had an opportunity to read through your attachment.

Mr. HALL. I believe it does and we should get back to you on that very quickly. We will.

Mr. ADAMS. Would you do that, please, so we know both what your position is and where it might need to be inserted. If you could work with the staff on that, and let me know, I would appreciate it.

Mr. HALL. Yes, sir.

[The information requested was not available to this committee at the time of printing.]

Mr. ADAMS. Maybe this should go to Mr. Reistrup, but I would like you to comment on it.

Have you retained your right to operate on the trackage portions of the U.S. railroad system that you either have curtailed service on or you may not have service operating at all at the present time? Do you understand what my question is?

It is that one of the purposes of creating Amtrak is that we were looking, some of us, to the fact we were going to have an oil shortage and not able to move people throughout the country, and we would need to retain the right to have a national rail service returned to the people.

Now I just want to know whether you have done that? I think the original act does it, but I don't want, in passing a new act, our group to let the railroads off the hook on that because we bailed them out and part of the exchange for that was that we would have rights to run.

Mr. HALL. Our proposed amendments, Mr. Adams, would in no way affect that provision, and it is my understanding that Amtrak does

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have that right and will continue to have it. I would suggest that perhaps counsel for Amtrak should answer a detailed question on that.

Mr. ADAMS. All right. I just wanted to be very sure that we were not, by passing the act, wiping out that original provision?

Mr. HALL. Not at all because it would remain.

Mr. ADAMS. Thank you, Mr. Chairman.

Mr. ROONEY. Thank you very much, Mr. Hall. Mr. Reistrup, I want to take this opportunity to welcome you before this committee. I think we are fortunate in Congress to have you as the head of the Amtrak system in this country. I think we are extremely fortunate in having you head this very vital agency.

I know your past, your expertise in the field of railroads. I commend you for taking a trip throughout the country on many of the Amtrak trains and seeing some of the problems.

I also want to thank Mr. Lewis for the tremendous job he has done over the years in helping us organize Amtrak and we welcome both of you here today. I regret very much that I won't be able to hear all of your testimony because a minister in my district will deliver the opening prayer in Congress today, so I hope you will excuse me.

For the benefit of the two agencies that will testify tomorrow I must announce, because of the Democratic Caucus, I regret very much that the hearings will be called off tomorrow but will be rescheduled in the very near future.

I wonder if Thursday, will you gentlemen be here Thursday?

Mr. SKUBITZ. I will be here.

Mr. ROONEY. All right, we will reschedule them for Thursday.

Mr. Reistrup.

STATEMENT OF PAUL H. REISTRUP, PRESIDENT, NATIONAL RAILROAD PASSENGER CORPORATION (AMTRAK), ACCOMPANIED BY ROGER LEWIS, IMMEDIATE PAST PRESIDENT; AND DON R. BRAZIER, TREASURER

Mr. REISTRUP. Thank you, Mr. Chairman and members of the committee.

First, I would like to introduce those who I really don't believe need introduction. On my right is Roger Lewis, my predecessor, who has been and is continuing to be of immeasurable aid during the transition period. We work closely together and he is at my right hand.

On my left is Don Brazier, who will be able to assist me with the numbers since my background is very varied, but I am not a numbers man, so I may need some assistance.

We appreciate the early opportunity you have given us to present our request for a fiscal year 1975 supplemental authorization of $63 million, and our request for fiscal year 1976 authorizations of $350 million for operations and $300 million for capital. Because of the coming change in the Federal Government's fiscal year, our request at this time also includes an authorization request for $105 million for operations and $25 million for capital to finance the Corporation during the transition quarter of July–September 1976.

Mr. Chairman, I would like to discuss each of these requirements separately, but first I must emphasize our need for early action on our

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fiscal year 1975 supplemental request. We will be in a serious cash position after March 31 unless these additional funds are available.

FISCAL YEAR 1975

When we appeared last fall to request additional funding for fiscal 1975, we advised the committee that the request at that time did not include significant contingent requirements related to incentive and other payments to the railroads, inflation during fiscal year 1975, and the continuation of our passenger car overhaul program. Funds to cover these costs were not requested at that time because of their uncertain nature and our determination to minimize any future request for funding.

We have now developed sufficient experience in terms of operations under the new railroad contracts and actual wage and price increases to project our firm requirements for fiscal year 1975. These revised requirements are described in detail in the justification data provided separately to the committee.

Fiscal year 1975 has been a year of extreme difficulty in forecasting revenues and costs. Economic recession and high-inflation rates have impacted heavily on the railroad industry as well as on other segments of our economy. This has adversely affected financing both in terms of revenues and costs.

Despite our actions in November 1974 to partially offset cost increases by carefully considered fare increases, the economic situation has made it impossible to generate any significant additional revenues. Our original estimate last year projected revenues at $268 million, which we later adjusted upward to $282 million as reported to the committee last September. We now estimate that our total revenues will be $277 million. Thus, our revenue estimates have been adjusted downward by $5.2 million. The impact of economic conditions on travel, along with the greater availability of gasoline for automobile travel, were the major contributing factors to this reduced estimate.

While revenues have remained essentially fixed, costs have increased from our original fiscal year 1975 estimate of $411 million to our current estimate of $602 million—an increase of $191 million. More than 75 percent, or $144 million, of these costs were uncontrollable by management because they were related to wage and price increases, new routes, critical equipment maintenance, and equipment depreciation.

Another $44.4 million, or 23 percent of our cost increase, is related to our new contracts with the railroads. These fall into two categories.

First, performance incentive costs: The new contracts provide for incentive and penalty payments for on-time performance, car cleanliness and equipment availability. We have experienced major improvements in these areas in recent months under the new contract provisions. For example, on-time performance for many of our routes now exceeds 90 percent and in some cases reaches 95 percent. All railroads' performance has improved after signature of the new contracts with the incentive provisions. The cost of these incentive payments is estimated to be $32.2 million for fiscal year 1975. Over the long run the improved service resulting from these incentives will result in greater public acceptance of rail passenger service and therefore in increased revenues.

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The second category is a monthly payment of $1 million to the Penn Central Railroad for the use of its Northeast Corridor system for passenger train operations.

The remaining items in this supplemental cover car overhaul, additional wage and price increases during fiscal year 1975 and costs of new trains, offset by a number of cost-savings actions.

The car overhaul program was originally estimated in our previous list of contingent items to require an additional $20 million. We have reduced this amount to $5 million, consistent with our current requirements and car overhaul schedules.

Wage and price increases continue to be a frustrating problem. Our previous estimates did not make provision for such cost increases occurring after July 1, 1974—during fiscal year 1975. Based upon the first half fiscal year 1975 experience and on estimates for the second half of the fiscal year, we estimate that wage and price increases will total $49.7 million.

Two new train services have been initiated that were not previously funded. These are an additional train between New York and Philadelphia and extension of an empire service route from Buffalo to Detroit. These new services, although partially State supported, will increase our costs by $1.1 million.

Offsetting all of these increases are cost savings of $14.6 million, which reflect reduced operating levels, and an accounting adjustment transferring $4 million of actual fiscal year 1974 costs to that fiscal year. The cost-saving actions involve the reduction of 900 positions in our employment level and other actions totaling a $9.6 million savings, plus a $5 million reduction in railroad operations.

Each Amtrak department has been directed to operate under firm dollar and personnel ceilings to assure that these cost reductions are attained and maintained. We intend this to be a continuing program of the highest priority as we further improve our control over costs.

The net effect of these changes is an increase in our fiscal year 1975 deficit of $86.8 million. Because we have cash resources of $8.9 million and $14.9 million of currently available authorization to apply to this increase, we require additional authorization of $63 million to permit the financing of our program through June 30, 1975.

In looking ahead to fiscal year 1976, Mr. Chairman, I believe it is important to have a perspective of where Amtrak has been and where it now stands. We summarized that situation in the 1974 annual report submitted to you last month, and I would like to suggest that the text of this report be printed as an appendix to my statement.

Mr. ROONEY. Without objection, it is so ordered [see p. 48].

Mr. REISTRUP. In brief, Amtrak in 1974 carried about 18.5 million passengers, operated nearly 29 million train-miles with 240 daily trains serving 457 stations along an expanded route system of 24,315 miles. We did it with an average on-time performance for all trains that reached more than 75 percent in December. And, the 1974 total revenue of $256.9 million was $54.8 million higher than 1973 revenues and $94.3 million higher than 1972 revenues. Car availability increased during 1974 from 69 percent to 74.2 percent as our overhaul and maintenance programs improved. New locomotives and cars were ordered and received as part of our continuing program to

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modernize the Amtrak fleet, our nationwide ticketing and reservation system became fully operational, and some 8,000 employees performed dedicated service.

Many difficult challenges remain ahead, of course, and I am here because I believe that, with the help of this committee and other Americans interested in enhanced, realistic rail passenger service, these challenges can be met. It is toward that end that Amtrak's program for fiscal year 1976 is directed.

Our budgeted request for the coming fiscal year consists of $350 million for operations and $300 million for the capital program.

REVENUES

Revenues for fiscal year 1976 are estimated to increase by $89 million over fiscal year 1975, composed of an increase of $41.5 million through the annualization of fare increases effective in fiscal year 1975 and $47.5 million related to a 17-percent increase in ridership. This assumes a moderate improvement in economic conditions and ridership gains from auto travel as a result of gasoline price increases. As a result of the present economic outlook, revenue projections are necessarily uncertain.

COSTS

Costs during fiscal year 1976 are projected to increase by $135 million. The resultant budget projection, therefore, is for a fiscal year 1976 operating deficit of $371 million. Because equipment depreciation expense of $21 million does not require cash funding, the authorization and appropriation requirement is $350 million.

WAGE AND PRICE INCREASES

The major increase, as in fiscal year 1975, is attributable to inflation. Unlike our original fiscal year 1975 estimates, we have made for this request an estimate of total wage and price increases through the end of fiscal year 1976.

Increased wages and prices will add $90 million to fiscal year 1976 expenses. Of this amount, $53.5 million represents the annualized costs of inflation that occurred during fiscal year 1975; that is, the extension of price levels in effect as of June 30, 1975. The remaining $36.5 million is the estimated cost of wage and price increases during fiscal year 1976, representing an average increase of 5.9 percent for the year. This assumes a significant decline in the rate of inflation in fiscal year 1975, which averaged 10.4 percent, but is consistent with the economic outlook contained in the President's budget for fiscal year 1976.

ADDITIONAL ROUTES AND SERVICES

Additional routes and services will increase fiscal year 1976 expenses by $44.4 million over fiscal year 1975. Approximately 80 percent of this increase, $35.2 million, is related to services that will be added during fiscal year 1976. The principal components are an additional train serving New York-Washington-Chicago, $18.7 million, and the new Boston-Cleveland-Chicago service, $10.6 million. The remaining $5.9 million will provide for the Chicago-Denver

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route, $4.6 million, and $1.3 million for yet-to-be-identified 403(b) service.

The annualization of the costs of services started in fiscal year 1975 and service standards increases will require an additional $9.2 million in fiscal year 1976.

NEW RAILROAD CONTRACTS

As discussed earlier, the new railroad contract provisions apply incentives and penalties to performance. The fiscal year 1976 estimate of the net of these payments is $32.2 million, or $10.7 million more than in fiscal year 1975. The increase is directly attributable to the full-year cost of the incentives in fiscal year 1976. New contracts were negotiated during fiscal year 1975 and thus were in effect for only a portion of the year.

One other major factor relates to the new contracts. The previous contracts with the railroads provided a 5 percent add-on to costs incurred by the railroads to cover costs that could be avoided if there were no passenger trains. These costs will no longer be paid, and a reduction of $16.8 million has been reflected in the fiscal year 1976 budget plan because of this and other minor cost changes associated with the contract change.

PASSENGER CAR OVERHAUL

The fiscal year 1975 supplemental includes $5 million for major overhaul of our passenger cars, and $10 million will be required for this purpose in fiscal year 1976. Initial overhauls were treated as capital costs, but as the fleet requires a second major cycle of repair, the costs must now be treated as operating expenses.

While we have a large number of new cars on order, deliveries will not come in volume until late fiscal year 1976 and fiscal year 1977. Meanwhile, the fleet of old cars must be maintained in service. The $10 million requested is critical to the continued use of our older cars and will provide for the heavy overhaul of 100 passenger cars.

DEPRECIATION

During the past 2 years the corporation has purchased more than 225 new locomotives and overhauled 1,000 passenger cars, thereby substantially increasing the book value of equipment owned. Depreciation of this equipment must be charged as an operating expense. It is estimated that this expense will increase by $7.3 million for fiscal year 1976. Since depreciation expense does not require cash financing, these costs are not included in our request for fiscal year 1976 funding. They are, however, included in total expenses and in the accounting deficit for the corporation.

INTEREST COST

The Amtrak capital program through fiscal year 1975 has been financed by loans guaranteed by the Government under provisions of section 602 of the Amtrak Improvement Act—Public Law 93-496.

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At the end of fiscal year 1974, outstanding loans were $217 million. The balance at the end of fiscal year 1975 will be about $465 million and this will increase to approximately $600 million at the end of fiscal year 1976. As a result, interest costs for fiscal year 1976 will be $38.8 million, an increase of $13.1 million over fiscal year 1975.

COST SAVINGS

As noted earlier, Amtrak will continue to pursue ways and means to improve the efficiency of our operations and reduce costs. We have set an objective of reducing fiscal year 1976 costs by $19 million through close control over personnel, more effective controls over railroad operations and costs, and by improving our equipment usage and availability.

Close budget control over every element of the Amtrak organization has been established to set cost reduction objectives and to measure our progress against these goals. Every manager will be held accountable for his budget and will be expected to operate within the level of resources provided. We now have an effective budget control system within Amtrak and I fully expect to achieve these cost savings.

FISCAL YEAR 1976 AUTHORIZATION—CAPITAL

Fiscal year 1976 is the first year Amtrak has submitted a request for a capital grant. Prior capital programs have been financed through the guaranteed loan authority provided by section 602 of the Rail Passenger Service Act.

Debt servicing of these guaranteed loans has been an increasing burden to the corporation as outstanding loans and interest rates have increased over the past three years. Since fiscal year 1974, interest costs have increased from $11.4 million to $38.8 million in fiscal year 1976—more than 240 percent. To reverse this trend, the fiscal year 1976 request is made in terms of a cash grant of $300 million for: $100 million to purchase additional electric locomotives, and to modernize and standardize the best of our current fleet of passenger cars; $200 million for track right-of-way improvements.

Our 5-year financial program submitted to the Congress last August and our recent annual report discussed in some detail our great concern regarding the continued deterioration of track over which our trains must operate. Track improvement and track maintenance are our highest priority needs.

FISCAL YEAR 1976 TRANSITION QUARTER (JULY–SEPTEMRER 1976)

The Congressional Budget and Impoundment Control Act of 1974 changed the Federal Government's fiscal year to October 1–September 30, effective October 1, 1976. To bridge to the new fiscal year, the President's budget for fiscal year 1976 includes a request for funds for the 3-month period of July–September 1976.

Based upon the estimated level of activity for this quarter, which includes the high summer operating periods of July and August and the Labor Day holiday, it is estimated that $105 million will be required for operations. This amount provides for wage and price increases at the same average level as fiscal year 1976.

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Capital grants in the amount of $25 million will be required during this quarter for the continuation of locomotive and passenger car modernization programs and facilities projects.

LEGISLATIVE CHANGES

Mr. Chairman, my staff and yours have discussed several perfecting amendments to the basic Amtrak legislation. I hope the committee will give consideration to these changes, which would assist us in the effective and efficient operation of the corporation.

AMTRAK FISCAL YEAR

The Amtrak fiscal year is currently calendar year while the Federal Government's fiscal year ends June 30. With the forthcoming change in the Government's fiscal year, we recommend that Amtrak's fiscal year and annual report requirement be changed to coincide.

GUARANTEE OF LOANS

It would be very helpful if section 602 could be changed to make it clear that the loan guarantees also apply to leases. The corporation has entered into a number of long-term leveraged leases for new locomotives and is currently negotiating leases for passenger cars. Some reservations have been expressed by the financial community concerning the applicability of the loan guarantee to these long-term leases for capital equipment. Such leases are a significantly less-expensive method of financing the acquisition of rolling stock. The clarification would enhance our ability to use this lower cost method for acquiring major equipment.

FINANCIAL INVESTMENT ADVISORY PANEL

Sections 501 through 503 establish a Financial Investment Advisory Panel. It is recommended that these sections be deleted. The panel was designed to function during Amtrak's formative months, and is no longer active or necessary in view of the development of Amtrak's own internal financial staff.

SUMMARY

Mr. Chairman, I fully appreciate that our authorization request represents a substantial amount of money. The request appears larger, however, because of special circumstances. The operating period covers 15 rather than 12 months because of the change in the fiscal year, and for the first time we are requesting capital grants rather than guaranteed loan authority for Amtrak's capital improvement program.

Nevertheless, the amount and trend of Amtrak's deficits is a matter of great concern to management and the Board of Directors. But these deficits should be put into a perspective that relates to overall economic trends of the country for the past 3 years.

The railroads that joined Amtrak in 1971 paid, as an entry fee, one-half of their reported calendar year 1969 operating loss of $394 million.

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In 1974 dollar values, after adjusting for inflation, this loss would equate to $666 million. The basic route structure assumed by Amtrak was about 50 percent of the routes operated by the railroads.

Therefore, assuming no changes in the scope of operations or in the level of performance, Amtrak would have had losses in calendar year 1974 of $333 million. The audited loss for calendar year 1974 was $273 million, or 18 percent less than the pre-Amtrak level of railroad losses. But many improvements have been made, and routes have been expanded. These improvements have occurred in all aspects of Amtrak operations: Reservations and ticketing, equipment reliability and availability, ontime performance, levels of onboard services, and planning and programing for the future.

Despite the improvements we have made, the Amtrak deficit is still too high and must be reduced. The key to this reduction is a more efficient and less manpower-intensive operation. Our planning is directed toward this objective, but it will not be an easy task. The economics of our present equipment fleet are not good. Even if our current occupancy rate could be increased from the current 55 percent to 70 percent—its maximum feasible limit—revenues would increase only $70 million and losses still would be substantial. Replacement of our current passenger car fleet is essential to improving Amtrak's revenue-to-cost ratio, and this is provided for in the Amtrak 5-year program submitted to the Congress last August. The plan calls for 782 high-capacity, high-flexibility, passenger cars, of which 547 are now on order and 235 will be ordered in the near future. Floor tracks permitting variable seat spacing as well as other configuration changes will allow us to maximize revenue and to provide for more attractive service. Loan authority has been provided by the Congress to finance this equipment.

After retirements of over-aged equipment, we still will have a seating capacity increase of 84 percent above our current passenger car fleet. With a ridership growth of 15 percent a year over the period, revenue without fare increases can rise to almost $600 million in 1980. This would cover a large part, if not all, of the operating deficit, depending, of course, on the rate of inflationary cost increase.

An important element in attaining the ridership growth potential of our new equipment is the condition of the roadbed and track over which Amtrak trains must operate. That is why the Amtrak 5-year program requested a capital grant of $200 million in fiscal year 1976 for this purpose. We fully recognize that Government financing of right-of-way improvements is a complex question. The ICC, DOT, and Amtrak are seeking solutions to the problem, and the ultimate success of Amtrak is directly dependent upon the condition of the track of the railroads over which it must operate. This is the single most-important problem currently facing the Corporation, and early affirmative action to initiate extensive right-of-way improvements is a critical national need.

I would like to urge that early consideration be given to the funding for the coming quarter.

In view of the Easter recess, we are quite concerned we will have to take some managerial steps in this 3-month period should we not have the funding by the beginning of April.

Mr. ADAMS. By the beginning of April?

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Mr. REISTRUP. Yes.

[Testimony resumes on p. 69.]

[Attachments to Mr. Reistrup's prepared statement follow:]

NATIONAL RAILROAD PASSENGER CORP.—FISCAL YEAR 1976 PRESIDENT'S BUDGET, OPERATING BUDGETS

[In millions]

	Fiscal year—			
	1974 actual	1975 estimate	1976 estimate	1977 transition July–September 1976 estimate
Revenue:				
Transportation	218.2	247.9	329.7	108.7
Other	21.9	28.9	36.1	11.0
Total	240.1	276.8	365.8	119.7
Operating expenses:				
Maintain way	6.2	14.0	17.0	5.3
Maintain equipment	78.9	109.8	133.8	41.6
Traffic	31.0	42.6	51.9	16.1
Transportation	179.0	215.2	276.2	85.9
Dining and buffet	45.0	57.2	69.6	21.6
General	22.3	26.9	32.8	10.2
Taxes	31.2	46.4	56.6	17.6
Rents	6.5	9.0	10.9	3.4
Railroad performance incentive		21.5	32.2	10.0
Allowance avoidable cost	18.9	16.8		
Assumption risk	.9	1.1	1.4	.4
Total	419.9	560.5	682.4	212.1
Corporate expenses:				
General and administrative	13.9	15.6	15.6	3.9
Interest	11.2	25.7	38.8	15.1
Total	25.1	41.3	54.4	19.0
Total expenses	445.0	601.8	736.8	231.1
Net deficit	204.9	325.0	371.0	111.4
Non cash items			21.0	6.4
Operating grant authorization and appropriation requested		63.0	350.0	105.0

NATIONAL RAILROAD PASSENGER CORPORATION

Analysis of Changes fiscal year 1976 versus fiscal year 1975 (dollars in millions)

	Change from fiscal year 1975
Revenues:	
Fare increase	+41.5
Ridership increase	+47.5
Total	+89.0
Costs:	
Wage and price increases	+90.0
Additional routes and services	+44.4
New railroad contracts	−5.8
Passenger car overhaul	+5.0
Depreciation of equipment	+7.3
Interest on debt	+13.1
Management cost savings	−19.0
Total	+13.50

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NATIONAL RAILROAD PASSENGER CORPORATION

FISCAL YEAR 1976 PRESIDENT'S BUDGET CAPITAL PROGRAM BUDGET

[In millions of dollars]

	Total revised program through fiscal year 1974	Fiscal year— 1975 program	Fiscal year— 1976 program	July to September 1976 transition quarter
Passenger equipment:				
Turbine equipment:				
2 UA–FRA 5 car trains	2.3			
2 CN 4 car trains	2.0			
13 new 5 car trains	48.5			
Subtotal, turbines	52.8			
Passenger cars:				
235 new bilevel cars		168.0		
92 new metro type cars	38.7			
200 new low level cars	82.4			
200 new low level cars		82.4		
Leased conventional cars	22.5			
Modernize used cars	99.8	23.3	8.6	
Modernize used RDC's	1.9			
Purchase used metro cars	5.3			
Standardize conventional cars			80.0	
Subtotal, passenger cars	250.6	273.7	88.6	
Motive power:				
Lease purchase electric locomotives	.5			
175 new diesel electric locomotives	84.7			
28 electric locomotives	21.2			
30 new diesel electric locomotives	3.4	12.5		
13 electric locomotives			11.0	
Used diesel locomotives	6.8			
Used electric locomotives	1.5			
Diesel electric overhaul	22.5			
Diesels, conventional H/E power	.8	.6	.4	
Radios	.6			
Subtotal, motive power	142.0	13.1	11.4	
Facilities:				
Major ($100,000+over)	41.1	17.2		
Minor (under $100,000)	14.3			
Repair	44.8			
Subtotal, facilities	100.2	17.2		
Right of way:				
Northeast corridor		15.0		
Other	.7		200.0	
Subtotal, right of way	.7	15.0	200.0	
Research and development	5.0			
Autotrak	1.6			
Total	552.9	319.0	300.0	25.0
Capital grant authorization and appropriation request			300.0	25.0

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1974 AMTRAK ANNUAL REPORT

building a national rail passenger system

Submitted on February 15, 1975, to the President of the United States, the President of the Senate, and the Speaker of the House of Representatives, pursuant to Sections 308 and 805 of the Rail Passenger Service Act, Public Law 91-518, as amended by the Amtrak Improvement Act of 1973, Public Law 93-146.

The President's Summary

Amtrak, the National Railroad Passenger Corporation, is pleased to provide this Annual Report for calendar year 1974.

One year ago I reported that Amtrak had made sufficient progress on the administrative and operational fronts so that we stood in a position to deal effectively with the challenges and opportunities of 1974. The year did, in fact, present unparalleled challenges and opportunities for our company and has afforded the American public an important demonstration of the potential inherent in this now indispensable transportation resource. I believe this report clearly demonstrates that Amtrak, during 1974, moved forward convincingly in a manner that justifies the confidence and patience of the American public.

In reviewing a year marked by important accomplishments in virtually all areas of company activity, I wish first to list several developments that merit particular notice:

- During 1974 Amtrak carried a substantially greater number of revenue passengers, which made it possible for us to report solid growth in earned revenues. Positive trends in this regard were especially strong during the more acute phases of the energy crisis when demand often exceeded our capacity.
- Even in the face of increased demand, on-time train performance as measured by the Interstate Commerce Commission standard improved substantially. Nationwide on-time performance increased from an average of 61.7 percent to 75.3 percent during 1974.
- The Amtrak nationwide ticketing and reservation system was completed in 1974, enabling our ticketing and reservations personnel to provide a far better service than ever before. Without this system our daily call capacity in the summer of 1973 was 50,000. By last summer we were able to handle as many as 78,000 calls a day, with a higher degree of efficiency.
- The organizing and staffing of Amtrak's headquarters, which had continued throughout 1973 and into 1974, was tested and proved entirely sound during the period of unusual demand created by the energy crisis. This soundness was a major factor in our overall progress during the year.
- On the operations side, more than 3,000 jobs previously performed by employees of the contracting railroads were transferred to the direct control of Amtrak. Henceforth, all service functions on board the trains, all commissary functions, all reservation functions, all revenue accounting functions and most station service functions will be discharged by Amtrak's own personnel. In implementation of this important development, ten labor contracts have been concluded on behalf of 7,743 Amtrak employees.
- Undoubtedly the most significant administrative accomplishment during the year was renegotiation of the cost reimbursement and service provisions of the operating contracts with most of the participating railroads. The new contracts establish fixed rates for major costs areas, and, most significantly, tie compensation to the quality of service provided. Under this arrangement the contracting

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railroads can earn larger payments than before, but only on the basis of improved performance. Ten of the 20 participating railroads, accounting for 83 percent of cost billings, now have executed the new contracts.

- 1974 was a year in which our fiscal planning staff was able to formulate a basis for Amtrak's growth that enables us to meet our responsibility to the American taxpayer while also increasing our service to the traveling public. With the basic route structure stabilized by Congress, it was possible to develop a Five Year Operating and Capital Acquisition Program, which provides the planning basis for decreasing operating deficits over the five-year period.

I have placed at the end of this list a series of accomplishments that many undoubtedly regard as the most important items in terms of advancing Amtrak's capability to convey travelers at the highest possible level of comfort and convenience. These accomplishments relate to the upgrading of the old equipment inherited from the railroads; to the acquisition of new equipment; and to our capacity to maintain what we have, old and new, so that our level of utilization remains as high as possible at all times. Obviously, these are massive undertakings; nevertheless, 1974 has been a year of signal accomplishment in these fields:

- Car availability, which is a measure of mechanical condition, increased during 1974 from 69 percent at the start of the year to 74.2 percent in December. Of the cars out of service, 10.5 percent were undergoing heavy overhaul to recover from the effects of long-deferred maintenance. This time-consuming and expensive heavy overhaul of the Amtrak-owned passenger car fleet is nearing completion. A total of 1,422 overhauled cars are in service, and overhaul of 375 more cars will be completed during the next six months. Once these remaining overhauls are complete the overall condition of our fleet will be reflected favorably in a very high car-availability percentage.
- Cumulative orders for Metroliner-type passenger cars for both day coach and overnight service now total 292, and another order for an additional 200 is now ready to be placed.
- Orders have been placed for 13 five-car train sets of turbine-powered cars of French design with 6 sets coming from France and 7 sets—equipped with third rail capability—being manufactured in the United States.
- Design of a bilevel car has been completed. The design incorporates advance features to greatly increase standardization of both basic structure and mechanical equipment. At the same time, revenue capability will be raised to the maximum through careful attention to interior configuration. Three bids have been received, and orders for 235 new-design, bilevel cars will be placed early in 1975.
- One hundred and fifty 3000-horsepower, diesel-electric locomotives were delivered and put in service during the year. Eighty-nine additional diesel-electric and electric locomotives are on order or included in the coming year's program. Thus, we have nearly completed this vital program to replace our old fleet of smaller power units with new high-horsepower locomotives.

Several additional performance indicators illustrate the significant advances made by Amtrak during 1974.

Revenue and Ridership

Earned revenue for calendar year 1974 was the highest in Amtrak's three-year-and-eight-month history. Total revenue of $256.9 million was $54.8 million higher than revenue for 1973 and $94.3 million higher than 1972. Total passengers carried in 1974 exceeded 18.5 million—a 10 percent increase over 1973 and the highest volume in Amtrak's history.

During the year, Amtrak strengthened its relative position in the intercity passenger market. While Amtrak reported an increase in revenues of 27.1 percent and in total passengers of 10 percent over 1973, the nine largest Class I motor carriers of passengers reported an increase in revenues of 11.8 percent and a decrease in revenue passengers of 1.1

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percent. The domestic airline scheduled carriers reported that revenue passenger miles in 1974 increased 2.9 percent.

Average occupancy of available Amtrak seats day and night during the year reached a new high of 54.9 percent, and during peak travel periods it topped 80 percent.

Seven new routes were initiated during the year, five with the financial participation of the states of Illinois, Michigan and New York, and two at the direction of the Congress and the Secretary of Transportation.

Although progress has been gratifying during 1974, sizable management tasks and overall problems lie ahead, which only can be successfully accomplished if there continues to be strong, concerted effort on the part of Amtrak, the railroad industry, the Executive Branch and Congress.

One area we must always watch carefully is the growth of Amtrak's route structure. The high fuel-efficiency of rail travel in the context of a chronic fuel shortage has led to increased demand for the initiation of new intercity rail service. Responding to this demand, Amtrak initiated the new routes mentioned above during 1974. In addition, Amtrak was directed by the Secretary of Transportation to initiate service on three more routes, and the Congress has also instructed the Secretary to designate a fourth new route. It is important to bear in mind that these new, long-distance routes will add another 2,500 miles or 10 percent to the Amtrak route system.

Route Criteria

Committees of the Congress as well as the Secretary of Transportation have expressed concern about what they view as lack of adequate control over service expansion and about the lack of comprehensive criteria with which to evaluate service and route requests. Congress has directed the Secretary of Transportation to develop and submit such evaluation criteria, and he has requested the assistance of Amtrak in this important task.

The development of criteria by which to evaluate new route proposals requires accurate and comprehensive cost and market data. Because the railroads have been performing most of the Amtrak



operating functions it has been only in the past year that Amtrak could install a modern cost control system. The new system has been developed with the assistance of a national accounting firm, and it will provide for economic evaluation of specific trains and routes currently operating, as well as of those proposed for addition.

Route-by-route analyses are underway for the entire system. When completed these analyses will clarify the relative values to be placed on the factors that control decisions about new routes to be initiated or existing routes to be discontinued. In this manner, informed decisions, based on realistic economics and on overall public interest, can be made about the future expansion of the Amtrak route system.

It must be recognized that, although route-analysis data will be of great assistance in route expansion decisions, a basic policy issue underlies these decisions: Should Amtrak continue to expand its route structure in order to provide a truly national system of rail transportation even though such expansion contributes to Amtrak's deficit and postpones fulfillment of the statutory goal that Amtrak operate at a profit? Emphasis on the importance of profitability would indicate that the system should be pared down to the high-density corridors. On the other hand, establishment of a national system that can serve as a feasible, energy-efficient alternative to other modes

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of transportation requires the initiation of new routes that—at least during the formative period—would detract from Amtrak's profitability. It is important to recognize that, to a certain extent, Amtrak is subject to conflicting priorities.

Decisions on route expansion must be based on a thorough evaluation of all quantifiable factors. There are other considerations, however, which, while difficult to quantify, should influence such decisions. One such factor is the possibility of a change in the preference of the traveling public. Demand does not arise full-blown when a service is first initiated. The services must first be provided at a level of quality sufficient to attract demand. Because of the inherent advantages of rail travel in the areas of speed and comfort, we are confident that a significant number of travelers now using automobiles for intercity travel would utilize good rail service were it available. While the extent of this traveler diversion may be difficult to project, its potential impact must be considered.

Furthermore, route extension decisions should be influenced by the public interest in encouraging rail travel for reasons of fuel efficiency and lack of adverse environmental impact. National policy and social considerations may justify operation of passenger rail service at a loss in certain instances.

The impact of the route-expansion question is an important factor in any assessment of Amtrak's major problem—a large and growing operating deficit. It is estimated that routes added to the basic system will account for more than $30 million of the Amtrak deficit for 1975. Continued route expansion will have a similar impact on the deficit for succeeding years.

The amount and the trend of the deficit is a matter of great concern to the management of Amtrak, its Board of Directors, the Administration and the Congress. An understanding of this problem requires first, an historical overview of the Amtrak system and second, an understanding of the economics of intercity rail passenger traffic.

The railroads that elected to join the Amtrak system in 1971 paid, as an entry fee, one-half of their reported 1969 operating loss from intercity rail passenger service. That reported operating loss in 1969 totaled $394 million; and in 1974 dollar values the amount of the railroad loss would be $666 million. Amtrak was directed to operate about one-half of the route structure of the participating railroads and, on this basis, might be expected to incur a loss of some $333 million. For calendar year 1974, Amtrak is, in fact, reporting an audited deficit of $273 million or 18 percent less than the comparable pre-Amtrak level of railroad losses.

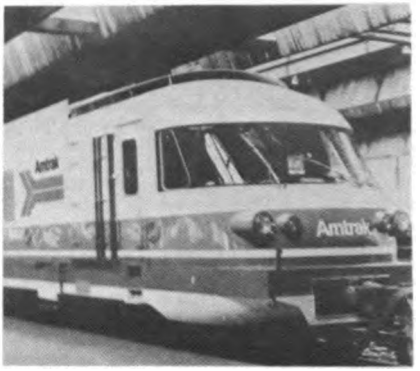
Although the Amtrak level of operating loss is lower than a comparable pre-Amtrak level, it is still too high and must be reduced. This is an extremely complex undertaking, to which Amtrak management has given a great deal of careful attention.

A further increase in our occupancy rate would partially alleviate the deficit, but would not—given



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the limitations of equipment presently available—result in its elimination. Annual costs of the Amtrak system now total $530 million. Annual revenue for the year totals $257 million. The resulting loss is $273 million. If the current occupancy rate of Amtrak trains were increased from 55 percent to its feasible maximum limit of 70 percent, revenue with existing equipment could be increased to $327 million. Even if no additional costs were incurred because of this increased passenger traffic, the loss still would amount to $203 million. There is no way to turn this deficit into a profit given the current over-aged equipment fleet with its inadequate seating capacity and given the requirement of operating a national network of intercity routes.



Revenue Productivity

A substantial improvement in Amtrak's cost-to-revenue ratio will result, however, from the introduction of new equipment under the Amtrak five year program. Improved designs for railroad coach and sleeping accommodations will permit a new generation of high-revenue equipment to be placed in service. Then, with the same number of railroad cars in a train, seating space availability can be more than doubled without increasing operating cost more than minimally. The five year program calls for 782 high-capacity, high-flexibility passenger cars of which 347 are on order now and 435 will be ordered early in 1975. Floor tracks permitting variable seat spacing and other configuration changes will allow us to maximize revenue as well as to provide varying interior arrangements for more attractive service. Loan authority is available to acquire this equipment.

Because of the need to retire over-aged equipment, the total Amtrak car fleet will increase only 12 percent over the five-year period; but the seating and sleeping space availability will be increased by 84 percent. With a ridership growth pattern of 15 percent per year over the period, revenue without fare increases can rise to almost $600 million in 1980. This revenue increase would offset a substantial portion, if not all, of the operating deficit; depending, of course, on the rate of cost increases.

Introduction of this new equipment should also sharply change the relationship of revenue to cost. With much greater seating capacity per car, the ratio of attendants to passengers decreases substantially, while the costs of providing food-service and entertainment space and of maintaining and cleaning cars increases only marginally. Automated reservation and ticketing service now installed on a nationwide basis should lower the unit cost of increased ticket volume.

Route-by-route and train-by-train analyses will permit optimum matching of equipment to routes and customer preferences, to meet seasonal shifts and peak demands. The 492 new stainless steel, Metroliner-type, locomotive-powered cars will be used primarily in corridor service and on midwestern and eastern long-distance routes. The 55 Turboliner cars will be primarily in corridor service north of New York and will bring the type of public ridership acceptance that the electrified Metroliners have gained in service south of New York. Most importantly, the Metroliners and Turboliners in service or on order will permit substantial improvements in service speed — two hours from Washington to New York and two and three-quarters hours from New York to Boston — just as soon as track and right-of-way improvements planned for the Northeast corridor can be made. The 235 new bilevel passenger cars with sleepers, coaches and dining cars will be used on long-distance routes—primarily where the number of cars per train is currently limited.

One major problem that has plagued Amtrak since

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its inception has been the unsatisfactory contractual arrangement between Amtrak and the railroads providing services to Amtrak. The problems involved in operating a nationwide rail system on the private property of multiple railroads under a cost-plus contract paid in advance on the basis of cost estimates of the railroads have been extremely frustrating to both Amtrak and the railroads. Under the original contracts, there were no quality-of-performance requirements, making it virtually impossible for Amtrak to insist on a level of service it considered adequate.

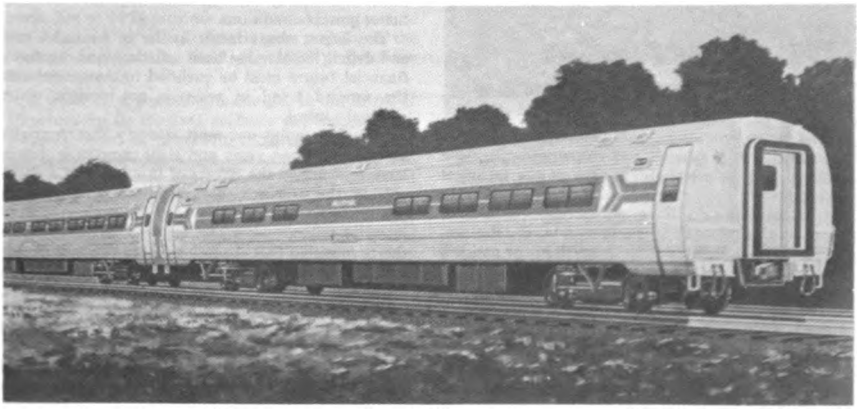
Amtrak is currently in the process of negotiating new contract cost provisions with the railroads and, as previously noted, almost all costs are now covered in new contract provisions already agreed to by the major railroads. These contractual documents contain detailed descriptions of the quality and quantity of service to be provided by the railroads. Performance requirements are in conformance with the standards set by the Interstate Commerce Commission; and, most importantly, the railroads make no profit unless they reach or exceed the specified performance level.

Cost, on a comparable basis, will be less under the new contracts. Performance—in terms of on-time trains, cleanliness, equipment availability and equipment operability—already has shown dramatic improvement and, over time, will lead to faster schedules and more comfortable service. This change in contractual relationship is undoubtedly one of the most encouraging milestones of progress in Amtrak's short history.

Track and Roadbed

One constraint on continued progress that becomes more serious with each passing day is the deterioration of the roadbed and track upon which Amtrak trains must operate. Americans have become accustomed to very high standards for superhighway construction as well as for airway travel, and nothing less than a comparable standard for passenger rail service can be considered acceptable. The continually growing need for intercity travel capability in our nation creates an urgent requirement for improved passenger rail service as a viable and significant alternative to the private automobile, the bus and the airplane.

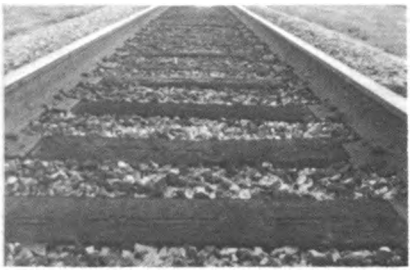
Amtrak has found it necessary to seek reaffirmation of the standard of track maintenance required under the contractual agreement between Amtrak and the participating railroads. The National Arbitra-



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tion Panel has authoritatively determined that the level of utility to Amtrak of the rail lines is reflected in the schedules initially agreed upon for Amtrak trains and that rail lines must be maintained in such a way as to allow accomplishment of the agreed-upon schedules with a reasonable degree of regularity and passenger comfort. Although Amtrak has the legal means to enforce compliance with this standard, much of the trackage utilized by Amtrak is the responsibility of railroads in bankruptcy, and it is here that the problem is most acute and worsening.

Not just Amtrak but the nation as a whole faces the imperative need to find the proper means of arresting roadbed and track deterioration and the follow-on means of upgrading track to the standards required for quality intercity rail passenger service. The ultimate success of Amtrak is directly dependent upon the condition of the rail lines of its contracting railroads.



In a larger sense, the existing network of rail lines represents a very valuable and virtually irreplaceable national asset, particularly in view of the technical and monetary problems generated by the worldwide energy shortage. As track deterioration continues, repair costs escalate at an alarming rate. If deterioration is allowed to go unchecked, much of the nation's track will become unusable, necessitating either replacement at prohibitive cost, or abandonment.

The Amtrak five year plan includes a program to upgrade track. The fiscal year 1976 funding plan requests an initial capital grant of $200 million for this purpose. The Interstate Commerce Commission currently is collecting evidence in a proposed rule-making and order concerning the "Adequacy of Intercity Rail Passenger Service—Track." Committees of the Congress have recognized the seriousness of the problem and are seeking the proper solution. The Regional Rail Reorganization Act of 1973 contemplates track upgrading in the Northeast corridor, and the Department of Transportation and Amtrak are developing plans and programs for this purpose. Funding is needed, however, and the problem spreads well beyond the Northeast corridor. It is a national problem, which demands priority attention.

Still another continuing problem that has had a serious effect on Amtrak's attempt to reduce operating deficits is the escalating cost of labor and material. In the past five years the country has experienced the most virulent period of inflation in this century, and this has complicated Amtrak's financial operations during the start-up years. From 1969 to 1974, the Association of American Railroads Wage and Price Indices show an increase in railroad labor cost of 65 percent, in material prices other than fuel of 66 percent and in fuel prices of 190 percent.

The impact on Amtrak of cost inflation has been particularly acute because Amtrak inherited a railroad operation in which total costs were twice as much as revenue. To stay even, any increase in cost must be met with doubling of that amount in revenue—an impossible task to accomplish through fare increases under present conditions.

The largest single factor by far in Amtrak's cost and deficit increase has been inflation, and Amtrak's financial future must be qualified to the extent that the upward trend in prices is not brought under national control.

I want to point out most strongly that Amtrak's progress in three years and eight months is due in large measure to the efforts of thousands of individuals in the railroads, government agencies and in Amtrak who are convinced of the importance of intercity rail passenger service. Each is dedicated to the proposition that Amtrak's future depends on our ability to attract and to satisfy the traveling public. With little in the way of modern physical resources, what has been done to date is a result of teamwork by many individuals who, before May 1, 1971, had never met.

The Amtrak organization of 8,488 employees—all but 745 of whom were taken over from the railroads

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as ticketing, station maintenance and on-board service functions were assumed—is highly motivated and increasingly effective in improving service and in controlling cost and revenue.

Amtrak now has assumed all the on-board service functions from the railroads. The next major function to be transferred must be the heavy overhaul, repair and maintenance work. Although repair and maintenance operations have been progressively established by Amtrak at Fields Point, Rhode Island; Brighton Park, Illinois, and St. Louis, Missouri, much more remains to be done. Negotiations are now underway with certain of the participating railroads aimed toward the transfer of repair and maintenance functions facilities, and definite progress is expected during 1975.

The Amtrak Board of Directors has authorized the purchase of the big Penn Central railroad car overhaul and repair shop at Beech Grove, Indiana. The bankruptcy judge has agreed to these negotiations, and Amtrak hopes to use Beech Grove as a central overhaul point for cars from all over its nationwide system. This would give Amtrak, for the first time, direct control over major overhaul operations.

During 1974, the Executive Branch and the Congress provided Amtrak every encouragement and full legislative and funding support. The Amtrak Improvement Act of 1974 provides a solid legislative structure for balanced growth in future years and forms the basis upon which the fiscal year 1976 program has been developed.

A word of appreciation is due also to our Board of Directors for its constant guidance and support, with a special word of thanks for those no longer active: The Honorable John Volpe, Secretary of Transportation; his alternate, John Olsson, Deputy Assistant Secretary of Transportation; Mrs. Catherine May Bedell, Mr. David Bradshaw, Mr. John J. Gilhooley and Mr. David Kendall, representing the public; and Mr. Louis Menk, representing the common-shareholder railroads.

In summary, Amtrak is now firmly established, and intercity rail service has proved fully acceptable to the public as a needed mode of public transportation. In mandating a route structure, Congress has provided the basis for our Five Year Operating and Capital Improvement Program, which was submitted to the Department of Transportation and to Congress in 1974. Funds to meet current deficits and for capital equipment acquisition are available.

But the constraints remain, and important questions of national policy need to be addressed and resolved. Track and roadbed deterioration must be stopped and in some cases significantly reversed; a situation complicated by the problems of the owning railroads. Inflation must be controlled.

Most importantly, however, Amtrak's longer-term growth must take place within a national transportation policy, yet to be spelled out. In formulating this national policy, we hope that Congress and the Administration will be mindful, as in the past, of the inherent advantages of rail transportation. Rail transportation is highly fuel-efficient and environmentally sound. The existence of rights of way and roadbeds makes unnecessary the disruptive and expensive land acquisition required for highway construction. Rail travel is a pleasant, safe, and comfortable experience particularly when compared to the tedium and risk of long distance automobile travel.

At present, 87 percent of intercity travel moves by private automobile and 13 percent by all modes of public transportation. We are encouraged by the growing acceptance of rail travel by intercity travelers. Both for reasons of fuel economy and personal comfort we anticipate a continued and substantial shift from private automobiles to rail travel. In order to facilitate this shift, we intend with the continued support and direction of Congress and the administrative agencies to give the highest priority to improving the quality and extent of our service.

Our goal is no less than to provide Americans with the best system of intercity rail passenger travel in the world.



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Marketing

Sales

Amtrak's gross revenue from sales of transportation, mail and express, and other services continued in 1974 to follow the uptrend that has been underway since Amtrak's inception--

- Earned revenue increased $54.8 million in 1974 compared to 1973 and was $94.3 million higher than in 1972.
- Amtrak package express sales were $679,254 in 1974 compared to $120,726 in 1973, and the service was expanded.
- A major transcontinental mail route was developed cooperatively with the U. S. Postal Service between New York City and Oakland, California. Amtrak's nationwide mail traffic revenue increased almost 50 percent from $4.3 million in 1973 to more than $6 million in 1974.

Passengers in increasing numbers were aboard Amtrak trains in 1974--

- Total passengers carried in 1974 numbered more than 18.5 million--a 10 percent increase over 1973. Ticket sales revenue increased 11.8 percent.
- Amtrak's average load factor--the average percentage occupancy of available revenue seats in 1974--increased to 54.9 percent during the year.
- Reduced-rate or pass travel also reached a new high of 624,000 trips in 1974. Priced at the average ticket value for revenue passengers, Amtrak provided $8.7 million worth of free transportation for those eligible for free or reduced-rate travel privileges under the Rail Passenger Service Act. As of December 31, 1974, Amtrak had issued 457,161 Rail Travel Privilege Cards covering 1,128,440 railroad personnel and their families eligible for free or reduced-rate travel privileges.

Government sales of Amtrak travel increased from $1.8 million in 1973 to $2.6 million in 1974. Late in the year--

- Amtrak and the Military Traffic Management Command of the Department of Defense cooperatively developed a military-travelers program. Amtrak now bids to supply

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travel for small military contingents——a large potential source of revenue that increased more than ten-fold in 1974.

- General Services Administration authority has been obtained for government personnel to use official Government Travel Requests on trains in lieu of a ticket.
- Similar authority from state officials has increased state government personnel use of Amtrak.

Amtrak's advertising and promotional activities in 1974 included:

- $3.3 million for advertising over 367 radio stations, in 183 newspapers and in 83 magazines. It was directed at consumer markets including such special groups as the military and students.
- Distribution of more than 8.1 million promotional brochures, describing train travel, route attractions, vacation plans, special tours and ski trips.
- Amtrak's single-most-important sales tool continued to be its timetables:
  ——More than 12 million timetables were distributed in 1974——eight times the number printed in 1971 and 4 million more than were distributed in 1973.
- Amtrak's promotional highlight in 1974 was participation in Expo '74 at Spokane, Washington. Amtrak's exhibit was visited by more than one million fairgoers.

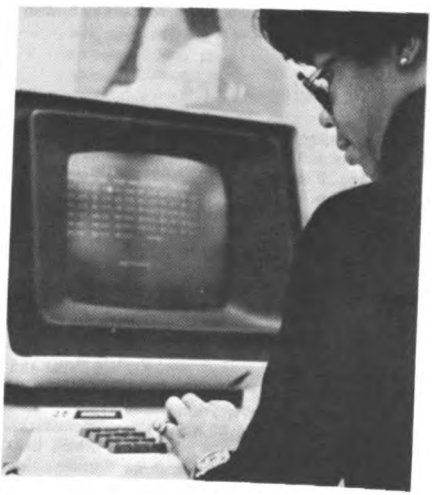
Sales strategies were further refined in 1974——

- Family plan, group and excursion fares were expanded to encourage increased ridership and revenue in the off-peak travel periods.
- Since January 1973 Amtrak has collected origin and destination data by class of service for each day on nearly 10,000 individual segments of the route system. This information makes it possible to schedule trains and consists for optimum load factors, to make adjustments for seasonality, to project traffic growth, to identify slack areas and to plan marketing strategies. Since January 1974 data has for the first time been available for actual year-to-year comparisons on all routes.
- In September, 1974, Amtrak concluded an interline agreement with Greyhound Bus Lines, which will permit either party to sell connecting-travel tickets over the lines of the other.
- Joint tour programs involving the use of bus, air, ship or rental-car travel have been expanded to permit Amtrak to participate in markets not directly served by train.
- Sales of Amtrak travel by independent travel agents grew from $7 million in 1973 to more than $20 million in 1974.

Steps were taken to make it easier for passengers to use rail service——

- Use of credit cards was expanded to cover service on trains as well as for purchase of tickets at stations. Amtrak's total credit card sales more than doubled in 1974 to $29.5 million.
- Since March, all reserved coach space except for Metroliners is by specific seat assignment to facilitate group seating.

On June 27, 1974, Amtrak completed installation



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and achieved full nationwide operation of its Advanced Ticketing and Reservation System (ARTS).

- In dual CDC 3500 data processors located in Washington, D. C., ARTS stores reserved-space inventory 180 days in advance, passenger reservation records, fare, schedule and consist information. In addition, it provides current train arrival and delay information. Access to this information is provided by 718 Cathode Ray Tube (CRT) display units at 78 locations in the U. S. and Canada.
- Regional Reservations Centers at New York City, Bensalem, Pa., Jacksonville, Fla., Chicago and Los Angeles provide the public with prompt, 24 hour, nationwide, toll-free reservations, ticketing and general information.
- The ARTS system has the capability to handle 120,000 calls per day. On July 4, 1974, it actually handled 78,649 calls.
- The number of ARTS-associated, electronic ticket printers was increased during the year from 63 to 113, and these issued up to 20,000 tickets per day.
- Since September Amtrak has been under contract to provide Southern Railway System with ARTS service.

New Service—1974

- Chicago – Dubuque, Iowa (The Black Hawk). This service, inaugurated in February 14, 1974, is partially funded by the State of Illinois.
- Oakland – Bakersfield, California (The San Joaquin). This daily service, inaugurated on March 6, 1974, serves San Joaquin Valley points.
- St. Louis – Laredo, Texas (The Inter-American). With the implementation of this tri-weekly service on March 13, 1974, an existing Laredo-Fort Worth operation was extended northward overnight via Dallas and Little Rock to make St. Louis connections for Chicago and New York.
- New York – Montreal (The Adirondack). Supplementing the Montrealer, which links Washington and Montreal via Northern New



England, the Adirondack, inaugurated August 6, 1974, runs through upstate New York along Lake Champlain to Montreal. The trains are partially supported by state funds.
- New York is also partially supporting an additional New York–Albany train, which began operating on October 27, 1974.
- Chicago – Port Huron (The Blue Water). This daily operation, partially supported by Michigan, started on September 15, 1974.
- Buffalo – Detroit (Empire State Express). This daily train, inaugurated on October 30, 1974, as an extension of existing New York–Buffalo service, connects Detroit with New York via southern Ontario. It is partially supported by Michigan and New York.

New Routes—1975

- Norfolk – Cincinnati. This service will begin on March 25, 1975. The trains will make connections with Amtrak's present trains 50 and 51 near Ashland, Kentucky, for through car service to Cincinnati and Chicago.
- Boston – Chicago. In September 1975, new service connecting New York/Boston and Chicago is to be instituted via Cleveland and Toledo, Ohio.
- Minneapolis – Duluth. A state-assisted ser-

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vice between Minneapolis and Duluth is expected to begin in early 1975.

- Detroit – Jackson. Michigan has requested and will partially fund additional Detroit–Jackson, Michigan, service. Start-up was January 20, 1975.
- Washington – Denver. The Secretary of Transportation has designated a new service to connect Washington, D.C., and Denver, Colorado, via Parkersburg, West Virginia; Cincinnati, and Indianapolis, Indiana. This train will be combined with existing Amtrak service between Indianapolis and Kansas City.

Service

On May 1, a total of 2,411 on-board-service personnel, stewards, waiters, cooks, car attendants, and sleeping-car porters transferred to Amtrak's payroll. This completed the takeover of these functions from all railroads, involving 3,357 employees. Commissary operations were established in New York City, Washington, Jacksonville, Miami, Chicago, St. Louis, Oakland, Los Angeles and Seattle.

- During the year the number of stations staffed with Amtrak personnel increased from 152 to 197. Twenty-three new stations were opened––18 as a result of new routes. Total station employment at year end was 1,963.
- Checked baggage service was greatly expanded, and at year end Amtrak was offering this service at 302 points.

The assumption of these functions from the railroads together with the transfer of this large number of employees and the establishment of uniform, high-quality standards of service is a major continuous undertaking.

One knotty problem has been the development of an effective on-board-service organization when conductors and brakemen are railroad employees and the service personnel work for Amtrak. Amtrak's dedicated Passenger Service Representatives and On-Board Service Directors rendered invaluable service during this transition period.

Conducters employed by railroad companies now have full responsibility for operation of individual Amtrak trains, and their long railroad experience enables them to be particularly responsive to the demands of passenger comfort and accommodation, on-the-spot correction of problems, the demands of on-time performance and proper equipment utilization.

- Quality and price of food service continues to receive high praise from Amtrak's customers. However, as in the case of other operating costs, the unfavorable ratio of revenue to cost remains a major management concern. Ways must be found to reduce the cost of food service while at the same time enhancing quality and attractiveness to the passenger.
- In July 1974 Amtrak in close cooperation with the Food and Drug Administration initiated extensive measures to insure full adherence and compliance with health and sanitation standards throughout the system. Amtrak employees remove all perishable and sensitive food from food-service cars at the end of each trip. Railroads were directed to clean and sanitize food-storage lockers on a strict schedule, to regularly flush and sanitize potable water tanks, and to steam-clean dining-car food preparation areas every 90 days.

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Operations

By the end of 1974 new service standard and cost reimbursement provisions of our operating contract had been negotiated with 10 railroads, including seven of the original participating railroads—Penn Central; Burlington Northern; Milwaukee Road; Seaboard Coast Line; Southern Pacific; Boston and Maine; Delaware and Hudson; Grand Trunk Western; Richmond, Fredericksburg and Potomac; and Louisville and Nashville. These railroads account for 83 percent of total railroad-charged costs.

Renegotiated service provisions and cost-reimbursement provisions of railroad operating contracts

The cost and service amendments reflect the particular operating and service characteristics of the individual railroads. The critical provisions are:

Definition of service–

- Routes and rated track speed
- Schedules with intermediate stops
- Train equipment consists
- Cleaning, servicing and maintenance specifications
- Cars and locomotives assigned for maintenance
- Personnel and facilities required at specific locations

These services are subject to adjustment for schedule changes.

Definition of cost–

Amtrak pays only the incremental cost of defined service as follows–

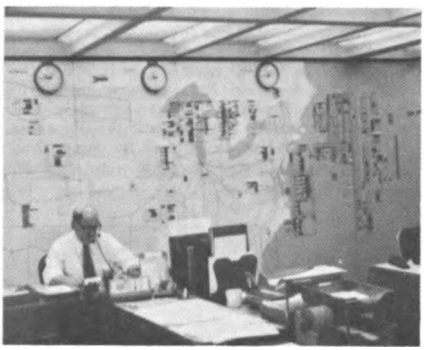
- A fixed sum per trip for train and engine crews, track maintenance, switching and en-route servicing.
- Actual cost, subject to a not-to-be-exceeded limit for specified equipment maintenance and servicing labor and materials at major yards.
- A fixed monthly amount for transportation supervision, station operations and other defined support activities.
- The actual cost of train fuel.

These payments will be modified for changes in services to provide or to reflect actual changes in negotiated wage rates.

Incentives and Penalties–

Incentives are paid for on-time performance in excess of 65 percent.

- On-time performance is determined in accordance with the Interstate Commerce





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Commission standard, which provides a tolerance from the published schedule of five minutes per 100 miles, up to a maximum of 30 minutes.

- There is no other allowance for lateness, whatever the cause.
- 90 percent "on-time" performance earns incentives equal to 21 percent of initial costs.

There are also incentives for—

- Improving schedules
- Recovering lost time on a train received late from another railroad.
- Maintaining equipment in operable condition for 95 percent or more of the trips.
- Equipment availability for service in excess of 88 percent of the cars or 90 percent of the locomotives assigned to the railroad for maintenance.

There are penalties for—

- Excessive delays in train operations.
- Failure to clean cars.
- Failure to maintain equipment in operable condition for 95 percent of the trips.

Penalties charged cannot exceed incentives earned during each year. Incentives and penalties are not adjusted for changes in service or cost.

Payments—

Amtrak pays after the service is performed.

- Railroads submit monthly bills within 30 days after the end of the month.
- Amtrak verifies cost, incentives and penalties and pays the amount due within 15 days thereafter.

Term—

The amendments are effective for a term of two years.

Maintenance Centers

- Amtrak assumed responsibility for maintenance at Brighton Park in Chicago, St. Louis, Houston and Jacksonville, and also reached agreement to assume control of all operations at New Orleans.
- Negotiations to assume maintenance func-



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tions in the Northeast corridor, Miami, Chicago and Los Angeles were under way with Penn Central, Seaboard Coast Line and Santa Fe.

- In November the Board of Directors approved Amtrak's acquisition of the centrally located, 64-acre Beech Grove Car Maintenance Shop near Indianapolis, with its 588 employees. This will be Amtrak's central heavy-overhaul, engineering and modification shop for passenger cars.

System performance

On-time performance improved substantially between January 1974, when the new ICC service standards went into effect, and December 1974.

- Comparative on-time performance——

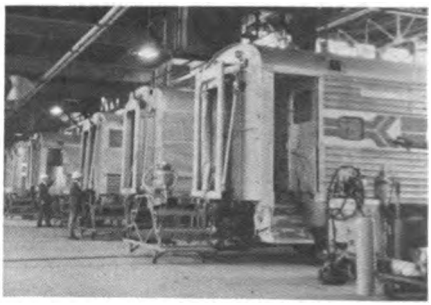
	Percent on-time	
	January 1974	December 1974
Turboliners	40.5	63.4
Metroliners	64.0	75.6
All corridor/ short-haul trains	70.0	80.0
All long-distance trains	41.2	62.1
Total of all trains	61.7	75.3

- Passenger cars available——that is, the number in the total useful inventory less cars out of service for damage repair, heavy overhaul for deferred maintenance or awaiting or undergoing work in servicing yards——also improved during 1974 from 69 percent in January to 74.2 percent in December.
- Reflecting delivery of the new, 3000-horsepower diesel-electric locomotives, Amtrak's locomotive availability also improved from 76.6 percent in January to 85.3 percent in December. This is especially significant because these new, higher-horsepower locomotives replace over-age and smaller-horsepower locomotives, permitting retirement of 83 old units and eliminating dependence on the railroads for supporting power.

More Amtrak service was offered in 1974——

	1973	1974	Percent increase
Route miles	22,433	24,315	8.3
Train miles operated	27,478,000	28,814,000	4.8
Trains operated per day	225	240	6.6
per year	82,125	87,600	6.6
Stations served	414	457	10.4





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■ There were 34 derailments in 1974 in which 169 passenger cars were so damaged as to require withdrawal from service for heavy repair. There were no fatalities.

■ In August the Federal Railroad Administration prohibited all service--freight and passenger--between Chicago, Indianapolis and Louisville on Penn Central tracks for failure to meet Class I track standards--the lowest class, which permits only 10 mph operation. This necessitated rerouting the James Whitcomb Riley and the Floridian over Chesapeake and Ohio, Baltimore and Ohio and Louisville and Nashville tracks. At year's end the Floridian had been able to resume its former route, at reduced speed, but the Riley had not.

■ Major improvement to the Old Saybrook Bridge in Connecticut was started in November. Engineering is complete, and bids have been requested for improvements on the Hell Gate Bridge in New York City. Negotiations are underway for specific track and signal improvements between New York and Boston.

Equipment and Facilities

■ During the year, 110 new diesel locomotives were placed in service following 40 delivered in 1973. Twenty-five additional diesels are scheduled for delivery by August 1975, and 26 electric locomotives are scheduled for delivery by May 1975.

■ No new passenger cars were delivered in 1974. However, 292 locomotive-drawn Metroliner cars ordered from the Budd Manufacturing Company in 1973 and 1974 are scheduled for delivery starting in April 1975,

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with deliveries building to a rate of 20 per month.

- Four, five-car RTG French-built Turboliners will be delivered and readied for service in February and March 1975.
- Seven, five-car RTG Turboliners manufactured by Rohr Industries in the U.S. will be delivered starting in March 1976.
- Bids were received late in the year for an additional 200 locomotive-drawn Metroliner cars, which Amtrak ordered on January 30, 1975.
- As a result of a competition initiated in 1973 the corporation solicited bids on 235 bilevel, multi-use passenger cars designed by Louis T. Klauder Associates. Bids were received in November, and Amtrak planned to place orders for these stainless-steel cars with Pullman-Standard Manufacturing Company in February 1975. These cars will be bought in three basic configurations--coach, sleeper, and food service. Deliveries will start in December 1976 and run through June 1978.
- Heavy overhaul of passenger cars to recover deferred maintenance accelerated during the year, reaching a peak of 49 a month for a total of 449 for the year. The bulk of this work is being done by Penn Central, Santa Fe, and Illinois Central Gulf in shops at Beech Grove, Indiana; Topeka, Kansas, and Chicago. Industrial facilities of Rohr Industries, Pullman-Standard, and Mechtron account for the balance. Intermediate overhaul and damage repair is performed at the Seaboard Coast Line's Rocky Mount, North Carolina, shops and at Burlington Northern's Como shop in St. Paul, Minnesota.
- Twenty-five locomotives were rebuilt in 1974.

At the end of 1974, Amtrak was serving passengers at a total of 424 stations. During the year, a number of stations were renovated or reopened. An increasing number were improved under cost-sharing agreements with the states or communities.

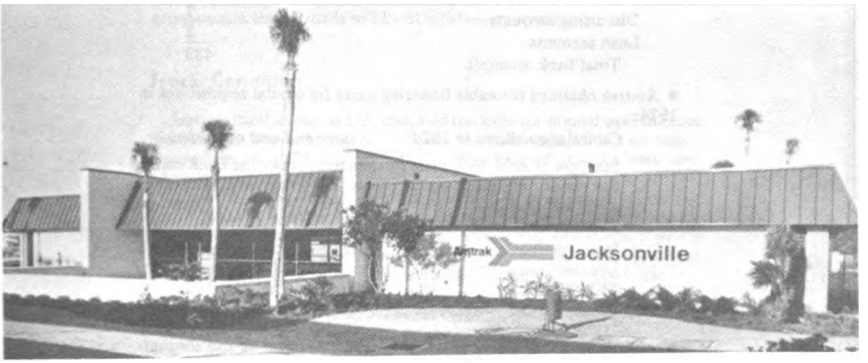
- A new passenger facility was placed into service in September 1974 at Poinciana-Kissimmee, Florida, near Disney World.
- Construction was begun on a new passenger lounge and mechanized baggage system for Chicago's Union Station. The $811,000 project is designed to accommodate more than 300 persons at a time and will include a coffee bar and information center.
- Construction of a $1.8 million relocated



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station and associated facilities for Richmond, Virginia, was begun in November 1974.

- Amtrak's new Jacksonville, Florida, station was opened in January 1974.
- Ground was broken for a new terminal at Port Huron, Michigan, in August 1974. Total project cost, with two-thirds to be paid by the state, is $223,500. Completion is expected in early 1975.
- Four other stations on the Grand Trunk's portion of the Chicago-Port Huron route in Michigan were upgraded by painting, remodeling, building new platforms and installing train-servicing facilities, also with state support.
- In July 1974, Amtrak consolidated all passenger operations in Houston into one station. The station building was renovated and space for Amtrak operations was enlarged. Train-servicing facilities were also augmented.
- During the year, seven stations were remodeled and opened on the Missouri Pacific Railroad to accommodate new service between St. Louis and Fort Worth. Two intermediate communities on this route in Arkansas—Newport and Walnut Ridge—are working cooperatively with Amtrak as part of an experimental-stop program.
- Seven stations were opened and improved on the new San Joaquin Valley route in California.
- Ground was broken for a new suburban station serving the Washington metropolitan area at New Carrollton, Maryland, which will also be a terminal for the new Washington Metro rapid-rail transit system.
- Steps were taken to save and restore the architecturally historic station at New London, Connecticut, under a local initiative with which Amtrak is cooperating.
- Agreement was reached between the Department of Interior, the Department of Transportation, and the Washington Union Terminal Company and its owners, which permitted resumption of construction of the National Visitors Center in Washington, D. C. As part of this project, a passenger station will be constructed to the north of and adjoining the Center. The station will be directly accessible at street level from the Visitors Center Plaza. It will be completed in time for the Bicentennial and will meet the needs of all intercity railroad and commuter passengers.



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Finance and Legal

- Congressional action improved Amtrak's financial position in 1974–

Appropriations and loan-guarantee authority

Grants from U.S. Government–	Amount (millions)
Total grants through calendar year 1973	$312.1
Grants appropriated in 1974	247.3
Total grants appropriated as of Dec. 31, 1974	$559.4
Grants drawn through 1974	472.6
Grant funds available, Dec. 31, 1974	$ 86.8
Loan guarantee authority from U.S. Government–	
Authority enacted through calendar year 1973	$500.0
Authority enacted in calendar year 1974	400.0
Total loan guarantee authority enacted	$900.0
Loan guarantee authority committed, Dec. 31, 1974	314.0
Loan guarantee authority available, Dec. 31, 1974	$586.0

- Amtrak has nationwide banking relations–

Open lines of bank credit	Amount (millions)
Federal Financing Bank, U.S. Treasury	$280.0
Chase Manhattan Bank	100.0
Total bank credit available	$380.0
Banking relationships	**Number of banks**
Deposit accounts	425
Concentration accounts	5
Disbursing accounts	7
Loan accounts	2
Total bank accounts	439

- Amtrak obtained favorable financing terms for capital acquisitions in 1974–

Capital acquisitions in 1974:	*Source and cost of financing:*
Purchase of used equipment and major overhaul of equipment and facilities: $92.2 million	Federal Financing Bank current weighted interest cost of 8.66 percent
Lease-purchase of equipment, Locomotives and cars: $103.7 million	Regional banks in conjunction with Federal Financing Bank; effective interest cost of 4.76 percent

- Amtrak assumed direct control of all revenue collecting and accounting functions in 1974–

Cash collections in 1974	Amount (millions)
Ticket and other sales	$248.2
Mail revenue	6.2
Other income	3.6
Railroad entry payments	20.7
Total cash collections	$278.7

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- Amtrak obtained large audit recoveries from railroads through 1974–

Audit recoveries and findings	Amount (millions)
Cash collections from railroads through CY 1973	$ 27.0
Cash collections from railroads in CY 1974	15.0
Total cash collections as of Dec. 31, 1974	$ 42.0
Audit findings in negotiation as of Dec. 31, 1974	20.8
Preliminary audit findings as of Dec. 31, 1974	6.8
Total audit findings as of Dec. 31, 1974	$ 69.6

Legal proceedings

Amtrak continued in 1974 to be involved in a substantial amount of government regulatory proceedings, litigation, arbitration and other legal proceedings and activities normally associated with the conduct of a nationwide transportation business.

Several of Amtrak's 1974 legal proceedings dealt with two major areas that are of particular significance to Amtrak's relationship with the railroads and therefore extremely important to Amtrak's future success. The first involves the scope of Amtrak's rights to receive services of various kinds from the railroads and includes the fundamental question of the quality of those services. The second involves the condition of the rail lines over which Amtrak must operate. Both areas involve important issues with respect to the levels of compensation to be paid by Amtrak for the provision or improvement of services and the development of mechanisms to ensure that the services and facilities for which Amtrak compensates the railroads will be of satisfactory quality.

Track Condition

Amtrak itself owns no rail lines, and trackage for normal operations is provided by the contracting railroads. Amtrak engaged in two major proceedings in 1974 dealing with the condition of the rail lines over which its trains operate:

- In 1974 Amtrak received a final arbitration award against the Illinois Central Gulf Railroad implementing an earlier award, which interpreted the operating agreements with the railroads to require that rail lines used in Amtrak service must be maintained in such condition that contractually agreed-upon schedules can be met with a reasonable degree of regularity and with a reasonable degree of passenger comfort. On the basis of extensive investigations and reports by the parties, the final award specified in detail the work that must be done by the ICG at its sole expense by the end of 1976 in order to restore the utility of the track to the level that existed on May 1, 1971, when Amtrak began operations.
- Amtrak participated in a rulemaking proceeding in which the Interstate Commerce Commission has announced its intention to

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issue regulations requiring rehabilitation of rail lines used in Amtrak service to the level of utility that existed May 1, 1971, as well as regulations providing for the further upgrading of certain routes beyond such basic condition.

Railroad services and compensation

Most services are provided to Amtrak by the railroads under the standard contracts originally negotiated in 1971. (Important provisions in a number of these contracts have been subsequently renegotiated as described on page 14.) In 1974 Amtrak's right to receive services and its obligation to pay for such services were significantly affected in court proceedings, in arbitration proceedings, and in proceedings before the Interstate Commerce Commission. The most significant developments were as follows:

- Amtrak obtained an arbitration award interpreting the operating contract to require the contracting railroads to provide new, modified or emergency service over their rail lines upon reasonable request by Amtrak, to be paid for under the terms of the contract.
- As a result of the settlement of an antitrust action filed in 1973, the charges Amtrak pays for the use of the Kansas City Terminal were very substantially reduced. In addition, Amtrak was paid $1.9 million.
- As the result of the settlement of an action brought in 1974 against the Washington Union Terminal Company and its owners, Amtrak obtained necessary assurances that a satisfactory new railroad passenger station would be built at Washington, D.C., in conjunction with the National Visitors Center project.
- Amtrak obtained an order from the Interstate Commerce Commission under Section 402(c) of the Rail Passenger Service Act requiring the Texas and Pacific Railway, a railroad that had no passenger service on May 1, 1971, and with whom Amtrak has no operating contract, to provide services in use of its rail lines for operation of Amtrak trains. The Interstate Commerce Commission has yet to fix the terms and conditions specifying what Amtrak would be required to pay for such services.

During 1974, under the terms of the renegotiated liability provisions in the railroad contracts, which became effective in June 1972, Amtrak continued to bear certain legal responsibilities for personal injuries of passengers, employees and persons injured at grade crossings. Under the original contracts Amtrak made payments to the railroads of 4 percent of costs to cover liability. Had the original contract provision remained in effect, Amtrak would have paid the railroads $26,372,080 for liability from June 1, 1972, through December 31, 1974. Under the renegotiated contract Amtrak has paid $1,547,221 for liability for the same period.

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Mr. ADAMS. Thank you very much, Mr. Reistrup, for an excellent statement.

Mr. Metcalfe.

Mr. METCALFE. Thank you, Mr. Chairman.

Mr. Reistrup, you have answered many of the questions I asked of Mr. Hall. However, in your summary, do you give us a balance, a figure, because starting on page 6 you indicated what the revenues would be and the costs, and then you went into wage and price increases, and then you further developed the pluses and minuses? In other words, the assets as against the deficits. But what is the net figure as to the needs? I am sure it is short, the expenses are going to exceed the income.

Mr. REISTRUP. For the quarter, fourth quarter of fiscal 1975, the period April 1 through June 30, 1975, we need an additional authorization of $63 million.

Mr. METCALFE. $63 million. I have one small question to ask: In your testimony that you gave, you indicated that during the summer travel period of July and August and over Labor Day that the cost of operating would be increased, but you did not at that time indicate that the revenues would also be increased.

Are you suggesting that there will not be a sufficient amount of revenue because you don't relate the two items at the same time?

Mr. REISTRUP. What I was trying to say, Mr. Metcalfe, was that the revenue projections for that quarter have been raised seasonally because of the relatively heavier travel of July and August and September, and that the costs on the other hand reflect the fiscal year 1976 cost level projections. So there is seasonality involved in that estimate.

Mr. ADAMS. Mr. Reistrup, I am sure you have read the preliminary system plan recently published by the U.S. Railway Association.

In discussion of passenger service in the region, the USRA criticized Amtrak on a number of points. I am specifically interested in one of these criticisms which appear on page 169 of volume 1. Let me quote.

"Rail service today is limited and able to attract only a small share of the travel market. One reason is that the railroads have had little incentive to economize because of cost-plus contracts which Amtrak is now negotiating to provide performance standards, together with appropriate penalties and incentives."

Could you briefly answer this criticism, and let us know how these so-called cost-plus contracts work?

Mr. REISTRUP. Well, today, the contracts with most of the railroads are now under an incentive arrangement. This, of course, was led by Mr. Lewis and his staff and pretty much handled by Mr. Tomlinson who had been executive vice president of Amtrak, and 83 percent of the business that we do with railroads is under these new incentive contracts. So only 17 percent are under this earlier so-called cost-plus arrangement.

Now, that was an outgrowth of the original legislation, which in effect provided that the railroad would be compensated for avoidable cost-plus certain overrides. There was one for a 5-percent override or overhead for all other costs that might not be determined, and then there was a 4-percent override for liability. The first step that was made by Mr. Lewis and his staff was the elimination of that liability override. Amtrak now carries its own liability for passengers.

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The second step was to completely get away from that cost-plus type of contract. We now actually pay the railroads at about a 90-percent cost level compared to what they would have billed under the old contract. Then they get add-ons for doing better than they were doing during the period prior to the new contract.

So, as they do better—the cars are cleaner, the trains run better and on time and the cars have a better in-service-ratio percentage—they get more money. Amtrak gains, the passenger gains, the railroad gains.

Mr. METCALFE. Thank you very much, Mr. Chairman. Because of the time factor, I yield back any time I have.

Mr. ADAMS. The time of the gentleman has expired.

Mr. Skubitz.

Mr. SKUBITZ. Thank you, Mr. Chairman.

It is good to have you with us, Mr. Reistrup, and I am sorry to see you go, Mr. Hall. I assume you will accept the statements of the new gentlemen.

Mr. Reistrup, on page 1 of your testimony, the first paragraph, if I total the figures correctly I come out with a request for $843 million up to October 1, 1976; this is correct, isn't it?

Mr. REISTRUP. This would be a mixture of the fiscal year funding and capital and operations, yes, sir.

Mr. SKUBITZ. And the gentleman that preceded you, Mr. Hall, in his attachments for the same period of time gives us a figure of $608 million. That is only a small difference, only $235 million, but could you explain the difference?

Mr. REISTRUP. The main difference is that Mr. Hall did not include a rather substantial sum of $200 million for track and I did. The reason for this is that—although I agreed with Mr. Hall and I agree with the gentleman that I heard this morning that track is a bigger problem than Amtrak—it is such a significant challenge to Amtrak that we, in my opinion, had to provide funding in this request, because something has to be done about the track. You have to have track to run the trains.

The deterioration is evident, particularly in the Northeast where we have so many bankrupts.

Mr. SKUBITZ. When you speak of "track," just what do you mean, purchasing of track or putting on an additional $200 million to take care of and maintain the present track?

Mr. REISTRUP. This $200 million would be largely for maintaining the existing track. There would be some improvements included. But basically it is track maintenance, bringing it up to standards required for today's speeds.

Mr. SKUBITZ. Then, you are subsidizing the railroads for $200 million to bring up the tracks. Is that right?

Mr. REISTRUP. This is an underlying concept of the contract; yes.

Mr. SKUBITZ. I visited Mr. Adams often and I notice, Mr. Adams, in Sunday's paper you indicated lease and leaseback of the roadbeds and the Government taking care of them. I think that is a good deal. What do you think about that proposal?

Mr. REISTRUP. I would really rather give that more thought and I am not ducking the question. But, again, this track issue is such a big one and I think it is much more paramount in the freight business,

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from whence I came, than passenger business. My concern is on Penn Central particularly, because about 40 percent of our Amtrak operation is on Penn Central. Although we have a contract set up under the law, in 1970, providing us with track at the level of utility—this means in the state of maintenance that it was in on May 1, 1971—we don't have it, and apparently they don't have the money to get it to that state, and something has to be done because we are running trains and hauling people on those tracks every day.

This is the reason that Mr. Hall and I have a difference in our statements.

Mr. SKUBITZ. One thing you say, "good track is necessary," and I agree, but Mr. Lewis proved it was not so necessary. He kept running on the Penn Central and they had no good tracks.

Let me ask you this: On page 4 of your testimony, you mentioned two new train services have been initiated which were not previously funded. How did these new trains come about? Where are they located?

Mr. REISTRUP. Well, these trains came about before my arriving on the scene on March 1. One starts this month, hopefully on the 24th, running from Norfolk to Cincinatti and it ties in with an existing operation. That is funded, however, Don Brazier tells me.

The two that are not funded are Buffalo-Detroit, which was partially a State operation, so we share in that money, and also New York-Philadelphia, an added service. Those are the two that are specifically requested here.

Mr. SKUBITZ. Are the States in either instance chipping in on the route?

Mr. REISTRUP. On the Buffalo-Detroit they are.

Mr. ADAMS. The time of the gentleman has expired, and the Chair will return to him.

Mr. Santini.

Mr. SANTINI. Thank you, Mr. Chairman.

I am pleased, Mr. Reistrup, to note your ascendency or the decline, as the case may be. I do view you in, I suppose, if I may borrow an expression, "as the light at the end of the tunnel," I hope, and yet the tunnel concerns me considerably and currently much has preceded me here by way of economic rejuvenation.

I would like, at least in some summary fashion, your assessment of the projected future—dismal in my evaluation because it seems to me a continual outpouring of the taxpayers' dollars to sustain or maintain the existing railway. I support the concept enthusiastically, but I am much concerned about the continued U.S. dollars.

Mr. REISTRUP. I am concerned personally and the Board of Directors at Amtrak is and the staff is, and I believe many, many people in the country are. It has been some 6 years since I have been directly involved in the passenger business. I found it in the early years to be a tough one and I still think it is, and I think it is tough for the other modes as well as for rail passengers.

My feeling is that the best we can do, probably, is to get this deficit under control and begin to get the margins to decrease and to lose less money per passenger, and less money per passenger miles, and this will be our effort as we move into the future. We have to get more revenue density per train. The cars that are on order will help us in that direction.

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We must make every effort to run the trains where a train really is the proper alternative. A train gets its very name by pulling more than one car and it is a wholesale type operation, rather than a retail operation, compared to the private automobile.

Now, if I may say, the deficit is more apparent for rail passenger service because we have to request funding. But what we are providing is an alternate to the private automobile—our major competitor—and its costs are not evident at all, because of the provision of the highway rights-of-way between and all around the communities, and farm-to-market roads, and so forth—in spite of the trust fund for the Interstate Highway System.

The automobile is provided with a free right-of-way, basically, although there is some contribution to it. That is what we are competing with. We are not competing in Amtrak with air and bus, really. I think Amtrak is a rail alternative to be coordinated with the other modes, where we can, because I am an intermodalist, so we are providing an alternate to the automobile.

We will do everything we can to reduce the deficit. I do not think it can be eliminated but lessened at least in relative terms. That depends somewhat on what is determined to be our overall service level, and this is not entirely within Amtrak's control.

Mr. SANTINI. It has been your projection we will never operate on a money-making basis?

Mr. REISTRUP. Today in 1975, having been on the job 10 days, I would say that is true.

Mr. SANTINI. I undoubtedly will be talking with you again.

How do you feel about the USRA recommendations for 16 additional intercity passenger routes or have you had an opportunity to review that?

Mr. REISTRUP. I have. I read the chapter that Mr. Metcalfe referred to several times. I am very interested. The Amtrak staff is studying these recommendations. I am giving it further thought and we are going to be working, not only with USRA, but also the communities and the Interstate Commerce Commission as further analysis is made.

There are many unserved markets in the Lake Erie region, particularly Cleveland, which gets its first train this fall.

Mr. ADAMS. The time of the gentleman has expired.

Mr. Reistrup, I didn't notice in your statement, but I have in Mr. Hall's statement the authorization request that would take us through the rest of fiscal year 1975 which we are already in, fiscal year 1976, for which we are now authorizing the transition quarter, which goes to October 1; and for fiscal year 1977 there is a figure of $430 million.

If this committee were to authorize for those periods of time, are those your figures, too, or do you want to submit a different set for the record?

Mr. REISTRUP. I would like to have time for further analysis. The concept is philosophically interesting but there is a problem of escalation of the deficit due to inflation, which remains rather unpredictable.

Mr. ADAMS. Can you submit that to the committee for the record before the beginning of next week, because counsel informs us we will be, or try to be, in markup next week?

Mr. REISTRUP. Yes; we will do that. It is just a matter of checking the numbers.

[The following information was received for the record:]

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FISCAL YEAR 1977 ESTIMATES (*Oct. 1, 1976–Sept. 30, 1977*)

	Millions
Revenues:	
Base year 1976:	
Transportation	$330
Other	36
Total	366
Fiscal year 1977:	
Transportation ($330 times 115 percent)	380
Other ($36 times 110 percent)	40
Fare increase ($330 times 105 percent)	20
Total revenues	440
Costs:	
Base year 1976:	
Operating expenses	682
Less: Depreciation, fiscal year 1976	−21
Add: Annualize new services	9
Base operating expenses	670
General and administrative expenses	16
Fiscal year 1977:	
Operating expenses ($670 times 105 percent)	704
Annualize fiscal year inflation ($37 times 105 percent)	39
Fiscal year 1977 inflation ($743 times 6 percent)	45
Depreciation in fiscal year 1977	30
Subtotal, operating expenses	818
General and administrative expenses ($16 times 106 percent)	17
Interest espense	51
Total expenses	886
Operating deficit, fiscal year 1977	446
Less: depreciation	30
Operating grant requirement	416
Capital program:	
Equipment and facilities	100
Right of way improvements	200
Total capital grant requirement	300
Summary of fiscal year authorization requirement:	
Operating grant	415
Capital grant	300
Total	715

FISCAL YEAR 1977 BUDGET ASSUMPTIONS

(Dollars in millions)

Revenues:

1. A 15% increase in transportation revenues resulting from ridership increases.
2. A 10% increase in food and beverage and other revenues related to the ridership increase.
3. An average 5% fare increase to partially offset wage and price increases.

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Operating expenses:

1. A 5% increase in operating expenses related to the 15% increase in ridership.
2. A $9 million increase for annualized costs of service started in FY1976.
3. Annualization of inflation that occurred in FY1976 (Rate 5.9% average).
4. Inflation at 6% average during FY1977.

General and administrative expenses: 1. FY1976 budget plus wage increases and other cost increases at 6% average.

Interest: 1. Based on *average* outstanding loan balance of $710 million for the year. Ending balance of $820 million.

Capital program:

1. Funds for capital improvements will be grants in lieu of guaranteed loan authority.
2. Consistent with the August 30, 1974 AMTRAK Five Year Financial Plan, capital grants will be requested as follows:

Equipment and facilities	$100
Right of way improvements	200
Total	300

FISCAL YEAR 1977 ANNUALIZED COST/REVENUE BREAKDOWN FOR NEW ROUTES ADDED DURING FISCAL YEAR 1976

Route	Fiscal year 1976			Fiscal year 1977			Total
	Revenue	Cost	Loss	Revenue	Cost	Loss	
Boston to Chicago	7.5	10.6	(3.1)	9.4	13.3	(3.9)	
Washington to Denver	2.9	4.6	(1.7)	4.4	6.9	(2.5)	
(3) 300-mile routes 403(b) routes	.9	1.3	(.4)	1.3	1.9	(.6)	
New train: New York to Washington to Chicago	10.1	18.7	(8.6)	12.1	22.4	(10.3)	
Total		35.2			44.5		+9.3

FISCAL YEAR 1977 AUTHORIZATION REQUIREMENT, RECONCILIATION TO FISCAL YEAR 1976

[In millions of dollars]

Fiscal year 1976 authorization	$350
Add—	
Annualization of fiscal year 1976 inflation	39
Inflation in fiscal year 1977	45
Annualized cost of new service	9
	93
Subtotal	443
Less fare increase	20
Indicated authorization requirement	423
Fiscal year 1977 authorization request	415

Mr. ADAMS. The chairman has no further questions.

Does another member wish to question further?

Mr. SKUBITZ. Yes, Mr. Chairman.

Mr. ADAMS. Mr. Skubitz.

Mr. SKUBITZ. Mr. Reistrup, I am worried about one statement you make which is only based on 10 days' experience. Is it really your feeling that Amtrak will not be a break-even operation in years to come?

Mr. REISTRUP. This is my feeling at the present time. Given the present posture in which we find ourselves, under the present act and

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with the services being designated for us—and several each year are being added—it is the situation.

Mr. SKUBITZ. You believe the Government is going to be in the business of subsidizing Amtrak from here on out; is this correct?

Mr. REISTRUP. This is correct, under today's law and today's way of doing business.

Mr. SKUBITZ. What changes should be made in the law in order to get you on a sound basis?

Mr. REISTRUP. I think that some changes are in order and it is a little early for me to comment on that. This is why I have not responded directly to Mr. Hall's proposed legislative changes.

I really have to give this thought and study. I am new to this arena and I have to have consultations with my staff.

Mr. SKUBITZ. If I thought for a moment what you say is correct—that Amtrak is not going to be able to get on a sound basis and you can't come forward with any program to put it on a sound basis, except Government subsidy, I would be ready to vote you out of business. I am serious about that, because I don't see any reason why you folks should be a little "scringy" about adding on to the price of the ticket the actual cost of operating a railroad. The railroads could have done that themselves.

We could have subsidized them and would probably be further down the road than we are today. I was hopeful that Amtrak had some answers.

Now if it is the longer route you are talking about, that is something else. I think if we ever get into the area where one can travel at a decent rate of speed, where a train does operate at 125 miles an hour, like they do in other countries, where a 3-hour trip is considered as economical as 3½ hours on a train, whereas we are taking them by plane; if you could get into that area, then we can make Amtrak a feasible program.

I see the bells are ringing.

If you want a good suggestion and really to put a "feather in your hat," I would suggest you look at a route I once suggested to Amtrak. The route is not a long one. It goes from Kansas City to Tulsa, and three times the railroads tried to get rid of the route and the ICC wouldn't let them. However, we came along and got rid of them.

If maybe you can get one little railroad that broke even, it would save some of us who have to go to the Floor all the time and talk about deficits and give us something to hang our hats on.

Mr. REISTRUP. The Metroliner does contribute some money as does the high-speed train in Japan, but, to my knowledge—and I have been a student of this quite a bit and while I have not ridden the Japanese lines I have ridden the European roads with my family on my own money—I know of no operation in the world other than those two that contribute a profit to overhead.

Mr. SKUBITZ. I will find more about that in this next year talking to you about it.

Mr. ADAMS. The time of the gentleman has expired.

Does another member wish to question?

If not, Mr. Reistrup, we appreciate very much your testimony and, Mr. Lewis, we appreciate your being here this morning.

The committee will stand over until Thursday at 10 o'clock in this same room when testimony will be heard from ICC and the National

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Association of Railroad Passengers, and the committee will adjourn until 10 o'clock Thursday.

[The following letter was received for the record:]

NATIONAL RAILROAD PASSENGER CORPORATION,
Washington, D.C., March 13, 1975.

Hon. FRED B. ROONEY,
Chairman, Subcommittee on Transportation and Commerce, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: During this week's hearing several members of the subcommittee, including Mr. Adams, asked that I elaborate on the importance Amtrak and I personally attach to the need for authorization of funds for Amtrak and right-of-way improvement programs.

While I realize that the need for track work is being recognized increasingly more widely in both Houses, in the Administration, by the United States Railway Association and by the public; it appears that most of the possible wide-range and job-producing solutions being proposed will at best take many, many months before fruition. Amtrak can't wait many, many months for track maintenance and improvement if it is to continue to provide safe, reliable service to its millions of passengers.

Throughout our route system—and particularly on Penn Central routes—slow orders are impacting on our on-time performance, and rough trackage is disrupting passenger comfort and skirting the margins of acceptable safety. One section of track, between Chicago, Indianapolis and Louisville, actually was shut down by the Federal Railway Administration. Last year Amtrak suffered 34 derailments in which 169 coaches, diners and sleeping cars were so badly damaged as to require heavy repair. This, of course, severely escalates our repair costs and massively complicates consist management by reducing car availability rates. Virtually every day an Amtrak train is delayed someplace in the country by a freight-train derailment on the routes we use. One can only be extremely thankful that no passenger fatalities have yet occurred.

The Five-Year Financial Program we submitted to Congress in August specified an urgent need for $235 million in FY–76 track-work funding. We have refined that figure in light of existing economic pressures and now ask that only $200 million be provided in FY–76, with further funding being delayed to subsequent fiscal years. This $200 million would be applied by Amtrak in accord with the most urgent Priorities our engineering and operations staff see. I have reproduced below the 10 route segments which we identified for possible track improvement work in the Five Year Program. I strongly urge the subcommittee's close attention to this overriding problem and respectfully request that you authorize the maximum amount possible so that we can make a start on ameliorating the present unsatisfactory and dangerous situation.

Right-of-way	Net new capital requests	
	Fiscal year 1976	August, fiscal years 1977–79
Northeast corridor	65.0	53.3
Chicago–Carbondale	15.0	20.0
Philadelphia–Harrisburg	20.0	8.3
Washington–Richmond	25.0	10.0
Chicago–Detroit	15.0	20.0
Chicago–Quincy		13.3
Chicago–St. Louis	25.0	30.0
Chicago–Milwaukee	15.0	20.0
Seattle–Portland		18.3
Los Angeles–San Diego	15.0	21.7
Chicago–Indianapolis–Cincinnati	25.0	30.0
New York–Buffalo	15.0	20.0
Total	235.0	264.9

Sincerely,

PAUL H. REISTRUP,
President.

[Whereupon, at 12:15 p.m. the subcommittee adjourned, to reconvene at 10 a.m. Thursday, March 13, 1975.]

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AMTRAK AUTHORIZATION

THURSDAY, MARCH 13, 1975

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON TRANSPORTATION AND COMMERCE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2218, Rayburn House Office Building, Hon. Fred B. Rooney [chairman] presiding.

Mr. ROONEY. Without objection, the Chair wishes to place in the record, as though read, a statement submitted by Congressman J. J. Pickle of Texas.

STATEMENT OF HON. J. J. PICKLE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. PICKLE. Mr. Chairman, I could go into a great deal of detail about how Amtrak at times seems to work against better train service. But your hearings are to decide authorization questions, not to delve into the many deficiencies of passenger train management, which must be discussed later.

Much of my knowledge in this area comes from working on improvements for the Inter-American train. This is one of the congressionally mandated trains for international service. The train runs through my congressional district.

As I have said previously, the Inter-American is a case study in how an attractive train route must struggle to accomplish its mission because of what I would characterize as Amtrak's "no care" attitude toward long-distance trains.

There are many things wrong with the InterAmerican, and all can be laid at the feet of Amtrak's management of this route.

Other than merely initiating and operating a truncated service, Amtrak has ignored the basic provisions of the congressional mandate to provide an adequate international service. The train provides a minimal service. It operates 3 days a week in each direction over a circuitous route at extremely slow speeds with poor on-time performance. Moreover, the train does not provide an international service as it does not connect with the southbound Mexican train at Nuevo Laredo—an oversight layover is required to make the connection. Also, the northbound InterAmerican does not connect with the westbound Amtrak train at St. Louis. In addition, the equipment assigned to the train is marginal and was plagued with electrical and air-conditioning failures, particularly during the first 6 months of operations. Maintenance and repair procedures are not being adequately enforced.

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Many of the train's operational deficiencies are inexcusable. The circuitous routing could be greatly alleviated if Amtrak rerouted the train on the tracks of noncontract railroads. Speeds could be increased if Amtrak would implement the applicable provision in the act. On-time performance could be improved by eliminating freight train interference prohibited by the act and if Amtrak took actions with the railroads to prevent other types of delays. International service could be provided if the schedule were changed, the train went to Nuevo Laredo, Mex., or through-car service were provided. Amtrak, however, refuses to take any of these corrective actions.

An unpublished report by the Commerce Committee's Investigations Subcommittee spells out the problems in detail, and is a scathing indictment of Amtrak mismanagement. This report details how Amtrak has misled Members of Congress, refused to negotiate with Mexican rail officials, ignored increasing the speed along the route, et cetera, et cetera—I could go on and on. I commend the report to the members of the committee, and am attaching a copy of that summary.

But, Mr. Chairman, let me point out my major concern, and a matter that is directly before this committee. This is the fact that Congress gave Amtrak $4.5 million to spend on the Inter-American route. The purpose was to create good international train service between the United States and Mexico.

With $4.5 million this could have been done. Certainly there would remain some rough spots along the route, but all in all, $4.5 million last fiscal year would have done the job.

What did Amtrak do with the $4.5 million legislatively earmarked for the Inter-American? I really don't know, but $2 million of the $4.5 million was diverted to other purposes.

In other words, Amtrak thumbed its nose at Congress, and took Inter-American money and spent it elsewhere.

Mr. Chairman, I consider such defiance of Congress a serious matter—and one that this committee should examine.

The question becomes, what can Congress do to make sure Amtrak does what Congress intends?

Last year the authorization bill did not have specific language in the bill detailing what was to be spent on the Inter-American. The conference report language accompanying the bill was clear in stating Amtrak was to spend adequate funds on the Inter-American to provide for international service.

The Appropriations Committee made the issue point-blank clear. Its bill said, "4.5 million for the InterAmerican."

It would seem Congress would not have to do any more to explain what it wishes to be done with the money it appropriates. But since Amtrak obviously did not get the message, Congress must consider other alternatives.

The alternative that I would propose is that the authorization bill give greater guidelines to Amtrak as to what to do with their money. For example, Amtrak should be told in no uncertain terms—"You are to run a train from St. Louis to Laredo, Tex., that is through car service to Mexico City."

Another step that I would suggest is that Amtrak become accountable to Congress on how it plans to spend its money. Amtrak makes no comprehensive plans for capital improvements for long-distance trains.

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This results in Amtrak telling U.S. Representatives one thing and is doing another. It also results in Amtrak not saying anything.

For example, when I was the ranking Democratic member of the subcommittee with direct oversight of Amtrak, I wrote over a year ago, to Amtrak to give me a breakdown on where new moneys from loans would be spent. I'm still waiting for an answer. Amtrak doesn't know.

I have made inquiries with Amtrak as to how much money in capital improvements the agency intends to spend on the Inter-American. Amtrak does not know the answer to my question on the Inter-American, or for any other train route. Meanwhile, Amtrak has written me over the past year outlining improvements to be made on the Inter-American. The improvements have not been made, and the Amtrak budget office has no idea whether they will be made or not.

I urge this subcommittee to make Amtrak come up with some plans. We need to know what the agency plans to do with long-distance trains. Now we are in the dark.

Before concluding, Mr. Chairman, I want to bring another problem to the subcommittee's attention. This problem is directly related to the health of our railroad companies, Amtrak service, and the Inter-American.

My concern is the reluctance of the USRA to give loans to non-Northeast railroads. Certainly Northeast railroads are bankrupt, but why should railroads in other parts of the country go bankrupt before getting assistance?

USRA seems intent on shutting the roundhouse doors after the iron horses have fled.

We are familiar that the USRA may not help the Rock Island. In my area, there is another railroad that needs help—the Missouri, Kansas, and Texas Railroad, or the KATY, as it is better known.

The KATY needs a loan to improve tracks running in southcentral Texas to Houston. Meanwhile, Amtrak is considering improving the KATY tracks between Dallas and Temple. If the Inter-American could run over the KATY tracks, then at least connections could be made in Laredo with the Mexican train.

Amtrak and KATY negotiated a deal which needs approval by the Amtrak board of directors.

This approval has been held up because Amtrak is afraid of entering into an arrangement with a railroad that might possibly go bankrupt.

The KATY is made of stern stuff, and I doubt the railroad will go bankrupt. In any event, the KATY needs a USRA loan. If KATY did get USRA help, we could have better passenger train service.

The point is that somebody needs to give DOT and the USRA a good shake on its rail policy toward railroads outside the Northeast corridor. Mainly, the USRA and Amtrak should work together to provide good railroads that can provide good train service. As it is now, USRA policy is hurting the Inter-American.

In sum, Mr. Chairman, I would ask that this committee make sure Amtrak spends the money on the international runs Congress wants it to spend, that Amtrak be made to develop a program for capital improvements for each route, and that better coordination be established between agencies set up to help financially hurt railroads and Amtrak, which needs good tracks to provide good rail service.

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Thank you, Mr. Chairman.

Mr. ROONEY. The first witness we will hear this morning will be the Honorable Alfred T. MacFarland, Commissioner of the Interstate Commerce Commission.

We welcome you to the committee this morning, Mr. MacFarland. Before we begin the questioning this morning, I just want you to know, I just returned from St. Albans School, where I addressed the C form, which is equivalent to 4th grade. My son is in that. I was very impressed with the questions after I gave my initial presentation, but after it was all over, this little boy came up to me and said, Congressman, you are supposed to be the head of the Transportation Committee in this country, and he said, why don't you do something about passenger service? Why can't we have trains running in this town? I read all about Japan and Europe. I said, well, you are coming back to the Capitol next month, and we will have a postgraduate course when you return, and this morning I am going to talk to Mr. MacFarland of the Interstate Commerce Commission, and you tell me, Mr. MacFarland why, so I can tell him.

STATEMENT OF HON. ALFRED T. MacFARLAND, COMMISSIONER, INTERSTATE COMMERCE COMMISSION, ACCOMPANIED BY FRITZ R. KAHN, GENERAL COUNSEL; AND RICHARD LEWIS, COUNSEL

Mr. MACFARLAND. Mr. Chairman, in passing, let me say that I have a son at Episcopal High, that has asked me some of the same questions, because he has ridden recently, so I will attempt, as best I can, to—not give you all of the answers—but try to give you some.

May I say, sir, in passing, Chairman Stafford would have been here—he is with his doctor this morning—not anything serious. He had made his arrangements to be here yesterday, and then you rescheduled the hearing for today. Chairman Stafford had this engagement, and knowing physicians, as you and I do, you know we have to be there when they call you.

Mr. ROONEY. I appreciate that very much.

Mr. MACFARLAND. Mr. Chairman, and members of the subcommittee you have requested our appearance here today to brief you on our actions with respect to our authority over adequacy of service on Amtrak as set forth in section 801 of the Rail Passenger Services Act (Amtrak Act).

Initially, I would like to point our that putsuant to section 308(c) of the Amtrak Act, the Commission is required to report to Congress on the effectiveness of the Amtrak Act in meeting the needs for a balanced national transportation system. That report will be delivered to Congress next Monday, and it will amplify matters discussed here today.

By way of background, in 1968, the Commission instituted an investigation, adequacies—Passenger Service—Southern Pac. Co., 355 I.C.C. 415 in which the Commission found that its jurisdiction under the Interstate Commerce Act, notably sections 1(4), 12(1), and 13a, was of limited scope and did not include jurisdiction to pass upon the adequacy of passenger train service. This lack of jurisdiction was remedied by enactment of the Rail Passenger Service Act of 1970 and subsequent amendments thereto.

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Under the existing statutory scheme, we are charged with the duty to assure that adequate rail passenger service is available to the public. Accordingly, in ex parte No. 277—subchapter No. 1—Adequacy of Intercity Rail Passenger Service, the Commission, we prescribed regulations to assure the adequacy of rail passenger service. The regulations became effective on April 1, 1974. A copy of the regulations is submitted for the record [see p. 87]. They do not include any reference to track adequacy because the Commission did not receive jurisdiction over that until after the passenger service regulations were published. Track adequacy standards are being considered in a separate proceeding which is still pending. I will discuss that proceeding later in the statement.

The regulations set standards of quality for all intercity passenger trains, other than commuter or short-haul trains. The regulations cover reservations, performance, equipment, and services in stations and trains, and complaint procedure, enforcement and penalties. They require the establishment of a 24-hour nationwide system for information and reservations, set rules for holding space, and prescribe remedies for reservation errors that inconvenience travelers. They establish criteria for monitoring on-time performance, prohibit cancellation of individual runs, and provide remedies for missed connections. The standards require adequate equipment to meet public need, mandate cleanliness in trains and describe the amenities needed in terminals.

The regulations are enforced in two ways. First, there are specific provisions by which the carriers must abide and noncompliance may lead to initiation of a civil action. Second, the regulations provide for a complaint procedure which permits the passenger inconvenienced by an alleged violation of the regulations to file a complaint with the carrier and direct a copy to the Commission. The carrier, within 15 days, must respond to the complainant and to the Commission. The response must indicate to the complainant what action the carrier will take to correct the matter that led to the complaint, or must explain the reason why the conduct is not in violation of the regulations—see regulation 24. The passenger may then respond to the carrier with a copy to the Commission that the remedy is not acceptable. When these circumstances arise, the Commission may attempt to mediate the controversy, conduct a formal investigation, dismiss the complaint, or consider initiation of a civil action.

For several years, our field staff has been conducting compliance surveys of passenger operations. Following adoption of the regulations our monitoring efforts were increased. In order to facilitate the handling of rail passenger complaints a passenger service branch was established within the Commission's Bureau of Operations, Section of Railroads. The primary responsibilities of this branch are to: Direct the entire field inspection program through the regional directors; analyze the compliance survey program results; conduct special studies; direct full field investigations; and generally keep the Commission informed as to the condition of rail passenger service.

Within a short time after the Commission's adequacy regulations went into effect, it became apparent that Amtrak was not complying with many of the regulations. Under the Commission's regulations intercity rail carriers must make complaint forms available in stations

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and aboard trains. During the period from April 1, 1974, when the regulations became effective, through February 28, 1975, there were 6,871 "Passenger Response Forms" and/or ordinary letters of complaint received by the passenger service branch. It is from the review and classification of these individual complaints that patterns emerge suggesting problem areas for investigation by our field staff. Our Amtrak report to Congress, in this respect, notes the failure of Amtrak to make complaint forms available on many of its trains.

There are two other important sources of information regarding Amtrak performance; namely the "Train Compliance Reports" and the "Station Compliance Reports" both prepared by Commission's field staff. These forms are used for the accumulation and tabulation of violations of the regulations. Since April 1, 1974, the Commission has received 2,617 "Train Compliance Reports" and 756 "Station Compliance Reports" for a total of 3,373 field staff reports.

Patterns of violations developed in areas such as the lack of a reservation system for some long distance trains and failure to protect passenger seating on trains where reservations were available and had been made. It was discovered that checked baggage service was not available on some long-distance trains and in many instances there were large numbers of standees aboard the trains. Compounding these deficiencies were numerous air-conditioning failures on trains during the summer, heating failures on trains during the winter, unclean cars, and general discourtesy on the part of the train personnel. For instance, the Commission has received over 2,000 complaints just on the subjects of air-conditioning and heating.

These general deficiencies and other problems were discussed by us with Amtrak officials. In the late summer Amtrak did make some corrections. These corrections, however, were very limited and serious deficiencies continued to be reported by our field staff and the passengers.

An additional effort was made to secure voluntary compliance with the Commission's adequacy of service regulations. On September 16, 1974, Chairman Stafford sent a letter to Roger Lewis, then President of Amtrak, requesting specific responses regarding each of the areas in which the Commission has observed inadequate service. The explanations offered by Mr. Lewis in his response of October 16, 1974, were found, in many instances, to be inadequate, misleading or contrary to the Commission's evaluation of the problem.

The Commission continued to be extremely concerned about the inadequate service being rendered. On September 23, 1974, Chairman Stafford, Commissioner Gresham, and I met with Mr. Lewis, in order to discuss the problems involved and to try to find some satisfactory solution. The meeting did not prove to be very productive. for the same type of problems continued to exist.

On November 20, 1974, Chairman Stafford notified Mr. Lewis that unless Amtrak demonstrated a marked improvement in eliminating violations, the Commission would bring a civil action pursuant to section 801 of the Rail Passenger Service Act. Mr. Lewis did not respond to this letter and the violations continued.

By December 1974, the Commission concluded that enforcement action would be necessary. Accordingly, three significant areas of noncompliance were fully documented. They were (1) failure to

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provide advanced reservations on certain trains; (2) failure to provide checked baggage service at certain stations and on long-distance trains; and (3) limitation of liability for baggage prohibited by the regulations. The investigation report on Amtrak's failure to provide reservations was legally reviewed and a complaint was prepared and sent to the Department of Justice with a recommendation for prosecution. The complaint was filed by the Department of Justice on February 6, 1975, in the District Court for the District of Columbia. In anticipation of this court action, Amtrak has filed a petition with the Commission requesting that regulation be repealed. This would have the effect of eliminating all the requirements for the maintenance of a reservation system. The petition is now pending before the Commission. Complaints in the other two investigations have been drafted and forwarded to the Department of Justice.

The Commission also decided that it was necessary to institute an administrative proceeding[1] to inquire into the present quality of intercity rail passenger service, with a view toward determining whether the Commission should promulgate additional rules and regulations, should modify those already in existence, should recommend additional legislation, or take other appropriate action.

This proceeding was initiated on December 26, 1974. Public hearings were held last week in New York, and are being held in Chicago this week. Other hearings will be held soon in various metropolitan areas where complaints about service have been most frequent.

We are making every effort to see that all potentially interested persons actually receive notice of the hearings. In addition to sending formal notice to the Governors of all 50 States and to all organizations known to be interested in some aspect of rail passenger service, such as the National Association of Railroad Passengers, the Federal Railroad Administration, and the Public Health Service, the Commission has ordered notice of the proceedings to be posted in every train station and depot and in every passenger car. Public service television time also has been obtained for spot announcements to encourage interested persons to communicate with the Commission on the subject. In this connection, departing from the record, I arranged with a local television station, Channel 7, to appear in a 30-second spot which I understand was aired some 80 times over a period of several days. I stated that hearings would be held regarding Amtrak's service and if anyone had anything to contribute, they would be welcome. As a result of those spot announcements, that appeared roughly 4 times a day for 20 days, we received—I believe our latest count was some 45 letters. Let me say that three of the letters that I read were complimentary to Amtrak's service. The remainder either asked questions or did have some very definite complaints and wanted to know where the hearings would be held. Each letter was answered.

One letter written by a nice little lady out in Virginia stated, "I am sure this will go in file 13 and like all of my other correspondence to any Government official, I would be very surprised if I ever heard from it." Upon receipt of the letter, I picked up the phone and called her, and she didn't believe it. I had to assure her I was Commissioner MacFarland, and she said—I'll be—over and over. As I said, the spot

[1] Ex Parte No. 277 (Sub. No. 3), Adequacy of Intercity Rail Passenger Service.

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resulted in roughly 45 letters. We have made a good many efforts to get people who are interested to attend the hearing. If they have something to say good about Amtrak, we want to hear that. If there is a complaint, certainly, we are very much interested in that.

Continuing—Through these measures we hope to obtain broad public participation, to enable us to make a comprehensive evaluation of the current state of rail passenger service.

Section 801(a) of the Amtrak Improvement Act of 1973 vested in the Commission authority to promulgate regulations to establish track standards that will provide the riding public with adequate rail service.

In order to fulfill the congressional mandate to promulgate trackage regulations the Commission instituted a rulemaking proceeding on July 3, 1974.[2] This proceeding will secure relevant data on the existing condition of trackage and the need for upgrading of selective trackage. The Commission's initial analysis indicates that there exists an immediate need to bring the condition of all trackage used for intercity rail passenger service up to the level which existed on May 1, 1971, the date upon which Amtrak commenced operations. This will give the Commission a base for which it can require the upgrading of trackage.

This upgrading would be performed over various lines in accordance with a schedule which would take into consideration cost, demand for service and availability of resources. In effectuating this goal, the Commission envisions a regulation wherein a time schedule will be implemented requiring trackage to be maintained at various levels in accordance with Department of Transportation safety classifications. Trackage will be required to be upgraded to meet successively higher safety classifications thus enabling trains to proceed at successively higher speeds. It is anticipated that in the future, track and roadbed will be available to sustain trains traveling at speeds in excess of 110 miles per hour, the maximum allowable operating speed for passenger trains under present regulations of the Department of Transportation. Amtrak currently possesses equipment capable of speeds in excess of 110 miles per hour, but is unable to utilize this equipment to its full capabilities due to inadequate trackage. For example, the turbo-engines which Amtrak purchased for service between Chicago and St. Louis are capable of speeds in excess of 110 miles per hour, yet they average approximately 57 miles per hour. This is caused, in part, by inadequate trackage.

This proceeding is now pending and has generated considerable interest and response. Numerous statements and exhibits have been filed by all affected railroads, consumer groups, and governmental agencies. Final regulations will be promulgated as soon as practicable, and will be directly responsive to the congressional mandate. If properly implemented, they would be instrumental in providing the American public with adequate rail passenger service.

There are two other matters to which we would like to address ourselves. First, the Department of Justice has filed a complaint with the U.S. District Court for the District of Columbia requesting

[2] Ex Parte No. 277 (Sub. No. 2), Adequacy of Intercity Rail Passenger Service—Track.

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injunctive relief against enforcement of the Commission's adequacy regulations and specifically from the regulation dealing with safety (1124.27 (49 CFR 1124.27)). We find it somewhat inconsistent that on the one hand the Department of Justice has filed a civil action against Amtrak for violation of these regulations, and on the other has filed a suit which, if successful, would block enforcement of these very same regulations, at least on a temporary basis. This dichotomy in positions could be rectified by the Commission being given primary jurisdiction to institute court actions to enforce its regulations. We are presently considering the presentation of a legislative proposal to accomplish this result.

This morning, after I came into the room, I was told by legislative counsel, that Amtrak had, as late as this morning, introduced a new bill. I have not seen it—therefore, some of the remarks I may make in the next page and a half may be inappropriate.

Mr. ROONEY. I don't believe Amtrak has sent a bill up.

Mr. MACFARLAND. DOT, sir, I am sorry. We understand, sir, it was submitted this morning. I want to make that explanation because, from a cursory glance at it, it would appear some of these remarks may not be appropriate in view of the submission this morning.

I don't want to confuse the matter, Mr. Chairman.

Mr. ROONEY. I think the bill you are discussing is the bill that has been developed by my staff. It has nothing to do with DOT, nothing to do with Amtrak. The bill that you saw this morning is the bill that the staff has developed.

Mr. MACFARLAND. Yes, sir. Excuse me. I may be in error. It was our understanding, when I came into the room, it had come in. With that understanding, in order to clarify this, some of the following may be inappropriate.

The second matter is the Department of Transportation's draft bill entitled the "Amtrak Improvement Act of 1975" which it has presented to this subcommittee. There are three sections of the Department of Transportation's bill that deal with the jurisdiction of the Commission—sections 5, 10, and 13. These sections remove all effective Government regulation over Amtrak, a private corporation, in the crucial areas of discontinuance of rail passenger service and maintenance of adequate service for the traveling public. Since these provisions strip the public of substantial protection, they are patently inconsistent with the public interest.

Sections 5 and 10 would have the effect of eliminating—this is the DOT bill, now—the Commission's jurisdiction over Amtrak's discontinuance of passenger trains pursuant to the procedures of section 13a of the Interstate Commerce Act.

Since its inception, the Rail Passenger Service Act has provided that discontinuance could be achieved only by an application to the Commission filed under section 13a. In ruling upon such a discontinuance, the Commission may institute an investigation, and may suspend the effective date of proposed discontinuances for a period of 4 months pending investigation. If, after hearing, it concludes that continued operation of the train is required by public convenience and necessity and will not unduly burden interstate commerce and foreign commerce, it may order continuance of train service for a period of 1 year. At the expiration of the 1 year period, if Amtrak still wishes

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to discontinue the service, it would be required to begin section 13a procedures anew.

Under the proposed DOT amendment, the Commission's jurisdiction over train discontinuances would be entirely eliminated, and the authority to discontinue any train would be lodged solely in Amtrak. No substantial protection is afforded the public. Notice of the discontinuance must be given, and if a "Governor" responds, then Amtrak must review his comments, although there is no requirement that those comments be given even the slightest weight. In our opinion, the amendment does not provide protection for members of the traveling public who might be seriously disadvantaged by a discontinuance. Thus we strongly oppose this amendment.

The second change affecting this Commission is section 13, which would eliminate the Commission's jurisdiction to prescribe and enforce regulations designed to insure adequate service for the traveling public. We also strongly oppose this amendment.

In our opinion, the Commission's adequacy of service authority represents one of the most important features in the congressional plan to assure the continuation and revitalization of adequate rail passenger service. When the statute was first enacted, it included the provision (section 801) authorizing the Commission to "prescribe such regulations as it considers necessary to provide safe and adequate service, equipment, and facilities for intercity rail passenger service." In 1973, Congress strengthened this provision by (1) amending section 801 to accord us jurisdiction over track adequacy and to require the Commission to promulgate its regulations by a specified deadline; (2) by adding the provisions that the regulations should be designed to provide quality service; and (3) providing for a civil penalty for violations of the act. We believe what the Commission's regulations, promulgated in early 1974, set an entirely reasonable standard, and that any deletion of the Commission's power requiring adherence to its regulations will be detrimental to the traveling public.

In support of that, departing from the record, there are four private carriers that still haul passengers. I have told you, sir, and Mr. Skubitz, of the number of complaints we have had about Amtrak. With the four private carriers, we have had a total of 40 complaints. We have had from Southern Railroad, approximately 10; from the Rock Island about 15; from the Denver Rio Grande, 5; from Auto Train, 10. Therefore, we say we feel these regulations have been reasonable. The private carriers have had no difficulty whatsoever. It is extremely unusual that we ever hear from one. The bulk, of course, is done by Amtrak—Southern, in that period, hauled 284,000 passengers. Denver Rio Grande, 100,000, Rock Island, 94,000. We do not have the number of passengers hauled by Auto Train. We submit respectfully, sir, our regulations are not unreasonable, but most reasonable, because they are being complied with by a minimum of effort, apparently, by the private carriers.

The report to Congress, which will be submitted next week, will explain in some detail the substance of the Commission's regulations and the actions taken by it to secure Amtrak's complete compliance. It will detail the Commission's establishment of a special office to handle passenger complaints, its efforts to secure redress from Amtrak

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for such passengers, and the ongoing proceeding which has recently been instituted into the entire subject of the adequacy of intercity rail passenger service. We consider the Commission's role to be of the greatest importance in securing adequate service for the traveling public, and firmly believe that this responsibility should not be diminished.

Because sections 5, 10, 13 are so clearly inconsistent with the public interest, we strenuously oppose their enactment.

Thank you for giving me the opportunity to address this committee today. I assure you that the Commission will make an effort to insure that the traveling public has available to it adequate passenger service.

[Testimony resumes on p. 96.]

[The regulations referred to follow:]

FINAL REGULATIONS AS AMENDED TO JANUARY 6, 1975

PART 1124 REGULATIONS GOVERNING THE ADEQUACY OF INTERCITY RAILROAD PASSENGER SERVICE

Definitions, applicability, and exemptions

1124.1 (Regulation 1) *Definitions*

a. "Amtrak" means the National Railroad Passenger Corporation.

b. "Train" means an intercity passenger train subject to these regulations and to the Rail Passenger Service Act of 1970 (RPSA).

c. "Amtrak train" means an intercity passenger train operated by or for Amtrak.

d. "Non-Amtrak train" means an intercity passenger train operated other than by or for Amtrak.

e. "Station" means any point at which passengers may board or leave a passenger train and the facilities, such as buildings and platforms, associated therewith. Stations not listed as regularly scheduled stops, but at which trains will stop to entrain or detrain passengers only on signal or advance notice are referred to as "flag stops".

f. "Carrier" means Amtrak and any common carrier by railroad which provides intercity rail passenger service on its own behalf or by contract for Amtrak.

g. "Passenger" means anyone, except working crew members, who travels on a train the service of which is governed by these regulations.

h. "Customer" means any passenger who pays: (1) full fare, (2) a reduced fare where such fare has been traditionally provided for by law, as in the case of the reduced fares for the blind; or (3) an incentive fare, when such fare has been traditionally used in the travel industry to increase ridership in periods of low demand, such as midweek fares. For the purposes of these regulations it excludes passengers whose fare status is on a conditional (space-available) basis, such as standby and pass riders. For the purpose of the regulations regarding reservations the term "customer" includes the representative of the customer.

i. "RPSA" means Railroad Passenger Service Act of 1970, as amended.

1124.2 (Regulation 2) *Regulations regarding applicability, exemptions, and effective date*

a. These regulations are binding on Amtrak and any carrier or agency providing intercity rail passenger service. Every carrier or other agency providing intercity passenger train service under agreement with Amtrak pursuant to the RPSA is bound, individually and jointly with Amtrak by these regulations, except to the extent that Amtrak or such other carrier or agency has control over the provision of the services, facilities or functions covered by these regulations, in which event sole responsibility for compliance with these regulations will be with the one controlling the service.

b. All intercity passenger trains, Amtrak and non-Amtrak are subject to these regulations, unless specifically exempted as provided for in these regulations.

c. Charter and excursion trains (whether operated by private parties or by a carrier), trains operated by tour companies for tour members rather than for the general public, and regularly scheduled intercity passenger trains operated by

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carriers whose aggregate regularly scheduled intercity passenger train-miles do not exceed 500 miles in any calendar day are hereby exempted from all the regulations, except those pertaining to health and safety.

d. Exemption may be sought from any of these regulations, except those pertaining to health and safety, for reasonable periods of time, as to carriers, specific stations, or trains, by filing with the Commission an appropriate petition, and such petitions may be granted upon a showing of good cause therefor.

1. Carriers seeking exemption from any regulation must, in addition to such information necessary to support the granting of an exemption, include in their petitions the following information:

(*a*) The specific regulation or regulations for which exemption is being sought.

(*b*) The reasons why exemption is necessary, and the effect, if any, upon travelers if the exemption should be granted.

(*c*) A statement describing present operations relating to the exemption being sought.

(*d*) A statement describing how operations will be conducted if the exemption sought should be granted.

(*e*) Statement that the carrier has complied with all pre-requisites to exemptions as may be required by the regulation from which carrier seeks to be exempted.

(*f*) Complete operating details relating to each train to be effected by the sought exemption including, but not limited to, schedules, connections, total number of passengers carried in each direction, passenger on and off counts at each station along the train route, relevant financial data, etc.

(*g*) Copies of notices proposed to be posted, and certification of posting at all points required as hereinafter provided.

(*h*) Certificate of service of petition for exemption on persons hereinafter designated for service.

2. Before any petition for exemption shall be considered, the carrier shall give adequate notice in the following manner:

(*a*) A copy of the petition filed with this Commission shall be mailed to the governor and appropriate regulatory agency of each state affected; and where timely notice is required to be given to communities affected or carriers affected, to all such communities and carriers affected. For the purpose of this regulation, notice to the community shall be considered timely if a copy of the petition is mailed to its mayor or chief executive officer and published in a newspaper of local circulation within time limits set forth in this regulation; and notice to carriers affected shall be considered timely if a copy of the notice is mailed to their chief operations manager within such time limits.

(*b*) Notice shall be given to the public by placing a copy of the following announcement, reproduced on a placard of at least 8½ inches by 11 inches in dimensions, with the lettering at least the size of ordinary typewritten material, except that the word "Notice" must be printed in letters at least one inch high and in proportional width, so as to be readable at a distance, and such announcement shall be placed in a conspicuous location in each and every train car and station to be affected by the exemption petition and in every train car and station to be affected by the exemption petition and in every station through which an affected train passes. The announcement shall read as follows:

NOTICE

(Name of Carrier) hereby gives notice that it has petitioned the Interstate Commerce Commission in Washington, D.C., to grant exemption to its (name of train or station) from Regulation (Number) of the Commission's Regulations for the Adequacy of Intercity Rail Passenger Service. Regulation (Number) states that (description of regulation or portion thereof from which exemption is sought). If exemption is granted, the aforementioned (names of station or trains) would no longer be required to comply with the aforesaid regulation(s). In the opinion of (name of carrier) the requested action on exemption by the Commission will not significantly affect the quality of the human environment. The proceeding will be handled without public hearings unless protests are received which contain information indicating a need for such hearings. In accordance with the Commission's regulations (49 C.F.R. 1100.250) in Ex Parte No. 55 (Sub-No. 4), Implementation-National Environmental Policy Act, 1969, 340 I.C.C. 481 (1972), any protests may include a

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statement indicating the presence or absence of any effect of the requested Commission exemption on the quality of the human environment.

Any person opposed to this petition for exemption should advise the Commission promptly, with an original and six copies of a "protest", identifying the carrier and train or station, and regulation(s) from which exemption is opposed, and stating the grounds for such opposition. A copy of this protest should be sent to (name and business address of office at carrier to whom protests should be addressed). All protests submitted shall be filed with the Commission no later than (date at least 30 days after posting of notice). (Signature of carrier and authorizing officer therein)

(*c*) To be considered adequate, the above notices must be given at least 30 full days in advance of the proposed action.

(*d*) The carrier shall send copies of the aforesaid notices to the Commission and shall certify that notice has been given in accord with this regulation.

3. Representations of the petitioning carrier and protestants must be considered by the Commission before decision is reached on exemption.

4. This regulation shall not preclude the issuance by the Commission of temporary service orders in appropriate energy situtations. However, such orders shall not be used by the carrier as a means to circumvent the notice requirements as set forth in this regulation.

5. All petitions for exemption must follow the procedures set forth in this regulation.

(*e*) These regulations are promulgated as an aid to the rail passenger and shall not be so construed as to subject a passenger to a civil penalty for failure to comply herewith.

(*f*) Except where otherwise noted, these regulations shall take effect on April 1, 1974.

Reservations

1124.3 (Regulation 3) *Reservations—General*

a. A nationwide reservation and information system which incudes all carriers providing intercity rail passenger service shall be readily available at any time of day or night to anyone located in the continental United States for the reservation of space on trains and for the dissemination of general train information. Each carrier may have its own reservation system, provided it can be coordinated with the national system.

b. The carriers shall provide the type of accommodation on the train and departure date confirmed to the customer and for which the customer paid.

c. If a carrier cannot supply a customer with the type of accommodations on the train and departure date it confirmed to the customer and for which the customer paid, it shall fulfill its obligation under this regulation if it:

(1) tenders to the customer without additional charge accommodations of a better type on the "confirmed" train and departure date or on a train scheduled to arrive within 4 hours of the "confirmed" train: or

(2) tenders to the customer without additional charge accommodations of equal or better type on the next available train and provides food and shelter for the customer during the interim: or

(3) employs other fair and reasonable means of relief to the customer, and the customer is satisfied with the relief given.

d. All revenue sleeping-car and parlor-space shall be available for specific assignment, and all carriers shall make provision for its advance reservation by customers.

e. For passenger trips of 200 miles or more, sufficient revenue seats in coaches shall be made available to meet the normal demands of customers requesting reservations, and all carriers shall make provision for advance reservation of such coach-seat space by customers.

(1) The provisions of this subsection do not preclude, when warranted by the public demand, the operation of unreserved coach-seat trains in addition to "reserved-space" trains on routes capable of sustaining more than one train daily in each direction, provided that no more than 50 percent of the trains on any given route are unreserved coach-seat trains.

(2) The provisions of this subsection do not preclude, when warranted by the public demand, the operation of unreserved coach-seat cars on "reserved-space" trains in addition to reserved coach and other reserved cars.

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1124.4 (Regulation 4) *Reservation-making process*

a. Upon receiving telephonic request for a reservation, the carrier shall determine space availability and shall inform the prospective customer of its findings promptly, or, if necessary to call back the prospective customer with such findings, to do so within an hour. For the purposes of these regulations, "telephonic" communications shall be considered to embrace teletype communications.

b. If the prospective customer accepts the space the carrier has available, the carrier shall reserve such space in the customer's name and state to the customer the terms and conditions under which the reservation will be held.

c. The terms and conditions under which reservations will be held must be just and reasonable under the circumstances.

(1) Under ordinary circumstances, it shall be deemed just and reasonable that reservations, once made, shall be held by the carrier for the customer at least until 30 minutes prior to the scheduled departure of the train from the customer's boarding point without requiring the customer to prepay the tickets.

(2) Under extraordinary circumstances, such as in holiday periods, carriers need not follow the 30-minute rule of regulation 4c(1). However, alternate terms and conditions, to be considered just and reasonable, (A) must permit the holding of reservations for a sufficient period of time to enable a customer to pay for and thereby confirm the reservations, and (B) shall be filed with the Commission immediately upon implementation together with supporting statements, and be subject to modification from time to time upon order of the Commission.

(3) For the purpose of regulation 4(c)(2), supra, the "energy shortage" is an extraordinary circumstance. Therefore, until September 30, 1975, or further order of the Commission, whichever first occurs, carriers need not follow the 30-minute rule of regulation 4(c)(1). Carriers may, instead, upon filing a statement with the Commission to the effect that the extraordinary circumstance reservation option of regulation 4(c)(3) is being adopted, implement the following policy in processing reservations:

For reservations made	[1] *Reservation shall be held until*
0 to 7 days before departure	30 minutes before departure.
8 to 21 days before departure	5 days before departure.
22 to 45 days before departure	15 days before departure.
46+ days before departure	30 days before departure.

[1] If the time limit expires at a time when the ticket offices are closed, the time limit should be extended to the next business day.

Carriers may file alternate terms and conditions to those listed above. However, for such alternate terms and conditions to be considered just and reasonable, they must comply with the standards of regulation 4(c)(2).

(4) For other extraordinary circumstances which recur periodically during the energy shortage such as holiday periods, the alternate terms and conditions shall be filed with the Commission in advance, and shall not be implemented until expressly authorized and approved by the Commission.

1124.5 (Regulation 5) *Confirming a reservation*

a. Upon receipt of a customer's payment for tickets in full, through major credit card or cash, the reservation shall be confirmed by the carrier by telephone or, upon reasonable request in writing, and shall be held for the customer at least until 30 minutes prior to the scheduled departure of the train from the customer's boarding point, unless canceled by the customer.

b. A customer who has paid for his tickets may request that confirmed space be held for an extended period of time. In such event, the carrier shall hold the space for the time required unless canceled by the customer.

(1) If the customer cancels such reservation at least 30 minutes prior to departure, no penalty or service charge shall be imposed.

(2) If the customer, after requesting the carrier to hold his ticket for an extended period as described in regulation 5b above, thereafter fails to cancel such reservation at least 30 minutes prior to departure, the carrier must refund the ticket price but may retain a service charge in an amount not exceeding 20 percent of the ticket price, or $5, or the difference between the fare assessed the original customer and that which would be assessed a standby user, whichever is greater. No service charge in excess of 5 percent of the ticket price, or $5, whichever is greater, can be imposed if the space held for the original customer is entirely resold at the price quoted the original customer, or if the carrier failed to hold the space for the customer.

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c. At points where tickets are available only on the train, carriers shall consider reservations confirmed and shall hold them until the departure time of the train from the point where the customer was to board, unless the customer cancels the reservation.

Performance of trains

1124.6 (Regulation 6) *Arrival and departure times*

a. Under normal circumstances, a train shall not depart from any passenger-boarding station, except flag stops, earlier than its scheduled departure time. Where a customer misses the train because of carrier's failure to give adequate notice of a departure earlier than scheduled the carrier shall to the extent reasonably possible, mitigate inconvenience thereby caused the customer. This mitigation may take the form of providing food and shelter until the customer is boarded on the next available train or providing other reasonable means of transportation.

b. Insofar as the scheduling and operation of any train is within a carrier's control, and where safe operation permits, the train shall arrive at its final terminus no later than 5 minutes after scheduled arrival time per 100 miles of operation, or 30 minutes after scheduled arrival time, whichever is the less.

c. If a train arrives late at any scheduled destination by an amount of time greater than the permissible allowances set forth in subsection b, where safe operation would have permitted an earlier arrival, the delivering carrier and Amtrak, jointly and severally, shall be obligated to mitigate, to the extent reasonably possible, the inconvenience to customers whose travel plans are disrupted thereby. This mitigation may take the form of bridging a missed connection and providing food and shelter until such is accomplished, or other relief appropriate to the needs of and acceptable to, the customer; and the cost shall be borne by the carrier or carriers responsible for the delay.

1124.7 (Regulation 7) *Expeditious service: Schedules shall be designed as to provide expedilious service*

a. In order to facilitate expeditious service, all intercity passenger trains without the benefit of an exception are to be accorded priority over freight trains except in emergencies or unless the Commission has issued an order to the contrary in accordance with subparagraph b.

b. Any railroad whose rights with regard to freight train operation are affected thereby may petition the Commission for an exemption to side-track intercity passenger trains other than those operated by or on behalf of Amtrak. Such petition may be granted upon a showing that non-exemption will materially lessen the quality of freight service provided to shippers, and subject to just and reasonable conditions.

c. Schedules shall be designed so as to provide expeditious service, and in determining whether a schedule meets this requirement, consideration may be given (among other things) to the schedules of similar runs in prior timetables, and to any applicable Federal safety standards.

1124.8 (Regulation 8) *Cancellation of scheduled trains—general*

Except for reason of health, or safety, or beyond the carriers' control, individual runs of scheduled trains shall not be canceled.

1124.9 (Regulation 9) *Cancellation of scheduled trains—en route*

When a run is terminated en route, the carrier must:

(*a*) Make reasonable attempts to provide or procure alternate service to its on-board passengers and to provide food and shelter for them until they are able to resume their journey.

(*b*) Immediately notify all up-route stations of such cancellation.

(*c*) Make reasonable attempts to provide or procure alternate service for all passengers who were waiting at stations to board the train at the time of its cancellation and shelter them until it does so.

1124.10 (Regulation 10) *Through car service and reasonable connections*

Through car service shall be provided between points designated as "points between which intercity passenger train shall be operated" in the service standards established in the *Final Report on the Basic National Rail Passenger System*, submitted by the Secretary of Transportation January 28, 1971, as amended by Act of Congress or by Commission decisions in discontinuance proceedings; and, at points where rail passenger lines meet so as to form a reasonably direct rail route between points on one line and points on the other line. Reasonable connections shall be provided as indicated in paragraphs a and b of this regulation 10.

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a. A connection between 12 midnight and 6 a.m., is deemed reasonable if through car service is provided. If a carrier can demonstrate either (1) that immediate compliance is impossible, or (2) that after no less than 6 months trial, market demand does not justify a connection, the carrier may upon petition, be exempted from this regulation be the Commission for such time as the Commission may deem appropriate in the circumstances. For the purposes of this regulation, impossibility of immediate compliance means any situation where facilitating a connection would require completion of a substantial undertaking such as, but not limited to, the construction of a track connection, or the negotiation of an interline contract between two or more carriers.

b. A connection after 6 a.m., but before 12 midnight is deemed reasonable if through car service is provided or the layover does not exceed 4 hours. If a carrier can demonstrate that adherence to this rule would necessitate extra cars or trains not justified by market demand, it may, upon petition, be exempted from this regulation by the Commission for reasonable periods of time.

Station

1124.11 (Regulation 11) *Hours of operation*

a. All stations other than flag stops shall be open to passengers, and their attendants and be adequately patrolled for safety and security purposes for a sufficient period of time before departure of the train to enable passengers and their attendants to purchase tickets, check baggage, and perform other transportation related tasks, and for a sufficient time after arrival of a train to enable passengers and their attendants to retrieve checked baggage and obtain safe passage from the station.

(1) If a station has so little traffic that compliance with this regulation would impose a severe financial burden on the carrier, and if the provision of safe and adequate service at that location does not require an open station, the carrier may petition the Commission for relief from this regulation, giving timely notice to the community affected.

(2) If the Commission is satisfied that a station of the type described in (a) above when operated as an unopened station will not involve undue risk to the safety or comfort of the passenger, but will constitute reasonably safe and adequate service at that location, it may exempt such station from this regulation for reasonable periods of time.

1124.12 (Regulation 12) *Consist of stations*

a. All stations, and their adjoining service and parking areas, shall be provided with lighting adequate to permit their safe utilization by passengers.

b. All stations shall be equipped with 24-hour telephone service and shall have adequate train information available.

c. All stations shall have operating ticket sales facilities unless tickets are available on the train and sold without penalty for boarding without a ticket.

d. Stations other than those operated as flag stops and those operated as unopened stations pursuant to Commission exemption shall have clean, serviceable restroom facilities with adequate toilet supplies, and the restroom areas shall be patrolled for safety while the station is open.

1124.13 (Regulation 13) *Facilities for checked baggage in stations*

a. All stations at which trains providing checked baggage service make scheduled stops shall have facilities for the checking of passengers' baggage available up to 30 minutes prior to the departure from that station.

b. A carrier may seek exemption from regulation 13a for stations other than those located in cities designated as "end points" by the Secretary of Transportation in his *Final Report on the Basic National Rail Passenger System*, submitted January 28, 1971, or as may be designated as "end points", provided the carrier, on petition to the Commission, can show:

(1) That in-station facilities for the checking of baggage at a particular location is not required by passenger usage of that station, and

(2) That it has adequate baggage assistance on board trains stopping at the station in question to enable the passengers at that station to have their baggage placed on the train, and, if possible on trains with checked-baggage service, to have their baggage checked if they so desire.

c. If a carrier refuses to accept baggage after a point in time more than 30 minutes prior to the scheduled departure of a train with checked-baggage service, the carrier shall forward the baggage by such means that the baggage will arrive at passenger's destination within 30 minutes of passenger's arrival at that destination.

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d. All checked baggage must be made available to the passenger within a reasonable time not to exceed 30 minutes after the passenger's arrival at his destination station.

e. If a carrier fails to make checked baggage available within 30 minutes after arrival of the train with checked-baggage service on which the passenger was riding it shall forward the baggage to the passenger at the carrier's expense.

Consist for trains

1124.14 (Regulation 14) *Equipment required to meet public demand*

Carriers shall provide coaches, and where required by these regulations or by the standards establisned by the Secretary of Transportation in his *Final Report on the Basic National Rail Passenger System,* dining cars, lounge cars, dome cars, and parlor cars in sufficient numbers to meet the normal travel demands of the customers, including ordinary weekend demand and usual seasonal travel demand.

a. Carriers shall also provide, to the extent equipment availability permits, additional units of the above-mentioned equipment during periods of predictable peak demands, such as holidays and special weekends, to meet the peak demands of its customers.

(1) If a carrier does not have sufficient equipment reserves to meet these predictable peak demands, it shall seek out from other reasonable sources, including noncarriers, railway cars which meet these regulations and the quality standards of the carrier, and shall use such cars to meet the obligation under regulation 14a.

(2) A private rail car tendered to a carrier for its use in meeting its obligation under regulation 14a shall not be denied carriage by any carrier during nonpeak travel periods when request upon reasonable terms is made for that carriage by the car's owner at least 30 days prior to anticipated movement provided such car meets the regulatory standards of safety and adequacy. This regulation shall not be construed to prohibit the carriage of noncarrier-owned rail cars that have not been tendered or used by a carrier, if they meet the applicable adequacy and safety regulations.

b. Carriers shall facilitate railroad travel by elderly and handicapped persons, and to that end shall, to the extent financial resources permit, acquire or design and construct special facilities and equipment, eliminate architectural and other barriers in present equipment and facilities, and provide appropriate assistance to, from, and on trains and in terminals.

1124.15 (Regulation 15) *Services required to meet public demand*

Carriers shall provide and maintain services on trains sufficient to assist all passengers with their train travel needs:

a. These services shall include such things as baggage assistance, sleeping car room assistance, meal service, and train schedule information.

b. Carriers shall, upon reasonable advance notice, provide to the extent reasonably possible, the necessary assistance to customers who, because of age, physical condition, or dietary restrictions need special assistance in their travels.

1124.16 (Regulation 16) *Baggage service on trains*

a. All trains on trips scheduled for 200 miles or more shall have checked-baggage service en route. Trains on trips of less than 200 miles need not have checked-baggage service provided another train with checked-baggage service traverses the same route at least once daily in each direction.

b. A carrier may seek exemption by petition from regulation 16 for a particular train or series of trains if:

(1) The train is of a design or function to which a conventional checked-baggage service is incompatible, and

(2) The carrier provides sufficient baggage assistance on board so that customers will not be burdened with self-handling of baggage, and

(3) There is adequate room on board the train so that the carry-on baggage is not a hindrance to the safety or comfort of passengers.

c. An exemption petition under regulation 16b shall be accompanied by an affidavit that timely notice has been given to all carriers with which the train in question connects to form a through service.

1124.17 (Regulation 17) *Food and beverage service*

a. Carriers operating trains which travel for 2 hours or more shall make food and beverage service available at all times to all passengers on those trains. Complete meals shall be made available during customary dining hours.

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b. Food and beverages and the surroundings in which they are made available must comply with the health regulations of the Public Health Service as set forth in parts 12.21 through 12.47 of title 42 of the Code of Federal Regulations.

c. A train traveling for 12 hours or more must have at least one full-service dining area where sit-down, complete meals are served, unless it has dining service available in the dome-lounge car, lounge car, or dome car, or has meal service available to sleeping car rooms, and at coach seats, serving complete meals and beverages.

1124.18 (Regulation 18) *Temperature control*

a. All regularly scheduled train cars must be equipped with operable climate conditioning equipment and be maintained at a room temperature of at least 60 degrees above zero Fahrenheit and no higher than 80 degrees above zero Fahrenheit.

b. Should air conditioning or heat fail so that temperatures go beyond the range specified in regulation 18a, carriers shall offer the passengers affected alternate accommodations of similar or better type at no extra charge, or other appropriate relief.

1124.19 (Regulation 19) *Sleeping cars*

a. Private-room standard sleeping car service which includes private functioning restroom facilities shall be provided for all trains having a journey of 6 hours or more during the time period from midnight to 8 a.m.

b. To the extent that such equipment is available, in addition to private-room standard sleeping car service, each train traveling 6 hours or more during the time period from midnight to 8 a.m. shall have at least one sleeping car, which because of its design or appointments, may be offered at a lower price, unless the carrier provides, in addition to overnight service, a daytime service over the same route. These may include slumber coach or berth car, or other type of private economy sleeping accommodations.

(1) A slumber coach is a car containing private rooms with private restroom facilities, but usually smaller than standard sleeping car rooms allowing more rooms per car and hence usually able to be rented at a lower price.

(2) A berth car is an open section car with beds enclosed behind draperies but without individual sink and toilet facilities thus allowing more passengers per car and hence usually able to be rented at a lower price.

c. Sleeping car rooms and their restrooms, and berth cars shall be sanitary, free of debris and objectionable odors, and water tight. This regulation is one related to health, and no exemption can be made hereto.

1124.20 (Regulation 20) *Coaches*

a. All coaches shall have functioning restroom facilities and drinking water available.

b. Apparatus for support of legs or feet, reclining seats, and clean pillow shall be provided in all coaches on all trains having a journey of 4 hours or more during the time period from 10 p.m. to 8. a.m.

c. Coaches, including restrooms, shall be sanitary, water tight, and free of debris and objectionable odors. This regulation is one related to health, and no exemption can be made hereto.

1124.21 (Regulation 21) *Nonrevenue space*

a. On trains traveling for 6 hours or more, nonrevenue lounge space shall be provided. Dome or flat-top observation car may be used to fulfill a carrier's obligation under this regulation.

b. To the extent that such equipment is available, on trains traveling for 16 hours or more, at least one dome car shall be provided where railroad clearances permit the use of such cars. If railroad clearances prevent the use of such cars, flat-top observation cars shall be substituted to the extent such cars are available.

1124.22 (Regulation 22) *Allocation of space for nonsmokers and smokers*

a. Smoking shall not be permitted on trains except in appointed areas with fire-resistant materials and equipped with ventilation systems adequate to exchange air completely in reasonably short periods of time.

b. In train cars meeting the above requirement, smoking may be permitted as follows:

(1) Smoking may be permitted in private-room sleeping cars.

(2) Smoking may be permitted in up to one-half of the space in a car which is the sole one of its type in the consist, or if there is more than one car of this type

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in the consist, smoking may be permitted in a ratio of up to one smoking car for every nonsmoking car of its type in the consist. Unreserved coach, reserved coach, parlor car, dining car, dome car, and lounge car shall each be considered a separate "type" of car.

(3) Carriers may prohibit smoking altogether in nonrevenue lounge and dome cars, in dining cars, and between midnight and 8 a.m., in coaches except their lounge sections.

Penalties and enforcement

1124.23 (Regulation 23) *Prescription of penalties for carriers in violation*

Any carrier in violation of any of these regulations shall be subject to the penalties prescribed in section 801 of the Rail Passenger Service Act of 1979, unless such carrier takes corrective action as prescribed by the Commission (in the manner set forth elsewhere in these regulations), or in a manner acceptable to the Commission and passenger, provides satisfaction to passengers injured as a result of the violation.

1124.24 (Regulation 24) *Complaint procedure*

a. This complaint procedure shall be initiated upon receipt by the Commission of two copies of a complaint stating the following:

(1) Train name (if any) and number, or location of station.
(2) Date of alleged violation.
(3) Location of entraining point.
(4) Location of detraining point.
(5) Description of alleged violation.
(6) Relief offered by carrier, if any, and reasons why relief was unacceptable.
(7) Requested relief.
(8) Name and address of complainant.

b. A copy of the complaint shall be served by the complainant on the carrier or carriers against whom a violation is alleged.

c. Carriers shall make complaint forms similar to the one attached hereto readily available on all trains and in all stations to facilitate their use by passengers.

(1) Notices as to where passengers may obtain such forms shall be conspicuously posted in each train car and in each station.

(2) Failure to use a complaint form shall not preclude a passenger from filing a complaint, provided that it is in accordance with regulation 24a.

d. The carrier, within 15 days after receipt of the complaint, shall notify the Commission and the complainant of the action it will take to correct the matter that led to the complaint, or of the reasons why it does not believe the matter complained of constitutes a violation of these regulations.

e. If the complainant notifies the carrier and the Commission that the carrier's reply or proposed remedy is not acceptable, the Commission will take such steps as it deems appropriate in the circumstances, including, but not limited to, further efforts to mediate the controversy, or a formal investigation or dismissal of the complaint, or procedures directed at obtaining assessment of a fine or fines against culpable carriers pursuant to section 801 of RPSA.

f. Dependent upon the nature and effects of the matter complained of, the Commission may construe a group of complaints or each complaint as involving a separate alleged violation.

1124.25 (Regulation 25) *Commission initiation of proceedings on own motion*

The Commission, upon its own motion, may institute a complaint proceeding to determine a violation of these regulations.

1124.26 (Regulation 26) *Execution of penalties against carriers in violation*

Where the Commission staff determines that a violation of these regulations has occurred, the matter may be referred to the Department of Justice for appropriate enforcement under section 801 of the Rail Passenger Service Act or the Commission may take such other steps as it deems appropriate in the circumstances, including among others, informal or formal steps to settle the matter in dispute on a fair and equitable basis.

1124.27 (Regulation 27) *Safety*

The regulations in chapter II of this title, parts 225, 228, 230–234, and 236, prescribed by the Federal Railroad Administration, Department of Transportation, under rail safety statutes, are hereby adopted, confirmed, and continued in

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effect until modified or superseded by appropriate authority as to inter-city rail passenger service. (Note: This regulation was formerly cited as section 1124.1 CFR).

1124.28 (Regulation 28) *Modification of regulations*

These regulations shall be amendable by the Commission, pursuant to establish rulemaking procedures.

Mr. ROONEY. Thank you very much, Mr. MacFarland, for that very fine presentation, and I wish you would go back to the Commission and tell them as long as I am chairing this subcommittee, the proposed DOT amendment, dealing with disposition over train discontinuances, will not be eliminated and will remain with the ICC as long as the ICC remains downtown.

Mr. MACFARLAND. Thank you, sir.

Mr. ROONEY. I wonder whether or not you can comment, at this early date, and I know it is an early date, about the change in the administration of Amtrak, with the new Director, Mr. Reistrup. Have you seen any change in recent days as far as the opinion of the employees or the ICC? Do you foresee it going to be an improvement?

Mr. MACFARLAND. Sir, there is always hope, even if there is just a little light at the end of the tunnel. I would say that light appeared, or, at least it seemed to me to appear—I, along with the other members of the Commission received a very pleasant conciliatory, and I believe altogether helpful letter, from Mr. Reistrup on his first day on the job. I have this letter simply saying, on his first day on the job, he wanted to work with us, and looked forward to working with us. I immediately answered the letter and assured him I would be very much interested in discussing with him, at our mutual agreement, the problems we have. As I see it, we have a congressional mandate to require adequate service. They have that to furnish it as far as possible. We are both striving for the same thing. I don't want to take a stand and be a goad in the side of Amtrak unless we have to. I would say that the situation, to me—and I have followed it—I should have stated this at the outset—that I have been asked by the Chairman to head a committee consisting of Commissioners Gresham and Glapman and myself to ride herd on this Amtrak situation. I worked very closely with it and we got no response from Mr. Lewis, in frankness and in truth. We went over to see him, had a very agreeable and pleasant meeting with him, but nothing was accomplished. I have not had sufficient experience with Mr. Reistrup to say if our experience is going to be good or bad. I will say the initial contact I have had with him would indicate to me he has some intention of making an effort to work with us. I shall pray this be so. It would certainly make his work and ours a great deal easier.

Mr. ROONEY. You have stated that the Commission is a party to a civil suit against Amtrak?

Mr. MACFARLAND. Yes, sir.

Mr. ROONEY. What specific relief are you seeking—injunctive or monetary damage?

Mr. MACFARLAND. Injunctive relief. We had an amendment to an act—I don't know how it happened—original legislation—Mr. Kahn is here and can explain it perhaps better than I. We could seek some civil penalties—an amendment to that bill went in which removed that jurisdiction.

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Mr. ROONEY. If they are not complying with the regulations, now, how can you seek injunctive relief?

Mr. MACFARLAND. We are trying. We are doing the only thing we can, through a mandatory injunction, and if we can get a judgment in court, as I certainly don't have to tell you, sir, and then show a violation of that order, then the penalty comes by way of contempt of court.

Mr. ROONEY. You spoke about the few complaints you have received from the private carriers and you specifically mentioned, I believe, Rock Island, and you talked about the 94,000 passengers. Is that a correct figure?

Mr. MACFARLAND. Rock Island, my figures would reveal, since the regulations went in, and we have clearly had the congressional mandate, is 94,000 passengers, yes.

Mr. ROONEY. What period of time is this?

Mr. MACFARLAND. April 1, 1974, to the present.

Mr. ROONEY. How many carriers are now serving the Chicago-Omaha run?

Mr. MACFARLAND. Passenger carriers?

Mr. ROONEY. Yes.

Mr. MACFARLAND. May I ask one of my people here? I don't know. Just a minute, sir. Our best information is Amtrak, one train a day. I do not make that as a positive statement. That information has been handed me. I have an Amtrak statement here. I was trying to run it down. We can supply it for the record, if we may.

Mr. ROONEY. So ordered.

[See letter dated April 8, 1975, from Commissioner MacFarland to Chairman Rooney, p. 105.]

Mr. ROONEY. What is the ICC currently doing about the Rock Island dilemna?

Mr. MACFARLAND. We met yesterday, sir, for this conference, beginning at 3:30 p.m. until quarter of 6 p.m. Another meeting is being held today. We have been presented with a list of options, roughly about 4, as I understand it. Another meeting is going on today by staff. No decision was made. Staff was not ready to make a hard and fast recommendation yesterday and on Friday, at 9 in the morning, we are going back into conference, and I trust sometime by Friday, we will have a method of procedure that we believe is best.

Mr. ROONEY. Can you save the Rock Island from going under?

Mr. MACFARLAND. I question that, sir.

Mr. ROONEY. What are your alternatives that you spoke about?

Mr. MACFARLAND. Well, we have at present four plans. We can do nothing ——

Mr. ROONEY. That is what you have done for the past 12 years.

Mr. MACFARLAND. I know that. We have been criticized for that. We could do nothing—the Rock Island would fail. Put other rails there, and that is one plan that has been advanced.

Mr. ROONEY. Why hasn't that plan been advanced?

Mr. MACFARLAND. It has been advanced but I don't believe it has any following with the Commission. You are speaking of the——

Mr. ROONEY. The merger.

Mr. MACFARLAND. The merger case.

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Mr. ROONEY. I mean, you talked about calling this nice little lady that had a complaint over there in Virginia. The complaints I receive about the ICC is the redtape, your inability to act, to make decisions.

Mr. MACFARLAND. Yes, sir.

Mr. ROONEY. And I must say, since I have chaired this committee, your Commission has been more than cooperative with me. I don't know what has occurred in the past.

Mr. MACFARLAND. Excuse me. May I speak with counsel, here? I am informed that the Chairman has already called for a meeting of the Board of USRA Directors to pursue the possibility of a loan for the Rock Island.

Mr. ROONEY. How much?

Mr. KAHN. The loan application of the Rock Island is for $100 million. The Board of Directors previously approved a $9.1 million loan. Chairman Stafford, as a member of the Board of Directors of the U.S. Railroad Association voted in favor of that and when the U.S. Railroad Board rescinded its authorization for that loan, Chairman Stafford disagreed with the majority, and voted in favor of that loan.

If I may, with respect to the long-standing application by the Union Pacific to acquire the Rock Island, so-called Rock Island case, it is my recollection, Mr. Chairman, that the application by the Chicago & Northwestern Railroad, the initial applicant, it was filed in 1963, there was a lot of opposition by the other railroads in the area opposing it, so the matter was not right before the Commission to proceed with a hearing until 1966. The hearings were held, I believe, at seven different locations. They extended, I believe, some 250 days, so the record was not closed, it is my recollection, until about 1968.

After the filing of briefs and long before the administrative law judges could proceed with their initial decisions, there was a request for further hearings, and these were held late in 1969, and again, in 1970, and the first administrative law judge, I believe it was Mr. Albus, suffered an injury. He was out for a couple of months with a broken bone. The second administrative law judge, while preparing the initial decision, suffered a heart attack, and he was out. The Commission determined to reassign the case, or to speed an early decision. Some of the parties petitioned the Commissioner in response to that, an examiner as fully familiar with the record as Mr. Kleintell, should not be pulled off the case. Mr. Kleintell's initial report was completed, I believe, in late 1973 or early 1974—I am not sure exactly when. The Commission heard oral argument at the request of the parties in—it must have been 1973 the Commission heard the argument—November of 1973, and within a year's time, by December of 1974 the Commission had rendered its decision.

Mr. ROONEY. Will you identify yourself for the record?

Mr. KAHN. Yes. I am Fritz R. Kahn, the Commission's general counsel.

Mr. ROONEY. Mr. Skubitz.

Mr. SKUBITZ. Thank you, Mr. Chairman. First, I want to apologize for having to leave the meeting. I had to go to the Interior Committee to make a quorum over there. I see you have the same difficulty with your people as I have on my side of the aisle. They usually fight to get on the committee, but don't follow up.

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Mr. ROONEY. If we are going to put these trains on the track, we should pay more attention to our responsibilities.

Mr. SKUBITZ. I agree with you, Mr. Chairman.

Mr. MacFarland, I am sure you know your popularity with the Committee on Interstate and Foreign Commerce is about 1 percentage point below what the country gave the Congress of the United States?

Mr. MACFARLAND. Yes, it has drifted down.

Mr. SKUBITZ. I say that seriously because of the action last year when we began trying to change some of your rules to make you expedite some of these cases. The Chairman has just questioned you about the Rock Island case, which you piddled along with for about 12 years. Your counsel has said on one occasion the fellow broke his leg, so we have to start over again, and another one had a heart attack, so we start over again. Really, they grow old gracefully over there—keep starting over again. What I am trying to get at is this: I think the trouble with the ICC is either your inability or your unwillingness to change your procedures to meet the requirements of modern times. I think you had better change your procedures on moving these cases along, or we will do it for you, and I am afraid we will do the wrong thing. I have been one of the supporters of the Commission for a long time. Your Chairman and I are close friends. It gets kind of hard when you go in and have these things develop. I tell you most sincerely, I think you fellows better start modernizing your procedures over there and come into this century. Otherwise, you are going to be in a lot of trouble. There are some people that would like to do away with the Commission. They feel you are just obsolete.

Mr. MACFARLAND. Let me say to you, sir, since I have been on, a little over 2 years, that is one matter that has troubled me more than anything, that is, the regulatory delay. There are 11 Commissioners, as you know better than I do. Every effort has been made, insofar as I can, insofar as I may, to get over that situation. It is a most difficult thing to do.

Mr. SKUBITZ. I understand how you work yourself into a corner. You try to be fair with everybody—get in their case. They have 90 days to file an answer, 120 days if they break their leg or have a heart attack to come in, and then they have the response, and this sort of thing. As a result, these things are piled up on the Commission. As I asy, your rating is pretty low in the Congress of the United States today.

Mr. MACFARLAND. If we don't sometimes do those things, we are immediately slapped down by the courts.

Mr. SKUBITZ. You don't think the court would slap you down—I think 12 years on a case is a long time.

Mr. MACFARLAND. I understand that case had over 100,000 pages of testimony.

Mr. SKUBITZ. Don't you think about 75,000 sheets of it was straight repetition?

Mr. MACFARLAND. I have read some of the record.

Mr. SKUBITZ. I am sure you didn't read all 100,000.

Mr. MACFARLAND. I wouldn't suggest to you I did. I read the résumés and heard the oral argument. Perhaps it could be pointed to as the horrible example. It is one of those things that went as it did, as Mr. Kahn related to you, it was not as bad as it sounds that we

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were 12 years in deciding this case. We were not. It took a tremendous amount of time.

Mr. SKUBITZ. I understand perfectly but that record is nothing but a lot of repetition. It is like a discontinuance of a railroad case where you have 10 hearings up and down the line. Each town you go into, Old Mother Jones comes in and says, I have got to go to the doctor once a week. So, we have to keep this train running. I don't think we have to have 25 elderly ladies come in and tell us that. We let the other side come in and keep repeating things. Somewhere along the line, this is getting to the point we have got to keep moving. You are going to have to modernize yourself or we will have to do it for you. If we do it for you, you are going to be in a awful mess. I suggest the Commission, itself, start changing its rules. If you need legislation to do it, come down and give it to us. Take the initiative on something once in awhile.

I am sorry I didn't get to hear your statement, but there are a few questions that I would like to ask you.

Number one, you spoke of being given the jurisdiction to pass upon the adequacy of passenger train service?

Mr. MACFARLAND. Yes, sir.

Mr. SKUBITZ. What does that jurisdiction extend to? What do we mean by adequacy of service?

Mr. MACFARLAND. I think it means just what it says. It don't mean the finest or greatest service, but service which is adequate for the traveling public. It is a term our lawyers could argue about what is adequate.

Mr. SKUBITZ. Does adequacy of service extend to dining services upon the train?

Mr. MACFARLAND. In our opinion, it does.

Mr. SKUBITZ. Does it extend to the air conditioning, and that sort of thing?

Mr. MACFARLAND. Very definitely, and to heating.

Mr. SKUBITZ. Does it extend to the pullman services they have?

Mr. MACFARLAND. Yes, sir, I am of the opinion it does—cleaniliness.

Mr. SKUBITZ. All right. Let's go to the food car. I have been in several discontinuance cases, and each time you go into one, the company points out how much money it costs to operate the dining car to provide sandwiches and milk and coffee and tea. This is one area they point out their losses.

Do you have any limitation—I mean, does every train that goes down the track have to have a dining car attached to it?

Mr. MACFARLAND. No, sir.

Mr. SKUBITZ. How many miles do they have to cover before they are required to have a dining car?

Mr. MACFARLAND. 200.

Mr. SKUBITZ. I mean, timewise, if a train traveled 50 miles an hour, and we are talking about 4 hours, aren't we?

Mr. MACFARLAND. Yes, roughly. A train traveling 12 hours or more must have at least one full service dining area where sit down complete meals are served.

Mr. SKUBITZ. You said every train that travels 200 miles or more.

Mr. ROONEY. He is talking about full service, plate meal service. Isn't that right?

Mr. MACFARLAND. Yes, sir.

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May I say to you, I worked with the State commission a good many years ago, and it was right at the time passenger service was being discontinued, and I sat in on, as you apparently have heard, many of those cases.

Now, these regulations that we promulgated provide that should the passenger train, Amtrak or any of these four private carriers, find a rule or regulation incapable of being compiled with, they may file an application for its exemption. By Amtrak, in spite of some 6,800 complaints, we have only had six petitions to amend these regulations. We almost in effect begged Amtrak—if you find the regulation is intolerable, that you cannot comply with this regulation, file an application for exemption, and let us take a look at it and they have filed six.

Mr. SKUBITZ. When did they file the six?

Mr. MACFARLAND. One has been granted.

Mr. SKUBITZ. When were they filed?

Mr. MACFARLAND. They are pending right now. They filed in December—we brought about one of them, as I stated early in the testimony, as a result of our going into court. Amtrak said, we have an application, a petition to file, so we may ignore that particular regulation concerning reservations.

Mr. SKUBITZ. Let me ask this. Between here and New York City, do you require a dining car?

Mr. MACFARLAND. No, sir.

Mr. SKUBITZ. What do you require?

Mr. MACFARLAND. May I read this? I am reading from 1124.17, Regulation 17, Food and Beverage Service: "Carriers operating trains traveling 2 hours or more shall make food and beverage service available at all times to all passengers on those trains. Complete hours shall be made available during customery dining times.

"Food and beverage surroundings, when they are made available, must comply with the health regulations of the Code.

"(c) A train traveling 12 hours or more must have at least one full service dining area, where sitdown complete meals are served unless it has * * * et cetera."

Mr. SKUBITZ. Lets get back—if a train would leave Washington at 11:00, going to New York, you would require a dining car?

Mr. MACFARLAND. No sir; only food service.

Mr. SKUBITZ. What do you mean by food service?

Mr. MACFARLAND. A vending machine with sandwiches, hot coffee, and cold drinks.

Mr. SKUBITZ. That would meet your requirements?

Mr. MACFARLAND. Yes, sir.

Mr. SKUBITZ. If a train was on a route that took 12 hours, would a full dining car be required?

Mr. MACFARLAND. Yes.

Mr. SKUBITZ. Another question—in a dining car, do you have to change the number of workers every 125 miles, like we do the other railroad workers, or not? I understand, in 1930 or 1935, we had a regulation go into effect that said 125 miles was a full day's work. Does that apply to the dining car?

Mr. MACFARLAND. I will have to answer you frankly and say, I don't know. That is a management problem of Amtrak and I just don't know.

Mr. SKUBITZ. That is your problem.

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Mr. MacFarland. It is our problem to enforce.

Mr. Kahn. Congressman Skubitz, I would respectfully suggest that the Congress has taken that area away from the ICC, and the ICC does not have any jurisdiction to intrude into labor-management matters. The courts time and again have slapped our wrists whenever we have attempted to get into such an area.

Mr. Skubitz. I understand, but do you know whether that is going on in the railroads today, in the Amtrak service?

Mr. MacFarland. We are advised it is not.

Mr. Skubitz. This is one of the big costs railroads bring up. They have to keep changing crews every 125 miles. This runs up the costs of operations.

Mr. MacFarland. Let me say, we received a petition for exemption of this particular rule, which was very promptly granted. One of the private carriers, Southern, had complied with the regulation, and then they filed an application saying—and showed us to our satisfaction, as I recall—there was not any need—it was a train that left in the evening, and there was really no demand for full meal service, and they were allowed to put in vending machines, and as far as we know, that has been very satisfactory.

Mr. Skubitz. The thing that bothers me a little about this whole thing is Amtrak is going head over heels in debt, and I can understand why. When these routes were under private enterprise or under holding companies, let's put it that way, perhaps you had to do some checking on it. It is difficult for me to see why one governmental agency has to look after another, and then we have to look after both of you. It seems to me there should be some sort of harmony here.

Mr. MacFarland. I have made every effort to get in touch—early in the testimony, I told of our efforts to get together with the then management of Amtrak to work out some satisfactory solution, and we were unable to do that. We made that effort and made a sincere effort.

Mr. Skubitz. Do you know what these special requirements are, these standards you set down—how much is added on to the cost of operating Amtrak?

Mr. MacFarland. No; we have no idea. I said earlier in the testimony here, apparently they have not been found to be opressive. We have four private carriers meeting those standards, because, if they are, nobody has complained. We have had roughly 40 complaints from all four private carriers. At the same time we are having 6,800——

Mr. Skubitz. You put all of the bad ones off and we took them over.

Mr. Rooney. Will the gentleman yield?

Mr. Skubitz. Yes.

Mr. Rooney. In all fairness to Amtrak, I think most of your complaints, coming from the passengers utilizing Amtrak's services, are due to old equipment.

Mr. MacFarland. Yes; we recognize that. The equipment Amtrak got, at the time it got it, was 20, 30 years old. Some of it was not compatible. They came in under some rather difficult circumstances and came in with old equipment and with some contracts, with some of the rails which we have found to be almost unconscionable. As I say, give the devil his due. They have had an extremely hard time operating with this old equipment. We believe they could do better and have

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made an effort to see they do better, and it is that simple. We know that they can't repair the roadbed between here and Philadelphia. We know they have to run over the tracks of other carriers, and we know there are many things physically they can't do. They can't build a new car, but we believe they could buy new cars compatible with the system already in operation.

Mr. SKUBITZ. Let me ask you this. Did you have the same authority to oversee the railroads prior to the time that Amtrak took over?

Mr. MACFARLAND. No, sir, we did not.

Mr. SKUBITZ. No one checked into the service?

Mr. MACFARLAND. Yes, sir. We had a case and a hearing, a rather long and complete case, where it was decided, in 1968, in the Southern Pacific case it was determined that the ICC, under the existing statute, at that time, did not have any jurisdiction over passenger service. That was written into the act of 1970, but there was a body of opinion who believed it at the Commission. We had no jurisdiction.

Mr. SKUBITZ. Did it take the ICC until 1970 to come here and ask for that authority?

Mr. MACFARLAND. No, sir.

Mr. SKUBITZ. Had you been asking the Congress to give you the authority prior to that?

Mr. MACFARLAND. The question—I am not——

Mr. SKUBITZ. Counsel says we had to give it to you. You never asked for it. We passed a law and gave you the authority.

Mr. MACFARLAND. We do what you tell us, or try to.

Mr. SKUBITZ. This is where I disagree with you folks. I feel, if we hire a fellow to be a commissioner, we expect him to be a commissioner, not a clerk. We think we should be able to depend upon you to come before us and tell us what is wrong and ask authority to do something. Don't wait for us to go and find out about it. I understood you were supposed to be an arm of the legislative branch. As an arm, you should be making recommendations to us. Apparently, you did not do it in this instance.

Mr. MACFARLAND. I tried to this morning.

Mr. SKUBITZ. Yes; but it is sure a long wait. Here we are, 1975, clear up to 1970, you had no authority to go onto a train and find out if it was providing services it ought to provide, I am telling you, Mr. Commissioner, the one reason the trains went down the drain is not because the people left the trains, they were pushed off the trains, and you helped do it when you didn't do something about——

Mr. KAHN. Mr. MacFarland was not at the Commission at the time, but I was, and I assure you, Congressman Skubitz, that the trend that we then perceived on the American railroads providing passenger services were timely and forcefully brought to the Congress.

Mr. SKUBITZ. When did you first bring before this committee the need to——

Mr. KAHN. The deficiency in the Commission's statute was brought to the attention of the Congress, I think, in 1968.

Mr. SKUBITZ. 1968?

Mr. KAHN. And long before then, I believe we brought to the attention of Congress——

Mr. SKUBITZ. You recall way before 1968 is when the railroads were trying to get rid of this passenger service.

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Mr. KAHN. I think Congress, in the 1958 legislation made it perfectly clear it favored that policy when it laid down standards that gave the Commission little alternative but to allow such discontinuances.

Mr. SKUBITZ. I understand you are holding hearings all around the country, now, related to Amtrak service. Is that correct?

Mr. MACFARLAND. Yes.

Mr. SKUBITZ. Did this hearing prompt that?

Mr. MACFARLAND. No, because we were working on this long before we knew we were coming here today. I am glad we did it when we came here, but the hearings were planned—my answer would be this hearing did not prompt those hearings.

Mr. SKUBITZ. One other question. Of course, you know the administration thinks Amtrak ought to have the authority to handle discontinuance cases without your interference?

Mr. MACFARLAND. Yes.

Mr. SKUBITZ. One other question for you. I ask you to put this in the record. I would like for you to place in the record how long it takes—let's take from the year 1960 to 1975—the number of discontinuance actions for passenger service that were submitted to the Commission, and how long did it take, from the beginning of the action, to finally make a decision?

Mr. MACFARLAND. The time period was 1960 to 1975? May I supply the record with this?

Mr. SKUBITZ. Just when was it started and when did you make a decision. I want to see whether there is any justification for the Amtrak group to ask that you be taken out. I want to see if you stalled along on these as much as you did the Rock Island case.

Mr. MACFARLAND. We will supply the record with it.

[See letter dated April 8, 1975, from Commissioner MacFarland to Chairman Rooney, p. 105.]

Mr. ROONEY. The next witness will be Orren Beaty, the president of the National Association of Railroad Passengers.

Mr. SKUBITZ. Could I ask the Commissioner to submit one other thing for the record?

Mr. ROONEY. Without objection.

Mr. SKUBITZ. Yesterday, we had the Amtrak people before us. During that discussion, the question was raised regarding the possibility of getting a passenger service that could pay its own way. I was rather disturbed with the remarks. In the foreseeable future, it looks like we are going to have to subsidize the passenger service. Do you think it is possible for us to develop a profitable, or at least, a break-even passenger service?

Mr. MACFARLAND. I have the figures anticipating that question. I have about four pages of testimony, which I prepared.

Mr. SKUBITZ. Mr. Chairman, may I ask that be inserted into the record.

[See letter dated April 8, 1975, from Commissioner MacFarland to Chairman Rooney, p. 105.]

Mr. ROONEY. Yes.

Mr. SKUBITZ. No. 2, I would like for you folks to make specific recommendations on the record. What should be done to get Amtrak on its feet.

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Mr. MACFARLAND. Thank you, sir. We will do that and I will supply the record with this.

Mr. ROONEY. About $10 billion dollars.

Mr. MACFARLAND. You are very modest in your appraisal, sir.

[The following letter was received for the record:]

INTERSTATE COMMERCE COMMISSION,
Washington, D.C., April 8, 1975.

Hon. FRED B. ROONEY,
Chairman, Subcommittee on Transportation and Commerce, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR CHAIRMAN ROONEY: At the Subcommittee on Transportation and Commerce hearings on H.R. 4975, held on March 11 and 12, several Members of the Subcommittee asked me to supply certain information for the record. The purpose of this letter is to forward that information.

First, we were asked about Amtrak's current financial condition and Amtrak's outlook for the future.

Amtrak does not appear any closer to becoming a self-sustaining operation than it was at its inception four years ago. The net loss in 1974 climbed to $272.7 million (compared to $158.7 million in 1973). A combined loss of $97.7 million was realized for the years 1971 through 1973, and a total combined loss of $670.4 million for the years 1971 through 1974. It is evident from these figures that the Federal Government will continue to be called upon to supply funds, through grants and guaranteed loans, to meet Amtrak's operational and capital needs. Due to inflationary pressures, the expiration of railroad buy-in payments, and increasing operating losses, Federal grants and loan guarantees will probably be substantially greater in 1975 and beyond the $413.5 million taken down in 1974, simply to continue operations at current levels. Without Federal grants and guaranteed loans, Amtrak could not continue operations as it cannot depend on adequate private sector financing. A considerable portion of Federal funds is used to pay interest costs.

Due to continuing equipment acquisitions, there is every reason to believe that Amtrak's interest costs will increase. Interest on one new equipment obligation alone will cost $1.6 million in 1975 and $3.2 million in 1976.

Amtrak's basic problems stem from an undercapitalized financial condition at inception. There was not, and still is not, sufficient money for Amtrak effectively to perform adequate passenger service. For example, the cost of acquiring 1,000 new passenger cars to replace old and antiquated cars would be around $500 million. Amtrak probably should replace nearly all of the approximately 2,000 passenger cars it now owns; the average car age is over 20 years with nearly 25 percent consistently out of service for repairs. Insufficient and poor quality equipment have undoubtedly lowered operating revenues and increased costs, resulting in progressively increasing losses. Consequently, the cost to the Government in grants and guaranteed loans will be much greater than that originally anticipated, and probably considerably more than would have been necessary if sufficient seed money had peen granted Amtrak at its inception.

Another factor limiting Amtrak's progress is its reliance on other railroads to perform the actual operational function of running the trains and maintaining the roadway. Many of the contracting railroads have indicated that they regard passenger operations as subservient to their freight operations. This makes it difficult for Amtrak to make changes or exercise flexibility in scheduling of equipment.

The roadway of many of the operating railroads is undermaintained, particularly in the Northeast which has the heaviest concentration of passenger traffic. This contributes to poor service, loss of traffic and added costs. Passenger operations require a higher standard of track maintenance than does freight traffic because of higher speeds and stricter safety considerations. Unfortunately, some contracting railroads, particularly Penn Central, do not have the financial capability to properly maintain their roadway. Other carriers seem to give higher priority to maintaining the track from which the greatest economic benefits are derived, i.e., mainline freight rather than passenger.

We cannot determine, when if ever, Amtrak's losses will be appreciably reduced. Federal guaranteed loans are being rolled over and the limits increased. Interest costs on the guaranteed loans are increasing and it could well be more economical for the Government to make all funds available in the form of Federal grants or

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direct Federal loans instead of guaranteed loans. Presently, in order to pay the interest costs on the guaranteed loans, Amtrak must continually request more Federal funds. In future years, the Government probably will also be requested to repay the loans In addition to the interest it has been paying.

The railroad's charges for services rendered in each year have either exceeded or been equivalent to the total revenues generated by Amtrak. The cost of services previously rendered by the railroads and now performed by Amtrak has drastically increased. The increase has partially resulted from the nationwide reservation and information system, more sophisticated equipment, and installation of more rigid controls, all of which are needed for more efficient operations.

Because of rising costs the railroads' charges will not decrease. Amtrak has absorbed most of the services it is capable of performing. The railroads must continue to operate the locomotives and maintain roadway and plant facilities.

Amtrak's financial position is unique in that, if nationwide rail passenger service is to continue to exist, Amtrak cannot be permitted to run out of cash; however, the prospects of Amtrak becoming a self-sustained operation are not good.

Second, we were asked to supply information concerning the number of passenger train discontinuances processed by the Commission and the amount of time these cases took. From August 1958 through May 1970, the Commission considered 367 interstate passenger train discontinuance cases. All such cases were decided within four months of their inception.

Third, we were asked to supply the number of passenger trains operating between Chicago and Omaha. Trains 5 (westbound) and 6 (eastbound) provide daily service once each way between those points.

I hope this information is helpful to you. Please let me know if I can be of further assistance.

Sincerely yours,

ALFRED T. MACFARLAND, *Commissioner.*

Mr. ROONEY. Mr. Beaty.

You may proceed.

STATEMENT OF ORREN BEATY, PRESIDENT, NATIONAL ASSOCIATION OF RAILROAD PASSENGERS, ACCOMPANIED BY ROSS CAPON

Mr. BEATY. Mr. Chairman, I want to introduce Ross Capon. He was formerly with the Massachusetts State Department of Transportation, and is serving with us.

Mr. ROONEY. Tell me something about your association, how it began and who founded it.

Mr. BEATY. It was really started by a group of three or four people, who began on their own contesting train-off cases in the mid-1960's. They were successful in some, lost some. Largely operated in the beginning by Anthony Haswell, a lawyer from Chicago, Ill., NARP was started in 1967. It expanded to about 6,500 members, all individual citizens interested in riding or preserving train service.

Mr. ROONEY. This is consumer-oriented?

Mr. BEATY. Consumer-oriented. We operate on the basis of dues and contributions from the members, and Mr. Haswell served as the executive director. He financed it out of his own pocket. January 1, I took over, in place of him, because he felt the need to give up some of his public service work and go back to earning a living.

Mr. ROONEY. Proceed with your testimony.

Mr. BEATY. As you may have observed, my name is Orren Beaty. I am president of the National Association of Railroad Passengers. I apologize for the fact my statement is printed on both sides. We are operating on a limited budget.

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NARP is nationwide, and while individual members may have greater concern about one regional project or another, overall our specific objective is the same: to obtain modern train service wherever it is needed and useful, whether for commuters, intercity travelers in the corridors, or for cross-country vacationers.

Our association, long before I got associated with is was helpful in bringing Amtrak into existence.

Mr. ROONEY. Are you pleased with that decision?

Mr. BEATY. We think it would be a lot worse if it hadn't happened. There is a lot of room for improvement.

Except for rail commuter service, which we support but which is not a subject of this hearing, Amtrak is just about the only game in town in railroad passenger service. We support it, and regret having to criticize it occasionally for avoidable shortcomings which have delayed the kind of service which, we believe would make the railroads the important part of a balanced national transportation system they must be.

At this point I would like to express our delight that Amtrak's board of directors selected Paul H. Reistrup to be president. He headed the most imaginative rail passenger operation in the Northeast during the sixties bringing to Baltimore & Ohio passengers colorful timetables, movies on trains, and flexible fares which included off-peak bargain rates. Subsequently, at the Illinois Central, he developed the successful mini-corridor between Chicago, Champaign, and Carbondale. Ironically, that service was dismantled in 1971 by the corporation he now comes to head.

We welcome Mr. Reistrup to a difficult job and offer him our help and support, and we are confident he won't view it as personal when we criticize what had gone on before he took over.

This is not a particularly optimistic time for us. It should be, but for a lot of reasons it isn't.

Amtrak has just dropped passenger service between Springfield and Boston, Mass. Southern Railway wants to eliminate one passenger route entirely and reduce service on three others.

We believe that any loss of passenger train service (given its already limited scope) is senseless at a time when the Nation is being asked to curtail consumption of petroleum products, and when nothing has been done to discourage reliance on private automobiles which are notoriously inefficient in use of fuel.

Bankruptcy stalks the Nations' railroads. If the recession continues, it may hit a lot of those regarded as healthy railroads right now. The worst single problem is the deterioration of the roadbeds and rails, which affects the freight hauling railroads as much as it does the passenger movement. Everybody seems to agree there should be something done about it. Congress has appropriated money to get on with roadbed improvements on Amtrak, but nothing seems to get done.

NARP favors a plan for public ownership, upgrading and maintenance of the roadbeds, charging appropriate user fees to compensate the Government for the cost of doing this work. We think it won't be done by the individual railroads—there has to be some direction of this at the national level.

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The Wall Street Journal, March 11, Tuesday, the day you started these hearings, reluctantly endorsed this idea—says, there ought to be some better way, but, apparently, there isn't.

Mr. ROONEY. If you have no objection, we will include this in the record [see p. 120].

Mr. BEATY. Fine. Thank you.

Amtrak suffers a decline in ridership, as other modes of transportation also are enduring in this economic downturn, and costs continue to outdistance revenue.

It is a period of waiting for the recession to end so more people can afford to ride the trains; for new railroad coaches to be delivered so the trains can be improved; for doubts to be resolved about the legalities of using tax money to improve privately owned roadbeds so that all pervasive roadblock to comfortable rides and on-time service can be removed.

It has been almost 4 years since Amtrak began running the Nation's railroad passenger service. It started with outdated, well-worn coaches, sleepers, and diners. That same equipment, much of it refurbished to one degree or another, is still being used today. Some of it has reached the point where it needs upgrading the second time. Except for two complete turbo-train sets obtained from France, no new passenger equipment has been put into service.

Mr. Chairman, I have noticed a pillow on the couch in your office with the inscription: "God, give me patience and I want it right now!"

Mr. ROONEY. That was given to my at Christmas time by my 9-year-old son, and he insisted it be there.

Mr. BEATY. After 4 years, even the most patient railroad passengers are beginning to grow tired of waiting. I think they want some action now.

Friendly and knowledgeable journalists have quit praising Amtrak and have taken to warning to get the show on the road, or they are going to lose the support of Congress and the people. Don Phillips of United Press International wrote last fall in Passenger Train Journal that "Wait until next year" won't work anymore. Amtrak, be observed then, "is just beginning to order the new equipment that should have been ordered 2 years ago," and we agree with that.

We don't blame Amtrak's management exclusively. We assume, without knowing for sure, that DOT was encouraged in this attitude by the Office of Management and Budget, but the effect is that by using this old equipment, not getting the new equipment, the costs of operation have been much higher than they should have been, contributing to the deficit.

For all its doubts, the National Association of Railroad Passengers believes we may be in that dark period before the dawn—dawn is going to come, and with the arrival of new management and new equipment, over the next year or so, we may see some improvements—we certainly hope so.

We support H.R. 3282. We believe Congress should approve the current request for $77.9 million in additional appropriations to get Amtrak through June 30. And NARP urges that the simple 1-year extension of Amtrak's authority with the required funding, be approved as soon as possible without trying now to agree on long-range

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plans. I have a figure in here several places, $77.9 million, Amtrak has an unused authorization of $14 million——

Mr. ROONEY. Correct.

Mr. BEATY. So this makes the difference between the $63 million dollar figure they are talking about in the testimony the day before yesterday. We would like to see you extend Amtrak's authority for 1 year, provide the money needed, and give Mr. Reistrup time to get his feet on the ground, before asking him to approve or disapprove of various long range schemes.

Also, the U.S. Railway Association plan will have been considered by the Congress by the time you take up the additional Amtrak legislation, if you do wait a year or so.

I will skip some points here and get on to the testimony.

It is not easy to understand Amtrak's financial situation from just the cursory glance you get at a 1 day hearing. This committee authorizes, and the Appropriations Committee appropriates on a fiscal year basis, while Amtrak has its annual report based on a calendar year. We understand that this is one of the things you are proposing to change, and we support that idea. It is confusing unless you have an accountant with you pointing out the differences.

One fact is clear, regardless of different bookkeeping systems: Amtrak's deficit has been increasing much faster than the Department of Transportation or Amtrak anticipated, based on previous statements.

The deficit for the current fiscal year—1975—was originally estimated at about $150 million, to be made up from $20 million in carryover cash from fiscal year 1974, plus a basic appropriation of $130.3 million. In December, Congress appropriated another $70 million in the first supplemental. Now, as you know, you are being asked to authorize another $77.9 million. Obviously, that original figure is long since inoperative.

Mr. Reistrup has testified that the operating deficit for fiscal year 1975 will be $325 million; the deficit for 1976 will be $350 million.

As recently as last spring, the Department of Transportation reported that it expects Amtrak deficits to average $150 million a year through 1977.

I mention this not to object, because we believe the cost is still reasonable in comparison with what is spent in public moneys on other modes of transportation and with what the cost would be if Amtrak had not been created. USRA has stated that Federal, State, and local laws have subsidized rival forms of transport for a grand total of $450 billion since 1920, "with expenditures for highways by all levels of government amounting to over $20 billion per year in the 1970's"

But we are concerned that not enough rail passenger service is being provided to the public for the taxes it must pay to finance the operation. We are concerned, if the public and Congress lose confidence, that a lot of Amtrak may go down the drain. We think the system is good, but it must be expanded, and we would like to have a little more reason for confidence in our operation.

We are pleased by improvements in Amtrak trains' ontime performance since the addition of 150 new locomotives to its fleet, and since the new incentive oriented contracts became effective. Their ontime record is not as good as the overall averages may appear.

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Mr. Hall, the Acting Administrator of FRA in trying to get some new legislation, which would enable Amtrak to eliminate certain routes, if not profitable—suggested we are now in a position to really test the market. We are not, because Amtrak is not running on time, not providing the kind of service they can provide, if given a fair test.

Just as an example, Indianoplis has no north-south service because two trains intended to go there have had to be rerouted because of bad tracks.

Mr. ROONEY. Would your association consider freezing the present route structure for another year?

Mr. BEATY. Yes, sir. I would hate to see anything abandoned before it has a chance to get a fair test.

Mr. ROONEY. Do you think Amtrak may eliminate these long haul unprofitable routes that are currently existing?

Mr. BEATY. I would like to see how they work. There may be routes that don't belong in the system. Until there is adequate equipment and roadbeds, you can't tell what the public response really would be. Some of the long haul routes are developing good ridership, some aren't. We need to get some type of criteria to judge it by and go on from there.

Two of the main east-west trains from New York to Washington to the Midwest, the National Limited and the Broadway Limited, had zero ontime performance. Two major routes from Washington to New York or Chicago-Kansas City—different routes

Mr. ROONEY. Have you done any study as to why?

Mr. BEATY. It is largely the roadbed. You get one slow order after another. Bad weather, I suppose, contributed some of it but it happens in good weather or bad weather, they don't run on time.

Mr. Haswell came into Washington yesterday—he rode the Broadway Limited, as he always does. He had to get off in Harrisburg, and catch a plane in order to get into town—he would have been 3 hours late, probably, by train. It is not just a 5 minute or 15 minute delay. A lot of these trains run 2 or 3 hours late every run. In fact, in Amtrak's time table they take note of this. Let me see if I can find this. The time table entry says that, due to operating additions, it is subject to delay." When it says that in the printed timetable, you can be pretty sure it is going to be late nearly every day. The Broadway Limited must operate 30 miles an hour for some portions of their track; 16 out of the 30 major routes Amtrak operates over had faster schedules when they were operated by the railroads before Amtrak came into existence. The tracks have deteriorated and the record will back this up.

But it must be remembered that until about a year ago, a train was regarded as late if it arrived at its destination 6 minutes after the scheduled time. Now, under prevailing standards, a train may be 15 minutes behind schedule on a route 350 miles long without being regarded as late, and if the distance between end points on a route is as great as 550 miles, the train may be 30 minutes behind the posted arrival time and still be considered on time. It is not easy to look at ontime records for 1973 and the improved records for 1974 and arrive at a valid comparison.

Also, largely because of poor track and roadbed conditions, Amtrak's schedules are slower than the railroad companies' own schedules for

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comparable routes in the years before Amtrak. Of 30 major schedules, 16 are slower than in pre-Amtrak days. So, we need to look at ontime performance statistics in the light of slower schedules and more lenient ontime standards.

I mentioned ontime performance, because we are told that one reason for the current need for more money is that additional payments are due the reailroads because they are getting the trains to destination faster than they did a year ago. At the same time, it is stated that the increased payments for better ontime records don't really cost any more because the new contracts eliminate the 5-percent override on Amtrak payments to the railroads for the basic cost of operating the trains, and the 4-percent payment which was made in the earlier days for insurance. I don't understand it and I think this committee and subcommittee needs to understand it better than I do. How, if you are saving money on a contract, and using that savings to pay the incentives, why do you need another $32.4 million above the appropriation of this fiscal year to meet that?

Mr. ROONEY. I see you have a copy of the USRA preliminary system plan. They criticize Amtrak's new contract with the railroad for cost-plus arrangements which fail to encourage economy in the operations. What do you think about this arrangement?

Mr. BEATY. I think the criticism might be based on the original contracts. They are changing from the old cost-plus arrangements to the new contracts, and the indicated result, I think, is encouraging. I think you should get a better accounting of what the cost is under the new contracts.

Also, as was brought up earlier, about the employees. If Amtrak had more control over the employees, instead of contracting with the railroads to provide the conductor and people in charge on the trains, I think there might be a better accounting for the use of personnel, for the collection of fares enroute, and this sort of thing. It is something we advocated right from the beginning. You can understand why when Amtrak was first starting, it didn't want to take on all of these responsibilities. We think the time has come for them to be responsible for their employees, the people serving their trains.

Let me just mention one thing. You mentioned the complaints. We get a number of complaints every week from riders of Amtrak trains, who, apparently, feel they can't get any response out of Amtrak. We forward some of these to Amtrak. We ask for explanations or Amtrak's side of the problem, if there is an Amtrak side. We haven't sent them all down. We should have brought it along. We have a stack this high in the office which we would like Mr. Reistrup to take a look at. These are horror stories. I get very few responses from Amtrak, or maybe I will get them. I have only been on the job since the 1st of January. The management hasn't been sensitive to the needs of consumers. We have nothing to gain by trains running late or too hot or too cold or having toilets that won't work.

Mr. ROONEY. You don't concern yourself with buses, do you?

Mr. BEATY. No.

Mr. ROONEY. Just merely trains?

Mr. BEATY. We think there is a great place for buses. We are not against it. Buses and trains should take up the slack.

Mr. ROONEY. I think the bus industry is run very well in this country. They run on schedule and serve a very useful service.

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Mr. BEATY. We don't object to that statement at all.

Skipping on the the final point that I want to discuss—this is the comparison between future services, as envisioned by Amtrak in its 5-year plan and as suggested by USRA in its recently released preliminary plan.

The large number of metropolitan areas in fairly close proximity in every State east of the Mississippi and, generally, north of the Ohio River, represents a sizable market potential for Amtrak corridor services. Today, many of the links among these cities have no passenger trains at all, while several others are served only by long-distance trains which are unreliable and poorly scheduled for corridor purposes.

Amtrak's proposal, as illustrated in exhibit 24 of its plan, is restricted to the few lines which now have corridor service, and proposes operation of trains at 90 to 110 miles per hour. The USRA "Concept", page 303-7 proposes 79 miles per hour service to be operated on a much more extensive network.

If they could go 79, we would see improved service all over the country. We would rather aim it at a middle level of performance. Let's get them up to 79 now, and then see what we can do.

Mr. ROONEY. Has your association ever done any cost analysis to run a train—let's say a train running from Washington to New York? What is the minimum number of round trips per day it would take to have Amtrak break even on that run? Have you done any cost studies on that?

Mr. BEATY No, I don't think we have. By observing, it is clear. I don't know what the cost of maintaining the roadbed between here and New York is. Metroliners are making money. The cash income is more than the cost of operating. We think, from just a standard practice of passenger riding, if there is more than one train a day, with reliable service, more people will start riding, and this will lead to revenue gains—the service provided, we think, will balance the minimum losses sustained. In a country this big, industrially oriented, it has to have a reliable transportation system. Taxpayers pay large amounts to provide air control systems and airports for the commercial airlines and for the private plane flyers as well, and facilities for the trucks, barges buses. Railroads aren't the only ones. Amtrak is not the only one that needs a subsidy. It is just a question of balancing out, so you will have a balanced transportation system, in our view.

NARP prefers the USRA approach and believes that the basic Amtrak system should be enlarged to include the additional corridors identified by USRA, corridors which should have been included in the 1971 basic system.

USRA noted that Amtrak could realize a major cost savings by limiting its speeds to 79 miles per hour, since it is planned to upgrade the ConRail freight mainlines to standards which would permit passenger operations at those speeds. This would be without any additional upgrading for the 110 mile per hour. Sixty miles per hour with no additional cost. The passenger trains could run at 79.

Mr. ROONEY. Your testimony, as submitted, will appear in the record [see p. 113].

Mr. BEATY. We would like to call to the attention of the committee a significant need for funding not yet explicitly noted by the executive branch.

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Many of the track segments designed by USRA, in its preliminary system plan, as being unnecessary for freight operations are vital to Amtrak operations, both existing and proposed.

It seems clear that Congress will have to provide new funds to protect these segments, whether this action takes the form of direct authority and appropriations to Amtrak for acquisition, or of enabling ConRail to acquire the segments for lease to Amtrak. As presently written, the Regional Rail Reorganization Act does not authorize passenger-related expenditures outside the Northeast corridor, and Amtrak has not yet indicated that it will request funds for this purpose, though it may so state in its expected formal response to the preliminary system plan.

For the record, we are submitting a list of the "passenger only" segments.

Mr. ROONEY. Without objection [see p. 118].

Mr. BEATY. Amtrak operates the only service operating over the Burlington Northern tracks. We would hate to see the Rock Island disappear. They have the best round trip between Chicago and Omaha. It serves the State capital of Des Moines, which is a population center, industrial center. It is 3 miles shorter than the route Amtrak is now using. If they start rejuggling this, we would like to see some of the Rock Island lines reserved for passenger service.

Now I think that I can wrap up my statement fast by quoting from Roger Lewis, chairman of the Amtrak board of directors and most recently its president. Based on his experience, he wrote:

> . . . Demand does not arise full-blown when a service is first initiated. The service must first be provided at a level of quality sufficient to attract demand. Because of the inherent advantages of rail travel in the areas of speed and comfort, we are confident that a significant number of travelers now using automobiles for intercity travel would utilize good rail service were it available. . . .
>
> Furthermore, route extension decisions should be influenced by the public interest in encouraging rail travel for reasons of fuel efficiency and lack of adverse environmental impact. National policy and social considerations may justify operation of passenger rail service at a loss in certain instances.

NARP fully agrees. But, in fact, most if not all Amtrak services may require subsidies for the foreseeable future. After having pursued public policies virtually designed to kill rail service for several decades, policies which have included the provision of highway completion with alinements superior to many railroad mainlines, it is unreasonable to expect that rail services should turn a profit after 4 years of extremely modest financial assistance.

Thank you, Mr. Chairman.

If you have some additional questions, I will be happy to answer them.

[Testimony resumes on p. 120.]

[Mr. Beaty's prepared statement and attachment follows:]

STATEMENT OF ORREN BEATY, PRESIDENT, NATIONAL ASSOCIATION OF RAILROAD PASSENGERS

Mr. Chairman, my name is Orren Beaty. I am president of the National Association of Railroad Passengers which for about eight years has worked to preserve and improve railroad passenger service in this country.

NARP, which maintains offices at 417 New Jersey Avenue, S.E., Washington, D.C., is an Illinois not-for-profit corporation which operates as a consumer-oriented organization, financed entirely by membership dues and contributions.

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It gets no financial support from the government, the railroad companies, Amtrak, or the railway labor unions.

It is, and will remain, an association completely free to speak its mind clearly on matters affecting railroad passenger service without fear of offending its supporters.

NARP's membership is nationwide, and while individual members may have greater concern about one regional project or another, overall our specific objective is the same: to obtain modern train service wherever it is needed and useful, whether for commuters, intercity travelers in the "corridors", or for cross-country vacationers.

Our association, long before I was associated with it, was widely credited with an important role in the decision to create Amtrak, and we have followed its development and operations with considerable interest.

Except for rail commuter service, Amtrak is just about "the only game in town" in railroad passenger service. We support it, and regret having to criticize it occasionally for avoidable shortcomings which have delayed the kind of service which, we believe, would make the railroads the important part of a balanced national transportation system they must be.

At this point, I would like to express our delight that Amtrak's board of directors selected Paul H. Reistrup to be president. He headed the most imaginative rail passenger operation in the Northeast during the sixties, bringing to Baltimore and Ohio passengers colorful timetables, movies on trains, and flexible fares which included off-peak bargain rates. Subsequently, at the Illinois Central, he developed the successful "mini-corridor" between Chicago, Champaign, and Carbondale. Ironically, that service was dismantled in 1971 by the Corporation he now comes to head.

We welcome him to a difficult job, offer our help and support in his work of making the service what it should be, and urge him to consider any criticism which may follow as directed not at him but at the way things were before he took over.

We do not believe that the president of Amtrak, the railroad riding public, or the Congress of the United States will be well served by holding back valid constructive criticism and suggestions. The members of this Subcommittee, Mr. Chairman, deserve to have all the facts before them as they legislate on this very vital—and very expensive—program.

This is not a particularly optimistic time for those of us who believe in railroad passenger service (except, as noted, for the arrival on the scene of Mr. Reistrup). It should be, but for a lot of reasons it isn't.

Amtrak has just dropped passenger service between Springfield and Boston, Massachusetts. Southern Railway wants to eliminate one passenger route entirely and reduce service on three others.

We believe that any loss of passenger train service (given its already limited scope) is senseless at a time when the nation is being asked to curtail consumption of petroleum products, and when nothing has been done to discourage reliance on private automobiles which are notoriously inefficient in use of fuel.

Bankruptcy stalks the nation's railroads. Operating deficits at Amtrak mount alarmingly without commensurate benefits to the public. Deteriorating roadbeds and rails—for all the brave talk of huge appropriations and a new resolve to upgrade the system—hamper freight and passenger movements alike. No one seems to disagree; Congress appropriates or authorizes money to start work on the trackage improvement program, but time passes and nothing is done—there seem to be endless details to be worked out.

Amtrak suffers a decline in ridership—as other modes of transportation also are enduring in this economic downturn, and costs continue to outdistance revenue.

It is a period of waiting—for the recession to end so more people can afford to ride the trains; for new railroad coaches to be delivered so the trains can be improved; for doubts to be resolved about the legalities of using tax money to improve privately owned roadbeds so that all pervasive roadblock to comfortable rides and on-time service can be removed.

It has been almost four years since Amtrak began running the nation's railroad passenger service. It started with outdated, well-worn coaches, sleepers and diners. That same equipment—much of it refurbished to one degree or another—is still in use today. Except for two complete turbo-train sets obtained from France, no new passenger equipment has been put into service.

Mr. Chairman, I have noticed a pillow on the couch in your office with the inscription: "God, give me patience—and I want it right now!"

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After four years, even the most patient railroad passengers are beginning to grow tired of waiting.

Friendly and knowledgeable journalists have quit praising Amtrak and have taken to warning that the time has come to deliver—else Congress and its constituents will cease financing the operations. Don Phillips of United Press International, for example, wrote last fall in Passenger Train Journal that "Wait until next year" won't work anymore. Amtrak, he observed then, "is just beginning to order the new equipment that should have been ordered two years ago."

NARP agrees with this statement but does not blame Amtrak's management exclusively. There was foot-dragging in the Department of Transportation as well. But for example, the widely advertised plan to order 200 or more bi-level coaches is still delayed, we understand, by slowness in agreeing on design. Delivery date must be at least two years away.

For all its doubts, The National Association of Railroad Passengers believes we may be in that dark period before dawn when there is no assurance that daylight will ever come, but you know it will.

Mr. Chairman, NARP supports H.R. 3282. We believe Congress should approve the current request for $77.9 million in additional appropriations to get Amtrak through June 30. And NARP urges that the simple one-year extension of Amtrak's authority with the required funding, be approved as soon as possible without trying now to agree on long-range plans.

There are two reasons for this. One year from now, Mr. Reistrup will know from experience what is needed. He will not have to depend on anyone else to tell him the good and bad points of a long-range plan. And, the United States Railway Association's final plan for restructuring the railroad system of the Northeast will have been considered by the Congress, and the Interstate Commerce Commission's study of the adequacy of railroad passenger service will have been completed.

Next year there won't be so many unknowns. We could even have a national fuels policy and a national transportation policy for guidance, although this may be wishful thinking.

In my testimony, Mr. Chairman, I want to touch on: The amazing acceleration of Amtrak's deficit which is requiring a second supplemental appropriation this fiscal year; the need for your committee to determine all the facts and problems in spite of some confusion caused by different fiscal years, and a brief comparison between Amtrak's five-year plan and the corridors proposed by USRA in the Preliminary System Plan for restructuring the railroad system of the Northeast.

Regarding the second point for a moment, it is not so simple to understand Amtrak's financial situation when Congress and the Executive Branch operate under a fiscal year which begins on July 1, and Amtrak's spokesmen discuss revenues and losses for the calendar year, which happens to be the fiscal year established for Amtrak. This committee authorizes, and appropriations are voted, for the governmental fiscal year, while Amtrak's annual report is based on the calendar year. It is a confusion which Amtrak and the Administration are asking the Congress to remove, and we concur.

One fact is clear regardless of different bookkeeping systems: Amtrak's deficit has been increasing much faster than the Department of Transportation or Amtrak anticipated, based on previous statements.

The deficit for the current fiscal year (1975) was originally estimated at about $150 million, to be made up from $20 million in carryover cash from fiscal year 1974, plus a basic appropriation of $130.3 million. In December, Congress appropriated another $70 million in the first supplemental. Now, as you know, you are being asked to authorize another $77.9 million.

Mr. Reistrup has testified that the operating deficit for FY 1975 will be $325 million; the deficit for 1976 will be $350 million.

As recently as last spring, the Department of Transportation reported that it expects Amtrak deficits to average $150 million a year through 1977.

I mention this not to object, because we believe the cost is still reasonable in comparison with what is spent is public moneys on other modes of transportation and with what the cost would be if Amtrak had not been created. USRA has stated that federal, state and local laws have subsidized rival forms of transport for a grand total of $450 billion since 1920, "with expenditures for highways by all levels of government amounting to over $20 billion per year in the 1970's."

But we are concerned that not enough rail passenger service is being provided to the public for the taxes it must pay to finance the operation. And we hope that future estimates will be accurate enough so that the taxpayers and their repre-

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sentatives in Congress will know what the cost is going to be. We don't want rail passenger service's support to be dissipated through lack of confidence in the management.

We are pleased by improvements in Amtrak trains' on-time performance since the addition of 150 new locomotives to its fleet and since the new incentive oriented contracts became effective. But it must be remembered that until about a year ago, a train was regarded as late if it arrived at its destination six minutes after the scheduled time. Now, under prevailing standards, a train may be 15 minutes behind schedule on a route 350 miles long without being regarded as "late," and if the distance between end points on a route is as great as 550 miles, the train may be 30 minutes behind the posted arrival time and still be considered "on time". It is not easy to look at on-time records for 1973 and the improved records for 1974 and arrive at a valid comparison.

Also, largely because of poor track and roadbed conditions, Amtrak's schedules are slower than the railroad companies' own schedules for comparable routes in the years before Amtrak. Of 30 major schedules, 16 are slower than in pre-Amtrak days. So, we need to look at on-time performance statistics in the light of slower schedules and more lenient on-time standards.

I mentioned on-time performance, because we are told that one reason for the current need for more money is that additional payments are due the railroads because they are getting the trains to destination faster than they did a year ago. At the same time, it is stated that the increased payments for better on-time records really don't cost any more because the new contracts eliminate the five percent override on Amtrak payments to the railroads for the basic cost of operating the trains, and the four percent payment which was made in the earlier days for insurance.

If I have understood and restated these positions correctly, why then does Amtrak need another $32.4 million above the fiscal 1975 appropriation and first supplemental? I believe that the Subcommittee needs to get a clearer understanding of this seeming inconsistency than I have, if it is to present the House with a factual defense of the need for the additional funds.

One final item in this question of the problems Amtrak faces. The Interstate Commerce Commission hearings now in progress around the country are putting a spotlight on some of the most deplorable service shortcomings on Amtrak trains. Naturally, thousands of satisfied customers won't take the trouble to testify, but the complaints need to be heeded.

NARP gets several complaints a week. Some of the instances cited by disappointed Amtrak riders are as bad as any which have been publicized by the newspapers recently as a result of the ICC hearings. We have transmitted some of them to Amtrak. We have asked questions of Amtrak with regard to others. Because we have not been satisfied that Amtrak was paying sufficient attention to the stories of poor service being told by its customers, we have not sent very many in recent months.

We have a stack of letters numbering at least 500 in this category. The complaints are most frequent about cars which were too hot or too cold; reserved seats; which were unavailable because they had been sold two or three times; surly responses from service personnel; late trains, and dirty windows. People like to ride the trains in order to see out, and Amtrak's window washing is sporadic at best. Even worse from the standpoint of inability to look at the scenery is the use of a plastictype window pane which changes color, scratches easily and is obviously unsuitable for passenger trains.

But the biggest complaint comes from those who can't find out what is wrong when a train is held up. When something goes wrong that makes a train late or makes the ride uncomfortable, the riders except to be told the cause. Our mail indicates they have been totally frustrated in getting answers. Changing this one thing would do more toward making harried and discomfited riders happy with Amtrak than anything else I can think of.

The third area to be covered here concerns future corridor service as envisioned by Amtrak in its five-year plan and as suggested by USRA in its recently released preliminary plan.

The large number of metropolitan areas in fairly close proximity in every state east of the Mississippi and, generally, north of the Ohio River, represents a sizable market potential for Amtrak corridor services. Today, many of the links among these cities have no passenger trains at all, while several others are served only by long-distance trains which are unreliable and poorly scheduled for corridor purposes.

Amtrak's proposal, as illustrated in Exhibit 24 of its Plan, is restricted to the few lines which now have corridor service, and proposes operation of trains at 90

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to 110 mph. The USRA "Concept", pp. 303–7, proposes 79 mph service to be operated on a much more extensive network.

NARP prefers the USRA approach and believes that the basic Amtrak system should be enlarged to include the additional corridors identified by USRA, corridors which should have been included in the 1971 basic system. The creation of a true "network", as USRA states (p. 305),

> . . . will tend to increase substantially the average number of passengers per corridor train as a result of travelers making non-corridor longer-distance trips on corridor trains. The corridor schedules should also be designed to act as "feeders" to certain long-distance trains in the Region . . . This should further enhance the economics of both the corridor and the long-distance trains.

While this approach would not initially have trains running as fast as 90 or 110 mph, it nevertheless offers substantial improvements over Amtrak's existing service (Chicago-Detroit, for example, would be accomplished in five hours rather than 6:50), service to more people (both in terms of geography and income brackets) and less chance of an economic backlash against soaring Amtrak deficits.

Again quoting USRA:

> To compete for business travel purely on the basis of speed, Amtrak would have to increase its train speeds to an extent which would be economically, if not technologically, infeasible.

USRA noted that Amtrak could realize a major cost savings by limiting its speeds to 79 mph, since it is planned to upgrade the ConRail freight mainlines to standards which would permit passenger operations at those speeds.

NARP is certainly not opposed to the eventual provision of "super express" service in corridors across the country. We do believe, however, that—outside the Northeast corridor—the most important task facing Amtrak now is to enlarge its coverage, to ensure, for example, that in five years, Cleveland is not merely served by the Boston-Chicago train, but is linked through Youngstown to Pittsburgh, to Detroit, and to Columbus-Dayton-Cincinnati with conveniently scheduled corridor trains.

On the basis of marketing and operating experience associated with the Northeast Corridor Project and with the 80 mph network, it will then be possible to make better informed decisions about which of the routes outside the Northeast Corridor should be considered for further upgrading, and what technologies should be used.

This sequence, it appears to us, offers the most immediate attack on wasteful energy consumption among intercity travelers. As USRA again writes:

> The great majority of travelers will be diverted from automobiles through provision of a reasonably fast service with fares and elapsed time competitive or better than that of the automobile.

We would like to call to the attention of the Committee a significant need for funding not yet explicitly noted by the executive branch.

Many of the track segments designated by USRA, in its Preliminary System Plan, as being unnecessary for freight operations are vital to Amtrak operations, both existing and proposed.

It seems clear that Congress will have to provide new funds to protect these segments, whether this action takes the form of direct authority and appropriations to Amtrak for acquisition, or of enabling ConRail to acquire the segments for lease to Amtrak. As presently written, the Regional Rail Reorganization Act does not authorize passenger-related expenditures outside the Northeast Corridor, and Amtrak has not yet indicated that it will request funds for this purpose, though it may so state in its expected formal response to the Preliminary System Plan.

For the record, we are submitting a list of the "passenger-only" segments, excluded from the Preliminary System Plan, divided into three categories: those required for operation of Amtrak's basic system and corridor services recommended by USRA; for other services currently in operation outside the basic system, and for other routes previously recommended by NARP. The list does not include the many commuter lines which were excluded by USRA, and, of course, the list is subject to change if the Final System Plan incorporates changes in the status of these segments, or if states move promptly to subsidize freight operations thereon.

However, from the passenger perspective, we believe that funding the acquisition of lines in the first two categories is clearly an exclusively Federal—and, presumably, Amtrak—responsibility. Some of the segments in the third category might logically command study and action by the individual states.

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However, considering the limited availability of Federal funds to states for rail planning purposes (in sharp contrast to that which obtains for other modes), and the short lead times we are discussing, we believe that Congress should enable and direct Amtrak to acquire any rights-of-way which might reasonably carry Amtrak trains in the future, including—but not necessarily limited to—all of the segments shown in our third category.

To underline the problematic nature of state subsidies, their uncertainty and lead time requirements, it is worth noting that although Illinois is the leading state in terms of using Section 403(b) the service on line in Illinois today is roughly half what it was before Amtrak took over: there are three daily Chicago-Champaign round trips, two of which also serve Carbondale, which compares with five-and-one-half daily round trips all the way to and from Carbondale which ran until May 1, 1971.

At the very least, Amtrak should be required to study the feasibility of inaugurating passenger service on the "category three" segments, and to make acquisitions on the basis of such studies.

In closing, I want to quote a few lines from the new Amtrak annual report—some personal comments from Roger Lewis, chairman of the Amtrak board of directors and most recently its president. Based on his experience, he wrote:

". . . Demand does not arise full-blown when a service is first initiated. The services must first be provided at a level of quality sufficient to attract demand. Because of the inherent advantages of rail travel in the areas of speed and comfort, we are confident that a significant number of travelers now using automobiles for intercity travel would utilize good rail service were it available . . .

"Furthermore, route extension decisions should be influenced by the public interest in encouraging rail travel for reasons of fuel efficiency and lack of adverse environmental impact. National policy and social considerations may justify operation of passenger rail service at a loss in certain instances."

NARP fully agrees. But, in fact, most if not all Amtrak services may require subsidies for the foreseeable future. After having pursued public policies virtually designed to kill rail service for several decades, policies which have included the provision of highway competition with alignments superior to many railroad mainlines, it is unreasonable to expect that rail services should turn a profit after four years of extremely modest financial assistance.

Thank you, Mr. Chairman.

SEGMENTS REQUIRED FOR INTERCITY PASSENGER SERVICE BUT NOT INCLUDED IN PRELIMINARY SYSTEM PLAN [REVISED MAR. 28, 1975]

Service affected	Segment	Length (miles)	USRA Line No.	Page[1]	Comment
I. AMTRAK BASIC SYSTEM AND USRA CORRIDORS					
Buffalo-Detroit	Black Rock, N.Y.—Welland, Ont.	14.6	101a	381	See note 1.
Indianapolis-Dayton (New York-Kansas City).	Indianapolis-Richmond, Ind.	67.3	633	472	See note 2.
Chicago-Indianapolis via Lafayette (Chicago-Newport News).	Kankakee Ill.—Sheff, Ind.	38.1	577a	475	See note 3.
	Lebanon—Brant, Ind.	23.5	574/574a	448	See note 4.
Chicago-Detroit	Michigan City, Ind.—Kalamazoo, Mich.	83.0	467	483	See note 5.
			466	556	
Cleveland-Columbus	Columbus Union Station	1.6	477a	663	See note 6.
New York-Pittsburgh-Chicago Kansas City.	Trackage in Pittsburgh	1.2	312	743	See note 7.
		.2	313	743	
		.2	314	744	
Philadelphia - Harrisburg (New York - Pittsburgh - Chicago Kansas City).	Parkesburg—Lancaster, Pa.	20.5	691	770	
	Conewago—Royalton, Pa.	4.0	691b	772	
Albany-Utica (New York-Buffalo)	Carman—Hoffmans, N.Y., via Schenectady.	13.4	74, 73	817	See note 8.
Cleveland Union Terminal	"QD"—Cleveland Union Terminal, West 25th St.—Clark.	11.9	381-383 384	817	See note 9.
II. SERVICE OPERATING OR DESIGNATED OUTSIDE AMTRAK BASIC SYSTEM					
Springfield, Mass.-Albany, N.Y. (Boston-Chicago).	Post Road—Rensselaer	12.0	12	819	See note 10.
Chicago-Port Huron, Mich. (See Chicago-Detroit under I.)					
Buffalo-Toronto (See Buffalo-Detroit under I.)					

See footnotes at end of table.

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SEGMENTS REQUIRED FOR INTERCITY PASSENGER SERVICE BUT NOT INCLUDED IN PRELIMINARY SYSTEM PLAN [REVISED MAR. 28, 1975]—Continued

Service affected	Segment	Length (miles)	USRA Line No.	Page[1]	Comment
III. ROUTES PREVIOUSLY RECOMMENDED BY NARP[2]					
New York/Boston-Cape Cod	Hyannis—Near Sandwich, Mass.	16.8	21	510	
	Buzzards Bay—Falmouth, Mass.	13.8	23-24	512	
Boston-Cape Cod	Stoughton—Easton, Mass.	5.6	25	513	See note 11.
New York-Pittsfield, Mass. via Danbury, Conn.	New Milford, Conn.—Housatonic, Mass.	53.5	60, 59	338, 398	
New York-Pittsfield, Mass. via Brewster, N.Y.	Wassaic—Ghent, N.Y., via Millerton.	44.7	66c, 67	602-3	
	Brewster—Near Mount Kisco, N.Y.	14.4	66	600	
Cincinnati-Indianapolis via Richmond, Ind.	New River Jct., Ohio—Richmond, Ind.	39.3	519/520	687	See note 12.
			520a	479	
Chicago-Grand Rapids via Kalamazoo (See Chicago-Detroit under I.)					
Grand Rapids-Mackinaw City via Cadillac.	Comstock Park—Cadillac, Mich.	92.4	454a, 461	549	
				543	
	Cadillac—Mackinaw City, Mich.	128.0	454	542	
Detroit-Mackinaw City via Saginaw.	Farwell—Cadillac, Mich.	43.4	1301	565	
	Cadillac—Mackinaw City (see above).				
Wilmington, Del.-West Ocean City, Md.	Farnhurst—New Castle, Del.	4.1	138a	401	

[1] Refers to page in Preliminary System Plan of the United States Railway Association where the segment is discussed.
[2] As listed in statement of Anthony Haswell before the Rail Services Planning Office of the Interstate Commerce Commission, ex parte 293 (sub-1), Mar. 28, 1974, except that the last entry (Wilmington-West Ocean City) was added for consistency with testimony of Orren Beaty at Salisbury, Md., before the Rail Services Planning Office in review of the Preliminary System Plan.

Note 1.—USRA notes that "an alternate route is available via Suspension Bridge" and that the Buffalo-Detroit service "is scheduled to shift to the Suspension Bridge route so that a stop can be made at Niagara Falls, N.Y." However, the latter route is 2.8 mi longer, and Amtrak should study retaining the shorter line for use by some of the corridor trains. In 1957, for example, New York Central ran 5 eastbound and 4 westbound daily Detroit-Buffalo passenger trains, of which only 1 eastbound train used the Suspension Bridge route, taking about 45 min longer than the other trains between Buffalo and Welland. Elimination of Line No. 101a might lead to discontinuance of the existing Buffalo-Toronto train since it is a Canadian Pacific service and the only practical Toronto-Suspension Bridge route belongs to Canadian National.

Note 2.—The superior alinement of this segment argues strongly for its retention, and against any attempt by Amtrak to consolidate with freight operations on another less direct route.

Note 3.—Amtrak's Chicago-Cincinnati trains are currently using the Chessie System via Muncie instead of Indianapolis due to track conditions. While it is imperative that the Indianapolis-Lafayette routing be restored, it would be possible at some expense to avoid Line No. 577a by using the Louisville and Nashville (ex-Monon) north of Lafayette, or by using Penn Central's freight line which runs north from Sheff and which USRA proposes to upgrade for freight traffic.

Note 4.—Amtrak should consider retaining thisjas its approach to Indianapolis (once service is restored). This route offers much better opportunities for locating a suburban passenger station, is subject to less freight train interference, and is 2.9 mi shorter than the Clermont-Davis routing. In addition, it offers the possibility of running specials to the speedway, which is connected to it by a short branch.

Note 5.—USRA stated that analysis on the 28.5-mi Michigan City-Buchanan segment would be completed "within 2 weeks," but that "it does not appear that this line segment is financially self-sustaining." These segments are also used by the Chicago-Lansing-Port Huron trains which are paid for partly by the State of Michigan, and would be required for Chicago-Grand Rapids via Kalamazoo service.

Note 6.—Freight operations may also continue to require this segment. The Public Utilities Commission of Ohio believes this is the only direct link between Buckeye Yard and the mainline north to Cleveland.

Note 7.—These tracks, which include the Pittsburgh passenger station, were to have been abandoned under a Port Authority rapid transit plan which is opposed by the Mayor and the Governor. NARP believes that Amtrak trains should continue to serve a terminal convenient to the business district, and should traverse the city on the most direct route possible.

Note 8.—This was a 75-m.p.h. main line used by Amtrak until Jan. 26, 1972. Currently, Amtrak is using a route which bypasses downtown Schenectady, has an inferior alinement which requires slower speeds, is subject to freight train interference, and is slightly longer. Restoration of the Schenectady route has the added advantages of making a connection with the Boston and Maine's east-west route and a downtown station possible.

Note 9.—Required if Amtrak were to use Cleveland Union Terminal, which is also served by the Windemere—Airport rapid transit line and several bus routes of the Cleveland Transit System and by the Shaker Heights Rapid.

Note 10.—Required for proper operation of the Boston-Chicago route if Amtrak uses the Penn Central between Springfield and the Albany area. (An alternative route via the Boston and Maine is feasible but would require capital investment to gain access to a passenger station in Schenectady, which in turn depends on restored use of USRA Lines 74 and 73. See note 8.)

Note 11.—This segment would be required only if the shorter Brockton route proves unworkable because of the Boston-Quincy-Braintree rapid transit line.

Note 12.—Amtrak may wish to consider this route because of the possibilities for suburban Cincinnati stops, including Hamilton which would also serve part of the Dayton area. The USRA report noted the possibility that the 14.1-mi. segment between Eaton, Ohio, and Richmond (Line No. 520a) might yet be included because of "the possibility of immediately increasing revenue." However, this route is 33.1 miles longer than the former Big Four via Greensburg, Ind.

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[From the Wall Street Journal, Tuesday, March 11, 1975]

REVIEW AND OUTLOOK

THE RAILROADS' FUTURE

As a plan for salvaging the bankrupt Northeast railroads, the United States Railway Association offers a 1,146-page, two-volume draft. Its most significant concept seems to be something called ConFac.

ConFac stands for Consolidated Facilities Corp., suggested in the plan as a potential owner of railroad rights of way and "structures"—rails, crossties, switches and the like. ConFac would be government owned and thus government would acquire and maintain rail highways much as it owns and maintains concrete highways, airports and air traffic systems and waterway facilities. Private railroads, principally the new ConRail to be formed out of the bankrupts, could use these facilities in return for a user fee just as truckers pay a weight tax, airlines landing fees, etc.

We do not see ConFac as opening the way to a bright future for the rail industry. All Northeast rail plans at this stage are, to a greater or lesser degree, Hobson's choices made necessary by years of politicized federal and state regulation, which has imposed costly cross-subsidization of uneconomic rail services, inhibited adaptations to changing conditions, brought about deferrals of maintenance and, finally, bankruptcy of a vital service.

But in that context, ConFac has one beauty. To wit, government would acquire direct responsibilities in railroading, whereas in the past it has dictated to the private railroads without accepting responsibility. If private rail companies merely became users of a public system, in the way that private truckers use the highways, the cost bases of various tansportation modes would seemingly be more competitive. And this would offer a sounder base for demanding more competition, and less federal rate and service regulation, among carriers of whatever transportation mode.

There is something to be said for having all transportation companies as operators and letting them charge whatever the market for the service dictates. That way, shippers and the nation would be on the way toward getting the maximum efficiencies of each mode.

Now this idea is of course a lot prettier in concept than it might prove to be in practice. Given the present physical state of the Northeast roads, ConFac would have to issue securities not only to acquire but also to rehabilitate them. Government borrowing is already dangerously swollen.

If ConFac's debt is to be liquidated over some reasonable period, as it should be, its initial amortization costs might run up its user fees. This might throw still more business to trucks or barges before rail operators could start offering the natural advantages of the rail mode.

More seriously, if ConFac took over only the bankrupt facilities, competitive lines that still own their own facilities—the Chessie and Norfolk and Western primarily—might be at a competitive disadvantage to the new ConRail. That, of course, will be a problem with almost any Northeast rail plan.

Finally, there is the natural problem of expanding government ownership of once-private property. It is easy enough to fear that this process would not end until not only rail facilities but rail operations were in government hands. The government's one venture into rail operations—Amtrak—shows what can happen. It is carrying passengers on some lines at many times what it recovers in fares but is yet under congressional pressures to retain or expand such services. Its deficits multiply.

We're not sure the reverse process, with the government getting into facilities but not operations, will work any better politically. The experience with the airlines is only so-so in that respect. But we are sure that transportation badly needs greater power to adapt to new needs and possibilities and should be put under greater competitive pressure to that end. We also are reasonably sure that, whether we like it or not, the government will become more directly involved in the railroads. ConFac is a Hobson's choice but it may be the best Hobson has available.

Mr. ROONEY. I think I asked all of my questions during your testimony. I want to commend you and your association for the tremendous job you are doing for the traveling public.

Mr Skubitz?

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Mr. SKUBITZ. It is hard for me to disagree with much of what you have said, Mr. Beaty. You pointed out, in your testimony, that Amtrak has been in operation for 4 years and is still using about the same type of equipment. Of course, each year Amtrak comes down, they use the same story, equipment, equipment, equipment. I have often raised the question, as far as equipment—a bucket of paint, some new seat covers, some Windex and rags, and some clean drinking water could answer a lot of complaints of the average passengers—dirty windows, dirty seats. We should put safety belts on the seats because of the roadbeds. I think we should start cleaning up what we have, while we are waiting for the new equipment. I don't think they have kept up with the times in that respect.

Mr. BEATY. I don't either, and part of the testimony I skimmed over alluded to some of this. But Amtrak has been using railroad passenger cars, some of which require steam type heating and air-conditioning. Some electric, and other types. The mechanics are not familiar with it. Something goes wrong and you will have a hot car all the way from Miami to Washington. The people swelter.

Mr. SKUBITZ. You should ride some of the trains in Europe. When we speak about our service, we should compare it with some of the improvements being made in other countries that have been pushing for years for better passenger service.

Mr. BEATY. I think the comparisons are good. If we can get some money together, maybe I will get a trip over there.

Mr. SKUBITZ. Mr. Chairman, I asked the Commissioner to place into the record some of the things that ought to be done to improve Amtrak to get it back on a paying basis. I think the figure $10 billion was thrown out as one of the costs.

Mr. ROONEY. I merely said that.

Mr. MACFARLAND. I didn't have that figure, sir.

Mr. SKUBITZ. The only point I raise, Mr. Chairman, is we are spending five times as much money today on the subway system here in Washington than we spent on Amtrak clear up to the year 1970. You are estimating right now. The estimate is it is going to take $3 billion dollars to complete METRO, and we have only spent about $600 million on Amtrak for the whole Nation.

Mr. BEATY. We think it is a modest expenditure.

If I may interpose, our organization really feels that inadequate use is being made of the additional surface rail systems in and around cities. Somebody should make use of the rails Southern Railroad has coming in from Manassas, coming in from the south. They could be providing service right now, within a year, a lot of commuter service at little expense, instead of letting those tracks sit there.

Mr. SKUBITZ. Did you see this article in the New York Times?

Mr. BEATY. Yes.

Mr. SKUBITZ. I would like to read it for the record.

March 10—it makes you weak when you read it.

Little Japan—it starts out March 10—

Mr. ROONEY. Do you want to make that part of the record?

Mr. SKUBITZ. I would like to read a little bit for the benefit of the people here.

At 5:40 a.m. today, Takahiro Inoue, a 10-year-old schoolboy, cut a ribbon at Tokyo Station to send a sleek blue and white electric train on its way to Hakata, 668 miles away on Japan's southwestern island of Kyushu.

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This afternoon, at 1:32, an identical train slid into Tokyo Station from Hakata. The two events marked the opening of the newest leg of this country's famed highspeed express train line.

It goes on to say that "Top speed is about 150 miles an hour". I have ridden the train and I know this is about right, and the average speed, including stopping, is around 95 miles per hour.

Opening of the new section cuts more than three hours from the rail time between here and Hakata. The air travel—this takes about 6 hours by train—the air travel is one hour and 40 minutes—you might say 2 hours—plus about an hour on either end getting to and from airports and waiting. That is 4 hours by plane for 667 miles and 6 hours by train. The train takes twice as long as the plane. A reserved economy seat on the train is $30.56 one way, compared with the economy air fare of $68.42, half the price.

Now, as far as their costs are concerned, they speak of a cost of $2.5 billion by the end of 1979 to meet their other new lines. The travel it says, on this new segment is something like a long subway train through mountain terrain, in and out of 111 tunnels. The longest tunnel is 11 miles under the Straits of Shimonoseki between the islands of Honshu and Kyushu. It is the second longest of its kind in the world.

Now, this shows what somebody else is doing that isn't as wealthy as this country.

[The article referred to follows:]

[From the New York Times, Mar. 11, 1975]

JAPAN EXTENDS HIGH-SPEED RAIL LINE TO HER SOUTHERN ISLAND

TOKYO, March 10—at 5:40 A.M. today, Takahiro Inoue, a 10-year-old schoolboy, cut a ribbon at Tokyo Station to send a sleek blue-and-white electric train on its way to Hakata, 668 miles away on Japan's Southwestern island of Kyushu.

This afternoon, at 1:32, an identical train slid into Tokyo Station from Hakata. The two events marked the opening of the newest leg on this country's famed high-speed express train line, known here as the Shinkansen, or New Tokaido Line, and sometimes called outside of Japan the "bullet train."

The newest segment, connecting the city of Okayama in central Japan with Hakata, which is part of the city of Fukuoka, brings rail travel time between Tokyo and Hakata down to seven hours, give or take a few minutes depending on the number of stops. The top speed is about 150 miles an hour and the average speed, including stops, about 95 miles an hour.

Opening of the new section cuts more than three hours from the rail time between here and Hakata. The air travel time is one hour and 40 minutes, plus about an hour on either and getting to end from airports, and waiting.

RAIL FARE MUCH LOWER

The train thus takes twice as long as a plane, but the fare is less than half. A reserved economy seat on the Shinkansen is $30.56 one way, compared with the economy air fare of $68.42.

The schoolboy who cut the ribbon this morning was chosen because he was born on Oct. 1, 1964, the day the new rail line went into operation between Tokyo and Osaka, Japan's second largest city. Since then the line has become the backbone of Japan's passenger travel, having carried more than 800 million passengers.

A second leg was opened between Osaka and Okayama in March 1972, and then the latest extension today, at a cost of $2.5-billion by the end of 1979, other new lines are scheduled to be in operation to Sapporo on the northern island of Hokkaido, to the west along the Japan Sea coast, and farther south on Kyushu to Nagasaki and Kagoshima.

Japan National Railways, the nationalized rail services operates two types of train on the Phinkansen, known as the Kikari or Light, and the Kodama, or Echo. The 23 fastest Hikari trains that will run daily from Tokyo to Hakata make only six intermediate stops at Nagoya, Kyoto, Osaka, Okayama, Hiroshima and Kokura. The more frequent and slower Kodamas stop at 28 stations.

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As the Shinkansen has extended its service, competing air and other rail travel has gradually been cut. Japan's airlines have already started reducing service into Tukuoka in anticipation of the new rail service opened today. Long-distance automobile travel here is in its embryonic stage since express highways are few and limited in length.

Traveling on the new segment of the Shinkansen is something like taking a long subway ride for the route runs through mountainous terrain in and out of 111 tunnels. The longest is the new 117-mile Kammon Tunnel under the Strait of Shimonoseki between the islands of Honshu and Kyushu. It is the second longest of its kind in the world.

Despite its progress, not everything goes well on the Shinkansen. The first train in from Hakata this afternoon was 12 minutes late, which is not unusal these days as the line's reputation for punctuality has gradually slipped in recent months. Nineteen other trains were delayed 10 to 35 minutes today because of power failures. Beginning last year, the Shinkansen has suffered a number of breakdowns most of them caused by fatigue in the 10-year-old line. The equipment has worn out faster than originally anticipated perhaps because it has seen much more and heavier use than was initially expected. There have been no major accidents.

In the United States, the closest approach to Japan's high-speed trains are the Metroliners, which average approximately 75 miles an hour between New York and Washington. Along some stretches of the route the Metroliners, which are electric-powered, reach speeds of 110 miles an hour. The trains are capable of 160 miles an hour, but the condition of the track requires them to go much slower.

The Metroliners went into service in January, 1969, and have registered steady increases in patronage each year. There are now 15 trains between New York and Washington in each direction every weekday, making the run in approximately three hours. In 1974 Metroliners carried 2,557,000 passengers.

Mr. ROONEY. I read an interesting article—will the gentleman yield?

Mr. SKUBITZ. Yes.

Mr. ROONEY. Last evening about a young lady traveling in a train. She had to pull the shade down every time the train stopped. The air-conditioning broke down and she had to disrobe from one end of the country to the other. Have you ever heard from her?

Mr. BEATY. No.

Mr. ROONEY. Any further questions?

Mr. SKUBITZ. I have no more questions.

Mr. ROONEY. The hearing on this matter is concluded and the committee will be in recess until tomorrow morning at 10:30, at which time we will mark up a bill.

[The following statement was received for the record:]

NATIONAL GOVERNORS' CONFERENCE,
Washington, D.C., March 14, 1975.

Hon. FRED B. ROONEY,
Chairman, Subcommittee on Transportation and Commerce, 2301 Rayburn House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: The National Governors' Conference wishes to submit this letter as its statement for the record of your hearings on the current status of AMTRAK.

The following is an excerpt from the policy position of the Governors:

"The Nation's Governors are concerned with reduced rail passenger service. We urge a reassessment of basic passenger needs and adequate federal funding to meet these needs. In addition, there should be a more significant role for the States in the determination of necessary services and facilities for a balanced rail transportation system. We strongly urge the federal Congress to review possible expansions of the Amtrak route system at an early date, and we further urge Congress to provide adequate procedures and administrative mechanisms for independent review of Amtrak decisions as they affect the various States.

"We continue to urge the National Railroad Passenger Corporation (AMTRAK) to re-evaluate its current approach to the problem of rail passenger service in the Nation. Amtrak must define long range goals for rail passenger programs in consultation with the States in addition to its current empha-

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sis upon operational problems. The Governors urge Amtrak to place more emphasis on its planning and thinking upon new and creative technologies and systems that will lead to an increase in rail passenger programs throughout the United States. In addition, Amtrak must strengthen its communications with State governments in order that Governors can play an important role in shaping the rail passenger systems of the future . . ."

In addition, the National Governors' Conference wishes to suggest the following ideas for your consideration:

The basic philosophy of Amtrak seems to have been to determine what passenger service should be abandoned, rather than to discover the means for stimulating modern, efficient, profitable service systems.

The Congress should require the execution of a comprehensive market analysis to determine what modern, speedy, efficient passenger service is needed. No such analysis has ever been conducted by Amtrak. Most of its management decisions concerning abandonment of service have been based on no analysis of the need for good service. Their decisions have been based on the fact that passengers refuse to use poor, inefficient, slow service. They continue to let the service deteriorate, then point to declining usage as a reason to discontinue service. The goal of Amtrak should be to develop new modern service along new and profitable corridors that will attract passengers and produce a profit.

Neither the Congress, nor the Amtrak have taken advantage of the experience of other nations with modern rail systems. Inviting these experts to testify before the Congress could prove profitable.

The concept that good rail service is an economic stimulant to communities across this nation seems to be missing from the Amtrak management philosophy. The product of Amtrak should be personal mobility, service, and economic growth. The people of our country will pay a fair price for good, safe, speedy personal mobility. Amtrak should reverse its philosophy and provide such service.

The Congress cannot any longer be expected to subsidize Amtrak blindly without more careful analysis of its management goals.

Several states have expressed interest in having some kind of a veto power over proposed abandonments of passenger service lines by Amtrak.

We appreciate this opportunity to submit these views for the record of your Committee.

Sincerely,

JAMES A. R. JOHNSON,
Special Assistant for Transportation.

[Whereupon, at 12 p.m., the subcommittee adjourned.]

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PUBLIC BROADCASTING OVERVIEW

HEARING

BEFORE THE

SUBCOMMITTEE ON COMMUNICATIONS

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

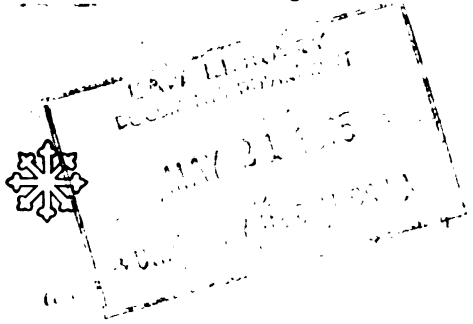
ON

ACTIVITIES IN THE FIELD OF PUBLIC BROADCASTING

MARCH 19, 1975

Serial No. 94–6

Printed for the use of the Committee on Interstate and Foreign Commerce



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PUBLIC BROADCASTING

WEDNESDAY, MARCH 1

HOUSE OF REPRESE
SUBCOMMITTEE ON CO
COMMITTEE ON INTERSTATE AND F

The subcommittee met at 10 a.m., pursua
Rayburn House Office Building, Hon. Torbe
presiding.

Mr. MACDONALD. The hearing will come
This morning the Subcommittee on C
the purpose of overview hearings on public
view hearing will provide a foundation fo
to be held next month on legislation to pr
for public broadcasting.

The Public Broadcasting Act of 1967 ba
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the public broadcasting community must b
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a significant financial commitment at a t
beset with far more pressing economic pro
surances that all those involved in publi
everything possible in order to achieve the id
the Commission Report.

One particular passage from that report
concerned, and I quote:

Public television is capable of becoming the cl
diversity, and of excellence within diversity. Wis
it must be, it will respect the old and the new alike,
nor worshipping the past. It will seek vitality in
modern experiment. Its attitude will be neither fe
short, a civilized voice in a civilized community.

That I have always believed to be the cre
and I take it that most of you do—and the
As one who has always strongly suppo
but who has not hesitated to offer construct
time—I hope it has been constructive critici

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PUBLIC BROADCASTING OVERVIEW

WEDNESDAY, MARCH 19, 1975

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON COMMUNICATIONS,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2359, Rayburn House Office Building, Hon. Torbert Macdonald, chairman, presiding.

Mr. MACDONALD. The hearing will come to order.

This morning the Subcommittee on Communications meets for the purpose of overview hearings on public broadcasting. This overview hearing will provide a foundation for more extensive hearings to be held next month on legislation to provide long-range financing for public broadcasting.

The Public Broadcasting Act of 1967 had its inception within this subcommittee, and the intervening years have not always been without conflict and controversy, both within and outside the Congress, as to the role of public broadcasting. These problems have often been related to how others perceive public broadcasting, but just as often have involved how public broadcasting perceives itself.

While it is not my purpose to deal directly in these hearings with the various proposals for long-range financing for public broadcasting, it is clear that multiyear funding differs from past practices in both concept and the level of Federal participation required. As a result, the public broadcasting community must be able to assure this subcommittee, and ultimately the entire Congress, that it deserves such a significant financial commitment at a time when this Nation is beset with far more pressing economic problems. There must be assurances that all those involved in public broadcasting are doing everything possible in order to achieve the ideals set forth in the Carnegie Commission Report.

One particular passage from that report stands out as far as I am concerned, and I quote:

> Public television is capable of becoming the clearest expression of American diversity, and of excellence within diversity. Wisely supported, as we conclude it must be, it will respect the old and the new alike, neither lunging at the present nor worshipping the past. It will seek vitality in well-established forms and in modern experiment. Its attitude will be neither fearful nor vulgar. It will be, in short, a civilized voice in a civilized community.

That I have always believed to be the credo of public broadcasting, and I take it that most of you do—and the panel members.

As one who has always strongly supported public broadcasting, but who has not hesitated to offer constructive criticism from time to time—I hope it has been constructive criticism, anyway—I hope that

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public broadcasting is now ready to accept the responsibility which it is seeking from the Congress. The purpose of these hearings this morning and of those next month will be to determine whether or not public broadcasting has arrived at this point.

I see a large panel. I was told that perhaps you would do it in two panels, but whatever way you want to do it is all right with me.

You have a voice to answer my questions, or how would you like to do it?

Mr. BENJAMIN. I would prefer, Mr. Chairman, with your blessing, to do it as we sat down, on the theory that this is one family of public broadcasting, there ought not to be segmented presentations. We are one mind in our goals, our purpose, and our efforts, and I therefore would like each of us or any of us to respond to any question of the chairman.

Mr. MACDONALD. Well, that of course is true this morning. I am not sure it has always been true. And I am not terribly sure that the fragile relationship is going to stay as solid as this panel is, but however you want to do it is fine with me. You may proceed.

STATEMENTS OF A PANEL CONSISTING OF ROBERT BENJAMIN, CHAIRMAN, CORPORATION FOR PUBLIC BROADCASTING; HENRY LOOMIS, PRESIDENT, CORPORATION FOR PUBLIC BROADCASTING; RALPH B. ROGERS, CHAIRMAN, BOARD OF GOVERNORS, PUBLIC BROADCASTING SERVICE; HARTFORD N. GUNN, JR., PRESIDENT, PUBLIC BROADCASTING SERVICE; MATTHEW COFFEY, PRESIDENT, ASSOCIATION OF PUBLIC RADIO STATIONS; AND LEE FRISCHKNECHT, PRESIDENT, NATIONAL PUBLIC RADIO

STATEMENT OF ROBERT BENJAMIN

Mr. BENJAMIN. Thank you, Mr. Chairman.

I am Robert S. Benjamin, chairman of the board of the Corporation for Public Broadcasting. Please permit me to thank you for the opportunity to appear before you.

Almost every year public broadcasting representatives have come before Congress to review past achievements. I have been involved in this process as a member of the CPB board for 7 years myself, and I can say without reservation that the corporation and all of public broadcasting have never been in a better position to report to you than today.

During the last 2 years, public broadcasting has made solid progress in sorting out the responsibilities and appropriate roles of its constituent organizations; in planning for its future; and in working together to use its limited resources and staffs to achieve our basic reason for being—to provide high quality public television and radio programs for the American people.

Public broadcasting is, after all, a very young and evolving structure. People tend to forget that public radio and public television began as educational radio and television—an electronic extension of the classroom. The Congress, by passing the Public Broadcasting Act of 1967, pulled the loosely allied educational stations together and launched public broadcasting.

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The corporation was incorporated in 1968 and interconnection services were begun in 1969. Current full-service interconnection services began in December 1972. The Public Broadcasting Service, PBS, was formed in 1970, and a year later National Public Radio, NPR, began its activities. Some say that public broadcasting has now reached adolescence and may even be nearing maturity. There certainly is growth toward understanding and confidence in each other by the national organizations, and the local stations.

I can now report to you that the CPB board sees as its major role the active pursuit of collaborative efforts by the stations, their representatives, and CPB to achieve short-term and long-term goals. These goals take into account the broadcasting sovereignty of the local station within its community, and the broad discretion, authority, and responsibilities given to CPB by law.

The record shows that CPB, together with public radio and public television, is making progress in many directions.

One. Federal appropriations have risen from $5 million in fiscal 1969 to $62.5 million in 1975. As a result of increased memberships, private gifts, and State and local government contributions, non-Federal contributions have more than doubled since 1969 and have exceeded $220 million in 1974.

Two. Direct financial grants, community service grants, from CPB to local radio and television stations total $29 million in 1975.

Three. The number and quality of national television programs have increased substantially. These, together with locally produced or acquired programs, give local stations more flexibility and diversity than ever before in meeting the needs of their audiences. The three main sources of TV programs available nationally are the Station Program Cooperative, through which stations purchase programs; underwritten programs available to all stations; and new and innovative programs paid for wholly or in part by CPB which are also available to all stations.

Four. Radio programs are available through the high quality service of National Public Radio, NPR, with immediate two-way communications access to national and local news, public affairs, and entertainment.

Five. Research and development of television program pilots is underway at CPB, with the corporation serving as a clearinghouse through which program gaps are identified, and programs to fill these gaps developed.

Six. In the field of new technology we have under serious consideration the use of satellites for the distribution of radio and television programs. Our experiments with captioning for the deaf on TV and closed-circuit broadcasts for the print handicapped on radio are providing a new dimension of public service.

Seven. A blueprint for CPB's role in educational uses of the broadcast media, conducted under the auspices of the Advisory Council of National Organizations, ACNO, will be reviewed and acted upon by public broadcasting representatives in the next few months.

Eight. CPB has better knowledge about public broadcasting's audience than ever before. Ascertainment by more local stations, as well as more CPB research, has given us a better understanding of the number and variety of our audience.

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Mr. Chairman and members of the committee, the close collaboration that the corporation has entered into with public radio and public television is intended to assure the closest possible communication, exchange of information, and joint planning; joint review of past activities; the solicitation of the reaction of one another prior to important decisionmaking; and the meshing of program ideas and proposals—all in order to minimize the danger of waste and increase the probability of acceptance. In short, to communicate, collaborate, and combine forces in thinking, planning, and programing. I believe the list of specifics I just presented, along with other projects and accomplishments, indicate that all of public broadcasting is working together harmoniously.

We are making progess, but we aren't there yet. The most fundamental need of public broadcasting, specifically proposed by the Carnegie Commission in 1967 and sought by the Congress since, has not become a reality.

The Corporation for Public Broadcasting needs long-range insulated funding legislation if it is to meet its objectives and its responsibilities. This legislation is needed to assure that future planning will be possible to further improve the quality and diversity of programs and services of local stations; to assure the independence of noncommercial radio and television for the Nation; and to create the incentive needed to encourage American families and other sources of non-Federal dollars to continue to invest in public broadcasting

Mr. Chairman, my colleagues and I are encouraged by the introduction of the Public Broadcasting Financing Act of 1975 in both houses of the 94th Congress. We are especially encouragd because of your personal support over the years for adequate insulated funding. As you and the committee members begin the legislative action on this bill, you can rest assured of public broadcasting's unity of purpose, common goals, and dedication to providing the best possible service to our constituency—the American people.

Now Mr. Chairman, you have received a letter——

Mr. MACDONALD. I have.

Mr. BENJAMIN [continuing]. From Dr. Killian.

Mr. MACDONALD. And I thought that first I would have identified for the record all the people who are working for it on your side of the aisle, so to speak, on the panel, and then I will introduce Mr. Killian's letter into the record, following that.

Mr. BENJAMIN. Thank you, sir. I was just going to list the members of the panel.

Mr. MACDONALD. Why don't you just take the CPB?

Mr. BENJAMIN. Thank you. Then I am finished, and I thank you very much. This is Mr. Henry Loomis, president of the Corporation for Public Broadcasting.

Mr. MACDONALD. And that is Mr. Robert Benjamin of New York.

I have received a letter from James R. Killian, all along a stalwart in this field, regretting that he is unable to be here, and giving his blessing to Mr. Benjamin, who has just concluded his statement, and also to Henry Loomis, who is not only doing a good job, but was a student of his, I understand, at MIT at one point.

So, without objection, Mr. Killian's statement will appear in the record following that of Mr. Benjamin.

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[The letter referred to follows:]

JAMES R. KILLIAN, JR.,
77 MASSACHUSETTS AVENUE,
Cambridge, Mass., March 17, 1975.

HON. TORBERT H. MACDONALD,
U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN MACDONALD: I have just heard of the public broadcasting hearing you have called on Wednesday and I regret ever so much that I cannot join the group that plans to appear. This letter is to express my appreciation that you are undertaking an overview.

I wish I were free to be present in person to emphasize my view that public broadcasting has made great strides this past year. The CPB–PBS partnership is working with an impressive degree of unity, public radio is showing increasing vigor, and public television programming has never included so much variety and exceptional quality. Dr. Edwin Land, who was a member of the original Carnegie Commission and is a perceptive critic, spontaneously called me the other day and said that he had had an opportunity on several recent occasions to watch public television programs and that he felt that the dreams we had back in 1967 were beginning to come true and that he watched programs that were of exciting quality and interest.

Two aspects of public broadcasting, however, remain to be accomplished. One is the long-awaited Presidential appointments to fill vacancies and expired terms on the Board of CPB. I hope that the Board will soon be brought up to full strength by appointments that fully meet the qualities of distinction and leadership. The other unfinished business is, of course, the crucially important achievement of long-range financing. All segments of the public broadcasting community strongly support the Long-Range Financing Bill that is now before Congress and feel that if this can be accomplished, a milestone would have been reached in the development of public broadcasting. I wanted particularly for you to know how strongly I support the proposals that are now before the Congress and how vitally important I feel it is to get away from annual appropriations.

I am immensely pleased that Robert Benjamin is now chairing the CPB Board and that Henry Loomis is providing excellent administrative leadership. We have a strong team.

In saying these things, let me further add that if the occasion arises, I would be glad to appear if I can at any later hearings that take place and that I regret that long-standing commitments prevent my getting to Washington on Wednesday.

I also wish to salute you for the strong leadership which you have provided in insisting on the importance of unity among the elements of public broadcasting and in wisely supporting sound measures which have come before Congress.

Yours cordially,

J. R. KILLIAN, JR.

Mr. MACDONALD. Appearing for Public Proadcasting Service this morning, Mr. Ralph Rogers and Mr. Hartford Gunn.

Are you prepared to go forward at this time?

STATEMENT OF RALPH B. ROGERS

Mr. ROGERS. Thank you, Mr. Chairman.

I am Ralph B. Rogers, chairman of the board of governors of the Public Broadcasting Service—and Hartford N. Gunn, at my side, is the president of the organization.

The Public Broadcasting Service is an independent, voluntary organization owned and operated by the 151 public television licensees. They in turn operate 253 public television stations in the United States, Guam, American Samoa, and Puerto Rico.

The board of governors of Public Broadcasting Service—all of whom serve without compensation—are elected by the licensees and are advised by a board of managers, also elected by the licensees.

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If there is a question before the meeting today as to whether there is unity in the public broadcasting family, the simple answer is that on fundamentals, there is complete unity. As you well know, differences of opinion may arise between strong and dedicated people, and that is in our best American tradition. No one would want to or like to see a dictatorship over media as important as public television and public radio.

The question is not whether or not there are disagreements from time to time. The real question is whether the institutions which exist in the public broadcasting family have the desire, will, and machinery to resolve these differences, and the answer is, we do.

Since we last appeared before you in 1973, public television stations have accomplished much. Stations have been able to increase anp improve their local program services to their communities. There are strong State and regional program services. The national programing which PBS distributes has been substantially improved. Stations provide educational programing to schools, at all grade levels. There are programs for senior citizens, job marts for the unemployed, local sports, music, art, and public affairs programs. Some broadcast school board, city council, and State legislative sessions. Nationally, there are programs of music, sports, and public issues: There are programs for the handicapped, such as our captioned news for the hearing-impaired, plus a wide variety of programing seen no other place.

The improvements in these national program services reflect foundation funds, grants from corporations, and Federal funds. In the past year, many of the national programs have been funded in part by the stations themselves, using money from their viewers, from their States, and from private and Federal sources. This new process is called the station program cooperative. It is the most locally responsive process developed anywhere in the world.

We're pleased with the response the local and national programs have received. Audience studies show that 32 percent of the Nation's homes tune in at least one PTV program a week, and 49 percent at least once a month. Our aim is to serve special target audiences with each program. This results in small per-program audiences by commercial entertainment standards, but because we offer so much diversity in our schedules, aiming at so many different targets, by the end of the week we have served a very substantial number.

The public is increasing its direct support of our operations and programing. Previously about 1 million individuals and families had contributed an average of $20 each to become members of their local station. This past week we helped set up the first nationally coordinated membership drive. Ninety-three licensees held membership and public campaigns. We estimate that the compaign has produced well over 200,000 new memberships and more than $4 million. Here in Washington, for example, WETA, channel 26, received over 6,600 new pledges totaling over $171,000. We hope to have 3 million individual and family memberships in less than 3 years.

There is still a long way to go before we are satisfied that public television is doing the job we believe it can do. Our goal is an independent public television system in which each community has the technical and financial resources to use its public television system to

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its full capabilities. This requires adequate local and Federal long-range funding. There will have to be improvements in the UHF delivery system. Possible new developments in satellite capabilities may link our stations together more economically and effectively, as well as enabling us to reach people beyond conventional TV signal range.

There is much more to do for educator at all levels—in schools and at home, and much more for all citizens in many other ways. The continuing assistance of educational broadcasting facilities grants are necessary for the public TV stations to obtain the equipment and power they need to be truly independent and vital assets for their communities.

We will be glad to answer any questions, to the best of our ability.

Just one more word, Mr. Chairman, if I may.

My first association with public broadcasting at a national level and before the Congress was in a hearing room very much like this one, before a committee, this same subcommittee, which you chaired. And at that time I was not active on the national scene, and I was trying to learn what this was all about.

I remember at that particular time, that you—I won't use the term "castigated" the various witnesses that appeared before you, because that may sound strong—but I would say you were very emphatic in saying that public broadcasting must come forward with a long-range financial plan. There could not be the progress without insulated long-range financing, and the failure on the part of the administration, the failure on the part of public broadcasting itself, to come forward with such a plan was one which was inexcusable, and that you expected this job to be done, and would insist on its being done.

Now, this job has been done. I am not sure it ever would have been done if you hadn't been so emphatic, but is has been done. And the time has come now, and in the hearings which you will hold in the next month, as I understand it, to tackle that job and get that job done, because it is every bit as important as you said it was then.

But there is one major difference. For many years you have stood virtually alone in carrying on the developing of financing for public broadcasting in the House of Representatives, and to a large extent in the Nation itself. Today you have behind you—I hope not too far behind—151 licensees. You have involved boards of laymen. You have literally millions of people today who understand what public broadcasting is, who endorse public broadcasting, and who are willing to fight for public broadcasting, and to follow the leadership which you have provided and which I am confident you will provide in the future.

And, although there are many problems in obtaining the proper kind of insulated long-range funding, it is my personal opinion that the time has come, and the people exist, to help get this job done now.

Thank you, Mr. Chairman.

Mr. MACDONALD. I just want to thank you, Mr. Rogers, for your very kind words. But I would like to point out to you as well that the Appropriations Committee—we are the first hurdle, but the Appropriations Committee and the subcommittee chaired by the gentleman from Pennsylvania, Daniel Flood, is also of great importance, and he

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too has appeared, I think, the first or second time around to become an advocate of public broadcasting, And so I—while it is a softening up process to tell me I was virtually alone, I had help, and I may be getting a little disenchanted, as others become enchanted.

I have some questions that I would like answered before I go on the record supporting your entire desires in this matter, but we will get to them, I think.

We have Mr. Matthew Coffey, president of the Association of Public Radio Stations, and Mr. Lee Frischknecht, president of the National Public Radio.

STATEMENT OF MATTHEW COFFEY

Mr. COFFEY. Thank you, Mr. Chairman.

I am Matthew Coffey, and I will be speaking for both organizations today in the interests of the subcommittee's time.

On behalf of the Nation's public radio stations I want to thank you for the opportunity to be here today to survey the present state of our service to the American public.

Public radio started in 1967. It started as a direct result of this subcommittee's efforts when you included radio in what became known as the Public Broadcasting Act and the Educational Broadcasting Facilities Act.

Public radio stations now serve just over 60 percent of the American public. In the next 5 years it is our goal to serve up to 90 percent of the population with local service.

Radio is a uniquely local service with the overwhelming percentage of programing being produced by local stations. Over 70 percent of all programs broadcast last year originated at the local stations while 15 percent of programing was provided by national interconnection service from National Public Radio.

I might explain, Mr. Chairman, that the Association of Public Radio Stations is an educational sasociation, and which was created by and funded by the stations, while Natioanl Public Radio is the program production and distribution system for national programing.

National Public Radio was created by the licensees of the public radio system in 1970 for the express purpose of providing unique program services which cannot be produced or acquired by the individual stations. The creation of NPR and its continued existence is largely due to the efforts of the Corporation for Public Broadcasting which provides the bulk of the funds for NPR operations. Mr. Frischknecht is here with me today to respond to any questions you might have about the National Public Radio and the national broadcast service.

Radio in our society has to be thought of as a distinctive service because of the extremely competitive environment in which radio operates. While there are many rural areas where public radio may be the only local broadcast programing, in major population centers that is not the case. For instance, here in Washington there are in excess of 40 licensed stations including three public radio stations.

Public radio stations have sought to fill the voids left by commercial radio and to provide unique services that may over the years stimulate changes in the entire radio community. Classical music programing is an example of the former while the award winning public affairs programing of National Public Radio represents the latter.

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NPR program offerings to member stations include the Peabody award-winning current affairs program, "All Things Considered," gavel-to-gavel coverage of congressional hearings, and other significant public events such as conventions, conferences, and speeches. The service includes cultural programs of performance and information about the arts and humanities.

The program service is characterized by several important elements that we believe are unique to our system:

1. Length—NPR service provides full and complete coverage of or information about an event or a subject, not just edited versions.

2. Depth—NPR gets at the why of the subject by analyzing and providing background to provide the listener with perspective.

3. Immediacy—NPR transmits, whenever possible, events at the time they happen; or at second best, retransmits them exactly as they happened.

4. Decentralization—to insure that the NPR service be a truly national service by utilizing widely diverse sources to obtain the materials for programs. Chief among these sources are the staffs of the member stations. Also materials are secured from many independent producers and reporters and from the British Broadcasting Corporation, the Canadian Broadcasting Corporation, and Radio Nederland which provide an international element to the service.

Part of the program service is designed in the form of complete programs that the stations may choose to use at the time of delivery or record for use at another time more appropriate for their local needs. Other materials are distributed in modular form intended for the station to record and incorporate into local productions as appropriate. The average hour of NPR programing is used by about 60 percent of the member stations.

In order to provide these services, NPR maintains staff, studios, and distribution facilities in Washington, D.C., and presently has bureaus in San Francisco and New York City. They lease 15,000 miles of long-line circuits from A.T. & T. and other common carriers for the interconnection system which is used both for program production and distribution.

Mr. MACDONALD. I hate to interrupt. I just make a comment. Does A. T. & T. donate any of those line services, or give you a cut rate?

Mr. FRISCHKNECHT. There is a reduced rate. There is no donation of service, but the rate is reduced.

Mr. MACDONALD. By about how much?

Mr. FRISCHKNECKT. We pay approximately 40 percent of the standard commercial rate.

Mr. MACDONALD. They have just been granted a rate increase, as you know.

Mr. FRISCHKNECHT. Yes, but that rate increase will not affect National Public Radio services.

Mr. COFFEY. The positive beginnings that public radio has made over the past 8 years require continued support if we are to develop the kind of significant service the public deserves. That is one of the reasons the stations across the country and National Public Radio strongly support passage of long-range financing for the Corporation for Public Broadcasting and renewal of the Educational Broadcasting Facilities Act.

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The stations need major changes in the way they are regulated by the Federal Communications Commission. In 1946 when the Commission set aside the noncommercial portion of the FM band, it did not create a table of assignments. In 1948 it allowed the operation of 10-watt stations in the noncommercial band.

These two decisions have brought us to a crisis point. Today there are 36 major population centers that have no public radio service and most of these will never have the service unless regulatory policy is changed. In most of these population centers, the frequency spectrum has been filled with 10-watt stations. Larger power stations are not allowed in the market because 10-watt stations block all frequencies. If the Federal Communications Commission had a table of allocations as they do in commercial broadcasting, this problem would never have happened. A petition has been pending for 3 years at the Federal Communications Commission to try to alleviate this problem by establishing a table of assignments and limiting 10-watt stations.

The passage of the All-Channel Radio bill by the Senate and its favorable consideration by this subcommittee and the full Commerce Committee in the last session was heartening to the public radio community. Public radio is almost exclusively on FM frequencies. Only 20 of 176 stations are on AM frequencies.

During the course of House and Senate hearings, several interesting facts came to light.

1. The only data available on FM sets in use came from the manufacturers and therefore must be viewed with some skepticism.

2. The manufacturers of car radios are the car manufacturers. By monopolizing the market they have kept the number of FM sets in cars to 10–20 percent of cars sold.

3. The profit to the manufacturer on AM-only radios is 87 percent of the price and although adding FM is a minor cost, the manufacturer is doubling the price.

4. New integrated circuit technology is avilable to reduce the cost of production for the AM–FM stereo radio below present costs for the AM-only car radio.

This subcommittee, as part of its consideration of the all-channel bill, called on the Justice Department to investigate the monopoly characteristics of the pricing of automobile radios. In response to the subcommittee's request, the Justice Department is conducting a vigorous investigation which quite possibly will result in suits against the auto companies and their radio subsidiaries in the near future.

The Federal Trade Commission is also investigating parallel pricing among the auto companies at the request of the Senate Commerce Committee. We hope all these efforts will succeed in solving a problem of crucial importance to the continued growth of public radio.

There is also a need to improve the NPR interconnection system. High fidelity and stereophonic broadcasting is the standard in public radio since virtually all of the stations operate on FM frequencies that permit such standards. But the interconnection system presently available is limited to voicegrade quality and no stereo.

In addition, the system is largely one-way going out from Washington which makes it difficult to implement the decentralization concept without sacrificing quality, length, and immediacy by resorting to inferior telephonic transmission. We believe that communication satellites hold promise for meeting these needs.

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Another matter that affects the continued growth of the public radio stations is the current consideration of copyright revision. Under the present law public radio is exempt from copyright payment. If H.R. 2223 is passed in its present form, it would take as much as 25 percent of the current average operating budget to comply.

The result of this will be that classical music, for instance, will all but disappear from radio in the United States. As you already know, it has virtually disappeared from commercial radio, and we are the last remaining broadcasters of it, and the result would be as bad for classical music composers in this society as it is for the listeners. We hope that this subcommittee will carefully observe this legislation as it moves through the Congress.

There is an overwhelming need to make more people aware of National Public Radio and its services. Those who use it are enthusiastic but are often frustrated by their inability to know of specific programs and services. New ways must be found to inform more people of the service.

A key to solving this problem lies in strengthening the local stations and giving them the tools to create attractive local programing and publicize their services. Of course, as the capabilities of the member stations improve, the national program service will be a beneficiary of both their programing and their increased awareness among the public.

Mr. Chairman and members of the subcommittee, public radio is at a beginning point in availability and service to the public. I have mentioned only a few areas that affect public radio's growth. These areas were selected because of their significance to this subcommittee.

I hope each of you will take the opportunity to visit the stations in your own State or during travels to other parts of the country. Please call on the Association of Public Radio Stations for information on any matter of concern involving public radio.

Public radio needs your continued support and assistance in order to improve and expand its service to all of the American public.

Mr. MACDONALD. Thank you, Mr. Coffey. I might say that I think you have been treated sort of as a retarded child in public broadcasting. You might be interested in knowing that I have already written the gentleman from Wisconsin, Congressman Kastenmeier, who has the copyright responsibility, and he, as of yet, has not scheduled hearings, but I certainly will recommend that you appear before that subcommittee with your dilemma.

Mr. COFFEY. We will do that, sir.

Mr. MACDONALD. When the hearings are held, I will also appear.

Mr. COFFEY. Thank you.

Mr. MACDONALD. If the panel has nothing else, I think that the subcommittee may turn to questioning.

I am going to try and operate under the 10-minute rule, not the 5-minute rule, because I find that the chairman gets engrossed in a subject, and just developing something can take 5 minutes, and so we will go 10 minutes. Remind me if I go over the 10 minutes, and then we will come back for another round.

The question I have of the CPB is, are your meetings open to the public?

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Mr. BENJAMIN. No, not regularly. We have had one open meeting, and propose to have another, and I hope that that process will be enlarged and the number of open meetings will be expanded. We have been waiting too, Mr. Chairman, for a new board to enter in this decision with us.

Mr. MACDONALD. As chairman, can you decree it, or do you have to have a vote of the board?

Mr. BENJAMIN. I think I have to have a vote of the board.

Mr. MACDONALD. Well, if you only think it, I would find——

Mr. BENJAMIN. Mr. Chairman, we have always acted as a board, in every policy decision.

Mr. MACDONALD. Yes, I was being half facetious, but I do think, inasmuch as it is public broadcasting, that the public has a right to know what is going on as far as the decisions that affect it so directly.

When do you think that you will go to the board and see if you can open up the meetings?

Mr. BENJAMIN. As quickly as I feel I am the continuing chairman. I have been kind of——

Mr. MACDONALD. Well, I saw you on the list.

Mr. BENJAMIN. Well, that was yesterday, Mr. Chairman. Even then, I have to be not too presumptuous, and assume I will be confirmed. But, to answer your question more directly, I will undertake to have an open meeting at the first possible moment.

We deal with a board now that is very small because of the vacancies and disengagement of some who know they are not continuing. Therefore, we have barely an ability to get a quorum, and there are people who have strong feelings about having open meetings. Some feel that not all meetings should be open, because it curtails discussion, analysis, and internal kinds of dialog that should be encouraged.

Mr. MACDONALD. Well, I would think the ordinary meeting should be open, and if you have something you feel should not be open, by majority vote you can close the meeting for that particular day. But I know a number of the good citizens who are on the board have come out very strongly to have open meetings in the Congress. We have followed their dictates—not dictates but advice—and also of many other people, and all our sessions except those dealing with national security or something like that are open and I would urge that you do the same.

I believe that the meetings of PBS are open to the public.

Mr. ROGERS. All the meetings of PBS are open, including committee meetings and executive committee meetings and so forth. The only time that we ever close a meeting is when a personality is involved, or there is some item of that kind, and I don't remember closing any meetings. They are open to the press, too.

Mr. MACDONALD. Have you had any adverse effects from having open meetings?

Mr. ROGERS. No. I think at the beginning it came as quite a shock to a lot of people, but after they had a little experience with it, there has been no problem whatever.

Mr. MACDONALD. I hope you share the same experience. I was not 100 percent for open meetings up here, but it works out very well.

Mr. BENJAMIN. As you know, Mr. Chairman, if I may tell you, we have recently opened up the proceedings of our board meetings to representation from PBS and radio. That is some progress.

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Mr. MACDONALD. Well, if you are saying you are one big happy family you can't close the door to a relative. [Laughter.]

Well, I can only urge that you take this up as soon as you are confirmed and feel strong enough in your position, and knowing you, I think that won't be too far away. Put this high on the agenda.

Mr. BENJAMIN. I promise that.

Mr. MACDONALD. The second problem that is bothering me, and I say this from a political standpoint, as far as when the bill and—when and if the bill hits the floor, and also from my own feelings about the matter, is to go in a little more carefully than this subcommittee ever has, as to minority representation and employment of the minorities.

For example, what is the situation with regard to employment of minorities in professional positions by public radio and television broadcasting stations? As I understand it, the record isn't too outstanding anywhere. And when I say minority, I am not just talking about blacks. That includes Chicanos, Indians, and women, if they don't mind being put in that same category. It seems to me that from the information I have, the minorities are not terribly well represented, and if you recall on the floor last time out, I had a good deal of difficulty defending the bill against certain criticisms from the women's lib members and also the Black Caucus members. I defended the bill just as vigorously as I could, because I was being an advocate but at the same time, I thought they had something to say of substance.

But I was interested in getting the bill through at that time. So I argued with them. You may be living up to the equal employment standards, but I don't think that is enough anymore.

Does anyone want to be heard about that?

Mr. LOOMIS. If I may respond to that, Mr. Chairman, in fiscal year 1974, 12.2 percent of the total full- and part-time employment at public TV stations was minority, which is in the same ball park as the commercials, or slightly better. I think what should be looked at is the rate of change, because unless you are going to fire incumbents, it is very difficult to change overall the percentage very rapidly, if you are not growing very rapidly.

In the case, for example, of full-time employment, the total of full-time employment from 1971 to 1974 has increased 13 percent, but the numbers of minority have increased 51 percent. Now, of course, you are dealing with a small number as a base but the point is that the numbers of minorities and growing significantly faster than the total employment.

This is particularly true when it comes to women, this is all women, irrespective of race. Males increased 11 percent in the period fiscal years 1971 to 1974; females increased 18.3 percent in the same 4 years. And the biggest increase of all among the females were minority females. They increased 69 percent in the same 4 years.

Mr. MACDONALD. Well, in the annual report put out by the Corporation for Public Broadcasting, some of what you say is backed up but the other part indicates that of the number, and we are talking about 8,000 full-time employees of public broadcasting, less than 30 percent are women, and then they say, "Of that number, most were in secretarial, clerical, or custodial positions."

Do you have any breakdown of how many minority employees you have in professional positions?

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Mr. LOOMIS. I think I have information here by the top four positions, if I can find it. Of the top four positions at public TV stations in 1974, the percentage of minorities total was 1.9 percent. That was for general managers, station managers, operations managers, and program managers.

Mr. MACDONALD. Well, that isn't very outstanding, is it?

Mr. LOOMIS. No, sir. Males are 1.8 and females are 4.5. That is a problem that we recognize, and as I said previously, the problem is that there isn't much turnover, particularly at the highest levels, so there are not many vacancies coming along.

Mr. MACDONALD. Well, Mr. Loomis, I don't mean to quarrel with you or anything, but I do remember you saying that you needed more money to pay better salaries because you were constantly losing many of the younger professionals. So what happened to that?

Mr. LOOMIS. Well, in the medium-level grades, rather than the top grades, more minorities and women are employed. However, they often move into commercial broadcasting out of public stations.

Mr. MACDONALD. Well, I am not just talking about the top grades. I am talking about all professional positions. Cameramen, all that.

Mr. LOOMIS. The specific figures I have mentioned here only involved the top four, the most senior jobs.

Mr. MACDONALD. No, I am talking about professions. Cameramen, directors, producers, writers. Staff news people.

Mr. LOOMIS. I have the total and I have the top, and I don't have the professional employment statistics with me. I can supply it for the record very easily.

Mr. MACDONALD. Well, if you would do it as soon as possible. I know that is a subject that will be well scrutinized by different groups, and then raised on the floor.

Mr. LOOMIS. While I don't have the statistics with me——

Mr. MACDONALD. I would like some strong backup.

Mr. LOOMIS. I understand that, Mr. Chairman.

[The following material and letter were received for the record:]

HIGHLIGHTS OF DATA ON MINORITIES AND WOMEN EMPLOYED IN PROFESSIONAL AND TECHNICAL POSITIONS IN PUBLIC TV AND RADIO STATIONS

Given the tight fiscal constraints on most public broadcasting stations over the past three years, and the corresponding low percentage increase in total employment, there is strong evidence that the stations have engaged in rigorous affirmative action by hiring minorities in professional/technical positions. While the percentages of minorities in professional/technical positions was 8.9% in fiscal year 1974, this represented an increase of 50.7% over the FY 1972 figures for numbers of minorities employed. (See Summary Chart attached.) During the same period the number of women employed in professional and technical positions increased by 58.9%, while total employment in professional and technical jobs increased by only 25.6%. Therefore, minority employment expansion in professional and technical positions was double the rate of system expansion from 1972 to 1974. Not only are minorities and women being hired for new positions, they are also being hired to fill vacancies as they occur.

UPWARD MOBILITY

Public broadcasting's commitment to training and affirmative action is evidenced by the high concentration of women and minorities in the category of professional/technical positions other than the top four or five at a station (Upper Management). These are the jobs where upward mobility is encouraged, and where some is already evidenced. For example, overall employment in the Upper Manage-

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ment category increased by only 19.7% from 1972 to 1974, however, minority employment in that category increased 80.0% and employment of women increased by 25.9%.

Another evidence of the commitment public broadcasting has to affirmative action is the change during the last year (FY '73–'74) in employment for professional/technical positions other than the Upper Management category. During the period FY 1973–1974, tight budgets in public broadcasting allowed only a 12.4% increase in total employment within the category, yet employment of minorities and women continued to rise at a rapid pace.

FURTHER INFORMATION

The attached charts contain information regarding the employment patterns of public television and public radio licenses for fiscal years 1972 through 1974.

The Summary Chart provides percentages of employment at public television and radio stations broken down into several categories and sub-categories. The percentages are calculated from detailed data provided in Charts A and B (Employment Statistics of Public Television and Public Radio Licensees).

FORMAT

Charts A and B categorize the information for professional and technical employees by the major functional categories of Administrative and Managerial, Production and Programing, and Technical functions. Each of these functional categories is subdivided into Upper Management positions and Other Professional Staff positions. The exact job titles classified under each section are listed in the footnotes for each chart.

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EMPLOYMENT STATISTICS OF PUBLIC BROADCASTING STATIONS—SUMMARY CHART

[In percent]

	1972		1973		1974		Percentage change, 1972-74			Percentage change, 1973-74		
	Minority	Women	Minority	Women	Minority	Women	Total employment	Minority	Women	Total employment	Minority	Women
Total employment	9.3	26.9	9.7	27.7	10.7	28.9	+21.5	+41.1	+30.4	+12.5	+25.0	+17.4
All professional/technical	7.4	15.0	8.1	19.1	8.9	19.0	+25.6	+50.7	+58.9	+11.9	+23.4	+11.2
Upper management	2.2	6.0	2.7	6.3	3.3	6.3	+19.7	+80.0	+25.9	+9.3	+33.3	+7.9
Other professional/technical	8.5	16.8	9.1	21.6	10.0	21.4	+26.8	+49.2	+61.2	+12.4	+22.8	+11.4
All nonprofessional (clerical, custodial, etc.)	17.5	80.2	18.8	76.5	20.9	83.2	+2.7	+22.7	+6.5	+16.1	+28.9	+26.2

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CHART A

EMPLOYMENT STATISTICS OF PUBLIC TELEVISION LICENSEES

Television stations	1972			1973			1974			Percentage change 1972–74		Percentage change, 1973–74	
	All employees	Minority	Percent minority	All employees	Minority	Percent minority	All employees	Minority	Percent minority	Total	Minority	Total	Minority
Total employment:													
Male	4,183	362	8.7	4,364	390	8.9	4,828	465	9.6	+15.4	+28.5	+10.6	+19.2
Female	1,588	192	12.1	1,732	225	13.0	2,028	294	14.5	+27.7	+53.1	+17.1	+6.9
Grand total	5,771	554	9.6	6,096	615	10.1	6,856	759	11.1	+18.8	+37.0	+12.5	+23.4
All technical and professional employees:													
Male	3,951	287	7.3	4,132	324	7.8	4,626	381	8.2	+17.1	+32.8	+12.0	+17.6
Female	679	65	9.6	964	103	10.7	1,064	129	12.1	+56.7	+98.5	+10.4	+25.2
Administrative and managerial:													
Male	183	4	2.2	188	3	1.6	201	4	2.0	+9.8	(*)	+6.9	+33.3
Female	5	0	----------	5	0	(*)	5	0	----------	(*)	----------	(*)	----------
Administrative and managerial: Upper management [1]													
Other professional [2] staff:													
Male	380	17	4.5	617	53	8.6	658	53	8.1	+73.2	+211.8	+6.6	(*)
Female	272	17	6.3	535	45	8.4	572	52	9.1	+110.3	+205.9	+6.9	+15.6
Production and programing: Upper management: [3]													
Male	266	4	1.5	269	6	2.2	304	8	2.6	+14.3	+100.0	+13.0	+33.3
Female	16	2	12.5	27	2	7.4	28	2	7.1	+75.0	(*)	+3.7	(*)
Other professional [4] staff:													
Male	864	72	8.3	838	82	9.8	1,016	101	9.9	+17.6	+40.3	+21.2	+23.2
Female	275	25	9.1	300	37	12.3	359	54	15.0	+30.5	+116.0	+19.7	+45.9
Technical: Upper management: [5]													
Male	139	0	0	147	1	.7	152	4	2.6	+9.4	NA	+3.4	+300.0
Female	0	0	0	0	0	----------	0	0	----------	----------	----------	----------	----------
Other professional [6] staff:													
Male	2,119	190	9.0	2,073	179	8.6	2,295	211	9.2	+8.3	+11.1	+10.7	+17.9
Female	111	21	18.9	97	19	19.6	100	21	21.0	−9.9	(*)	+3.1	+10.5
Nonprofessional (clerical and custodial):													
Male	232	75	32.3	232	66	28.4	202	84	41.6	−12.9	+12.0	+12.9	+27.3
Female	909	127	14.0	768	122	15.9	964	165	17.1	+6.1	+29.9	+25.5	+35.2

[1] General manager; station manager.
[2] Business manager; public relations director; promotion director; development director; other management and professional.
[3] Program manager; production manager; operations manager.
[4] Producer-director; on air talent; film director; film editor; art director; traffic manager.
[5] Chief engineer.
[6] Supervisory engineers; broadcast engineers; production crew members.
*No change.

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CHART B

EMPLOYMENT STATISTICS OF PUBLIC TELEVISION LICENSEES

Radio stations	1972			1973			1974			Percentage change 1972–74		Percentage change, 1973–74	
	All employees	Minority	Percent minority	All employees	Minority	Percent minority	All employees	Minority	Percent minority	Total	Minority	Total	Minority
Male	661	47	7.1	811	58	7.2	897	77	8.6	+35.7	+63.8	+10.6	+32.8
Female	193	12	6.2	246	19	7.7	294	29	9.9	+52.3	+141.7	+19.5	+52.6
Grand total	854	59	6.9	1,057	77	7.3	1,191	106	8.9	+39.5	+79.7	+12.7	+37.7
All technical and professional employees:													
Male	654	45	6.9	792	57	7.2	890	76	8.5	+36.1	+68.9	+12.4	+33.3
Female	133	5	3.8	196	7	3.6	226	20	8.8	+69.9	+300.0	+15.3	+185.7
Administrative and managerial: Upper management: [1]													
Male	85	2	2.4	106	5	4.7	114	5	4.4	+34.1	+150.0	+7.5	(*)
Female	7	0	.....	8	0	.....	7	0	.....	+28.6	.....	+12.5	.....
Other professional staff: [2]													
Male	24	3	12.5	42	3	7.1	76	5	6.6	+216.7	+66.7	+81.0	+66.7
Female	24	2	8.3	50	1	2.0	67	5	7.5	+179.2	+150.0	+34.0	+400.0
Production and programming: Upper management: [3]													
Male	88	3	3.4	116	5	4.3	138	10	7.2	+56.8	+233.3	+19.0	+100.0
Female	20	0	.....	18	0	.....	18	0	.....	−10.0	.....	(*)	.....
Other professional staff: [4]													
Male	215	19	8.8	251	26	10.4	255	28	11.0	+18.6	+47.4	+1.6	+7.7
Female	74	3	4.1	114	6	5.3	122	15	12.3	+64.9	+400.0	+7.0	+150.0
Technical: Upper management: [5]													
Male	92	5	5.4	105	5	4.8	109	3	2.8	+18.5	−40.0	+3.8	−40.0
Female	6	0	.....	5	0	.....	8	0	.....	+33.3	.....	+60.0	.....
Other professional staff: [6]													
Male	150	13	8.7	172	13	7.6	198	25	12.6	+32.0	+92.3	+18.1	+92.3
Female	2	0	.....	1	0	.....	2	0	.....	(*)	.....	+100.0	.....
Nonprofessional:													
Male	7	2	28.6	19	1	5.3	7	1	14.3	(*)	−50.0	−63.2	(*)
Female	60	7	11.7	50	12	24.0	68	9	13.2	+13.3	+28.6	+36.0	−25.0

[1] General manager; station manager.
[2] Business manager; public relations manager; promotion direction; development director; other management and professional.
[3] Program manager; production manager.
[4] Producers; music director; news director; on-air talent; production assistants; continuity director; traffic manager.
[5] Chief engineer; operations manager.
[6] Supervisory engineers; broadcast engineers.
* No change.

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PUBLIC BROADCASTING SERVICE,
485 L'ENFANT PLAZA WEST SW.,
Washington, D.C., March 31, 1975.

HON. TORBERT MACDONALD,
Chairman, Subcommittee on Communications, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: In response to the questions raised during the Overview Hearing of March 19, 1975, regarding minority concerns, I am submitting this interim report on behalf of PBS and the nation's public television stations. It is my understanding that the Corporation for Public Broadcasting is supplying you with an industry-wide employment profile based on data received from the stations as of mid-1974. It is our intention to have a comprehensive report on minority concerns and activities in time for the upcoming hearing on long-range funding.

Clearly, your questions went to the heart of some of the system's most urgent concerns: how best to address the problems of minority groups and women within the context of a diversified national television service, and the extent to which our governing bodies and station staffs reflect the nation's population mix. I can say unequivocally that our commitment to finding and implementing effective answers is absolute. We recognize our shortfalls. We intend to do better. Indeed, as we look toward your Subcommittee's hearings on Long-Range Funding for Public Broadcasting, it is particularly appropriate that we focus on minority concerns. With the stability of assured Federal assistance to stimulate our own efforts to derive increased funding from diverse sources, and particularly from the publics we serve, we are convinced we can do better.

In preparing for the hearings on Long-Range Funding, we are gathering detailed information on every aspect of our record—past, present, and prospective—in the area of minority concerns. A comprehensive report will be submitted to you and your colleagues prior to the hearings. I want here simply to outline the contents of that report.

THE POLICY-MAKING PROCESS

We are assembling data on the composition of our governing boards, both national and local, along with population profiles of the communities served by some of the major stations in the public television system. And let me stress the local orientation of this system: PBS is an association of member stations, licensed to serve particular communities; here at PBS we can and do provide guidance, as to both law and policy, but we cannot and we do not dictate to the stations. They must ascertain the needs and interests of their communities. They must respond to these needs and interests, and develop a base of dedicated audience support. The character and the essential quality of our system evolves from each community, and not the other way around.

EQUAL EMPLOYMENT OPPORTUNITY

We will report to you on the composition of the PBS staff, on the system-wide employment profile, and on affirmative action plans—both present and prospective—at both the national and local levels. We will report as well on the programs we are instituting at PBS to stimulate an effective recruitment and training effort throughout the system, and we are canvassing our stations in major urban centers for the specifics of their present such efforts and their plans for the next five years, in the framework of increased Federal funding. The public broadcasting community is more even than PBS and the local stations: it includes certain major production entities, and we will have data for you on their employment, recruitment, and training efforts as well.

NATIONAL AND LOCAL PROGRAMMING

Obviously, the core of our service to minorities and women is quality programming. We will include in our report a comprehensive listing of all national programs (in FY 74 and FY 75) that were designed for and directed to various minority groups as well as those that, in substance or in terms of participants or both, clearly addressed matters of particular relevance to these groups. We will supplement this list with a sampling of local programs of similar nature, with an emphasis on those stations serving major minority populations. There are a number of special efforts by CPB and PBS aimed at stimulating the creation of new programming directed to minority concerns, and we will detail these efforts in our comprehensive report.

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It goes without saying, Mr. Chairman, that long-range funding at the levels we have recommended will be crucial to the success of our efforts in the minority area—for the very fundamental reason that implementing effective recruitment and training programs and developing innovative programming demand long lead-time, assured resources, and the capability to take risks.

I want to assure you again of the sense of urgency we feel with regard to improving our service to minority persons and women. We promise no miracles. But we can and do express our deep commitment to improving this service substantially in as short a time as possible. We look forward to having an opportunity to present our findings based on the data now being collected by the time of our next meeting.

Sincerely,

HARTFORD N. GUNN, Jr., *President.*

Mr. LOOMIS. I have the very strong feeling from having seen and heard of this, that much of the new minority employment is in the middle grades, and as you know, the Corporation has a program of minority training grants through which we are trying to provide opportunities to minority personnel. We are spending about $200,000 a year to pay half the salary while the station pays the other half of the salary of a minority employee. The grants are awarded competitively. The station that offers the greatest responsibility to a minority person is awarded a 2-year grant to pay half the employee's salary.

There are 48 such people now employed, and I have seen several of them, a dozen of them, maybe, in visiting the stations. They are a very impressive group and by and large the stations are very pleased with them. The individuals are pleased.

There have been some problems with some of them, as you would expect. But I think that the system is working and this is one way of introducing new talent, new minority talent, into the system.

Mr. MACDONALD. Well, my point is, and I hope I am not belaboring it, but my point is that you are asking for an awful lot of money from the Federal Treasury.

Mr. LOOMIS. Yes; we are.

Mr. MACDONALD. And all groups are taxpayers and therefore I think all groups ought to be represented in better fashion—this is not a criticism, but just my opinion—in a better fashion than they have been, along the line and throughout public broadcasting.

I won't pursue it any further because of time and also you said that you would furnish a breakdown for the record, and at the same time, if you have plans to enlarge on that, I wish you would include that.

Mr. LOOMIS. I will, sir.

Mr. MACDONALD. And get to it as soon as you can so we can have it in the record so it just won't be within the subcommittee.

Mr. LOOMIS. Yes. I should point out, Mr. Chairman, that as you know each individual licensee is totally responsible for its own personnel and for its own personnel practices. I am giving just a statistic of the industry.

Mr. MACDONALD. Yes; I am not blaming any individual. I am just talking about the overall picture that I will have to defend if I take this bill to the floor.

Mr. LOOMIS. I understand.

Mr. MACDONALD. Plus the fact that it is only right, anyway.

Mr. LOOMIS. Yes, I understand, sir.

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Mr. MACDONALD. My last question in this round. We keep hearing about all the agreements between the family that you all represent, but how about the disagreements? The CPB and PBS had that meeting in Muncie, Ind., in the end of October or early November.

Now last year, after the Senate committee had reported out the financing bill and frankly, as I indicated earlier, that you repeated more or less my words, the House wasn't going to go ahead when you couldn't get together on it yourselves. What was that disagreement all about, anyway?

Mr. ROGERS. I will be glad to answer that question. The partnership arrangement between CPB and PBS has involved a great deal of necessity to accommodate the activities of each organization to the activities of the other organization, and it sometimes takes a little time, in a marriage like this, before the partners to the marriage understand what the duties and responsibilities they have to the other.

In that particular case, there were one or two very substantial disagreements on two matters. The basic principle, however, of the disagreement was not so much the specific difficulty as it was the feeling that one of the partners had made decisions without adequate consultation with the other. About the decisions that were taken at that Muncie meeting, it was recognized at the time they were taken that, if these were exposed to the press, there would be a big hullabaloo about it.

At the same time, if you are going to have open meetings, you have got to expect that they are going to be exposed to the press and since we are, to a degree, a press medium ourselves, albeit not the written press, we understand exactly how it functions and in this particular case it did not take very long either in time to resolve the differences.

Now, there is no way that——

Mr. MACDONALD. Are they permanently resolved?

Mr. ROGERS. Those particular differences are permanently resolved, and there are no substantial differences that exist between us today. But you know as well as——

Mr. MACDONALD. But you can't guarantee that—well, I am not asking for that.

Mr. ROGERS. Well, you know as well as I do that we can't.

Mr. MACDONALD. But there are no foreseeable problems. I thought your analogy of a marriage was, while very apt in some instances, not so apt in others, since the divorce rate has been going up. [Laughter.] The way I hear it.

Mr. ROGERS. Well, Mr. Chairman, the chairman of CPB made a statement at one time which says it more eloquently than I can, and I can't even do anything more than paraphrase the statement because he does it so much better. That was that the matters involving public broadcasting in which we are involved contain so many more areas in which we are in complete agreement than they could possibly be on which we would be in disagreement that the boards can and will and must find ways of resolving those disagreements as they arise.

Now I think that we have a splendid system of doing this today because we have a board of CPB, all of whom serve pro bono. We have a board of PBS, all of whom serve pro bono. They have no selfish interests, they are not out to preserve their own jobs or their own domains. They are not getting paid for it. They don't get any split

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of how much of the other is getting, and I have complete confidence in the way in which this is working ahead.

The fact that these disagreements arise from time to time is good and healthy. I even venture to say, Mr. Chairman, that there are disagreements from time to time on as well-run a committee as you run.

Mr. MACDONALD. I would say that is a fair statement. But your differences are——

Mr. ROGERS. In the implementation, but not in the principles.

Mr. MACDONALD. Completely so.

Mr. ROGERS. Right.

Mr. BENJAMIN. May I add a word, Mr. Chairman?

Mr. MACDONALD. Yes, after I hear from Mr. Coffey, because I understand the radio people were not too happy. Am I correct about that?

Mr. COFFEY. Well, Mr. Chairman, I think that that probably overstates it somewhat, but what we are are competitive for the limited funds that the corporation has and we had a very fair process through which the corporation heard the arguments of both sides and came to a conclusion which we have agreed to live with through the fiscal year 1976. But a procedure was set up, it is the first time we ever had a major part in the decisionmaking process.

Mr. MACDONALD. And you are satisfied?

Mr. COFFEY. And I am satisfied with the way it is working at the present time.

Mr. MACDONALD. Mr. Benjamin.

Mr. BENJAMIN. I merely wanted to add a summary word since the instance of our disagreement was over the satisfaction of all parties to the issue. You have to iron that out and reconcile differences and come up with a conclusion. That conclusion may be only 90 percent satisfactory to each side because you have only 100 percent to divide.

The real generic problem was a feeling of lack of communication. Now, since all sides are dedicated to complete communication, in order to reach agreements which at least are understood by the other members of the family, it is not a difficult thing to concur in that resolution and so say wholeheartedly we favor it.

The trick, then, is never—or try as seldom as possible—to forget the collaboration or the dialog and never to give anyone a fait accompli.

Mr. MACDONALD. I will be back for a second round. Any questions?

Mr. FREY. I have questions.

Mr. MACDONALD. Mr. Frey.

Mr. FREY. Thank you, Mr. Chairman.

If we could, I would like to get to the question that is going to plague us on this legislation as to long-range financing, the funding ceilings. Have you any indications at all from OTP or the White House whether the President will veto a bill with ceilings that are higher than those that have been recommended?

Mr. BENJAMIN. I have no indication of that. What I did find when we started to work with OTP on the framework of the bill they would submit was that they consented to our reservation on the ceiling question. That indicated an openmindedness about it and did not, therefore, give us an ultimatum such as, "Either you take the bill in toto or we won't submit it."

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They said, "We want you to take the bill as drafted, but if you want to reserve this ceiling question for testimony before the Congress, that is all right with us."

Mr. FREY. Well, I think it has been a healthy thing, as the chairman pointed out that, for the last week, there has been somewhat of a change in attitude in terms of the concept of public broadcasting and the funding for it. As you are well aware, we are going to have some problems, especially in the appropriations area for the 5-year funding.

I must admit, I generally don't like it. I think there are special reasons, however, in this area for the 5-year funding which appear to me to make some sense.

Let me just ask you if it is rejected either by this committee or by the Appropriations Committee, have you got anything else in mind?

Mr. BENJAMIN. As far as our discussions have gone, no. We have all come down unanimously and unequivocally that we need both the matching and the higher ceilings to do our job. Any compromise on that is a compromise that nobody has yet begun to want to think about because they can't conceive of the viability without it.

Mr. FREY. Where does the time come from? Why is 5 years magic? Why not 6 or 7?

Mr. BENJAMIN. The longer the better, but the best we could do was 5 years. Please recall that the Carnegie Commission suggested permanent financing.

Mr. FREY. What I am really asking is how, if somebody says to me, "Why not 3 years or 4 years?" What is the magic in 5 years? What do I tell them? Why is 5 years such a wonderful time?

Mr. BENJAMIN. Because that is the very least, I would suspect, that you can get the insurance of insulation, the insurance of security of future financing for your programing. People tend to overlook, that it is not only the first amendment which is involved in this concept. Anybody who has been in production, as I have been since I was 15 years of age, not always as an executive but as an office boy, knows that it takes a year to 2 years even in the commercial world to evolve a picture from the idea or the script or the book.

You can't plan a series in less than 2 or 3 years and everybody then points to BBC and how good they are. Well, they take 3 or 4 years for those very good programs.

Mr. FREY. You are as messed up as the Government, aren't you? Some of these things take that long.

Mr. BENJAMIN. Well, Mr. Frey, it is a creative process.

Mr. FREY. We are in that, too. [Laughter.]

Mr. BENJAMIN. Well, would you write a script for us?

Mr. FREY. Gee, I don't like the one we have been having. I want a new one. [Laughter.]

Mr. FREY. What about the passthrough, too? Is that working? Is there enough money being passed through?

Mr. BENJAMIN. Well, we certainly think so when we have gone all the way to 50 percent pass through at the $80 million level. When you add to the passthrough amount the cost of distribution, you find that between radio and television, and mostly on the television side, so much of our resources are committed, that the real question is how are you ever going to do any innovative programing when you have so little left for your national programing?

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Mr. FREY. Isn't it true, though, that most of the innovative programing, or at least the production of it, is really just two or three places? Are we getting a real spread throughout the country?

Mr. BENJAMIN. No, because we don't have the funds for it. What you can do is only three or four or five projects all together. There is only $10 or $11 million for production on national programing out of the vast sums of money we speak of that the Congress is asked to allocate and appropriate.

Mr. ROGERS. Let's put this in the proper perspective.

From the very first day, in public broadcasting the people of the United States who were interested and these committees have asked that we do a certain job. But from the very first day this entire institution has been starved to death, and let's put this in figures.

The three national networks last year, or the year before last—we don't have last year's figures—spent something like $110 billion. Well, they spent something like $1.1 billion, I think.

Mr. FREY. That is a difference.

Mr. ROGERS. $1.1 billion, I knew that figure was too big, on national programing over the networks. It has nothing to do with local programing. It has nothing to do with what the independent stations did. And the total amount of national programing done by public television in that same year when they were spending $1.1 billion, was something in the vicinity of $40 million.

Mr. FREY. But to keep it in perspective, how much did the Federal Government contribute to that $1.1 billion?

Mr. ROGERS. Well, the Federal Government——

Mr. FREY. You know, that is the other side. I agree with your statement.

Mr. ROGERS. Well, let's put it this way. The Federal Government didn't contribute very much toward the public broadcasting. It didn't——

Mr. GUNN. It didn't contribute $40 million. It contributed only about $15 million to national programing, I think, didn't it?

Mr. ROGERS. Yes, and what is more, we will present details in due time, Mr. Frey.

Mr. FREY. Are we ever going to be self-sufficient?

Mr. ROGERS. There is only one way we are going to be self-sufficient, in my opinion, and that is if the people of the United States will back public broadcasting the way they are beginning to understand they have to.

Mr. FREY. I guess that was my next question. What is going to come from the proposals and matching? Are we playing games, or do you really think it is going to work?

Mr. ROGERS. That is why I would have answered the first question that you asked on the question of compromise somewhat differently.

Mr. FREY. Well, why don't you answer it then? This is not a breakup or anything.

Mr. BENJAMIN. You go ahead and answer.

Mr. ROGERS. First of all, we do not believe that we are ever going to get adequate funds from the Federal Government to support public broadcasting, the way it was set forth in the Carnegie report which created this.

No. 2, in the years that have elapsed, we have come to the conclusion that even if you were in a position to do it and you were generous

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enough to do it, we don't want it. So what we are asking the Federal Government to do is to set up an incentive system, and say, "Public, if you furnish the majority of the money, we will give you an incentive of some sort of a match."

This new proposal is not based on a dedicated tax or any of these things that we thought of originally which were impossible to do and are probably impossible to do today. It is set on the basis that, "Public—you go out and get so much money, you prove that you have it—you would have had to have it 2 years ago, so that you have that time to prove it—and then we will give you a percentage of it."

Now, we thought that a good match, you see, was $1 Federal funds for $2 of local funds. We weren't able to get that bill through the administration. We compromised at $1 of Federal funds for every $2.50 of local funds.

We had a blue-ribbon committee, and we came up with a whole book, which is all available to you, as to how much money we need.[1] The amounts of money that we need are vastly greater than we are talking about. We couldn't get that through. And we couldn't arrive at an agreement with the administration unless, as we know, there has to be such a thing as ceilings. You can't have an open book, even though it is based on a match.

So we argued that out. We think that the amount that we compromised at was way lower than it ought to be, but we compromised on that, in order to get some unanimity. We never had an administration bill before on long-range funding, but we are trying to get one, so that everybody can be included.

Mr. FREY. Well, I think that is a good way to go, and I like the concept, because I think it is a partial answer to those who say that the 5 years isn't a problem. And there is also, of course, the continuing question as we have congressional oversight in this, even with the 5-year funding, Mr. Chairman, it seems to me that there is still obviously the need to exercise congressional oversight, and one of the answers may be, if they are not doing a good job, is to pass another bill.

Mr. BENJAMIN. And we welcome the oversight, so you have information from everyone that it concerns. I feel oversight is a very good idea and ought to be pursued.

Mr. FREY. And the 5-year program in essence is a program that if you meet these things and if you do it——

Mr. BENJAMIN. And if you are not contented with the job we do, you can always revoke.

Mr. FREY. That might put a different perspective on it in the sense of locking it in, because nothing is locked in around here to begin with, but I think talking in terms of locking it in causes some problems that I don't think we need, and which as a practical matter, we really don't have to face.

I have some other questions, but I guess my time is up.

But frankly, one last thing, Mr. Chairman, what percentage of the money in terms of the matching grants do you estimate that you are going to get from the public directly, from foundations, or where do

[1] Report, Task Force on Long-Range Financing of Public Broadcasting, Corporation for Public Broadcasting, 1973.

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you envision it is coming from? I am sure that you have given some thought to this.

Mr. LOOMIS. Mr. Frey, if you wish, I can give you where it came from in 1974.

Mr. FREY. But that is going to bear on where it is going to come from.

Mr. LOOMIS. I think it does, because it shows the growth, and because it also shows the foundations.

Mr. FREY. That they have testified in the past, contributing less and less.

Mr. LOOMIS. Yes, it does, yes.

Mr. FREY. If you could do it briefly, I would appreciate it.

Mr. LOOMIS. It shows the difference between 1972 and 1974, foundations went down from $25 million to $18 million.

Mr. FREY. Do you perceive in the future that they are going to continue to phase out?

Mr. LOOMIS. I doubt whether it would be out, but probably down some more, because much of the previous contribution was from the Ford Foundation. There are many other foundations now coming in as well.

Mr. FREY. When you are talking down, are you talking about to 1 or 2 million?

Mr. LOOMIS. I would hope more than that. Maybe 10 or something of that nature, because we are trying to get other foundations interested.

Mr. GUNN. Henry, I think maybe that is a good point, that the number of foundations contributing to public television is increasing.

Mr. LOOMIS. That is correct.

Mr. GUNN. What we are witnessing in the decrease of money is the withdrawal of one single foundation, and this may be a healthy development, to diversify resources.

Mr. ROGERS. Yes; but nevertheless, that foundation—the Ford Foundation—has given more money than all other single sources put together, including the Government of the United States.

Mr. MACDONALD. If you don't mind my interrupting, I think that these questions are all very good, and very pertinent, but this is sort of preliminary, and this is what Mr. Frey suggests would be a good idea if we do find it, and there is an oversight over what you have done, and at the time that anybody seems fit to put in a bill, to go forward, then you have to be prepared, both in your statements and with documents to back up what you are talking about financing.

The only question that I have on this, and it is a very small question, who mesmerized the administration? I never had any fights with them except over you people. And that was a long and lasting and bloody one, if you recall.

Then suddenly they come out, "Everything is great. Everything is fine." We couldn't get 1 year from them, and now they are proposing 5 years.

Mr. BENJAMIN. Mr. Chairman, when Dr. Whitehead testified before the Senate Commerce Subcommittee, I thought his statement was well nigh perfect as could be written on PBS or CPB, except for the ceilings. His philosophy, his ideas, his reason for wanting to do it, his reason for coming to the 5 years, his reason for protecting programming against interference.

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Mr. MACDONALD. We heard all those reasons for months.

Mr. BENJAMIN. Well, you adopted them. So when you asked the question how come——

Mr. MACDONALD. But he is no longer there. Who did you mesmerize this year?

Mr. ROGERS. Mr. Chairman, we were fortunate enought to have the general endorsement of the principle from the then Vice President of the United States, who is now President of the United States, and this was very helpful in getting the bill this year.

Mr. MACDONALD. He didn't do too much on the floor.

Mr. ROGERS. No; but he was not quite President.

Mr. BYRON. May I ask a question?

I don't want to shift ground, and I don't know the extent of this. Maybe, Mr. Loomis, you can tell me. Do you see the States increasing in the role here at all, if you put collectively?

Mr. LOOMIS. Yes, very much so.

Mr. BYRON. In other words, State tax money.

Mr. LOOMIS. In the same periods, as we discussed for foundations from 1972 to 1974, State sources increased their support from $78 million to $109 million.

Mr. BYRON. Is that where you see the gap being filled?

Mr. LOOMIS. Partly there, and the most encouraging of all is the increase from subscription, from memberships, and auctions. That is increased from $17 million to $31 million, and I am sure Mr. Rogers and Mr. Gunn will tell you the success they have had last week, where we have raised in the order of $5 million in just a week, in a special effort in 1 week.

Mr. BYRON. One final question. Do you see any conflict here developing in State efforts, to kind of take back ETV and kind of put it back into the Department of Education, this kind of thing?

Mr. LOOMIS. No, I see no conflict. In fact, again, the motion is the other way. The educators are welcoming the support of the public broadcasters for the prime time, and you are seeing some stations changing their licenses, or renting out their evening hours to a private—I mean, a nonprofit foundation. There are varying methods of cooperation. Those that were originally licensed to community foundations set up for public broadcasting purposes are now doing more instruction. Those who were originally licensed for instructional broadcasting are doing more public programing. They are all coming together in a more similar fashion, which I think is a very important thing.

Where we get true insulation is having a variety of sources of funds, no one of which is dominant. This is where the subscription money is so ideal, because that is for a whole bunch of people. We also have States; we have municipalities, local sources; we have foundations; we have business and industry, and we have the Federal Government, and the Federal Government is itself diverse, because the corporation's budget is only a part of the Federal contribution, as you are well aware.

In fiscal year 1974 CPB was only 16 percent of the total public broadcasting budget. Then again you had the Office of Education; you had the Endowments of the Arts and the Humanities; you had the National Science Foundation. All of these support programing in one form or another, and all are very welcome.

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Much of the programing, like "Villa Alegre," which is the children's program in Spanish, and "Sesame Street," or things like that, were supported by the Office of Education, in addition to CPB support.

Many of the historical dramas, such as "Adams Chronicles," that is about to be in production now, is supported by the Endowment of the Humanities.

Mr. BENJAMIN. Drama in Los Angeles.

Mr. LOOMIS. Drama and the arts have been supported by the Ford Foundation and others.

Mr. GUNN. I think on that question, Mr. Byron, that what we are seeing among the States is a realization that education is broader than just formal education, formal instruction. We think this is a very healthy development. With that has gone a tendency to see educational instruction, educational television, public television, general programing, as creating in effect a new institution within a State, which serves the public on a whole range of issues, some formal, some informal.

Mr. BYRON. Well, for instance, Maryland is expanding its microwave network, and the program here is enormous, right in the State government, in all the departments.

Mr. GUNN. That is right.

Mr. BYRON. I just wondered if that, will that add money to your overall?

Mr. GUNN. Yes.

Mr. BYRON. With a small——

Mr. LOOMIS. I think I might add two points. To show how the line between education and general programing is fuzzing, we have the program that many of you may have seen, "The Ascent of Man," which is considered general programing. It is on at prime time at night. There are over 25,000, this is a minimum—we know of 25,000, there may be additional—individuals taking it for credit, watching it for credit, from 200 different universities.

In the case of cable, more than 3,300 cable systems carry public television. And they reach about 15 million people that are beyond the grade A coverage of the stations.

So that this, the marriage between cable and public broadcasting is in everybody's interest. Some of these stations have relationships with 60-odd different cable companies, and are carried to three or four States. So it is a major additional way of having the public have the opportunity to see public broadcasting.

Mr. FREY. Just off the record a moment.

[Discussion off the record.]

Mr. MACDONALD. Do you have anything?

Mr. BYRON. No.

Mr. MACDONALD. The gentleman from Colorado.

Mr. WIRTH. Thank you, Mr. Chairman.

Mr. MACDONALD. Incidentally, I announced before you came that we are not operating under the 5-minute rule, but under the 10-minute rule, and we all have tried to keep ourselves to that, including me.

Mr. WIRTH. I compliment the discipline of this committee.

Mr. MACDONALD. We are coming back. There will be another round.

Mr. WIRTH. Mr. Benjamin, could you review for us the meeting at Endicott House, and the general sense of that meeting, and what the consensus of the participants was?

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Mr. BENJAMIN. Well, by characterization, they called it the best meeting they ever had.

Mr. WIRTH. And why is that?

Mr. BENJAMIN. That is not my characterization, and perhaps that is kind of customary; the last one you have is the one that excites you the most. Your memory——

Mr. WIRTH. That is not always true.

Mr. BENJAMIN. That is when it is a bad meeting. This was a good meeting.

Mr. WIRTH. OK. Why was it a good meeting?

Mr. BENJAMIN. Well, first the participation of the various segments of the industry who were represented. Second, the outsiders who came, who were not really outsiders but insiders, but who are not engaged in public broadcasting as their profession, or even in terms of their extracurricular activities. The dialog made it a good meeting in terms of what was their foremost responsibility. The sense of importance facing all of public broadcasting brought an immediate consensus, although it took 2 days to spell it out. That consensus was that long-range financing is public broadcasting's highest priority.

It would have been wonderful if we had had more than just one counsel of one committee present at that session, because one could see by participation in that 2½-day session how much everybody keyed to long-range insulated funding as the highest priority of all, even more than programing, for viability and strength of public broadcasting.

Mr. WIRTH. How often have you had meetings like this?

Mr. BENJAMIN. I have only been to that one at Aspen.

Mr. WIRTH. But generally——

Mr. BENJAMIN. I have been to other kinds of seminars.

Mr. ROGERS. This was the third such——

Mr. BENJAMIN. Others have been to such meetings.

Mr. ROGERS. This was the third such conference under the auspices of the Aspen Institute.

Mr. LOOMIS. Aspen Institute.

Mr. BENJAMIN. This was my first.

Mr. FREY. A great place to have it.

Mr. BENJAMIN. Forgive me, Mr. Frey, it would have been much better at Aspen, but we had it at the Endicott House in Boston which, in deference to our chairman, is still a nice place to be, being in Massachusetts.

Mr. WIRTH. Why was the group of participants able to reach a consensus on the No. 1 concern at Endicott House better than they had before? Maybe some of you who had been to previous Aspen Institutes.

Mr. BENJAMIN. I would have thought if we could have canvassed everybody who had been at Endicott House beforehand, they would have reached the same consensus, but here they were holed up for 2½ days, in constant communication, discussing many items, and ending up saying that this is the essential ingredient for our continuing responsibilities. That is what plagues most of us in public broadcasting. We have a mandate that is so magnificent that with the best of resources, and the most of resources, we will be hard put to fulfill that tremendous mandate. But absent the resources, it is virtually impossible.

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There is nothing that is more frustrating than to have somebody say, "Why did 'The Ascent of Man' have to be made outside of our orbit, productionwise, when it is such a good program, like 'Masterpiece Theater?' "

Mr. WIRTH. I know that the committee will be getting into this in much greater detail later on down the line, but maybe you could in a preliminary sense give us a feeling of the kinds of things that you would be able to do with the budget recommendation by the Endicott House meeting and your sense of long-range financing versus that which has been recommended by the administration. And what would be in that gap between administration funding and the kind of funding you would like to see that the public would otherwise not have?

Mr. BENJAMIN. Well, let me start by first saying that if the ceilings, and we are talking ceilings, the difference between the recommendation of the White House bill and our own proposal, we are talking about a difference in ceiling, that on one hand eliminates incentive for the time being, and on the other, creates the incentive. That is the heart of the whole subject matter. One ceiling emphasizes the principle that incentive funding is the best method by which to get the involvement of the public, the involvement of the States, involvement of the universities, the involvement of the population. You support it. This committee already approved a level of funding 2 years ago, which was much higher than the ceiling proposed in the OTP bill. With the OTP bill you are, therefore, eliminating incentives for the time being.

Mr. WIRTH. And do you have pretty good evidence that the incentive system is working in terms of money getting raised from those various ones? What incentives?

Mr. BENJAMIN. It will be raised even better when you have the incentive of a specific of two and a half times one. Anybody who is engaged in fundraising, and I have for the United Nations, for cultural societies, for Carnegie Hall, for any number of things.

Mr. FREY. If the gentleman would yield, we have those matters in the record before you came in.

Mr. WIRTH. Okay. Fine.

Mr. BENJAMIN. The matching incentive is a very fundamental method of raising funds.

Mr. WIRTH. OK. Have you gone into—I don't think you have gone into some of the specifics of the differences in programing, and the differences in the kinds of things that would be available to the public through public broadcasting on your budget that would not be included in the——

Mr. BENJAMIN. The greatest big difference comes in the amount of money that passes through to the stations. As you increase that ceiling the tremendous percentage of it goes right to the stations for local programing, or national programing, or any other kind of service they render the communities.

Mr. WIRTH. More specifically, what does that mean to the viewers and listeners of the country?

Mr. BENJAMIN. The emphasis has been placed so often on local autonomy and local production facilities and desire to let the community decide its needs and the local station respond to those needs, how better than to give them the money is the argument.

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We at CPB, bought that philosophy before it became incorporated in the draft bill, so we do agree with that philosophy and we pursue it up to that 50-percent margin.

Mr. WIRTH. I think all of us would agree with the notion of a great deal of local responsibility. How do you flesh that out, how would you flesh that out in terms of describing it, to, say, the viewers in the second district in Colorado?

Mr. BENJAMIN. In the second district people can get in touch with their station. They can get on that station the kind of programing they want in that community because they have the wherewithal with which to do it as these Federal funds become more substantial. They didn't have it before.

Mr. ROGERS. Could I give Mr. Wirth the specific figures? For example, KRMA in Denver in 1974 got an unrestricted community service grant from CPB into the bill that was passed by the House of $115,000 and in 1975, $177,000 or $62,000 more. Now that $62,000 additional—which if my arithmetic is correct, is half again as much as the grant in previous years—is available to them to do what the people in your district want done.

Now, if they want to invest that in national programing or they want to do something locally at home, that is their sole decision.

Now, the simple facts are, if I may be controversial for a moment, that $177,000 of Federal funds directly through is minute compared to what that station ought to have.

This institution has been starved to death from the very beginning and the trouble now is that when we come to hard times like this, everybody says we have budget problems. Nobody has ever looked at what ought to be done with this institution.

At this point I would like——

Mr. BENJAMIN. Not enough.

Mr. ROGERS. I would like to refer to the Freudian slip I made on the question where I talked about the $110 or $117 billion. It was a slip, but this is where the slip is.

Mr. FREY. The worse part is we didn't even clock that much.

Mr. MACDONALD. Well, it is private money. Here is the difference.

Mr. ROGERS. Last year the American public spent $117 billion, Mr. Frey, with their educational institutions both private and public.

Mr. MACDONALD. Mr. Frey will have another whack at you.

Mr. ROGERS. And I would like to get into how much we spend on public television and its cost effectiveness if somebody would like to bring that up in the next round.

Mr. WIRTH. In view of the discipline imposed for the protection of the time of the members could I jump very briefly to something that I find very interesting and that is proposals that are floating around related to the corporation covering various kinds of congressional hearings.

Could you summarize briefly Mr. Loomis where thinking is on that and what kinds of questions may be before this committee on that subject?

Mr. LOOMIS. Well, my understanding is that the Congress, both Houses of the Congress, are considering the possibility of radio and television coverage and that the Congress has not as yet sorted out whether they want to physically do it themselves on contract with

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somebody, or whether they are going to ask us, form a pool, or ask somebody else.

Mr. MACDONALD. Could I interrupt. Just to be clear, you are talking about the activities on the floor?

Mr. LOOMIS. That is correct.

Mr. MACDONALD. What about the committee hearings? Am I correct——

Mr. WIRTH. No; I was really talking about activities on the floor, Mr. Chairman, and that set of ideas that is now operating.

Mr. MACDONALD. Excuse me.

Mr. LOOMIS. And I think we feel that it would be very useful to the American public to have coverage. We think clearly that the raw coverage should be made available to us in television and radio, and also to the commercial networks. But that each of us will have to make the program decisions as to how much and when and where it is carried, and that we would undoubtedly carry more of it than the commercials as we did of Mr. Rockefeller's hearings and as we did of the Watergate hearings, and particularly that we can carry it at prime time when the commercials cannot do so because they would go broke.

Also, in this point, radio is particularly good for gavel-to-gavel because of the cheapness of it. At the present time we are doing much of that in many of the committees of the Congress which permit it. We think that while that is a small audience in the sense it is not 90 percent, it is 10, 15, it is that portion that are politically curious and are particularly interested in the subject being discussed.

Mr. WIRTH. Or gluttons for punishment.

Mr. LOOMIS. There are varying other possible descriptions.

But clearly, the case of Florida is a good example where the State legislature is carried widely. There is an increased—and we did some before-and-after tests—an increased knowledge, not only of the facts that were being discussed in the legislature, but an increased awareness of the responsibility of the legislature and the fact that the individual legislators were hard working, serious people, and the increase in that understanding is quite dramatic.

The coverage was carried in about half the schools of Florida in regular school hours in addition to prime time in the evening during the several months of the legislative session.

Mr. WIRTH. Who ends up picking up the tab for this kind of programing?

Mr. LOOMIS. In this case the legislature.

Mr. WIRTH. In Florida the legislature does it?

Mr. LOOMIS. Yes.

Mr. WIRTH. And the notion is that Congress would pick that up here?

Mr. LOOMIS. Oh, I think for the mechanical equipment that Congress would have to pick up the tab and then otherwise you get the question of possible interference by whoever picks it up. I would strongly urge that a bipartisan group or maybe bicameral group control.

Mr. WIRTH. Then we would pick up the tab for the networks if they were to be covering it or it would just be available if they wanted to use it.

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Mr. LOOMIS. You would provide the raw coverage audio and video, and in some cases like the U.N. You sell it by the minute or something to the people who want to buy it, but they would have to pay for part of the cost. You would probably never get back the full cost of doing it.

Mr. WIRTH. And what is the timeframe on decisionmaking of the various pieces? I have not followed this as closely as I should have.

Mr. LOOMIS. There are several bills now before both Houses of Congress, I believe, and I have no idea when they may be acted on.

Mr. MACDONALD. Chairman Jack Brooks and Lee Metcalf on the Senate side recommend that the Senate and the House both be open.

Mr. LOOMIS. Those bills have been now formally before both Houses.

Mr. GUNN. I think in both cases they have recommended that there be at least some period of closed circuit transmission so that the Congress, itself, can look at the coverage and make a determination as to whether to make it available to broadcasters.

Mr. WIRTH. I would hope maybe we could open up the Democratic Caucus as well. It would probably be a very healthy phenomena.

Mr. LOOMIS. That would be very interesting.

Mr. MACDONALD. The time of the gentleman has expired.

Mr. WIRTH. The discipline of the committee strikes again.

Mr. MACDONALD. Did anyone take a survey of about how many schools carried that program, take a poll of the children who became disillusioned with the State legislature?

Mr. LOOMIS. The figures that I saw indicated that a fairly large number of the children voluntarily listened in even during the evening when they didn't have to because they got sufficiently interested in the subject.

Mr. MACDONALD. We are a little off the track.

As Mr. Wirth has indicated, many subjects have been raised here this morning.

At the moment we are talking about the past. I would like to get to the future. I hope that we will. And one thing that I noticed in at least two statements is that you seem very proud of he station program co-op, and that everyone is pleased with this operation but the co-op, it seems to me, are the ones that make the decision about the programing; is that right? And yet in that programing there have been very, very few minority programs. Is that going to be improved or are there plans to get more minority programing going?

Mr. BENJAMIN. That, Mr. Chairman, is the province of the innovative programing sector of the family. Not only should the cooperative——

Mr. MACDONALD. It sounds like The Godfather.

Mr. BENJAMIN. No, just the nephew. The idea of a cooperative being the major source or the sole source of programing would be very deleterious because it would only mean those programs that have been on have the best chance of continuing. You have to have a replenishment of programing. A process of going onward.

Mr. MACDONALD. Well, who is going to see to it that there is more minority programing? That is what I am really talking about.

Mr. BENJAMIN. I should say in the pilot stage and in the processing of experimental programs CPB takes minority programing one of its highest priorities.

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Mr. MACDONALD. What is being done?

Mr. BENJAMIN. That is not exclude——

Mr. MACDONALD. What is being done?

Mr. LOOMIS. We went out on specifications for black cultural shows and have 70 proposals which are now being considered. We are piloting a Spanish show called Realidades being done in New York and also women—if again you want to count them as a minority, they tend to be erroneously put in the same category—we piloting a show on women as well.

Mr. MACDONALD. When it is piloted does it just go on one station?

Mr. LOOMIS. No. When it is piloted it is given to all stations free and they of course make the decision whether or not to show it. The concept that is being developed is that the Corporation will have the main responsibility of trying to develop new shows in areas where there are now insufficient programs.

Mr. MACDONALD. When is this all going to happen?

Mr. LOOMIS. It is happening now. The money that we have for national programing, which is only the $10 or $11 million which Mr. Benjamin spoke about, we are now putting a major portion of that into the cooperative, but, we will be phasing out of that.

The remainder of the money, currently in the order of $6 million, is for the piloting and the first and second year showing of new shows, so that when the stations have to make the decision as to whether they want the show or not, they will know it. They will not be making a decision from a brochure. They will have seen the show. They will the judgment whether or not they wish to keep it.

Mr. MACDONALD. Do you have a breakdown with you or will you furnish as soon as you can for the record what percentage of shows offered to the local stations could be considered minority programing? Now——

Mr. LOOMIS. In this year I have a total of $5.7 million or about 1 percent of the 12 percent of the total. Now, the most expensive ones are done by the Office of Education, "Villa Alegre" and "Carrascolendas" both of which happen to be Spanish.

We must remember that the sources of programing as well as the sources of funds are very diverse. The cooperative only provides for 25 percent of the money in the national program schedule. CPB provides about 10 percent and other supporters, meaning the other Government organizations, corporations, foundations, and so forth, supply the remainder. These are diverse sources.

Mr. MACDONALD. OK. So that doesn't actually come under this bill.

Mr. LOOMIS. That is correct.

Mr. MACDONALD. So when we go to the Floor here and the minority programming question comes up, how do we answer it?

Mr. LOOMIS. For the record, I did give you those figures.

Mr. MACDONALD. All right.

I hope you do that, Mr. Loomis, and of course at the same time the minority hiring practices and women are a minority, if not in the country then in your industry, and therefore I would like the women included as well.

Mr. LOOMIS. I understand, sir.

Mr. MACDONALD. Are there any programs in any of the organizations, the various arms of the family so-called, that have an affirma-

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tive program now working to latch onto and bring in qualified minority professionals?

Mr. LOOMIS. Well, the program I mentioned earlier, where we are spending about $200,000 a year paying half the salaries of minority people that have been given responsible jobs by the stations. The station is paying the other half. This was arrived at as being a sufficient carrot to have people take affirmative action.

On the other hand, we are not giving them a free person, who they might then just put up as a window dressing. By paying 50 percent they have to put their money into it so they will get people whom they will really use.

Mr. MACDONALD. When you say "they," does this go to all the stations?

Mr. LOOMIS. The grants are available to all the stations who compete for them. We get about four times as many applicants for this program as we are able to fund.

Mr. MACDONALD. In other words, you figure that they are going to get a full body for half cost and therefore will go get them?

Mr. LOOMIS. And they will work at it and many of the stations are.

Mr. MACDONALD. They have not done it yet?

Mr. LOOMIS. Oh, yes, We have about 50 of them.

Mr. MACDONALD. When did that program go into effect?

Mr. LOOMIS. Two-and-a-half years ago.

Mr. MACDONALD. The percentage you gave me of minorities still is very low in the professional field.

Mr. LOOMIS. Well, of course, the trouble is when you are dealing with a total mass of 8,000 people it takes a significant number of individuals to change the percentage.

Mr. GUNN. Mr. Chairman, I think it is also true that many of our stations who have employed and developed minority talent have found that that talent then moves on to higher paying jobs.

Mr. MACDONALD. That is what was said last year and who replaced them?

Mr. GUNN. We have to constantly feed them in.

Mr. MACDONALD. Well, those ought to be new.

Mr. GUNN. They would be new, but they won't raise our totals. That is, even though we make a considerable expenditure——

Mr. MACDONALD. Well, it is a soft spot. I will just put it that way. It is a soft spot in your programing content and it is a soft spot that the subcommittee and the committee will be hard put to defend if we take it to the floor, so what I am asking for is some kind of proof that you are firming up the soft spot.

Mr. GUNN. Mr. Macdonald, our board just this past year set up a committee on minorities and women's affairs. One of their first actions was to empower the staff to develop, and distribute to all stations for the first time a complete compendium of all the equal employment opportunity obligations for public television stations. Prior to this it was almost impossible for a public television station to meet its obligations because there was no single manual available to detail all of the responsibilities of the various level programs. That has been pulled together and has been distributed, and I think will be very helpful to stations now enabling them to better meet their obligations and to encourage them to do so.

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Mr. MACDONALD. I am not satisfied with the entire answer but time makes me go forward. I am not going forward with a pat on the back. I am just going forward and hope you can get cracking on this subject. It is not easy to do, but then it is necessary to do if we are using tax dollars and living up to fair employment standards.

I don't think there is enough, so I would hope if you have anything to do with it, Mr. Gunn, that you get cracking and also radio and also the programing board.

I have one question about radio stations and time is marching on. I want to to get back to some of the other members who have some questions.

The FCC statistics say that there are 700 noncommercial stations—and yet I understand it is about 155 or so, in that area—are eligible for CPB grants. Why is that?

Mr. COFFEY. Mr. Chairman, there are now about 176 stations of the 720, and it really goes to the 10-watt problem that I discussed in my statement. Most of those other stations are only 10 watts of power, which means they have——

Mr. MACDONALD. They are the ones you would like to see off the air.

Mr. COFFEY. Well, either that or moved, so that in many cities with many major population centers we could at least get coverage. I think that the attitude the FCC assumed in 1946 was that the 10-watt station would come on the air and then build itself up.

In fact, in many instances that has not happened. It is simply a mini-station operating in a local high school for the entertainment and training of the students because its signal could not get much further than the schoolyard.

Mr. MACDONALD. Do these go for the college stations?

Mr. COFFEY. Well, they are increasingly coming up to full power, but most of these stations wind up being in high schools around the country and are training ground kind of activities where the school has never had the resources to build it into a full public radio station serving the general public in the community.

Mr. FRISCHKNECHT. The purposes for which most of those stations are created are simply not to serve the community at large. They are for training for student extracurricular activities and whatever.

Mr. MACDONALD. Thank you. That answers my question.

My last question for now is—and it seems we have the same problems every time we have a hearing.

I got a letter dated February 18, 1975, from Video Tape Production Association, and if you remember what we went through with Mr. Goldwater, who was besieged by his people out around Burbank, and I, too, was besieged by that enterprise. This said that the public broadcasters were competing unfairly with private business by using equipment that was bought in large measure with public funds.

This man came and testified—I recall him very well and I thought that was all taken care of, and now here, as soon as we have a hearing, it is raising its head again in letters and people wanting to see me in the office. And I can't believe that you have not stopped that.

Mr. LOOMIS. My understanding, Mr. Chairman, is that the HEW Facilities Act supplies the equipment used, which is where the facilities' money comes from, HEW, we don't have facilities' money as such. I understand Secretary Weinberger has put out a very strong

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letter, an absolutely unequivocal letter about a year ago making it crystal clear that no equipment that they fund can be used in any way for commercial purposes.

It is a fact, however, that in most stations most of the equipment has not been funded from Federal sources. It has been funded from local sources——

Mr. MACDONALD. Well, but as I recall, Mr. Loomis, you indicated public broadcasting facilities studios and so forth would not be used for private programing, and I think that is only right. Private people putting up their own money should not be rivaled by aprogram that is at least partially funded and is going up all the time, which I have no quarrel with at this moment, that they should stay out of competition with private enterprise.

Mr. LOOMIS. I think that certainly is the principle that we agree on. There have been in the past individual licensees who have chosen to have on occasion small additional contracts, which is entirely legal——

Mr. MACDONALD. I am not saying it is not legal. I am just saying it is not right.

Mr. LOOMIS. Yes. We discourage it. We certainly do.

Mr. FREY. Will the chairman yield?

If it is legal, you know, maybe we ought to take a look at the subject, Mr. Chairman, and write something in the bill.

Mr. MACDONALD. We had everybody's assurances it was going to be stopped.

Mr. ROGERS. Mr. Chairman, let's just assume that everyone is in agreement they should not do this, and let's assume that there are violators of this law, this agreement, as there are violators of laws and agreements every day in this country.

If you will look at the substance of this, I don't think it is worth the chairman's time because this wouldn't amount to—out of the $220 million that is in public broadcasting what is returned is a very small amount for a Nation this size. This wouldn't amount to $1 million a year, and the cost of policing it would be greater than the amount.

Mr. GUNN. Mr. Chairman, I think there is another problem, too. We are dealing with sovereign entities here who in many cases are State universities and schools and school boards. It is difficult, if not impossible, and I think undesirable for us to tell them what they can and cannot do with their facilities.

We know universities rent out at least their stadiums, or other facilities, or their halls, and I think it would be inappropriate for us to tell a university how to use its resources.

We might deplore that use but I think we could not enter into a local university and say it cannot use its studio or cannot use its auditorium for those purposes.

Mr. MACDONALD. You can say you won't give them any money.

Mr. GUNN. Yes; we could do that.

Mr. MACDONALD. You don't say you are powerless to do that.

Mr. Byron.

Mr. BYRON. No questions.

Mr. MACDONALD. Mr. Wirth.

Mr. WIRTH. No, Mr. Chairman.

Mr. MACDONALD. One of the problems we will have to get over is—I want to be sure I have got the figures right before I go into this in great depth—the amounts of money, asked during the 5-year program.

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Why do they keep going up each year in the request that everybody has made? In 1976 you want $88 million, and for the period of 1977 you want $103 million, and $121 million the next year, $140 million then by 1980. It goes up to $160 million for a total of $634 million.

With the depression and the people out of work and the difficulties that we are having, if we come out with this amount I think a lot of people who are for public broadcasting will say, well, yes, public broadcasting is great, but it doesn't have the priority that some of the others perhaps have.

Mr. ROGERS. Mr. Chairman, let me talk to this. We are not asking for any $88 million or $160 million——

Mr. MACDONALD. Well, you recommended——

Mr. ROGERS. No; we are not recommending that. What we are saying is, what we are recommending, that you put a ceiling not to exceed these figures based on our ability to raise 2½ times that 2 years previously.

Now, if we don't raise $2½, you don't give us a dollar, and all this is an incentive for us to raise more and more money.

Now, the question of how much you need to operate this system is covered thoroughly and in detailed fashion in the task force report of which you have a copy. This doesn't begin to do the job that you want us to do, but we are not asking you to authorize or we are not asking the committee to appropriate money except in relationship to what we raise, and we have to raise $2.50 for every dollar. That is just the ceiling. It can't go beyond this. There is no guarantee that we are going to reach that ceiling.

Mr. MACDONALD. That is a good answer. But outside of the funding you are in agreement with the administration in every respect?

Mr. ROGERS. We are in agreement with the compromise.

Mr. MACDONALD. Well, the bill that the administration sent up, which you probably had a hand in writing as far as that goes.

This is not our room. I am told that the Small Business Committee is going to have some kind of luncheon here and we should expedite getting out, but I have not seen anyone come in to give us the out sign.

Mr. WIRTH. Mr. Chairman, you know you have talked a good deal about decentralization and I think part of that problem comes from the need to isolate or insulate the corporation as much as possible from Uncle Sam.

I would agree wholeheartedly with that. I have one fear in the back of my head which relates to increased amounts of money going to the corporation which immediately engenders thoughts of large office buildings jammed with corporation bureaucrats operating uptown somewhere.

What are you doing, what kind of cutoff do you have in terms of percentage of people who work overall for the corporation? Are you all concerned about the notion of this getting concentrated in Washington and its operation?

Mr. LOOMIS. We are very concerned with keeping overhead, which means our staff, to the absolute minimum and in the projection for the next 5 years there is no significant increase in staff whatsoever.

Again, it should be pointed out that the vast majority of the increased funds go directly to the stations. It doesn't require any more work on our side. You just figure out the amount, write the same

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number of checks, just have a bigger number on the checks, so that there is no reason that there be any more staff on our side to do that.

Most of our staff is in the common services such as doing research and particularly doing the piloting, and the amount of money that we see for piloting does not increase significantly. In fact it actually goes down slightly for the next few years so we think our staff should remain and must remain, for all intents and purposes, constant.

The increase that we see in the budget immediately is controllable by the board of the corporation. Really we feel there should be some flexibility so that we can have the ability to take advantage of unknow opportunities or to meet unknown crises.

For example, this last year the board voted $400,000 from its small reserve, which is only $3 million, to public radio to try to help them establish new stations in these 36 major markets that now have no stations.

The next year, which is giong to be for the next fiscal year, the board agreed to take a million and a half again out of this tiny reserve, to give to public television for additional support of the station cooperative.

We feel as the total budget gets bigger the call for this emergency fund will, in turn, get bigger and this is the only flexibility there is in a $200 million operation. And, as you know, a discretionary fund can be the most efficient thing you have because a little bit of money can make all the difference.

Mr. BENJAMIN. May I add, Mr. Chairman, the preoccupation by the board at Corporation for Public Broadcasting on the subject of piloting and creating more diversification of programs has been so frustrated by our inability to do it adequately or enough that if there were any moneys left over it could well be put to one of the very fundamental principles on which CPB was created to give the local stations free choices and not have them confined to one set of programs. The more we pilot, the more diversification and more choice, and we have never had within millions enough for that, the priority of the board is for piloting in order to help Public Broadcasting Service have a better choice in the cooperative as the years go by.

Mr. WIRTH. Mr. Chairman I would just summarize my reaction by saying I am a great enthusiast for this kind of decentralization as one of a number of steps that we have to maintain for the insulation of of public broadcasting from the Government, and I would hope that the board members and board appointments and your operations and the whole demeanor would continue to emphasize that, and I think that is what the people of this country want. They don't want the feeling that they are having any possibility of the U.S. Government coming into their livingrooms.

I appreciate your comments on that subject.

Mr. MACDONALD. Just two last questions, the first dealing with States.

Has the Corporation for Public Broadcasting taken any action to do anything about those nine Alabama stations that were denied licenses by the FCC?

Mr. BENJAMIN. The step we took, Mr. Chairman, was to continue to fund them and attempt to improve their programing and their service to their community, pending further developments, and one of the considerations is the showing they will make before the FCC as they seek new licenses.

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If we cut them off interimly we are frustrating the public far more than we are the stations by denying them the programing and taking the language of the FCC and decision literally——

Mr. MACDONALD. I am not quarreling with you, but the FCC has been terribly reluctant to lift anybody's license about anything, so they must have been doing something very bad. I don't know what it was but to keep funding them when they are not licensed to broadcast, I am just making inquiry, do you think that is wise?

Mr. BENJAMIN. We first gave notice of our decision to terminate unless they made a showing to us that they ought to be continued funding. We were appealed to by the Civil Liberties Union not to cut them off. The very people who opposed the renewal asked us not to cut them off at this time.

Mr. MACDONALD. What were the violations?

Mr. BENJAMIN. Denial of black programing to a substantial segment of the minority of the State. About 7 years ago.

Mr. MACDONALD. You are still funding them?

Mr. BENJAMIN. Pending the resolution of the whole question of what they are going to do to correct——

Mr. MACDONALD. They are still innocent until really proven guilty. Is that it?

Mr. BENJAMIN. Yes, if you like, or to encourage a conversion.

Mr. LOOMIS. I might point out, Mr. Chairman——

Mr. MACDONALD. Like "rather one returned sinner," the Biblical parable.

Mr. LOOMIS. They are operating under an interim commission so that the FCC has not lifted their license. It did not renew their license from 1967 to 1970. They are operating under interim license now and have been authorized as a special case to request a new license come next month. The FCC decision at that time obviously will determine our board's reaction.

Mr. MACDONALD. And if the FCC says, you still have not corrected this, then you stop funding; is that correct?

Mr. LOOMIS. That is correct.

Mr. MACDONALD. My last question, because of the time I guess, will be that which came as a bit of a surprise to me.

It was contained in a publication that is very well known, but I think we might want to enter it. It is called, "The Media Report," and under the heading of "Government in Media," I will read some of it. Some is a little vitriolic.

Strategically unattuned as usual, the Washington public broadcasting community has not yet tumbled to the enormous implications of a new station scheduled to go on the air this summer. The Maryland Center for Public Broadcasting, with studios and headquarters located at Owings Mills, Maryland.

And it is presently under construction near Annapolis—

The most powerful television transmitter, 5 million watts, of any kind in the United States. The driving force behind the project, Dr. Frederick Breitenfeld—

Whom I know you are familiar with. He testified here a couple of years ago—

Who knows that he is going to blanket all of the Washington area and WETA, which is in tough shape anyhow, which has a very poor signal, and may go out of business. Will someone alert WETA that the whole thing will go up in a big cloud of smoke, that they had better get cracking and do something?

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Have any of you heard about this?

Mr. LOOMIS. Oh, yes, sir. This has been on their plans for some time. It has been in construction for about a year.

Mr. MACDONALD. This doesn't have anything really to do with the Federal Government?

Mr. LOOMIS. No, not at all. They may have had an HEW facility grant.

Mr. GUNN. They did have an HEW facility grant. We have brought it to the attention of WETA because it will be an issue of some concern.

Mr. MACDONALD. Five million watts?

Mr. GUNN. That is needed by Maryland in order to reach their southern counties down this way. They are required, as the State commission, to reach the entire State of Maryland and in so doing they are going to put a signal over in the District of Columbia, and this electronically can't be prevented.

It does pose a problem, however, to WETA and we have called it to their attention. It means that WETA should increase the effectiveness of their signal as quickly as possible.

Mr. BENJAMIN. For that and other reasons.

Mr. LOOMIS. Mr. Chairman, this is not a unique problem. There are other cases where stations overlap in an area. It is inevitable.

Mr. ROGERS. Mr. Chairman, I never heard of this before but just to look at the other side of that coin, public broadcasting is in existence to serve the people of the United States. Some of the people of the District of Columbia are not being served adequately today because WETA's signal does not reach them.

Now, if this new signal will reach them, perhaps this will be beneficial rather than detrimental.

Now, the question of WETA's problem here is not solely within their control. They have petitioned the Federal Communications Commission time after time to get a VHF signal in here and many other things which we don't have the time to get into today. But you will find in my statement that I refer to the fact that there is a great deal that needs to be done to improve UHF reception in the United States and there are a lot of things that are needed to improve public broadcasting in the United States, and it is very difficult to do this with a paltry amount of money that is available to do it. We need your help.

Mr. MACDONALD. That has a familiar ring to it.

I take it that that station has been a production station.

Mr. LOOMIS. Oh, yes.

Mr. GUNN. Both of them are, both Maryland and Washington.

Mr. MACDONALD. Thank you, gentlemen, very much.

That is the call of the House.

We look forward to having you back about the oncoming bill.

The hearing is adjourned.

[Whereupon, at 12:15 p.m., the hearing was adjourned.]

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OFFICE OF TELECOMMUNICATIONS POLICY OVERVIEW

HEARING

BEFORE THE

SUBCOMMITTEE ON COMMUNICATIONS

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

ON

THE FUNCTIONS AND ACTIVITIES OF THE OFFICE OF TELECOMMUNICATIONS POLICY, EXECUTIVE OFFICE OF THE PRESIDENT

MARCH 13, 1975

Serial No. 94—7

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OFFICE OF TELECOMMUNICATIONS POLICY OVERVI

THURSDAY, MARCH 13, 1975

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON COMMUNICATIONS,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D

The subcommittee met at 10 a.m., pursuant to notice, in room
Rayburn House Office Building, Hon. Torbert H. Macdonald, c
man, presiding.

Mr. MACDONALD. The hearing will come to order.

This morning the Subcommittee on Communications meets fo
purpose of overview hearings involving the Office of Telecommu
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Because of a scheduling problem within the Department of
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SUBCOMMITTEE ON COMMUNICATIONS,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
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Because of a scheduling problem within the Department of Commerce, witnesses representing the Office of Telecommunications of the Department of Commerce are not able to be with us in person this morning.

However, our subcommittee staff has submitted to them a series of written questions responses to which will be made a part of the record later on during these hearings and it is entirely possible that on the basis of what we discuss here today the subcommittee may want to extend these hearings to include actual participation by the Office of Telecommunications of the Department of Commerce in order to expand on some matters that the interrogatories touched on.

The telecommunications industry, which I don't need to tell Mr. Eger and others, is one of the largest and most important in the entire Nation.

Telecommunications are essential to the security, welfare, and commerce of the country. It is for this reason that the Subcommittee on Communications, being released of some other duties, plans this year to become increasingly involved with those offices and agencies that are charged with formulating telecommunications policy.

The Office of Telecommunications Policy in the White House was established as a result of Reorganization Plan No. 1 of 1970, which came out of the committee on which I also serve, the Government Operations Committee.

Its creation grew out of a desire to provide a greater policymaking capability for the Government in the field of telecommunications and provide more effective coordination of Government use of telecommunications.

As has developed over the years since 1970, OTP got into a lot of matters which we did not mention at the time they were being formed within the Government Operations Committee.

While representatives of OTP have appeared before this subcommittee a number of times, we never have had a full opportunity to

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pursue extensive oversight of the functions of this office and its related offices.

The purpose of these overview hearings this morning is to begin what will become a continuing process of oversight by this subcommittee in the broad area of telecommunications.

Before we hear from Mr. Eger and the others he has brought up with him today, I would like to restate what has been a continuing concern of mine and, I expect, other members of this subcommittee.

When OTP was established in 1970, as I indicated, Congress made it clear to them that they were not to intrude on the prerogatives and functions assigned to the Federal Communications Commission, which of course is an arm of the Congress, and within the legislative jurisdiction of this committee.

Frankly, over the past 4 years, as I indicated, I have seen instances where OTP seems to have crossed the line between partnership and interference with the FCC. On many of these occasions I have spoken out in response to these actions by OTP. But because new personalities are now involved in OTP, I want to take this opportunity to indicate that, while I recognize the many areas in which OTP has been performing splendidly, I am still very much concerned that the prerogatives of the FCC not be encroached upon.

It has also come to my attention that there has been a continuing source of friction within the administration as to the role of OTP and the Office of Telecommunications of the Department of Commerce in formulating telecommunications policy.

It is not the intention of the subcommittee to become involved with what appears to be, from the outside at least, an internal bureaucratic power struggle. This subcommittee will not hesitate to take an active interest when those internal struggles, if indeed they are, and which we will go into at greater length with Mr. Eger and others, inhibit the formulation of a coherent telecommunications policy.

As a nation we are challenged by the need to utilize effectively our telecommunications resources to provide for the growth and development of our society.

Mr. Eger, we welcome you here this morning. If you will, you may proceed with your statement.

STATEMENT OF HON. JOHN EGER, ACTING DIRECTOR, OFFICE OF TELECOMMUNICATIONS POLICY, EXECUTIVE OFFICE OF THE PRESIDENT; ACCOMPANIED BY HENRY GOLDBERG, GENERAL COUNSEL, WILFRID DEAN, JR., ASSISTANT DIRECTOR FOR FREQUENCY MANAGEMENT, CHARLES C. JOYCE, JR., ASSISTANT DIRECTOR FOR GOVERNMENT COMMUNICATIONS, WILLIAM L. FISHMAN, ASSISTANT DIRECTOR FOR INTERNATIONAL COMMUNICATIONS, AND ROLAND HOMET, CHIEF, STUDIES AND ANALYSIS

Mr. EGER. Thank you, Mr. Chairman, and members of the subcommittee.

At the outset I will say that I certainly agree with your statement regarding the goal and the role of telecommunications in the executive branch. I am appreciative of your observations and your concerns.

Let me say also at the outset that I share them. I hope during the

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course of this hearing that we will be able to respond to some of those concerns.

We do very much welcome, Mr. Chairman, the subcommittee's increasing involvement in the area of telecommunications. We particularly welcome this opportunity to appear before you to discuss the functions and the activities of the Office of Telecommunications Policy over the last year.

Accompanying me today are my General Counsel and Assistant Directors of OTP. If I may, Mr. Chairman, I would like to take this opportunity to introduce them to you.

Mr. MACDONALD. Please do.

Mr. EGER. On your far left is Mr. Wilfred Dean, Jr., Assistant Director for Frequency Management. Next to him is Mr. William L. Fishman, Assistant Director for International Communications. The General Counsel, Mr. Henry Goldberg. Mr. Roland Homet, Chief of a new office at OTP called Studies and Analysis. Next to him is Mr. Charles Joyce, Jr., Assistant Director for Government Communications.

My statement today, Mr. Chairman, is rather brief and only touches some of the highlights of OTP's activities during the past year, leaving, I hope, some opportunity for discussion of the issues of particular concern to the subcommittee.

We have provided a current OTP activities report to the subcommittee. If I may, Mr. Chairman, introduce that activities report into the record.

Mr. MACDONALD. Without objection, it is so ordered. It may become a part of Mr. Eger's statement.

Mr. EGER. As you know, OTP was created 5 years ago pursuant to Reorganization Plan No. 1 of 1970, following hearings before the House Government Operations Committee. Under the Reorganization Plan and Executive Order No. 11556 assigning additional responsibilities to OTP, the Office performs two essential functions:

1. It serves as the President's principal adviser and spokesman on communications policy, covering a wide range of domestic, international government, and private sector issues;

2. Most importantly, it formulates policies and coordinates cost-effective operations for government communications systems, including assigning and managing frequencies used by Federal agencies, exercising the President's statutory responsibilities under the Communications Act and the Comsat Act, and providing policy direction for the National Communications System and emergency communications.

A major focus of our activity in the past year has been on the Federal Government's own use of communications systems and services. All Federal agencies utilize telecommunications to one degree or another, and the total Federal expenditure for communications is in the neighborhood of $10 billion per year.

It is OTP's responsibility to provide policy direction and coordination for these activities, to minimize overlapping and inefficient systems, and to evaluate the ability of existing and planned systems to meet national security and emergency preparedness requirements.

As a first step in meeting this responsibility we have established a Government communications planning program, initiated by OTP Circular 12, requiring each department or agency to document its

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long-term communications planning and submit those plans for interagency coordination and review.

We have now received and reviewed the first set of annual summary plans, which is basically an inventory of Federal communications utilization programs at this point, and have offered guidance to the departments and agencies for their 1975 activities. This first phase of the planning program will provide the foundation for future long-term planning efforts.

Within the framework of the planning program we recently completed an assessment of the cost-effectiveness of various system alternatives in two important areas: Radio navigation and emergency warning. With regard to the former, we are working to consolidate the Government's radio navigation program with the goal of reducing the number of systems that are operational or under development. I think in this area we have made some significant strides.

As to emergency warning, we have designated a single, cost-effective system as the means of communicating attack or disaster warnings to the general public in their homes. I might add at this point, Mr. Chairman, and this just came to my attention recently, that the President's 1976 budget includes $3.6 million to establish this VHF–FM broadcasting system.

Another initiative we have undertaken with regard to the Government's use of communications is the establishment of a formal policy of reliance on the private sector for communications system design, engineering, operation, and maintenance. In the absence of such a policy, agencies had been free to piece together their own customized communications systems; often at great cost, even if adequate service was commercially available.

Under our new policy, issued as OTP circular 13, agencies are encouraged to procure communications services from commercial sources except when commercial service is unavailable, technically or operationally inadequate, or significantly more costly.

In addition to overall coordination of government communications activities, OTP is vested with the authority for the management and assignment of radio frequencies used by the U.S. Government. As you know, demands on the spectrum, a limited natural resource, have increased dramatically in recent years, thereby giving rise to a need for more enlightened planning for future use. In order to ease the spectrum shortage problem and to assure frequency availability for telecommunications systems prior to the commitment of public funds, OTP instituted procedures in 1972 requiring all government agencies to submit their frequency plans well in advance of any budget commitment or commitment to procure equipment.

The benefits of this program are becoming increasingly apparent, particularly regarding electromagnetic compatibility, system interoperability and the prevention of harmful interference among the various users in the Federal establishment and, I might add, among the non-Federal establishments.

Another spectrum matter of continuing concern and one which is receiving increased attention is the effect of nonionizing electromagnetic radiations—radio transmissions—on human life and on the environment. We have been coordinating a multiagency effort involving testing and research to assess the potential biological and non-

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biological hazards of these radiations, and we are about to issue our third annual report on this subject.

In addition to our activities involving the Federal Government's use of communications, we have been busy during the past year on several issues relating to communications in the private sector.

As you know, the President's Cabinet Committee on Cable Communications, chaired by the Director of OTP, made public in January 1974 several policy recommendations requiring congressional action. OTP has now prepared draft legislation to implement certain of these recommendations and to provide a vehicle for expressing a national policy on the development of cable as a communications medium in its own right. The draft bill was submitted to the Office of Management and Budget in December 1974 for executive clearance and is expected to be sent to the Congress in the near future.

We have also drafted legislation to provide long-term Federal funding for the Corporation for Public Broadcasting—CPB. As this committee knows, when Congress created our system of public broadcasting in 1967, it envisioned the eventual adoption of some form of long-term funding to insulate the medium from the possibility of Government influence over programming that is inherent in the annual appropriations and budgetary processes of the Congress and the executive branch.

The administration's bill, which was sent to the Congress last July and resubmitted to the 94th Congress last month, would achieve this objective by means of a 5-year matching appropriation keyed to the level of non-Federal contributions to public broadcasting. Additionally, the bill would assure that a significant portion of the Federal appropriation is distributed by CPB to local public broadcasting stations.

While we are on the subject of broadcasting, I would like to mention that on the basis of a study completed in 1973, OTP determined that a substantial number of Americans residing in rural areas were deprived of an adequate level of television service. A second study, in 1974, examined the feasibility of improving rural service by means of a mixture of various technologies, including cable television, microwave and broadcast translator service.

Based on these studies, we have suggested, among other actions, a reexamination of certain FCC rules which appear to presently inhibit the combined operation of these different television distribution technologies.

We of course are interested in other communications problems affecting the rural areas and are intent on continuing our studies in this area. We have also continued our studies of common-carrier communications services, particularly the areas of data communications, pricing policy and resale of basic transmission capacity. With regard to the latter, we recently forwarded to the FCC policy recommendations to liberalize the present restrictions on resale and shared use of common-carrier services with the objective of promoting more innovative and diversified services while at the same time achieving more efficient utilization of existing common-carrier facilities.

As a corollary to this recommendation, we suggested that resale functions be allowed to develop in a competitive milieu and that the Commission refrain from unnecessary and burdensome regulation of these types of activities.

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International communications continue to demand a major portion of OTP's attention, and I would like to mention briefly two issues in particular. The first involves the growing interest in the international community in a global satellite system for providing communications to civilian ships on the high seas. The Soviet Union and the Western European nations, led by the United Kingdom, have advocated the creation of a new international organization to provide such a service.

A worldwide conference will be convened next month to discuss the technical, economic and institutional arrangements for a global maritime satellite service, and OTP has been coordinating the development of the U.S. policy position on these issues in preparation for the conference. Our principal concern, among others, is to insure that U.S. participation in any new international organization be on terms which permit private carriers to participate fully in the system.

A second issue of major current concern in international communications is the need for improved processes for planning and authorizing the construction of new international transmission facilities. OTP, together with the FCC and the State Department, recently met with European telecommunications authorities to review long-range telecommunication facility planning for the North Atlantic Basin. This meeting provided an opportunity for both the Europeans and the U.S. representatives to clarify present policies and positions and laid a foundation for future development of improved traffic forecasts, systems reliability studies, and related analyses required for sound long-range systems planning.

Finally, Mr. Chairman, I would like to make brief mention of some internal organizational matters. We have recently formed within OTP a new Studies and Analysis Division designed to strengthen our capability to direct and oversee the technical and economic support functions which are essential to sound policy development.

In addition, we have had satisfactory experience with the consolidated budgetary arrangement, established last year at the request of the Congress, whereby OTP funds the frequency management and policy development support activities provided by the Commerce Department's Office of Telecommunications. I do not mean to suggest by this that the budgetary arrangement has solved all the problems relating to our Commerce Department support function, but I do believe that we have made some headway toward a more effective working relationship.

That concludes my prepared statement, Mr. Chairman, which as I mentioned earlier, touches only briefly on some of the highlights of OTP's activities. The subcommittee has been furnished with more detailed information concerning the activities and functions of the Office, and my colleagues and I would be pleased to answer any questions you may have at this time.

[The activities report referred to follows:]

EXECUTIVE OFFICE OF THE PRESIDENT—OFFICE OF TELECOMMUNICATIONS POLICY

ACTIVITIES AND PROGRAMS, 1974–75

FOREWORD

Calendar 1974 was the fourth full year of operation of the Official of Telecommunications Policy in the Executive Office of the President. The following report

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summarizes the principal activities of the Office for 1974 according to four broad functional areas—Domestic Communications, Government Communications, International Communications and Spectrum Management—and sets forth the principal programs contemplated for 1975. The report omits those activities related to internal organization and management and to routine operations such as review of legislation referred for comment by the Office of Management and Budget.

I. Domestic Communications

A. Cable Television and Broadband Communications

Because of the large channel capacity available in the modern cable system and its capability for two-way communications, broadband communications technology offers the potential for increasing consumer choice in television programming and for delivering a diversity of new communications services. However, despite the new dimensions which cable offers in the provision of expanded telecommunications services, it presently serves as little more than a retransmission device for carrying broadcast television signals to areas where over-the-air reception is marginal. Moreover, the framework for the regulation of cable communications is premised on a law that addresses only limited-signal technologies and that does not, therefore, recognize the potential for this new medium.

1. Cable Communications Act of 1975

In January 1974, the Cabinet Committee on Cable Communications, chaired by the Director of OTP, made public recommendations to deregulate cable communications. During 1973, the Cabinet Committee examined, with OTP staff support, the potential economic and social effects of integrating within a single company the functions of cable program production and distribution of information services to the consumer; the probable impact of expected cable growth on the broadcast and program production industries and the public; the problem of insuring access to the cable media by all segments of industry and the public; and the potential problems related to the joint ownership of broadcast, cable, interconnection, and program production facilities.

Based on this work, the Cabinet Committee recommended a new cable policy founded on the principle of separating cable system control over the medium from control over the messages distributed via that medium. The Committee proposed that programming, advertising and other information services on cable channels should be allowed to develop on a free and competitive basis, with no more Government regulation over its program content than is exercised over the print medium. It perceived cable of the future as a medium open to all for programming or for information services, at published, nondiscriminatory rates.

However, recognizing that a full separations policy should be applied only to a mature cable industry, the Committee recommended a transition period for gradual incorporation of new cable policies. In early 1974, OTP prepared a draft cable bill to implement certain of the "transitionary" recommendations of the Committee report, and to provide a vehicle for expressing a national policy for cable before further cable growth made policy changes impracticable. OTP drafted a final version of the bill, taking into account comments on the bill made by various agencies of the Federal Government, by interested parties, and by the affected industry. The bill was sent to OMB in December 1974 for Executive clearance; it is expected to be submitted to Congress in early 1975.

2. Rural Extension of Television Services

As a result of a study completed in 1973, OTP determined that under current broadcast distribution techniques substantial numbers of Americans residing primarily in rural areas were deprived of an adequate level of television service. The study suggested that service could be improved in these areas through a "hybrid" mixture of cable television, radio microwave, and broadcast translator technologies. In 1974, OTP initiated a second study to examine the economic feasibility of improving rural service by this "hybrid" method. The results of the study establish upper and lower cost estimates for the provision of three and five channels of television service nationally.

OTP has formulated policy recommendations on the basis of these two studies for submission to the FCC in early 1975. The recommendations will invite reexamination of certain Commission rules that inhibit the combined operation of the three television distribution technologies.

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3. Subscription Cable

In December 1974, OTP also completed the first phase of a study to evaluate consumer demand for direct subscriber purchase of television programs over cable. The study assessed consumer demand in terms of a variety of program services. Results will be used to determine the feasibility and potential impact on the broadcast industry and the public of subscriber-supported programming.

B. BROADCASTING

1. Public Broadcasting

When Congress enacted the Public Broadcasting Act of 1967, it envisioned the eventual adoption of a long-term Federal funding system. It felt that such a scheme would insulate the Corporation for Public Broadcasting (CPB) from the possibility of Government influence over programming inherent in the annual appropriation and budgetary processes of the Congress and the Executive Branch.

In 1974, OTP drafted and sent to Congress legislation that would carry out this intent. The bill would insulate public broadcasting from the annual appropriation and budgetary processes of the Federal government, would encourage through a matching system continued contributions from private sources, and would require that a substantial portion of the Federal appropriations be distributed directly to local stations.

Specifically, the bill provides for a five-year authorization and appropriation for Fiscal Years 1976–80, whereby each $2.50 of non-Federal contributions would be matched by $1.00 in Federal funds. The matching appropriations are not open ended, however—the bill imposes ceilings on the maximum permissible appropriation for each fiscal year, beginning at $70 million in 1976, and reaching $100 million in 1980. The proposed legislation also permits CPB to support the use and development of new communications technologies, such as satellites and cable, for the distribution of educational television programming. The bill is expected to be submitted in early 1975 to the 94th Congress, in essentially unchanged form.

2. License renewal policy

The regulatory license renewal process, which in recent years has been characterized by uncertainty and delay, has in OTP's view injected an undesirable measure of instability into the broadcasting industry. OTP therefore moved for legislative reform of the license renewal process to assure that existing licensees who are satisfactorily serving their communities can reasonably expect license renewal in the face of competing challenges by new applicants.

As part of its efforts, OTP submitted license renewal legislation to the 93rd Congress (S. 1589). It testified before both of the appropriate House and Senate Subcommittees during 1973 and 1974 on the license renewal problem, on the merits of its own bill and on those of other renewal bills pending in Congress. The OTP legislation proposed four revisions to the present broadcast license renewal process: The term of licenses would be extended from three to five years; policies concerning ownership qualifications would be made through rule-making rather than renewal proceedings; specific procedures would be prescribed in the event that a renewal application is challenged by a competing application; and the FCC would be prohibited from establishing predetermined performance criteria to evaluate programming at renewal time. Some of these recommendations were incorporated in H.R. 12993 as enacted by the House and amended by the Senate.

OTP, in addition to its testimony, provided assistance at the request of Congress in analyzing and comparing provisions of particular license renewal bills, including H.R. 12993.

3. Fairness Doctrine

The scarcity of channels available for over-the-air broadcasting has led to a unique application of the First Amendment to a medium of expression. Those who control broadcast outlets are required to inform their viewers of contrasting points of view on controversial issues of public importance.

This "fairness" obligation is enforced by the FCC on a case-by-case basis, with the result that the Government may become the arbiter of the programming and journalistic judgments of broadcasters. In a society founded on principles of freedom of expression, this process represents a troublesome intrusion by Government into the journalistic function.

Although the Fairness Doctrine (or some similar mechanism) may be necessary as long as there is not a greater diversity of outlets than there is today,

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the fairness obligation should be enforced in a way that minimizes detailed Governmental supervision of program content. OTP therefore recommended in its proposed license renewal legislation that the Fairness Doctrine be enforced through a review of a broadcaster's overall performance at license renewal time, rather than in the present case-by-case fashion.

OTP will continue to explore various alternatives for resolving the current Fairness Doctrine problems and will continue to assist the Congress and the FCC in their efforts to enhance free expression in broadcasting and to minimize Governmental intervention.

C. MOBILE COMMUNICATIONS

Advancements in technology have fostered in recent years a rapid growth in the use of mobile communications. However, insufficient portions of the radio spectrum have been made available to meet the increased demand for mobile radio services.

OTP commenced a program in 1972 to assess new mobile radio systems and services and to formulate policy guidelines for the development of the mobile industry which would allow for maximum competition both in the manufacture and sale of equipment and in the actual provision of services to the public. OTP completed its study in 1973 and submitted its recommendations to the FCC. The suggested allocation plan was designed to encourage industry investment in new technologies and services while avoiding over-commitment to any particular service or technology.

During 1974, OTP has continued to study potential uses of mobile communications and methods for improving spectrum efficiency and has examined the likely effects of cross-elasticities of demand for new mobile services on existing ones. OTP has also directed special attention to one-way paging services—an area which has grown at twice the rate of other portable communications services. It has initiated a number of studies to determine the potential economic, technical and marketing implications of implementing one-way paging services on a local, regional or nationwide basis.

D. COMMON CARRIER COMMUNICATIONS

The introduction of competition into the common carrier marketplace and the growing demand for new, diverse and flexible communications services have combined to produce an expansion of services and equipment available to the public. During 1974, OTP has directed its efforts toward a review and analysis of competitive communications service offerings in this area in addition to an examination of data communications and common carrier regulation.

1. Data communications

In recent years, the computer and communications industries have been converging with several important results. The integration of computers into communications technology has enabled, or made considerably less costly, new modes of transmission, switching, network design, and system administration. Conversely, the addition of communications to computers has resulted in increased sharing of data-processing resources and pooling of information banks. Remote access to computers has opened up new opportunities in such areas as business, education, and social services.

OTP, in conjunction with the FCC, has encouraged new opportunities in the data communications marketplace, specifically, the offering of competitive data services by three different categories of companies: (1) specialized common carriers, such as those providing switched, all digital networks specifically engineered for data communications; (2) "value-added" service vendors, which purchase basic transmission capacity from existing carriers and add the processing, switching, and control equipment necessary to form specialized networks for data communications; and (3) the Bell System itself, which in 1974 filed tariffs for a special data transmission service, the Dataphone Digital Service (DDS).

OTP has maintained an active interest in data communications and in 1974 initiated a study of the level of demand for data communications services. The results of the study will serve as an independent, impartial source of information on current and projected data traffic, and will be used by OTP to conduct further qualitative and quantitative evaluations of the problems arising from competition in this expanding market.

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OTP has been particularly concerned with the complex problems of pricing competitive service offerings such as DDS. Since AT&T is a regulated company, the FCC must approve the price and other terms and conditions for its DDS service. This, however, is no easy matter, given the difficulty of appropriately allocating the common costs of competitive services and monopoly services offered by the same firm. In 1974, OTP, with the aid of its Department of Commerce support group and an outside contractor, examined the economic theories which deal with the problem of pricing competitive service offerings and developed a pricing model of its own. The OTP model utilizes the principle of maximizing the benefits and services to the consumer while allowing the carrier to recover at least its costs and a reasonable profit. The model, though applied specifically in the study to the case of DDS, is broadly applicable to all problems of regulated monopoly, particularly when that monopoly has entered a competitive market. In OTP's view, such a pricing model can make a valuable contribution to the development of criteria for fair competition and equitable prices in all segments of the communications industry.

2. Competitive communication services and equipment

The FCC has now opened up to competition two markets once dominated by AT&T and independent telephone companies—the interconnect (terminal equipment) and long-haul transmission markets. The 1968 Carterfone decision permitted subscriber purchase and connection of terminal equipment—such as answering machines, key sets and private branch exchanges—manufactured by independent suppliers. The long-haul transmission market was opened to the specialized carriers by the FCC in 1969. Data transmission is one important part of that market.

In mid-1974, OTP released the results of two major studies of telecommunication cost structures. Both studies examined economies of scale in the provision of telecommunication services. If economies of scale are present, the introduction of competition with its corresponding benefits must be balanced against the cost penalties associated with the division of the market among multiple suppliers. Both OTP studies arrived at the same conclusion using different approaches. The study conducted by OTP's Commerce support group examined published data through a statistical technique which compared trends in telecommunications service cost over a period of years as a function of the volume of services provided. The second study developed its data using an engineering cost and computer modelling approach. The evidence in each study gave preliminary indication that there are no returns to scale in the provision of local service, but that rather substantial returns may exist for long-haul transmission.

The models developed through these studies have been used by OTP not only to assess general policy implications, but also to examine AT&T's revised pricing structure for long-haul, private line service.

Through the years, telephone companies have used revenues generated in long-haul transmission to hold down local exchange rates. In 1974, as more specialized carriers entered the long-haul market, concern magnified over the possible impact of competition on local exchange rates. Consequently, the FCC has opened this issue for comment in Docket 20003. OTP is using the results of its engineering cost and computer modelling studies to assess this issue and has funded additional contract work to refine the models so that they address directly the problems of subsidy of local service by long-haul revenues.

In addition to the interconnect and long-haul transmission segments of the telecommunications market, "value-added" service vendors have emerged as potential competitive marketplace forces. In 1974 OTP sent recommendations to the FCC urging the adoption of an open-entry policy for these vendors. OTP also urged at that time that the question of resale, shared use and brokerage of common carrier services under current regulations must be addressed in a broader proceeding. The FCC has since opened the entire issue of resale, shared-use, and brokerage for comment (Docket 20097). OTP has initiated an extensive study of resale of communications facilities and services, the results of which will be made available to the Commission and the public in early 1975.

3. Common carrier regulation

Effective Government regulation of monopolies is necessary to assure quality service to the public at reasonable cost. But detailed oversight and regulation of an enterprise as large as the telephone industry, for example, are both

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costly and difficult. OTP is therefore exploring means for substituting for detailed regulation policy-established incentives for improved performance.

OTP has been particularly concerned about the need for adequate accounting procedures for common carriers which can be used to identify potential operating incentives for specialized services. In 1974, OTP completed a preliminary study of the FCC's Uniform System of Accounts for common carriers and forwarded the results to the FCC. The study indicated that because costs throughout the common carrier industry are classified by facilities, while revenues are classified by service, the reasonableness of a given rate of return for a specific service under review cannot be easily determined. In addition, this accounting method greatly hinders the evaluation of proposed tariff revisions in a competitive market and provides little incentive for minimizing investment or operating costs or for incorporating new and more efficient technologies. OTP is now making plans to expand on the results of its preliminary study.

Cost-related pricing precipitated by competition, external economic factors and regulatory interest is also an issue of interest to OTP. A carrier which charges considerably above cost for one service may attract competitors; a carrier which charges little or nothing for a given service may find that service overused at a cost to other ratepayers. OTP has addressed these problems with two studies completed in 1974: (1) the first definitive study of the effect on demand and revenues of making telephone installation charges more closely related to costs and (2) a study of usage sensitive pricing for local telephone calls. This method of pricing, which is now used for long-distance telephone service and for other utility services such as electric power and natural gas, has been proposed by some carriers as an alternative to the present flat rate pricing approach for local telephone service. Usage sensitive pricing would enable the pricing of local telephone service to reflect the degree of use by various customers. OTP is currently evaluating the results of these studies.

II. Government Communications

A. Federal Communications Policy, Planning and Evaluation

The Federal Government spends roughly ten billion dollars per year on telecommunications systems and services. Every Federal agency makes some use of telecommunications and many agencies are involved to a greater or lesser degree in telecommunications research and development, planning, design, procurement, and system operation. OTP has the responsibility for providing policy direction for these activities; for coordinating activities which deal with competing, overlapping, duplicative or inefficient agency programs; and for evaluating the ability of existing and planned systems to meet national security and emergency preparedness requirements.

To meet these responsibilities, OTP requires the cooperation and assistance of those Federal departments and agencies most heavily involved in the telecommunications area. OTP took its first major step toward obtaining the necessary cooperation in 1972 when it established the Council of Government Communications Policy and Planning chaired by the Director of OTP. The Council is comprised of policy level representatives from the Departments of State, Treasury, Defense, Justice, Commerce, and Transportation, and from the General Services Administration, the National Aeronautics and Space Administration, and the Central Intelligence Agency.

In October 1973, OTP took another related major action when it issued OTP Circular 12 and thereby established the Government Communications Planning Program, a program designed to aid OTP in meeting its objectives for simplified day-to-day operations of Government communications systems.

A third major policy initiative in Government communications was commenced in June 1974 with the issuance of Circular 13, "Federal Use of Commercial Telecommunications Services". Circular 13, designed to increase efficiency of Federal telecommunications programs, articulates and clarifies the long-standing national policy of relying on the private sector for telecommunications services and equipment.

1. Government Communications Planning Program

The underlying objective of the Government Communications Planning Program is to encourage each department and agency to undertake more explicitly documented long-term planning for its use of communications and to disclose its plans for interagency coordination at the earliest feasible time. Specifically, the planning program seeks: (1) identification of all communications activities

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and resources of the Federal Government; (2) determination of needs for effective information exchange among the various departments and agencies; (3) promotion of economy in the Government's use of communications through sharing of facilities, elimination of duplication, and effective use of commercial services; and (4) facilitation of greater use of telecommunications to improve productivity and to enhance coordination of Federal Government activities.

Under Circular 12, all appropriate Federal departments and agencies are assigned to one or more mission area planning groups according to their particular responsibilities. The mission areas are: Environment, Law Enforcement, National Security and Transportation. OTP has designated a lead agency for each group to assure that specific coordination procedures for the group are established and enforced.

Interagency coordination is accomplished under the planning program in two phases: First, the agencies most directly involved in a particular mission area review and coordinate plans for the communications systems designed to support those missions. Administrative and other communications systems not aimed at one of the four mission areas are coordinated by the General Services Administration. Next, the coordinated plans which emerge from the planning groups are reviewed by OTP and coordinated across all of the mission areas.

In late 1974, OTP received its first set of annual summary plans prepared and submitted by the four mission area groups and by GSA. This first set of summaries focused on identifying existing or planned communications systems. OTP has reviewed all of the summaries and has offered each group guidance for its 1975 activities. The inventory of communications programs resulting from this initial effort will set the foundation for future long-term planning efforts.

OTP will direct its efforts in 1975 toward meeting three primary goals for the Government Communications Planning Program: (1) completing and updating system inventory; (2) performing analyses of specific mission area requirements, developing alternative approaches, and evaluating the mix of systems and services; and (3) addressing special problems which may arise from the application of new telecommunications services.

Before it established the Government Communications Planning Program, OTP initiated several major efforts involving substantial intra-Government coordination. Recent progress in two areas merit mention: radio navigation and national warning systems.

a. Radio Navigation Systems

Within the framework of the planning program, OTP has worked to develop a comprehensive radio navigation system plan and to designate which radio navigation systems the Government will support in the future. Completion of two major undertakings in 1974 brought the Government closer to these objectives—(1) In 1972, OTP has undertaken an assessment of three radio navigation systems of differing accuracy and range. With completion of these assessments, the Departments of Defense and Transportation and the Office of Management and Budget chose on the basis of cost-effectiveness, accuracy and coverage area to utilize a combination of the two systems with the greatest ranges. (2) OTP completed a study which indicated that the number of navigation systems which either are operational or under development can be drastically reduced. Results from the study will be used to further consolidate the radio navigation program.

b. National Warning System

During 1974, OTP completed its efforts to determine the national warning system best suited for voluntary home use. In 1971 an interagency group chaired by OTP completed a review of national policies and programs on the use of telecommunications facilities for warning the general public of impending national emergencies. OTP completed an assessment of operational and planned Federal warning systems in late 1974 and designated the National Weather Service VHF/FM forecasting and warning system as the sole Government operated radio system for communicating attack or disaster warnings directly to the general public in their homes. The 1974 revised policy statement also reaffirmed OTP's view that the acquisition and use of any home warning receiver should be a voluntary decision by each citizen. As the Weather Radio is already operational in many communities, OTP felt that the Federal investment necessary to complete coverage by this system would be considerably less than what would be required to complete the other warning systems under consideration.

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2. Federal use of commercial telecommunications systems

In June 1974, OTP issued an elaboration of the long-standing national policy of relying on private enterprise to serve Federal needs. While this policy had generally been followed in the area of telecommunications, OTP felt that the policy directives were ambiguous and subject to varying interpretations when applied to the highly specialized and dynamically changing field of telecommunications. In the absence of specific guidance, agencies had been free to choose between purchase or lease of telecommunications facilities and direct purchase of telecommunications services.

Under OTP Circular 13, a Government-wide policy has been established for telecommunications which favors the direct purchase of service and which shifts much of the burden of system design, engineering, management, operation, maintenance and logistical support to the private sector. Under this policy the Federal Government will serve as the provider rather than as the user of telecommunications facilities only if the needed commercial service is unavailable at the time it is needed, or is inadequate from either a technical or operational standpoint, or is significantly more costly.

Each Federal agency head has been requested to advise OTP on the implementation of the policy outlined in Circular 13. OTP will evaluate these agency reports in 1975 to determine whether more detailed policy guidance is required.

B. EMERGENCY PREPAREDNESS

The purpose of the emergency preparedness program is to insure that national and Federal communications resources will be available and applied in emergencies to meet the most critical national needs. This is a demanding task in view of the number of possible contingencies which must be considered in developing the program. Emergency communications plans and capabilities must comply with three basic principles: (1) provision must be made for maximum common use of facilities for both emergency and routine operations; (2) balance must be assured between the survivability of communications systems and the durability of the facilities which they support; and (3) responsibilities must be clearly defined and delegated to insure maximum efficiency in times of emergency.

OTP completed a broad, general plan for managing the nation's telecommunications resources during war or national emergencies in 1972 and submitted it to appropriate Federal agencies so that specific programs to implement the national policy could be developed. These supporting final plans were completed in 1974. In late 1974, OTP began an interagency review of the support plan for natural disasters. Experience gained from actual disasters and changes resulting from the Disaster Relief Act of 1974, dated May 22, 1974, are being examined as part of the review.

OTP published a revised Emergency Broadcast Procedures Manual in 1974 which, in conjunction with the FCC's rules and standard operations procedures, clarified and simplified Emergency Broadcast Service operations. Closed circuit tests in July and November 1974 demonstrated that the revised procedures had improved the effectiveness and efficiency of the EBS. These tests simulated EBS operations under emergency conditions in order to provide training for government and industry personnel and to test the EBS system. Additional tests will be conducted in 1975.

In 1974, OTP and the FCC completed work begun the year before to supplement the EBS should it be incapacitated by enemy attack. These contingency procedures, which are more flexible and more likely to survive disaster than formera EBS backup procedures, will permit national leaders to use surviving commercial radio and television facilities to communicate with American people.

As a result of an overall review of the U.S. plan for restoring normal communications services, OTP and the FCC agreed to amend their respective restoration priority orders to establish a single priorities system. These changes were completed in 1974 and are ready for review by government and industry. OTP will publish the new procedures in 1975.

As part of its responsibilities for emergency preparedness, OTP continued in 1974 to participate in NATO communication planning activities. OTP provides the U.S. civil representative to NATO's Civil Communications Planning Committee and to the NATO Joint Communications-Electronics Committee.

C. COMPUTER COMMUNICATIONS AND PRIVACY

Computer communications, or teleprocessing, is a new technology which has emerged from the joining of the technologies for computers and communications.

Interconnection of user terminals and computers through communications technology provides remote access to computer capacity, remote access to stored data, and communications between terminal users.

One result of the growing trend within the Federal Government toward teleprocessing is the potential threat that such communications systems pose to individual rights to informational privacy. In February 1974, the Executive branch expressed its concern for this problem by creating the Domestic Council Committee on the Right of Privacy. The Director of OTP is a member of this committee and most OTP efforts in the privacy area have been in support of the committee's activities.

During 1974, OTP chaired Task Force 7—Federal Data Processing and Data Communication System Procurement—of the Domestic Council committee. The Task Force forwarded to the committee recommendations for the establishment of practices and procedures within the Executive branch which would insure that personal privacy rights receive systematic consideration in planning, interagency coordination and procurement of Federal data processing and data communications systems.

One example of the need for the procedures recommended by Task Force 7 was illustrated recently by the proposed Federal teleprocessing system, FEDNET. The contemplated data communications network would have linked the computer systems of several Federal agencies. As a result of questions raised by OTP, the Office of Management and Budget and the Congress on the need for controls on access to the personal data and on the potential for growth of incentives to fill the computers with unnecessary data on individuals and firms, the FEDNET procurement was cancelled.

The privacy issue in telecommunications and computers was raised a second time in 1974 with the proposed expansion of the FBI's National Crime Information Center. The suggested expansion would have provided the state and local law enforcement communities with limited message switching. OTP expressed its concern to the Attorney General that such an expansion could result in the absorption of state and local criminal data systems into a centralized, Federally controlled computer communications system. Additionally, OTP felt that adequate safeguards over the kinds of information to be included in computerized criminal histories and over who would have access to those files had not yet been developed.

OTP recognizes that legitimate needs do exist for a shared data communications network for Federal use, and accordingly, is working with OMB and the General Services Administration to develop policies which *inter alia* balance concerns for individual privacy in Federal record keeping systems with policies which encourage the shared use of resources.

D. NEW SERVICES DEVELOPMENT

In 1974, OTP initiated two efforts which focus on specific services being developed to support Federal programs. The first effort relates to the application of current communication satellite technology; the second is targeted to the application of communication technologies for remote interaction of two or more parties, often called "teleconferencing."

1. Communications satellite technology program

In the last half of 1974, OTP encouraged the development of a commercial alternative as follow-on to the ATS–6, the NASA-developed communication satellite which until mid-1975 will support several Federally sponsored Health-Education Telecommunications experiments in remote regions of the United States. OTP feels that if a commercial follow-on to the NASA program can be initiated, much of the burden for developing the market and establishing an operational system for communications satellite applications can be shifted from the Government to the private sector. Since no single public service group is big enough, however, to immediately underwrite such an enterprise, OTP and the Department of Health, Education and Welfare worked together to foster the establishment of a consortium of public service users who in concert could acquire high-powered satellite services. A private satellite user consortium was established in December 1974.

OTP has also taken steps to form an interagency group to identify potential Federal users of satellite services and to identify possible sources of Federal support for public service satellite applications. OTP will serve as liaison between the consortium and interested Federal agencies.

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2. *Teleconferencing*

In recent years, the interrelationships of communications and transportion systems have attracted a growing body of speculation and research. As a result of the energy shortage in late 1973, the Federal Government grew more interested in teleconferencing systems as one solution to the short- and long-range need to conserve energy by limiting travel. Many Federal agencies consequently have undertaken or are considering undertaking teleconferencing research projects.

In 1974, OTP commissioned a comprehensive study on teleconferencing. The study seeks to: (1) inventory what Federal agencies are doing in the area of teleconferencing, (2) explain the state-of-the-art and analyze middle-term technological options, (3) develop an analytical framework for evaluating existing or planned activities, (4) assess existing systems, and (5) explore policy options available to OTP for future coordination of the Federal Government's programs in this area. During 1975, OTP will receive and evaluate the results of this study and determine appropriate follow-on actions.

E. FEDERAL-STATE COMMUNICATIONS

One of OTP's assigned responsibilities is the coordination of Federal assistance to state and local governments in telecommunications. OTP's objectives in this area have been: (1) to eliminate duplication in the development of demonstration programs, (2) to assure that conflicting requirements of different Federal programs do not inhibit the efficient development of state and local government telecommunications systems, (3) to preclude the emergence of an undesirable degree of operational or technical control by Federal agencies over State and local government telecommunications systems, and (4) to encourage the coherent development of telecommunications systems for the delivery of public services, especially emergency services, by state and local governments.

During 1974, OTP directed its efforts in this area toward follow-up on the OTP policy for nationwide implementation of universal emergency telephone number, "911". This follow-up has principally involved three activities: (1) providing further policy guidance to Federal departments and agencies managing "911" assistance programs; (2) continuing support of a "911" Information Center at the Department of Commerce; and (3) working with the Departments of Health, Education and Welfare and Transportation to establish a role for "911" services with respect to all Federal emergency medical service programs. OTP's handbook for assisting communities with planning for "911" service implementation has received wide distribution and is in its third printing by the Government Printing Office.

To aid state public safety mobile radio planners and managers, OTP, with assistance from the Associated Public Safety Communications Officers (APCO), completed a study of aural brevity codes for public safety communications. The study outlined a recommended brevity code which already has been accepted by the Pennsylvania State Police for a new statewide police radio network serving 800 Pennsylvania communities. Other jurisdictions are expected to follow the Pennsylvania lead. OTP has made this study available for distribution to the public safety community.

III. INTERNATIONAL COMMUNICATIONS

A. INTERNATIONAL SYSTEMS AND FACILITIES

1. *Policy development and implementation*

The international communications industry has been the object of numerous reviews over the years by both Executive branch agencies and Congressional committees. Existing organizational arrangements, based on type of service and type of communications technology, are largely the result of statutory policies and ad hoc regulatory decisions that have evolved over time.

In order to remove some of the uncertainty resulting from prior industry reviews and to provide an orderly framework for future development of the industry, OTP issued in 1973 a broad statement of objectives and policies to guide industry and Government activities in international communications. Within this policy framework—which stresses reliance on the private sector for international telecommunications, while moving to assure that negotiations between industry and international entities result in maximum benefit to both the indus-

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try and the American people—OTP is continuing to review both regulatory and industry performance. In 1974, for example, OTP in conjunction with the FCC commenced a reexamination of Government policy on the planning and future licensing of U.S. overseas transmission facilities. The present effort seeks to augment 1971 OTP guidelines for regulation in this area by developing improved Government-industry mechanisms for dealing with foreign telecommunication entities in the planning, development and use of international facilities.

Also in 1974, OTP prepared draft legislation to amend the Communications Satellite Act of 1962 and submitted its bill to Congress in the spring of 1974. The amendments are intended to update the Act to reflect developments which have occurred since the original legislation was enacted, including authorization of COMSAT to participate in new international communications systems on a non-exclusive basis, thus legislatively affirming an FCC decision to the same effect for domestic satellite systems. The amendments do not change the basic policy premises underlying the original legislation.

The 1962 Act called for the creation of a commercial communications satellite system as part of an improved global communications network and created the Communications Satellite Corporation (COMSAT) as the chosen instrument of the United States for accomplishing the purposes of the Act. In 1962 numerous technical, operational and organizational uncertainties surrounded the establishment of COMSAT as the designated entity of the United States in the global system. These uncertainties resulted in the inclusion in the Act of several provisions which normally would not be associated with a private communications common carrier enterprise and which addressed COMSAT's ownership and the conduct of its affairs. Since COMSAT has now emerged as a relatively mature commercial common carrier, OTP believes it is appropriate to remove a number of the special provisions contained in the 1962 Act.

2. International communication satellites for mobile communications

a. Aeronautical Satellite Experiment

During 1974 a Memorandum of Understanding (MOU) was signed by the European Space Research Organization (ESRO), the Government of Canada, and the United States Department of Transportation, Federal Aviation Administration (DOT/FAA) for a joint aeronautical satellite (AEROSAT) program for testing the use of communication satellites for improvement of air traffic control. In 1971, OTP issued policy guidelines for the development of a national program on satellite communications for international civil aviation operations. Operating within the OTP policy framework, extensive negotiations with foreign authorities were carried out by the Department of State and the DOT/FAA. The signing of the MOU was the successful culmination of three years of difficult multilateral negotiations.

AEROSAT is an experimental program to explore methods of using communications satellite capabilities to improve the cost effectiveness of oceanic enroute services, including the possibility of combining or reducing air traffic control facilities. The experimental system will consist of two geosynchronous satellites in orbit over the Atlantic Ocean and two ground stations. One ground station will be located in North America, the other in Europe. Both satellites will contain UHF capabilities and two VHF channels.

Consistent with OTP policy guidelines, U.S. ownership in the space segment of the system will be jointly owned by ESRO and COMSAT (the U.S. private sector participant), each owning 47% with Canada owning the remaining 6%. The FAA will lease circuits in the system for air traffic control from the private U.S. commercial carrier, COMSAT. The initial satellite will be launched in 1978 and system experimentation will be conducted for a five-year period ending 1983.

b. Maritime Satellites

For a number of years, the Intergovernmental Maritime Consultative Organization (IMCO) has taken considerable interest in the development of space technology for maritime purposes. Preliminary studies of the operational requirements for a satellite communication system were undertaken by IMCO's Maritime Safety Committee, and in 1972, the Maritime Safety Committee established a panel of experts (POE) to consider the technical, economic and institutional arrangements for providing satellite communications to civilian ships on the high seas. The POE held five regular meetings between July 1972 and September 1974 and has now prepared its final report on the establishment of a global mari-

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time satellite communication system. A worldwide Plenipotentiary Conference will be convened in April 1975 under the auspices of IMCO to consider the POE report and to decide on the principle of establishing an international maritime satellite program.

OTP, together with other interested agencies of the Federal Government and representatives from the private sector, has actively participated in the meetings of the POE. Although it has agreed that considerable work has been performed by the POE, the U.S. nevertheless has reserved its decision on the entire POE report in the belief that sufficient analysis of all possible alternative institutional arrangements as well as the closely related economic and technical factors have not been made. The Soviet Union and the West Europeans, led by the United Kingdom, have advocated that a new international organization be created to provide global maritime communications services by satellite. Some sentiment also exists for the provision of maritime satellite service, either through a dedicated or multi-purpose satellite, without creating a new international organization. No definitive organizational positions can be taken prior to the 1975 Plenipotentiary Conference, and even then the concerned entities may need further time for the study of the issues.

Under OTP leadership, a U.S. policy position is being formulated for the 1975 IMCO negotiations. OTP is being assisted in this task by interested Governmental agencies, with particular assistance from the Department of State, the Department of Transportation (Coast Guard), the Commerce Department, and the Federal Communications Commission. Private sector communications and maritime interests are also being considered in the policy formulation process, as are Congressional views.

In a related matter, OTP continues its policy interest in the development of a maritime satellite system (MARISAT) by U.S. international common carriers, designed to meet U.S. Navy requirements between 1975 and 1977. The MARISAT program, which has a five-year design lifetime, will also provide limited commercial service for maritime users during the first three years of use. Later, when Navy use is terminated, the satellite will be capable of providing additional commercial maritime service.

3. North Atlantic facility planning

The development of an improved process for planning and authorizing the construction of new international communications facilities is a continuing OTP policy concern. At the invitation of European telecommunications authorities, representatives from the Federal Communications Commission, the Department of State and OTP met in Munich, Germany, in October 1974 to review long-range telecommunication facility planning in the North Atlantic Basin. The essentially government-to-government meeting provided an opportunity for both the Europeans and the U.S. representatives to elaborate and clarify present policies and principles on the planning, development and use of international transmission facilities.

Representatives at the Munich meeting agreed to establish an international working group which would consider specific issues and problems in this area. U.S. industry-Government teams are being established according to OTP guidance to facilitate the development of improved traffic forecasts, economic analyses, systems reliability studies and related analyses necessary for sound long-range systems planning. OTP will continue as an active participant in the Government's effort to develop a framework in which U.S. international communication entities and foreign counterparts can make long-range plans for facility requirements with greater assurance that regulatory authorities will grant timely approval for facilities and programs when appropriate.

B. INTERNATIONAL ORGANIZATION ACTIVITIES

1. United Nations

Government use of direct broadcast satellites has continued throughout 1974 to be a significant matter of debate within the United Nations. Both UNESCO and the U.N. have adopted resolutions to establish new regulatory controls over satellite broadcasting directly into the home. The United States has voted against both resolutions and is fundamentally opposed to any legal system governing the use of direct broadcast satellites which sanctions the concept of prior consent—the notion that no state should be allowed to engage in such broadcasting without the prior approval of the state which may be the intentional or unin-

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tentional recipient. The U.S. views such an approach as incompatible with the concept of maintaining the principle of free flow of ideas and information in international communications.

Many nations have expressed great concern over the possibility that communication satellite signals might be broadcast into standard home receivers. Although the U.S. believes that such a development will not occur within the near future, it has been receptive to discussing general principles which could appropriately apply to the use of direct broadcast satellites. In this regard, the U.S. tabled a set of voluntary principles in March 1974 at the Fifth Session of the U.N. Working Group on Direct Broadcast Satellites in Geneva. While some support for the U.S. views was expressed at that time, wide differences of opinion over the formulation and application of appropriate principles to govern the use of direct broadcast satellite technology remain.

These differences were also influential in the failure of the Legal Subcommittee of the U.N. Committee on the Peaceful Uses of Outer Space to achieve agreement on principles at its meeting in May 1974. OTP has participated in the deliberations of both the U.N. Working Group on Direct Broadcast Satellites and the Legal Subcommittee and will continue to work with other interested U.S. agencies in formulating and presenting U.S. policy views in this area.

In May 1974, a Diplomatic Conference was jointly convened in Brussels by UNESCO and the World Intellectual Property Organization to consider and ultimately to adopt a new Convention Relating to the Distribution of Program-Carrying Signals Transmitted by Satellite. The Diplomatic Conference, in which OTP participated, considered a draft Convention drawn up at the 1973 Nairobi preparatory meeting. At the close of the Conference, the U.S. was among the 15 nations which participated in signing ceremonies. The Convention will remain open for signature with the Secretary General of the United Nations until March 31, 1975.

2. *INTELSAT*

In 1974 the International Telecommunications Satellite Organization (INTELSAT) entered its second year of operations under the Definitive Agreements which came into force February 12, 1973. Enactment of the Definitive Agreements of INTELSAT had marked the end of a decade of development of this commercial organization. A cooperative international undertaking to establish and operate a global commercial communications satellite system, INTELSAT, had grown from 14 original Signatories to more than 80 member nations. The Definitive Agreements marked as well a new role for its U.S. Representative, COMSAT—one in which COMSAT no longer held a controlling vote in the governing body and which limited its role as Management Services Contractor of INTELSAT to technical and operational management of the satellite system.

Throughout 1974, OTP, the State Department and the Federal Communications Commission continued to exercise oversight authority over the activities of COMSAT in its role as the designated U.S. entity in INTELSAT. Meanwhile, by the end of 1974, INTELSAT membership had grown to 88 members and the volume of communications traffic carried over its global facilities continued to increase. The second annual Meeting of Signatories of INTELSAT was held in Acapulco, Mexico, in April 1974.

In February 1974 the first meeting of the Assembly of Parties was held in Washington, D.C. The Assembly of Parties consists of all States which have signed the INTELSAT Inter-governmental Agreement. An OTP representative participated as a member of the U.S. delegation to the Assembly. Among its actions, the Assembly concluded that the MARISAT proposed by the COMSAT General Corporation and the U.S. Geostationary Operational Environmental Satellite (GOES) system would cause no harmful interference with the INTELSAT system. Article XIV of the Inter-governmental Agreement requires that such specialized satellite communication systems which are separate from the INTELSAT system be coordinated with the Assembly of Parties through the INTELSAT Board of Governors. In that connection, OTP has issued instructions through the Interdepartment Radio Advisory Committee to insure that all appropriate Government agencies meet the requirement of Article XIV.

Following consultation with OTP, the Federal Communications Commission has adopted revised procedures which COMSAT must observe when seeking FCC authorization to participate in the construction or operation of INTELSAT facilities. With the global satellite system now well established, the new procedures are intended to make INTELSAT satellite authorization procedures comparable to those used to authorize other types or communication facilities.

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During 1974, the U.S. Government has authorized COMSAT to participate in the procurement of the fifth generation of INTELSAT satellites. The new INTELSAT IV-A series has been designed to meet expanding consumer requirements and will provide the bridge to the next generation, high capacity INTELSAT V satellites, which will be available for the 1980's.

3. CITEL

International communications within the American hemisphere are growing in volume and importance. In recognition of the contribution that modern communications makes to the affairs of Latin American countries, the Organization of American States (OAS) has established a regional telecommunications body, the Inter-American Telecommunications Conference (CITEL). The OAS elevated CITEL to conference status in 1971 with the objective of making it an effective organization for promoting the development of telecommunications within Latin America. CITEL provides a useful vehicle for the exchange of views on telecommunications matters of mutual concern to OAS member states. OTP provided a delegate to the annual CITEL meeting which was held in Quito, Ecuador, in 1974. The Conference was attended by 19 member Administrations of the OAS, five non-member Administrations, and representatives of six international organizations, including the International Telecommunications Union.

4. OECD

In late 1974, OTP provided the Head of Delegation to an international conference in Paris on computer/telecommunication policy. The conference, sponsored by the Organization for Economic Cooperation and Development (OECD) was convened to review new concepts and emerging policy dimensions in the field of computers and telecommunications. The delegates to OECD gave special attention to economic and social aspects of the information processing industry. OTP will continue to participate in the computer/telecommunications work of the OECD as it considers the broad policy implications of the emerging international information processing industry.

5. International Telecommunications Union

The International Telecommunications Union (ITU), a specialized agency of the United Nations with 148 member Administrations, maintains and extends international cooperation for the improvement and rational use of telecommunications of all kinds.

The ITU has two major international technical coordinating bodies, the International Consultative Committee on Radio (CCIR) and the International Consultative Committee on Telegraph and Telephone (CCITT). These bodies consist of numerous technical study groups which consider such issues as international standards, practices, systems planning, and tariff principles applicable to the international communications services. OTP participates in the preparation of U.S. positions for such activities, particularly those which deal with the technical and operational aspects of radio frequency spectrum planning, allocation, and use.

a. ITU Convention and Telegraph and Telephone Regulations

OTP participated in two major ITU Conferences in 1973; the Torremolinos Plenipotentiary Conference adopted a new ITU Convention and the World Administrative Telegraph and Telephone Conference completely revised the 1957 Telegraph and Telephone Regulations. Both the ITU Convention and the Telegraph and Telephone Regulations were forwarded in 1974 to the Senate for ratification. Hearings are expected in early 1975.

b. International Consultative Committee on Telegraph and Telephone

OTP maintains general oversight of the activities of the Study Groups of the International Consultative Committee on Telegraph and Telephone (CCITT) and participates in appropriate CCITT activities. OTP has been active in the work of the World Plan Committee and the Regional Plan Committees, which is carried out under the auspices of the CCITT. In November 1974, an OTP staff member served as alternate Head of Delegation at the Tokyo meeting of the Regional Plan Committee for Asia and Oceania. The Regional Plan Committees assist in the development of the international telecommunications network and generate data helpful to Administrations in planning improved international services.

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c. International Radio Consultative Committee Planning Assembly

Plenary Assemblies of the International Radio Consultative Committee (CCIR) are held every three or four years. In the period between assemblies, the technical work of the CCIR is carried out by eleven Study Groups and by the joint CCIR/CCITT Study Groups for TV and Sound Transmission and Vocabulary. The XIIth Plenary Assembly was held in Geneva July 15–16, 1974. Between February 5 and March 20, 1974, all of the CCIR Study Groups met in Geneva for final sessions prior to the Plenary Assembly. The technical reports approved by the Study Groups were subsequently adopted without significant changes by the Plenary Assembly. The U.S. contributed substantially to the work of these Study Groups and many of the final reports were of U.S. origin. Mr. Richard Kirby, a U.S. citizen, was elected by the XIIIth Plenary as the Director of CCIR, an International office with a four-year term. Both in general and from the standpoint of the U.S. Government, the meetings of the CCIR throughout 1974 were successful.

d. Maritime World Administrative Radio Conference

The ITU Maritime World Administrative Radio Conference (MWARC) was held in Geneva April 22–June 7, 1974. The purpose of the Conference was to revise and update the International Radio Regulation applicable to the maritime mobile service. Delegations from 104 countries and from ten international organizations were in attendance. The MWARC considered approximately 2500 proposals.

Except for adoption of a Radio Telephone Allotment Plan and related procedures which are incompatible with U.S. operational interests, the outcome of the Maritime WARC was consistent with U.S. proposals and interests. In the U.S. view, the Allotment Plan was determined on the basis of political considerations rather than as a result of sound technical and operational considerations. The MWARC followed voting patterns in this matter which had emerged at the 1973 ITU Plenipotentiary Conference. As a result, the United States entered a reservation on this issue in the form of a protocol to the Final Acts to protect its maritime radio telephone interests.

Significant accomplishments resulting from the MWARC related to maritime radio-telegraphy (e.g., direct printing and digital selective calling systems), maritime distress and safety communications and vessel traffic control systems. An entirely new telegraphy calling procedure was adopted for worldwide use and provisions were made for the orderly introduction of maritime satellite operations. The MWARC also elected a new 5-member International Frequency Registration Board (IFRB). The Final Acts of the Maritime WARC go into effect January 11, 1976, and have been submitted to the Senate for ratification.

e. World General Administrative Radio Conference

In 1974, the ITU reaffirmed its intention to convene a World General Administrative Radio Conference in 1979 to review and update the entire International Radio Regulations. These Regulations establish the basic technical rules, operating procedures, and radio frequency allocations (division of frequency spectrum by radio services) essential to the smooth flow of the world's telecommunications. In the United States, the Regulations have treaty status, requiring Senate ratification. The Regulations which result from the 1979 Conference will set the direction for telecommunications until the year 2000. Therefore, although still five years away, the magnitude and importance of this Conference necessitate extensive preparatory work and a long lead time. OTP, in conjunction with the FCC and the Department of State, has organized a large scale preparatory effort. The preparation is being conducted through interagency committees and working groups comprised of personnel skilled in the various facets of telecommunications.

f. Reorganization and Recodifying the International Radio Regulations

Over the years, the International Radio Regulations have grown into an unwieldy thousand-page book badly in need of reorganization and recodification. In 1974, the ITU announced plans to completely overhaul the Regulations in time for the 1979 World General Administrative Radio Conference. A special group of experts will be convened by the ITU in early 1976 to do the actual work of reorganizing and recodifying the text of the Regulations. In July 1974, OTP designated a team of U.S. experts to start developing U.S. proposals for the 1976 meeting. As 1974 closed, this group had met several times under the chairmanship of the OTP representative to work on U.S. proposals.

g. Broadcasting Satellite Conference

In the latter part of 1974, the Department of State requested OTP to furnish comments on the date, duration, and agenda for an ITU World Administrative

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Radio Conference to plan for the Broadcasting Satellite Service in 11.7–12.2 GHz (in Regions 2 and 3—the Americas and Asia) and 11.7–12.5 GHz (in Region 1—Europe and Africa).

An ITU circular proposed that the length of the Conference be six weeks, beginning mid-January 1977, and suggested an agenda. OTP has recommended to the Department of State that: (1) the Conference occur subsequent to the final 1977 CCIR Study Group meetings in order that documentation from these meetings be available to the Broadcasting Conference, (2) four weeks is a sufficient duration for the Conference, and (3) the subject matter proposed by the ITU serve as the base for agenda consideration. The agenda would include the necessity for developing sharing criteria for the respective radio services involved (fixed, mobile, broadcasting, and fixed satellite); procedures to govern the use of these bands by the Broadcasting Satellite Service and other involved radio services; and the possibility of planning the bands in accordance with Resolution No. SPA2-2 of the ITU 1971 WARC, which coordinates the orbital positioning for satellites. In the meantime, a working group established by OTP is continuing to develop U.S. proposals and position papers for use at the Broadcasting Satellite Conference.

h. LF/MF Broadcasting Conference

The ITU convened the first session of a Regional LF/MF Broadcasting Conference in Geneva October 7–27, 1974. The Conference met to redraft the 1949 "Copenhagen Plan" that assigned low and medium frequencies for standard broadcasting in the European, North African, and Middle East Areas. The Conference was unable to complete its work due to technical and political problems and a second session has been scheduled in Geneva October 6 to November 2, 1975. It is anticipated that the foreseen demands of the new and emerging countries for "equal opportunity" and demands for use of the radio spectrum for broadcasting purposes in the European/African area may lead to serious difficulties in attempting to develop a suitable frequency assignment structure.

Of particular interest to the U.S. in this Conference are the operation of Radio Liberty, Radio Free Europe and the extensive Armed Forces Network.

IV. Spectrum Management and Policies

The radio frequency spectrum, a valuable national and international resource, is essential for all forms of radio transmissions (radio communications, navigation, broadcasting, radar, air traffic control, etc.). Since the demand created by technology for use of the spectrum has outpaced the development of new spectrum-conservation technologies, there is intense national and international competition for its use.

Responsibility for allocation and access to this limited resource is effected at the national level. OTP is responsible for the management and use of the radio spectrum by the U.S. Government and, in coordination with the FCC, for long-range national planning for use of the spectrum. OTP is supported in fulfilling this responsibility by the Department of Commerce Office of Telecommunications, on a reimbursable basis. As a continuing effort, OTP is working jointly with the FCC, which should result in more effective use of the spectrum in the national interest.

As the demands on the spectrum from various public and private users increase, improved methods of spectrum management are required. Indeed, overall growth in the application of telecommunications, fueled by the introduction of new services, has created pressures for reallocation of spectrum among classes of users, and for new allocation procedures which are more responsive to demand. Highly complex and difficult decisions must be made about who will be allowed to use what frequencies, for what purposes, and where. For example, the introduction of space technology in the frequency bands already congested with terrestrial microwave systems creates complex technical problems in developing sharing criteria which will prevent interference. The introduction of Emergency Medical System communications, another example, has also made necessary the compression of existing frequency assignments. And the ever increasing requirements of a nation on the move have dictated the need for greater frequency accommodations for land mobile communications.

Specific spectrum management tasks fall essentially into four categories: allocation and assignment of frequencies; planning to meet Government and

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non-Government uses; electromagnetic compatibility analysis; and side effects of electromagnetic radiations.

A. ALLOCATIONS OF SPECTRUM

Working closely with the FCC, OTP has maintained a continuing review of the usage of the radio frequency spectrum to assure alignment of telecommunications requirements with the resources available. This cooperative review has taken on an even broader significance as the World General Administrative Radio Conference scheduled for 1979 has grown more imminent. Preparation for the Conference involves a complete review of U.S. allocations of the spectrum and planning for spectrum use through the 1980–2000 time frame. Under the leadership of OTP, with the FCC participating, technical studies and research to develop U.S. spectrum allocation proposals at the 1979 Conference have been initiated. The work began in 1974 and will accelerate each year leading up to the Conference.

One continuing effort in this area is a study begun in 1973 to determine whether analytical methods of demand forecasting can be used for projecting spectrum requirements. Such projections would be based upon forecasted sales of communication-electronic systems. This could be useful in preparing for World Administrative Radio Conference as well as for on-going domestic programs.

In support of its work on spectrum allocation, OTP also has undertaken the preparation of a long-range plan for fixed terrestrial radars, which are used primarily for air traffic control and national defense purposes. Such a long-range plan is necessary for effective spectrum planning since radars need large blocks of adjacent frequencies to accommodate their pulsed-type transmissions. At present, data is still being collected on the radars used by various U.S. interests.

OTP also concentrated its efforts on the allocation of frequencies for use by communications satellites. The U.S. and a number of other nations employ satellite techniques for such purposes as navigation, communications, and weather prediction. With the number of non-U.S. space systems increasing, OTP has instituted procedures for the review of information on such systems to assist with spectrum planning and the use of geostationary orbits.

B. ASSIGNMENT OF FREQUENCIES

U.S. Government radio facilities, supported by a significant research and development complex, fall in four major categories:

1. Conventional radiocommunication facilities—such as high-frequency overseas telegraph and telephone circuits, radiocommunication services to ships and aircraft, and land mobile and microwave communication facilities.
2. Radars (Radiolocation)—for the location of aircraft or ships, for missile detection, and for storm cloud observation.
3. Radionavigation facilities—serving ships and aircraft.
4. Telemetry—radio transmission of measured or sensed quantities of energy, or of conditions of such physical properties as hydro/meteorological or stress/strain data, including the receipt of such information from a spacecraft. Radio astronomy observations may be considered a form of telemetry in the broad sense as the transmitted signals are of a natural origin.

During 1974, OTP processed approximately 47,000 frequency assignment actions involving the U.S. Government radio stations and, by using the data compiled during 1973, implemented a reporting system for on-the-air use of frequency bands between 30 and 420 MHz. The measurement and monitoring capability developed under OTP direction in 1973 for measuring the Government use of the spectrum was applied on an operational basis in the Washington, D.C., Norfolk, Virginia, and Los Angeles, California areas. The use of measurement and monitoring, along with the established frequency usage reporting system, provides OTP with a reliable measure of spectrum occupancy. Such information has made it possible for OTP to assign additional frequencies to meet new and expanding telecommunications requirements.

One example of OTP efforts in this area is its maintenance of an Emergency Readiness Plan for the use of frequencies in a national emergency. At the end of 1974, OTP had updated the existing plan and analyzed the compatibility of high frequencies available for emergency use with those available for other operations.

In close coordination with the FCC, OTP also completed its frequency support

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role for the comprehensive communications plan developed in 1973 for Emergency Medical Services. In this regard, OTP established a subcommittee of the Interdepartment Radio Advisory Committee (IRAC), including representatives of the medical community and electronic equipment manufacturers. In December 1974, the subcommittee completed the development of equipment standards for two-way ambulance-to-hospital telemetry.

In another area, OTP forwarded to the FCC in May 1974 a second report on VHF television broadcasting frequency assignment criteria. This report provided further substantiation of an earlier OTP contention that existing criteria for assignment of VHF channels are overly conservative and that, with the application of readily available techniques, a substantial number of new VHF channels could be made available to the top 100 television markets.

OTP's ability to better manage U.S. Government frequency assignments was enhanced during 1974 by the continued application of computer techniques. A major review and upgrading of the computerized spectrum management support data base was initiated, and, at the end of the year, OTP was making arrangements for access to a computer dedicated for the support of radio frequency management.

The General Accounting Office (GAO) published its report in September 1974 on *Information on Management and Use of the Radio Frequency Spectrum—A Little Understood Resource*. While the report contained no specific recommendations, it emphasized several areas in frequency management deserving attention and endorsed the actions taken to date by OTP to improve efficiency in the use of spectrum resources. One area of particular concern to the GAO was that the "availability of people skilled in spectrum management has not kept pace with the increased demand and economic and technical complexities associated with expanded use of the spectrum . . . ". OTP shares this concern and in 1974 initiated a joint OTP-Civil Service Commission effort to develop a program to improve the frequency management personnel situation. The fact that the U.S. Government has over $60 billion invested to date in spectrum-dependent equipments dictates the importance of and need for sufficient effective personnel resources to manage the use of the spectrum.

C. ELECTROMAGNETIC COMPATIBILITY ANALYSIS

In late 1972 OTP developed and promulgated a set of management procedures (OTP Circular 11) which requires all Government agencies to submit their frequency plans well in advance of procuring equipment. The objective of Circular 11 is to assure spectrum availability for telecommunication systems prior to the commitment of public funds. (The Federal Government spends approximately $10 billion per year for communication-electronic items.) During 1973, Federal agencies gained considerable experience in the application of this new management procedure and the benefits of the program became apparent during 1974.

In June 1974 OMB Circular A–11, which provides guidance to Federal budget planners, was modified so that "consultation with the Office of Telecommunications Policy is required when (budgetary) estimates involve development or procurement of major communication-electronic systems." Over the course of the past three years, OTP has reviewed 37 proposals for various types of communication-electronic systems which are dependent upon use of the spectrum.

One example of how this new review process has been put to use is the Government's present and planned use of the 7/8 GHz portion of the radio spectrum, an investment estimated at about $350 million, with a potential addiional investment over the next five years of $500 million. This portion of the spectrum is currently utilized extensively for transportable and microwave systems for the military, for FAA, and for other Government agencies. It is also being employed by the Department of Defense for the Defense Satellite Communication System, and in the future, DOD use of this frequency band will be expanded considerably. Meteorological satellites of the Department of Commerce and earth resource satellites of the Department of Interior/NASA also are planned at 7/8 GHz.

Under OTP guidance, detailed engineering analyses of this area were initiated in 1973 and were completed in 1974 by the Department of Commerce, Office of Telecommunications. The analyses indicated that unless extreme care was taken in the design and development of future systems and in the engineering of frequency assignments for current and proposed devices, harmful interference with consequent unsatisfactory results would be experienced, as well as possible loss of investment and even loss of life and property. As a result of the studies, OTP forwarded to the appropriate Federal agencies guidelines for electromagnetic

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compatibility which were tailored to assist the agencies with their particular problems.

In its initial application of its systems review procedure, OTP has given priority to the study of the electromagnetic compatibility of satellite and earth stations to each other and to other earth stations. Since space systems are worldwide and once launched cannot be modified to eliminate interference, frequency engineering must be accurate and thorough before launch.

D. SIDE EFFECTS PROGRAM

In response to apprehension and some evidence about the hazards of non-ionizing electromagnetic radiations (i.e., radio transmissions) to man in particular and to the environment in general, OTP continues to oversee the five-year "Program Assessment of Biological Hazards of Non-Ionizing Electromagnetic Radiation," an effort commenced in late 1973. In this program, OTP coordinates a multi-agency effort involving surveillance, testing, and research to determine the potential hazards to man and his environment from these radiations. It examines the potential biological impact of non-ionizing radiations and will investigate possible nonbiological side effects of electromagnetic energy, e.g., the effects on electronic systems, devices, components, and materials.

To date, OTP has placed primary emphasis on the development of procedures to assure coordination among agencies in their research. At the same time, OTP initiated on-going efforts to analyze agency programs which deal with specific biological areas in order to identify shortcomings and to develop guidelines for priorities and for future direction. As a continuation of these efforts, OTP participated during 1974 in collaborative activities (including visits to selected Soviet laboratories) with the USSR and the US/USSR Health Cooperation Program.

The Second annual OTP report on the environmental effects of non-ionizing electromagnetic radiation was released in May 1974. A third report will be issued in early 1975.

E. SPECTRUM MANAGEMENT ADVISORS

Three advisory organizations assist OTP in conducting spectrum management activities:

1. Interdependent Radio Advisory Committee (IRAC)—composed of representatives of 16 Government agencies having major communication-electronic operations, plus a liaison representative from the Federal Communications Commission. The Committee met 22 times in FY 1974 and developed recommendations to OTP on numerous policy issues related to spectrum management. The associated subcommittees (Frequency Assignment, Spectrum Planning, and Technical) provide extensive assistance and support.

2. Frequency Management Advisory Council—comprised of recognized authorities from industry, universities, and research organizations. The Council met five times in FY 1974 to review Government spectrum-related activities and to provide recommendations to OTP.

3. Electromagnetic Radiation Management Advisory Council—comprised of experts in the fields of electrical engineering, biological research, and medicine. This body met four times in FY 1974 to review Government activities regarding possible biological effects of non-ionizing (radio) radiations and provide recommendations and suggested courses of action to OTP in its role of Government-wide program coordinator in this field.

Mr. GOLDBERG. If I may add one comment, Mr. Chairman.

In terms of your remark about encroaching upon the activities of the FCC, when we get into the policymaking area for the private sector and domestic policy we file papers at the FCC to participate in their proceedings or we make legislative proposals to the Congress. We have no operational authority to implement any policy in matters over which the FCC has jurisdiction.

Mr. MACDONALD. I take it that you are saying there has been no friction, lately at least? When did Mr. Whitehead leave?

Mr. EGER. Mr. Whitehead left in August of last year.

Mr. Chairman, I think we would be naive to suggest that there has

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not been some friction. I think we have tried, certainly during the time I have been in OTP, not to make recommendations on ad hoc applications on matters before the Commission.

But certainly where the Commission is considering, even in the case of a given application, a matter that has long-term policy implications, we have made our views known. We have tried to make them known always on the record.

To the extent that there is disagreement, I think that inures to the benefit of the American public. That is not denying that there has not been friction in the past and I would not argue to the contrary.

Mr. MACDONALD. I would say on the surface that sounds good enough. We don't want to have a monolithic bureaucracy. The FCC and the subcommittee have not always seen eye to eye on everything. When they come to make a decision do you participate?

Mr. GOLDBERG. Not when they make a decision. We file comments in some of their proceedings.

Mr. MACDONALD. When they hold hearings?

Mr. GOLDBERG. Yes, and when they conduct a rulemaking proceeding on a matter of policy on which we have a position or on which we have conducted research, we make our research and views available to the Commission on the record, Mr. Chairman.

Mr. HOMET. If I may offer two examples drawn from Mr. Eger's statement that may help make this concrete for you.

In the case of the rural television study, the upshot was a forwarding of the conclusions with a letter to the Commission, a public document, suggesting that the Commission inquire into the desirability and feasibility of reconsidering some of its rules for the purpose of facilitating expanded rural television distribution.

Now, we made a point of providing copies of that to the industry parties that would be most interested and also, of course, making sure that the press knew about it.

Mr. MACDONALD. I think you have those in the wrong order but go ahead.

Mr. HOMET. Whether the Commission chooses to institute a rulemaking proceeding or other inquiries is entirely up to them.

So also in the resale and shared use docket that was established by the Commission. We filed in accordance with their filing dates and all the parties in that proceeding will have an opportunity to comment on our filing and point out what they think may be wrong with it.

Mr. EGER. I don't think the chairman was referring to something recently. We are aware of section 4 of our Executive order,

> Nothing contained in this order shall be deemed to impair any existing authority or jurisdiction of the Federal Communications Commission. In carrying out his functions under this order, the Director shall coordinate his activities as appropriate with the FCC and make appropriate recommendations to it as the regulator of the private sector.

I think that is clear and we understand that.

Mr. MACDONALD. I am glad it is clear but I don't think it has always been practiced by the OTP. Your title is what down there?

Mr. EGER. Acting Director and Deputy Director according to reorganization Plan No. 1.

Mr. MACDONALD. How long have you been Acting Director?

Mr. EGER. Since August of 1974, since Mr. Whitehead resigned.

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Mr. MACDONALD. There are a couple of things I would like to clear up before we go into the meat of your statement.

First of all, what puzzles me—and that is the correct word, puzzles—is that in January your office came close to being abolished by the President; is that correct?

Mr. EGER. Well, I have yet to ascertain precisely, Mr. Chairman, what transpired during that period of time. I think it was clear, certainly, that that matter was under consideration.

Mr. MACDONALD. I also understand it was the Director of OMB that recommended you be disbanded. Is that your understanding, too?

Mr. EGER. Mr. Chairman, I don't know that for a fact. I do know that it seemed to be basically a budgetary decision. What was proposed, and again this is only my understanding, is that the employees, 53 in number, and the budget, in the neighborhood of $8 million, would be transferred to the Department of Commerce.

One of the reasons for this, as I understand, was the desire on the part of the President, an understandable one, to reduce the overall size of the Executive Office of the President.

You know, Mr. Chairman, and the Congress certainly knows, that there is a great deal of legislative history behind the creation of a strengthened executive branch communications capability in what is known now as OTP. There were a lot of Presidential task forces, GAO studies, OMB studies, studies going back 30 years.

It is my understanding that when all of this background was made available, a firm decision then was made that the President would keep this Office within the Executive Office and would become involved in communications matters.

Mr. MACDONALD. For how long?

Mr. EGER. Well, it didn't say for how long, Mr. Chairman.

Mr. FREY. At least until 1976.

Mr. MACDONALD. I would not bet on that. The reason I raised the question is that I would like to get it straight in my mind. You talk about OMB as if they were our friends. You are working closely with them, and then you find out that they have recommended that you be abolished. The two things seem to be sort of opposing views.

Mr. GOLDBERG. Mr. Chairman, I am not so sure that the recommendation of OMB was to abolish the Office.

Mr. MACDONALD. Well, to transfer its power to the Commerce Department. There is no question about that, which would not abolish it in the sense that it would be stricken from the record. You no longer would be an independent agency advising the President. You would be working in the Department and for the Department of Commerce. So, it is not as if money was to be saved. It would be going from the left hand to the right hand. That puzzled me.

I know in January, Mr. Eger, you were quoted as saying a fundamental misunderstanding, and I am quoting, in discussing the abolishment of OTP, you said that, "If it were to be abolished it would be a fundamental misunderstanding of what OTP is; they don't know where we fit." Now, who had the misunderstanding? Was it the President? Who didn't know where you fitted in?

Mr. EGER. When I said "they," Mr. Chairman, I was referring to the enemy, whoever they were. I didn't know who "they" were, which, unfortunately, in Government is part of the problem sometimes. One does not always know who "they" are.

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Mr. MACDONALD. That statement is certainly factual.

Mr. EGER. I think there has been a misunderstanding of the history of the Office and what we were mandated to do. We are doing our best to go about our business and accomplish our mandate.

Mr. MACDONALD. I have been going around and around with Mr. Whitehead trying to determine if he spoke in the name of the President, as he did on several occasions concerning news content, and he always said yes, he was speaking for the White House in the position of White House adviser.

Now, was that just a personal arrangement or was that an arrangement of OTP and its Director, which is now you, to advise the President on matters of telecommunications? Which is it?

Mr. EGER. Mr. Chairman, I can't speak to any particular prior arrangements. The Reorganization Plan and the Executive order establishing the Office provide that the Director is the President's adviser and spokesman on telecommunications.

Mr. MACDONALD. If you were the adviser, were you consulted about being disbanded or transferred to the Department of Commerce?

Mr. EGER. Mr. Chairman, I think it is fair to point out that right after the transition period we were full participants.

The President, like any President, and I think he ought to do this, looks at his people and their functions. He says who stays and who goes, what functions stay, what do I want and what don't I want. We participated fully in the process. Right to the time when there was consideration of transferring the functions of OTP, I was then advised and it was discussed.

Mr. MACDONALD. With the President?

Mr. EGER. No, sir, not with the President personally.

Mr. FREY. Mr. Chairman.

Mr. MACDONALD. Just 1 second. Let me finish this.

Don't you feel at liberty to say whom you discussed it with?

Mr. EGER. I don't think there was any individual in particular—there were a number of people within the White House staff who were participating, advising, and preparing a staff memorandum, Mr. Chairman.

Mr. MACDONALD. Mr. Frey.

Mr. FREY. I just want to comment, Mr. Chairman, on your line of questioning. I think it is a good thing that we are looking at the size of the staff. There has been tremendous pressure and complaints over the size not only of the White House staff but of the bureaucracy.

I look forward to working closely with you to see what you think on these many issues. I think it is going to be a lot better relationship, I hope, in these 2 years than maybe some of the interesting ones we have had in the past, Mr. Chairman.

Mr. EGER. Thank you, Mr. Frey. I appreciate your remarks. I think the "flap" was healthy.

Mr. MACDONALD. I would like to find out what is going on because it directly affects telecommunications and the telecommunications policy of the Government. I was not quarreling with OTP; I have had my fill of quarreling with OTP.

Mr. EGER. I hope the dialog in the future is more constructive. The net result of the reconsideration of this Office and its position in the executive hierarchy has been healthy, because we have had an opportunity to reexamine the old mandate and some of the history.

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I think there is a better understanding within the executive branch, within the White House, within the Congress, and among those interested in the body politic. That on balance has given us some renewed strength, vigor, and determination.

Mr. MACDONALD. I am glad to hear that.

To get directly to your statement during my period of time before others are recognized, you say on page 5 the draft bill was submitted to the Office of Management and Budget in December 1974 for executive clearance, and it is expected to be sent to the Congress in the near future.

Throughout your testimony you indicate that everything is going to be sent to the Congress. We hear about it, we read about it, but we wait expectantly and never see it. I shouldn't say never, but we don't see it very often. When do you think it is going to come up?

Mr. EGER. Mr. Chairman, I can't pinpoint it. Obviously, part of the clearance process is designed to elicit comments of people within the executive branch, and also the FCC, who are concerned with the substantive provisions. If they make a recommendation and it occurs to us that their thinking is more lucid than ours, then possibly some changes would be in order.

Mr. MACDONALD. Let us take CATV which is more or less a burning issue before this subcommittee and affects a lot of people, and many people are interested in it. You, as I understand it, propose some legislation which concerns the FCC; is that correct?

Mr. EGER. The draft bill went to the Office of Management and Budget. They, of course, coordinate it with all interested agencies within the executive branch and also an agency such as the FCC in this case.

Mr. GOLDBERG. As a mechanical matter, we submitted the draft legislation to the Office of Management and Budget. As part of their legislative clearance process, they determine that the Department of Justice, the Department of Commerce, and the FCC had an interest in this legislation, and they sent the draft to those agencies for their comment. At this point, we are waiting for the responses from the Department of Justice, the FCC, and I believe, the Department of Commerce.

Mr. MACDONALD. You should put an addendum on there, don't hold your breath until it comes up.

Mr. EGER. We try to be optimistic, Mr. Chairman. I do think that 60 days on the outside is a real possibility because we have gone through this twice now. This is the second clearance process that it has gone through.

Mr. MACDONALD. So, the legislation holdup is merely mechanical at this point?

Mr. EGER. I believe so.

Mr. GOLDBERG. I believe that OMB views its function as that of a clearinghouse, and once the comments are in, that we will be able to get legislation to the Congress. And I believe it will be a strengthened piece of legislation by having had the benefit of the views of the other agencies. There have been improvements.

Mr. MACDONALD. As I understand it, the FCC disagrees practically totally with your point of view, and their suggestions and your suggestions are 180° apart.

Mr. EGER. I don't know to what extent that is a fair statement. I think there is a lot of common ground. To the extent there are philo-

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sophical differences, I believe that it is healthy to present the Congress with alternative points of view.

Frankly, Mr. Chairman, we have said recently that we don't think that our legislation, although we are pleased with it, is the definitive work. We hope that the FCC will draft its own legislative recommendations and that others will contact their representatives in Congress and make suggestions.

Mr. MACDONALD. They are in the process of drafting a statement.

Mr. EGER. That is helpful.

Mr. GOLDBERG. Mr. Chairman, if I may add one comment, the clearance process has had the healthy effect of narrowing the issues. I think we are down at this point to some issues in which we would not want to compromise our philosophy and the FCC would not want to compromise its philosophy.

As Mr. Eger has said, various bills will be before the Congress, and these issues, which are fundamental issues on a complex subject, ought to be debated in the forum of the Congress so that the Congress can speak on whatever policy it wants for cable television.

Mr. MACDONALD. It would be, of course, impossible for us to judge the present status of CATV at the FCC because their regulations are so complicated.

They were here the other morning and I indicated to them that certainly their regulations on CATV were as complicated as the IRS Code, if not more so.

One thing that I was interested in is the remark attributed to you, which I am sure you made, saying that the FCC regulations tend to be anticompetitive. Am I correct in that?

Mr. EGER. I probably did say that. I don't know what the context was.

Mr. MACDONALD. Do you believe it now?

Mr. EGER. Yes, I do, Mr. Chairman.

Mr. MACDONALD. In what respect are their regulations anticompetitive?

Mr. EGER. Are we speaking about cable, Mr. Chairman?

Mr. MACDONALD. Yes. I have been right along. I don't know what you all have been talking about. I have been talking about cable.

Mr. EGER. Henry, do you want to address that?

Mr. GOLDBERG. I think the present FCC regulation of cable is designed to integrate cable into the mass communication structure of the United States. They are not writing on a clean slate. We have broadcasting, we have telephone companies providing services that perhaps cable now or in the future could provide.

For example, the pay-TV regulation by the FCC is designed to preserve a certain level of program and product, sports events, and series entertainment programs, for the public to receive on over-the-air broadcasting rather than through say cable or pay television. So what the FCC is doing really is saying that certain kinds of programing can appear on broadcasting and certain kinds of programing can appear on cable.

Mr. MACDONALD. I hope OTP is not recommending eliminating the siphoning rule saying that cables cannot siphon off sports events and other things that have been shown to the public "for free."

Mr. GOLDBERG. We are being guided by the policy stated by the President's Cabinet Committee on Cable which recognizes there is a valid

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interest in protecting a certain level of programing for the public on free broadcasting.

We certainly have not walked away from that. I think our concern is that we are in an area in which there is quite a bit of speculation as to possible injury.

What we would like to see is some more experimentation—perhaps experimental suspension of some of the film rules—to see if we can get some hard evidence as to what the competitive effects of liberalizing antisiphoning rules would be.

Mr. MACDONALD. Your rules support what the President's committee did—support the rules about antisiphoning of sports events.

Mr. EGER. I think that is a fair statement. We recognize their necessity at some point in time. We just question whether the evidence is in and whether the rules as previously drafted are burdensome.

Mr. MACDONALD. Of course, they are burdensome.

Mr. EGER. Without sufficient foundation. Take movies, for example, Mr. Chairman.

Mr. MACDONALD. I am not talking about movies for the moment. I am specifically addressing myself to sports. He indicated yes. Are you indicating no?

Mr. EGER. I think we are indicating that, yes, we are supportive of the necessity for reasonable antisiphoning restrictions. But we raise the question of whether now—with only 70,000 homes wired for pay cable—whether those restrictions are reasonable.

Mr. GOLDBERG. I might point out that in recognizing the need for some antisiphoning rules with respect to sports, the Cabinet Committee specifically stated that it did not endores the FCC's rules that are presently in effect.

As you pointed out they are very complex. I am sure there is a lot of room for simplification of these rules.

Mr. FREY. Will the Chairman yield at this point?

Mr. MACDONALD. Sure.

Mr. FREY. Can I get an answer? I am not sure I understand you. Are we going to allow siphoning as far as sports goes?

Mr. EGER. As far as sports we have not spoken out yet.

Mr. MACDONALD. That is correct.

Mr. EGER. On sports, sir?

Mr. MACDONALD. Yes. I am addressing myself to you as much as to him. We can question him about it. In your original draft you had favorable mention of antisiphoning but in the last draft, I am told, in section 706(d) you deleted the antisiphoning provision and indicated that your report would not specifically authorize the FCC to adopt antisiphoning restrictions.

Mr. EGER. I was speaking to sports only. I think you are right, we have spoken many times on the general antisiphoning principles.

Mr. GOLDBERG. If I may add one comment which really relates back to what I was saying about the give and take in the clearance process. The Department of Justice saw the provision that said the FCC shall have continuing authority to adopt antisiphoning rules and said they would prefer to see that section out of the legislation because they felt that it prejudged the issue of the FCC's authority to have antisiphoning regulations.

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The Department of Justice said that they had participated in FCC proceedings questioning the Commission's authority and would prefer to see the question of the Commission's authority resolved in the courts rather than in draft legislation submitted to Congress.

Mr. MACDONALD. I would like to point out to you, gentlemen—I don't know if you were around at the time—that the antisiphoning rules originated right here in this subcommittee. Therefore, we are very interested in the entire gamut that antisiphoning is verbally going through at the moment, telling people that we doubt very much that the Congress will hold still for siphoning of sports events particularly.

There might be some areas where something can be worked out. The number of wired houses in the United States as compared to those that are nonwired—I don't have the figures, I suppose you must—the wired houses are small in number compared to the general public. To siphon off for very, very few people who have the money to pay for cable and then, eventually, for pay cable, is something I don't believe that the Congress is going to hold still for. I know I am not.

Mr. EGER. We have made some distinctions between sports and movies. For example, there are several markets for movies. There are people who want to go to the theater, people who are willing to see them in their homes.

Mr. MACDONALD. I said there are areas that could be worked out.

Mr. EGER. Yes, sir. I think there is room. The thing that is troublesome is that we have rules telling people what they can buy and what they can see in terms of program product.

Mr. MACDONALD. You are saying that the Government is overregulating?

Mr. EGER. I see some of the regulations, particularly of movies, as overregulation.

Mr. MACDONALD. You think that this tends to have a dampening effect on the competitive market?

Mr. EGER. We have said that much as far as movies are concerned, with the caveat that some rules may be necessary at some future time; we are saying in effect, that the evidence is not in.

With regard to sports, I would like to refer to a letter I sent to the Chairman of the FCC in September. We said "In view of the close connection between congressional policies—antitrust exemption, antiblackout provisions, etc.—and professional sports programs, the Committee," meaning the Cabinet Committee, "recommended that the FCC continue to apply antisiphoning restrictions to such programs as the Congress and the Commission deem appropriate."

Mr. MACDONALD. That is why I said you were incorrect in your answer to Mr. Frey.

Mr. EGER. Yes, you are right.

Mr. MACDONALD. I take it you are all for competition?

Mr. EGER. It has worked pretty well, Mr. Chairman, over the years.

Mr. MACDONALD. I was fascinated and delighted to read your position vis-a-vis A.T. & T. because I know something of your background. You worked for Bell, did you not?

Mr. EGER. I was with the Illinois Company.

Mr. MACDONALD. Illinois Bell?

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Mr. EGER. Yes, sir.

Mr. MACDONALD. It was "Ma" Bell?

Mr. EGER. It is all the same. They get around, Mr. Chairman.

Mr. MACDONALD. There was some discussion here among the subcommittee membership about the FCC, about their position on the specialized common carriers, interconnection decisions, and residential users. OTP and you particularly, both officially and I guess privately, because you were quoted recently as indicating that you feel that there should be more competition within A.T. & T. and its related fields. I will not ask you what you mean but just elaborate on it.

Mr. EGER. I will be happy to, Mr. Chairman.

First of all, let me say, having been a member of the Bell System and a subscriber, myself, I think the telephone system of this country is one of the greatest in the world.

When I am talking about competition I am not referring to the telephone industry as such. I am talking about the data communications market, and what innovation in technology has brought to communications in the way of delivery of new services, particularly business services. This is a market that right now is very, very small.

The interconnect and data communications market where competition now exists probably account for no more than 15 percent of the Bell Systems' total revenue. It is a growing market. Bell, even within that 15 percent, will probably capture the dominant share. But it is a sector of the communications industry that is volatile.

Mr. MACDONALD. Volatile?

Mr. EGER. Yes, sir.

Mr. MACDONALD. Volatile I understand.

Mr. EGER. It is a sector of the economy that I think competition will serve us well. There are unsatisfied needs. Witness the number of new entrants seeking to provide "value added" service, for example, by leasing bulk facilities from Bell and adding computers or conditioning the channels, to provide subnetworks that do nothing but transmit facsimile or transmit packets of data, computer to computer.

There is certainly room for this kind of new entrant.

Mr. MACDONALD. And Bell does not want that kind of competition, I take it?

Mr. EGER. I don't know precisely how Bell feels about that kind of competition. I haven't personally read their pleading.

I think they are in favor of seeing some liberalization of the resale and interconnection restrictions because they see, too, that by more fully utilizing their existing plant they are getting a return on their investment, and there is a demand there obviously which is being satisfied which they otherwise would not fill.

Now, to what extent they would acquiesce in our proposals I am not precisely clear.

Mr. MACDONALD. Have you made up your mind? Since you gave that statement in September, have you backed away from indicating whether or not you favor antitrust actions against A.T. & T. and its subsidiaries? Are you ready to go on the record about that yet?

Mr. EGER. I will be happy to, Mr. Chairman.

I suggested in the past and I suggest today that I don't know what the answer is to solving the competition problem. When I say competition problem I mean the question of how you regulate a monopoly on the one hand, a monopoly getting into competitive markets on the

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other, and still permit fair competition. The problem is that of striking a balance between the establish carriers and new entrants competing in certain sectors.

Of the long list of suggestions for changes to accommodate competitive entry in communications, my position has always been that restructuring by antitrust action is one option.

Since the Justice Department filed their antitrust action I have no more or less desire to see that option pursued as any other.

Mr. MACDONALD. Just as long as the field is opened up for competition you don't care particularly what rules you follow in getting more competition in the area but you feel more competition should be permitted. Does that summarize your views?

Mr. HOMET. I think it is fair to say that what the Justice Department is addressing is the question of the vertical and horizontal integration within the Bell System as a whole, which is, of course, treating the question of competition, if you like, in gross.

What we have been doing and continue to do is to look particularly and more specifically at some of the questions concerning where competition can and should be introduced and what ground rules should govern that competition.

I would suggest that those questions will remain no matter how the antitrust suit comes out. Let us assume that the Justice Department asks for complete break up of the Bell System and prevails in court some numbers of years from now. In the operating area of Illinois Bell, Southern Bell, New England Bell, whatever it may be, you would still have the question in that area of what the ground rules should be for competition between a multiservice telephone company and a single service competitor that wants to provide station equipment or wants to provide specialized carriage.

Mr. MACDONALD. Is OTP prepared to make some suggestions, even though you don't believe they are written on stone and down from the mountainside concerning the problem?

It seems to me that is your man function to provide long-term answers to questions on subjects which do have much to be said on both sides.

Mr. EGER. Precisely, Mr. Chairman.

For example we are continuing our studies of the way in which the Commission evaluates investment questions, looking toward an updated uniform system of accounts which more meaningfully reflects investments and expenditures. Our goal is to develop better tools for addressing these issues. We will continue that program.

Mr. CARNEY. Mr. Eger, in your explanation you say you serve as the President's principal adviser and spokesman on communications policy.

During the last session of this body, I think it was the chairman of this subcommittee who introduced a bill to provide that all radio sets in the future have both FM and AM frequencies on them.

Now, the minority members of this committee were very vocal in that opposition—most of them were at least. Did your committee have any part in advising the President on this and, if so, what did you do?

Mr. EGER. We did take a position by means of submitting a letter to the Senate and I presume to the House as well, which opposed the all-channel radio bill basically on the ground that is appeared to eliminate consumer choice. The problem at hand was not one to be resolved through legislation.

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Mr. MACDONALD. I would like to correct the record. While it came before the subcommittee, I did not introduce the bill.

Mr. CARNEY. I am sorry. I thought you were the author.

Mr. MACDONALD. I never did believe in the all-channel radio bill.

Mr. CARNEY. In your book that you submitted you indicate that you feel the fairness obligation is a little too strict. Will you elaborate on that, please?

Mr. EGER. At the outset, there is a somewhat difficult distinction to make. We have a fairness doctrine for electronic journalism and not for the print media. It has been justified over the years on the scarcity of broadcast frequencies.

Mr. CARNEY. Not on scarcity. I think because it has been designed so that the people have an inherent right to the air.

Mr. EGER. The Supreme Court's decision in *Red Lion* did affirm the fairness doctrine in principle as affirming the listener's right to be involved, to be heard.

Our position with respect to the fairness doctrine has not been that there is no fairness obligation but rather that the obligation is enforced on an ad hoc basis, which puts seven people in Washington in a position of looking over the shoulders of a licensee.

We question whether that kind of regulation is really in the public interest.

Mr. CARNEY. Why is it not in the public interest?

Mr. EGER. Why is it not in the public interest?

Mr. CARNEY. Yes.

Mr. EGER. Because the licensees, knowing they have to come before the FCC every three years for renewal of their license, knowing that fairness complaints are resolved upon complaint to the Commission by the Commission, tend to start ascertaining and satisfying the needs of the FCC rather than the need of the communities that they serve.

There is a question as to whether the fairness doctrine, the way it is enforced now on an ad hoc basis inhibits the free, wide open, robust debate which it was intended to encourage.

Mr. CARNEY. This is only one side of the argument. You said you want robust debate. When only one side of the argument is presented on the air how can we have robust debate? Should we not have regulations to give the other side a chance to be heard. Do they have to buy a TV station?

Mr. EGER. Knowing the public license will come up every 3 years, they will try to present both sides in their overall coverage of a controversial issue. And I would be willing to give them a chance to do that and judge their fairness over a long period of time.

Mr. MACDONALD. Will you yield for one comment?

Mr. CARNEY. Sure.

Mr. MACDONALD. I hope you understand that you would have perhaps, if carried to an extreme, an entirely new Congress in many areas, if one station permits only one candidate to Congress to be heard and that is the signal that everyone happens to listen to because it is the only "game" in town. If you wait 3 years to see if they are going to be fair or not you are in tough shape.

Thank you, Mr. Carney.

Mr. EGER. Can I address your observation, Mr. Chairman?

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I am not suggesting that citizens should not continue as they do now to make their complaints and their voices known to the local station and by carbon copy, perhaps, to the FCC for inclusion in the record.

The way the licensee exercises his obligation in dealing with that citizen's complaint, however, I suggest is as important or more important than judging his overall record as a licensee.

Mr. CARNEY. When you say that the fairness doctrine should be reinforced by review of the broadcaster's overall performance at license renewal time, rather than on a present case-by-case fashion, are you indicating that guy should be able to go into a hundred banks and rob one?

Mr. EGER. I don't make the same analogy, Mr. Carney.

Mr. CARNEY. What is your analogy? If a guy is doing something that is not right will you call him the time he is right? You don't go to jail because you have been a good guy most of your life. You go to jail because you did something wrong in your life. Are you advocating that they can do a little wrong?

Mr. EGER. No; Mr. Carney, I am saying the license is a very, very valuable thing. That most licensees are not going to jeopardize that valuable property by taking a biased attitude and only presenting one side of a controversial issue of public importance.

Mr. GOLDBERG. I think also we have to rely to some extent on the professional responsibility of journalists, whether they work in the print medium or in the broadcast medium. It is a very sensitive situation when a Government agency with life and death control over a broadcast station and its business is second guessing the editorial judgment of a particular broadcast journalist.

To some extent under our system of constitutional protections we have to have some faith in the journalistic integrity of the news media. Of course the broadcast news medium is one that is relied upon to a great extent by the vast majority of the American people, and it is always a good idea to keep the Government from second guessing its journalistic judgment.

I don't think you would get any disagreement on this point from the FCC, itself.

Mr. FREY. Would you yield?

Mr. CARNEY. Yes.

Mr. FREY. What about the recent decision on obscenity? That is just counter to what you said.

Mr. EGER. No; I think obscenity poses a somewhat different problem because the first amendment protections, at last according to most legal thinking, are not absolute. There are some areas in which some kinds——

Mr. FREY. What about the pressure, because it is pressure that has been brought in terms of advertising in children's programs.

I am not saying it is wrong. I am saying that what you say has not necessarily been carried out.

Mr. EGER. I think when you get into the area of advertising——

Mr. FREY. And programs of violence.

Mr. EGER. Let us take cigarette advertising. The Congress determined that it didn't want, for certain social purposes, cigarette advertising on television and reached the determination to ban it. That determination has been upheld by the court. The closer you get to actual

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journalism, to actual news and public affairs judgments of the broadcaster and broadcast journalist, the first amendment calls for a more handsoff attitude on the part of Government.

Mr. CARNEY. I am thinking, however, that a radio station, say, in a political campaign gives unfair news and someone wants an opportunity to answer. If they don't get that opportunity they complain to the proper agency.

Don't you think in that individual case that particular person has a right to have the statement be brought up short at that time and not wait a couple years? Justice delayed is justice denied.

Mr. EGER. I think in the area of political campaigns we rely on equal time and what FCC is calling quasi-equal time protections recognizing the time sensitivity of a campaign situation or a bond referendum. In those instances, if a station has gone too far, then some right of reply for the political candidate or for the side of a bond issue that has been dealt with unfairly should be given. We are dealing in different areas when you are getting into an election campaign situation.

Mr. CARNEY. Maybe we are thinking along different channels. I don't think Government should step in, some seven guys in Government say "You do this." I am thinking where a well-documented complaint is made that some station, radio or TV, is off base on a particular issue and not doing a job they are supposed to do under the general terms.

I think that is when they should be brought up short, not take their license away. Straighten it out then and not wait 3 years.

I am thinking more in theoretical terms. I want to see some restrictions placed on some of the crap that the TV stations have to put out, that they are taking care of the programing of their district.

I get these TV stations and radio stations in my district that want to sit down with me and take a couple of hours time for me to tell them how they are meeting the needs of the area because they have to go to the leaders of the community to show the leaders they are doing a good job. That is a lot of baloney. They have to substantiate what they are doing.

If they are doing something in the eyes of the community that is wrong at that time, it should be corrected then and there.

Now, another matter. I read in the paper, one of the local papers this week, that a number of TV sets were recalled, thousands of a couple of makes, because they were supposed to be radiating rays harmful to children and people.

What have you done about that? You said you have done something. What have you done? I hear you talking about it. Every month I see radios and TV's recalled.

Mr. EGER. When I talked about the nonionizing effect of radiations I was not talking about the kind of interference you are referring to.

I also point out that the FDA and the Consumer Product Safety Commission are the agencies responsible——

Mr. CARNEY. You are not responsible for that?

Mr. EGER. No, sir, nor is the FCC.

Mr. CARNEY. I might issue a little complaint or a little observation. tration or the Consumer Product Safety Commission?

Mr. DEAN. HEW.

Mr. CARNEY. I might issue a little complaint or a little observation. I read a lot about Government gobbledygook. The average grade of

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schools in my district is about the 9th grade. I went just a little bit higher than that.

In this paragraph on page 6, if that is not Government gobbledygook I don't know what is. That looks very good. I imagine the young guy who wrote that thought he did a hell of a job.

I would like to tell a story. A late Congressman by the name of John Kluczynski was on the Small Business Committee. Some guy made a big speech. When he got done John said:

That is the finest speech you have ever given in your whole life but I don't know what you have said.

Mr. EGER. If it is any consolation I have had trouble reading it.

Mr. CARNEY. You ought to hire somebody who can write something you can read. That is a complaint I have against all Departments. They hide pretty well what they want to say. I don't know what they meant there.

Those are all the questions I have, Mr. Chairman.

Mr. FREY. The gentleman from Ohio has no trouble communicating. I guarantee that.

I do have some specific questions I would like to get into. Generally the subject you touched upon, despite the *Red Lion* case, the first amendment with application to communications, and to the use of the airways, is one that I still think is part of the problem we have. It is like being a little bit pregnant. The first amendment is there but it is not there. This is a matter that comes up frequently.

The fairness doctrine, 315, is a joke. Three hundred fifteen does not give equal time. It gives no time. That has been the effect of it in so many campaigns. People won't go on. Why give somebody else a shot at it. I hope you spend time on many of these problems.

It was noteworthy in your statement some of the mattters which you discussed such as a couple of real worms, like sports blackouts, the problem of obscenity, the problem of child programing, advertising, many of these things which are issues we are going to deal with.

How much do we have in the Government in terms of community facilities? About $50 billion?

Mr. EGER. I would say we have a gross investment of something like $50 billion right now.

Mr. FREY. $14 billion a year expenditures?

Mr. EGER. Closer to $10 billion including communications and electronics.

Mr. FREY. This is an area in all fairness you have not been looking at for a long time.

Mr. EGER. Before 1970 of course there was not anybody with the stature to put their arms around the whole Federal Government expenditures in a direct kind of way in which the money is being spent, the way systems are being developed.

You are quite correct, we are just now going through the first phase of that.

Mr. FREY. We really have not had a payoff.

Mr. EGER. Yes, we have. One in particular is the navigation problem. We notice that there were three different systems, loran A, B, and Omega systems. One for rivers and harbors, one for high seas, and one for the coastal confluence areas. We looked at the propagation characteristics of these various systems and said we don't think

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we really need three distinct communications systems with all the associated hardware that goes with it. That is probably a half billion dollars savings by reducing three to two.

Mr. FREY. Don't we have the Office of Telecommunications Policy in HEW, in Commerce?

By the way, speaking of money, we received the annual reports on this. I am afraid to ask how much—this is put out by the Department of Commerce—how much this one cost. It sure could be done with a lot less. There is very little in it and it could be done in a couple of pages. Why do we have three or four different little agencies working on telecommunications?

Mr. EGER. That is a good question. Let me say first that I think that the executive branch, as it deals with issues of communication and organizations, has to deal with it really in a formative stage. It took 25 years to get OTP.

Mr. FREY. It is not going to take that long to get the legislation.

Mr. EGER. No, I certainly hope not. Many of these agencies have their own internal communications entities. For example, HEW, Justice, Commerce, Interior, they all have communications systems large enough to justify an Office of Communications. Most of their responsibilities are operational responsibilities.

Our organization sits one notch above and tries to formulate policies which affect the way in which they do their business.

Mr. FREY. I sure hope you put some more time and effort into it. With the capital investment we have, $10 billion or $14 billion a year; and with nothing done in the past there has to be a way to do that.

Mr. WIRTH. Will the gentleman yield?

Mr. FREY. Surely.

Mr. WIRTH. It is important to point out when the HEW office was set up 6 years ago, there was great concern on the part of the health, education, and welfare agencies that there be an advocate for social programing and for those kinds of interests. There was fear at that time that an Office of Telecommunications Policy and the Defense Department together might not be looking out for that set of interests.

At the time that was set up there was a very clear and careful reason for doing that. That was right after Mr. Finch had become Secretary at the time. I think there is a good history to this. I am sure maybe in the other departments as well there is history to that. I happen to know the HEW one.

Mr. FREY. I appreciate the gentleman's colloquy. He sits on another committee. The use of the so-called social service satellites, the ones we have been using out in Arizona, could deliver health care to the Indians.

I think these are tremendous things we should do and should use. I am not convinced we need 15 different groups working on it to come to that conclusion.

Mr. EGER. We are as concerned as you are. We are trying now. The ATS-6 NASA advanced technology system to which you are referring has proven successful. We are beyond the experimental stage.

Many of us feel that the time has come to transfer this technology to the private sector. We called one meeting that I chaired, and I think there have been follow-on meetings, to try to coordinate the Federal Government in future involvement in the effort to create a private sector follow-on to the ATS program. There is that need; you are correct.

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Mr. FREY. It is important you work on this now and get the project going right, especially with the space shuttle in 1980 that will completely revolutionize the use of space.

Unless we lay the groundwork a lot better than we have done to date, cable TV rules and regulations will be simple compared to some of the problems we will get into and you know what a problem that is.

Let us take another problem, public broadcasting. Do you have any input on this in terms of a bill that is over the suggested ceiling?

Are we going to have a veto situation again this year in public broadcasting?

Mr. EGER. I can only speak to the bill we drafted and that the President submitted over a month ago. That is the administration's bill.

Mr. MACDONALD. It is for long-term, though.

Mr. EGER. It is for 5 years.

Mr. FREY. Could you comment on the rationale behind this 5-year funding?

Mr. EGER. Yes, sir. I think Congress spoke to it as I indicated in my statement when it created the Corporation for Public Broadcasting in 1967. When public broadcasting was conceived one of the long-range goals was some kind of insulation beyond just the Corporation for Public Broadcasting, which of course is a vehicle for passing through Government funds for the benefit of public broadcasting stations, some insulation from the annual budgetary and appropriations processes of the executive and the congressional branch. Our bill says 5 years; we could have picked 6, we could have picked 7, 5 is the number in our bill.

I don't think less than that would be particularly appropriate. The bill envisions that the Federal contribution would be increasing over that 5-year period from $70 to $100 million in the fifth year. It provides also for a matching formula.

Mr. FREY. I am familiar with the bill. I wanted to get in the record some of the reasons for it.

What about the exercise we went through the last 3 or 4 years on licensing? Do you have any words of wisdom that we should listen to in this area?

Mr. EGER. No.

Mr. FREY. Are you going to propose any particular bill or legislation?

Mr. EGER. As you know, Mr. Frey, we had a bill.

Mr. FREY. I am aware of that. It would be nice in some of these matters if you would check with some of us and with the chairman.

Mr. EGER. We certainly intend to do that. I think we have an excellent working relationship with the subcommittee staff on both sides of the aisle.

Mr. FREY. I am glad because I haven't heard about any of these bills yet. Maybe the chairman has.

Mr. MACDONALD. I don't know what staff he is talking about since we just got our budget yesterday.

Mr. EGER. I am sorry, I misspoke myself.

Mr. MACDONALD. Mr. Frey is going to have counsel and we will be adding to that. That is neither here nor there. They are too busy trying to get along with each other to bother with the Congress.

Mr. CARNEY. Mr. Chairman, Mr. Frey is a great man for economy.

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I think he is going to give up his man and do his own work.

Mr. MACDONALD. Time is running, gentlemen.

Mr. FREY. May I ask one last question?

I have been involved somewhat in the area of space, with the problem of the international satellites and the proposed agreement worked on for years about the question of broadcasting such as Radio Free Europe, the problem of the satellites being in space and reaching other countries. Have we gotten anywhere with this or is this a typical UN problem, more talk, and no action?

Mr. EGER. I would like to let Bill Fishman, who is our Assistant Director for International Communications, address himself briefly to that. We are a minority of one in the UN working group on the broadcast satellite issue. There are other related issues.

Mr. FISHMAN. Mr. Frey, only last week a member of my staff attended a legal subcommittee drafting session on the direct broadcast satellite treaty that the U.N. is working on. I think perhaps I could agree with your suggestion that this has been a very long drawn-out issue.

The fact is that the United States is in the minority of one so far as I know on the question of the free and unfettered exchange of information and programing across national boundaries.

Consequently, it is difficult for us to advance our position very far. Nevertheless, I think some progress was made at this recent drafting session.

I would hope that inasmuch as the decision is not going to be resolved in the near future we may be able ultimately to receive some accommodation of our viewpoint on it. It is a very difficult, highly visible controversy.

Mr. FREY. In some ways we are getting into new areas of law. It seems to me, Mr. Chairman, that maybe sometime we will want to look into this because it is going to affect some of the things we are talking about, the use of communication satellites and other things down the line. Perhaps we will have to deal with them whether we want to or not.

I thank the chairman.

Mr. MACDONALD. Thank you, Mr. Frey.

Mr. Wirth?

Mr. WIRTH. Thank you, Mr. Chairman.

I would like to focus a little more on the Corporation for Public Broadcasting, if I might.

First of all, to go to your mention of the process of insulating the corporation from incursions of the Government, first off, could we focus on the board for the corporation. Isn't there supposed to be some kind of board for the corporation?

Mr. EGER. Yes, sir, 15 members and they elect their own chairman.

Mr. WIRTH. How many members are now appointed to the board?

Mr. EGER. There are eight members whose terms have not yet expired. It is the other way around, seven whose terms have not expired and eight who must be reappointed. The eight down there are holdovers.

Mr. WIRTH. President Nixon sent up a number of names for appointment and those were withdrawn?

Mr. EGER. Yes, sir. President Ford resubmitted them, I believe, on a pro forma basis.

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I do understand that the slate is under serious consideration, with some names being reconsidered.

Mr. WIRTH. How long has that been going on?

Mr. EGER. Approximately 3 months.

Mr. WIRTH. What is your schedule for completing those appointments?

Mr. EGER. I can't answer that question. I will try to determine it.

Mr. WIRTH. Who can?

Mr. EGER. I think probably the head of the personnel office in the White House. We will be happy to ascertain the information.

Mr. WIRTH. We have called your office on a number of occasions and nobody over there seems to know. It seems to drift along. I think this is presumably meant to be the kind of mechanism that will help the corporation.

Mr. EGER. Yes, sir, I agree.

Mr. WIRTH. It is not a very good indication of the kind of support that is suggested at the bottom of page 5 of your testimony which seems to be supportive of the notion of a corporation.

Mr. EGER. Yes, sir.

Mr. WIRTH. Whom should we call about that or how do we find out what kind of process is being set up and what kind of timetable you are on?

Mr. EGER. We will be happy to ascertain that and supply it to you directly and if you wish, Mr. Chairman, supply it for the record.

Mr. GOLDBERG. One of the problems is that some of the people who were nominated on the first slate have indicated that they do not wish to be considered and they have withdrawn their names for consideration.

Mr. WIRTH. I would hope there would be some people on the slate that you would not want to consider, too.

Mr. MACDONALD. For the benefit of the committee I would like to point out that if our present plans hold we will be having an oversight hearing with the CPB next Wednesday.

Mr. WIRTH. Excellent.

On the funding of the Corporation you noted to Mr. Frey that you were behind your piece of legislation. How strong is your commitment to the legislation which the administration has proposed?

Mr. EGER. I would say we are 100 percent behind the legislation. This is the administration bill.

Mr. FREY. Not a thousand percent.

Mr. EGER. Not a thousand percent.

Mr. MACDONALD. Did you put the bill together?

Mr. EGER. Yes, sir. I might say, Mr. Chairman, we certainly discussed this bill with the Public Broadcasting Service people, members of the Corporation for Public Broadcasting, and representatives of public radio stations. We agree with the bill itself, entirely, except we agreed to disagree on the ceilings.

I think there is unanimous support for this legislation. Not just the administration, but CPB, and those members of PBS and others who are affected by it.

Mr. WIRTH. There are some of us who are concerned about long-term financing and making sure that will be supportive of the Corporation for Public Broadcasting in general. What kind of pressures do you feel against that?

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Mr. EGER. All I know is what I read in the newspapers.

Mr. WIRTH. Nobody calls you or talks to you or you don't feel pressure?

Mr. EGER. Some people call and talk to us.

Mr. WIRTH. Where do a lot of those calls come from?

Mr. EGER. With respect to the legislation I understand there is some concern in the Appropriations Committee that multiyear, 5-year, particularly, authorization and appropriation is a precedent. We can see how some of that argument can be made.

I think there may have been multiyear appropriations and authorization in the past, so it is really not that much of a precedent. Moreover, we are dealing with a first amendment subject, if I can wrap it in that blanket for a minute, in that public broadcasting requires insulation from Government control. This is unique and public broadcasting is unique and the provision of this bill, if it is indeed a precedent, is one that is well warranted.

Mr. WIRTH. You are supportive of this precedent?

Mr. EGER. Yes.

Mr. WIRTH. How does OMB feel about that?

Mr. EGER. OMB originally had questions, but the fact that the bill has been submitted and with a message from the President indicates that whatever prior objections they had are moot.

Mr. GOLDBERG. Mr. Wirth, it was not only in the Office of Management and Budget that had concern about it but the Department of the Treasury as well. The budgetary and financial people don't like to see multiyear appropriations which remove a certain kind of budgetary control on an annual basis in terms of the overall Federal budget.

We were able to persuade the President in this instance that the benefits to be gained by insulating the Corporation for Public Broadcasting from the formal budgetary process and from the formal appropriations processes were stronger than the interest in budgetary and fiscal control.

Mr. WIRTH. A final question.

Assuming, and this might be a great assumption, but assuming that the Congress in its wisdom were to decide that $70 million to $100 million was not an adequate amount I would hope that all of us would have a chance to talk about that and work out that amount of money before we get to the push-come-to-shove situation of some kind of veto program. I would assume a lot of people in the Congress would like to be able to discuss it in a friendly way with all of you before getting into a confrontation over such a budget.

Thank you, Mr. Chairman.

Mr. MACDONALD. I was not going to go into this at this point, but what caused the change? OTP used to be one of the stumbling blocks that we ran into. We were interested in public broadcasting and its insulation from the administration and others, but especially the administration.

What caused the change-about from 1 year, that OTP seemed to be so insistent on, to 5 years. A 4-year jump is quite a change without any explanation. Do you have any explanation? This is a friendly question.

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Mr. EGER. From a different vantage point, in view of the apparent struggle and conflict that ensued between PBS and CPB and the role that the Office of Telecommunications Policy played in that, the only thing I can conjecture for the record is that PBS and CPB have matured as entities. They have entered into a partnership agreement. They have sorted out some rights, duties, remedies, and responsibilities and parceled them amongst themselves.

Now that those organizations have matured, as the Congress suggested in 1967, now is the time for long-range insulated funding.

Mr. MACDONALD. Unless they stopped squabbling I was not going to bring out a bill. They stopped squabbling, we brought out a bill, and OTP still was opposed to it. Now you want 5 years. I was just wondering if something happened that made you change your view?

Mr. EGER. I think the chairman can take some credit for resolving the issues.

Mr. MACDONALD. Which chairman?

Mr. EGER. You, yourself, sir.

Mr. MACDONALD. I am ready to take any credit. I don't know what credit you have in mind.

Mr. FREY. Just say yes.

Mr. GOLDBERG. Mr. Chairman, my vantage point was a little bit closer than Mr. Eger's since I have been with OTP almost 4 years now working in the public broadcasting field. I don't disagree at all with his assessment that over a period of time people in public broadcasting started to resolve what were structural issues, the role of the stations in decisionmaking, the role of PBS.

PBS reconstituted itself as being a representative of stations and there was a partnership agreement There was a long-range financing task force within public broadcasting that came up with a long-range funding plan that they could agree upon, and as we looked it over we found that we could agree to it, too. It did take some time and it did take some acrimonious debate.

I think the position we find ourselves in now is that there is substantial agreement that this long range, and I stress the long range, insulated funding is the way to go. We are hopeful, as Mr. Wirth says, that whatever remaining difficulties we have over the funding ceilings can be worked out amicably.

Mr. MACDONALD. I don't mean to reopen old wounds. As I said earlier I like to look forward not backward, but I can recall the Director of OTP directing local public broadcasting stations not to take anything over the so-called fourth network.

You people seemed to feel that public broadcasting was getting to be too strong. You certainly know about that hullabaloo.

I think Dr. Whitehead gave a speech in Miami Beach as a warmup for a speech to the local network affiliates in Indianapolis and caused a great deal of discord. Rather than settling the discord it added to it.

Now, I am delighted that we have joined forces. I am just wondering what happened. I think that is a legitimate question.

Mr. EGER. I think that is the best explanation we can give, Mr. Chairman.

Mr. MACDONALD. I would like to go back to CATV and your proposal. Do you feel free to give us the highlights of the plan that you

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are going to send to us? We have been through the siphoning now. We are in pretty good shape, so you don't have to go into that. You indicated that in the field of movies you are not quite so sure. Sports aren't to be disturbed. Am I misquoting you?

Mr. EGER. No, sir. I think it is safe to say that there are at least two things we hope to accomplish by legislation. One is a recognition that cable communications has an abundant capacity, 20, 40 channels. Seeing the potential for diversity inherent in the medium, and recognizing in the preamble or elsewhere a separation of ownership of the facility from ownership of the messages or the programing, we will have negated the necessity for detailed and pervasive regulatory oversight by avoiding the problem of concentration of private power.

Two, the Congress should speak to the jurisdictional question of cable: Who should regulate it? It is our belief that this is an open question. In the *Midwest Video* case Supreme Court Justice Burger said the FCC, for example, in requiring originations on systems of 3,500 subscribers or larger, strained the outer limits of its jurisdiction. It got into it through the *Southwest* case in an ancillary way. Cable was not conceived of in 1934.

Mr. MACDONALD. Neither was TV.

Mr. EGER. Well, radio with pictures. I know that is not a very nice characterization of TV, but it was conceived of in that sense. But we think a regulatory framework and some allocation of jurisdictional powers over cable between the Federal level, namely the FCC, and one non-Federal level is appropriate.

Mr. MACDONALD. Do you suggest that it be the State or local community or what?

Mr. EGER. No, sir, we don't specify that it be the State or local community.

Mr. MACDONALD. Isn't that rule unfair just to say FCC and somebody? Aren't you back in the middle of a hullabaloo again?

Mr. EGER. The decisions on the non-Federal level are whether the municipalities should be franchising systems or a State entity ought to be licensing cable systems or how the States want to allocate its regulatory jurisdiction over cable. We don't believe these present a substantial Federal question, but they are questions best left to the States to decide.

Mr. MACDONALD. Not that it is a Federal question, if I may interrupt. We have been waiting for a long time for Senator McClellan to make some decisions concerning copyright.

As long as CATV is more interested in over-the-air and off-the-air programing and acting as a relay station with a better picture I don't see how anyone but a Federal agency could regulate it.

Mr. EGER. In our legislative proposal those aspects of cable that do affect the retransmission of broadcast signals and relationship between cable and broadcasting would be left solely and exclusively within the jurisdiction of the Federal Communications Commission.

The question as to franchising standards, construction, timetables and the like are more properly matters for non-Federal determination.

Mr. MACDONALD. You understand the types of cable companies. That seems to me to be an insurmountable problem. The cable people themselves are pulling in different ways because of their pride. Their vary-

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ing interests, so forth. Do you mean to say that the OTP wants to have 50 different sets of laws governing CATV.

Mr. GOLDBERG. It would not be 50 different sets of laws.

Mr. MACDONALD. There are 50 States.

Mr. GOLDBERG. The legislation that we propose would set Federal guidelines, Federal standards for regulation.

Mr. MACDONALD. It is still a law. You can get all the guidelines you want. We have guidelines on busing in south Boston, too, but it is not happening. That is why I don't understand your position. To have 50 different types of rules and regulations seems to me to be a very bad and wasteful thing when the whole point is that Federal regulations are too numerous and complex in the first place.

Mr. EGER. There are some aspects of cable operations, for example, in the technical standards for interconnection of cable systems, that do require uniform national regulation and our legislation would leave that to the FCC. There are other matters in which there is much less of a Federal interest.

Mr. MACDONALD. You mean the franchise?

Mr. EGER. The franchise.

Mr. MACDONALD. As far as I know, FCC has not gone directly into the franchising area of cable.

Mr. EGER. The FCC has used the standards and guidelines of what a franchiser can do, franchise terms and fees and the like.

Mr. MACDONALD. As a concrete example you keep hearing that some of the cable people want to service hotels and that sort of thing with X-rated movies. I guess from the hotel or maybe they start with a motel, I don't know, motel-hotel, then to a community. Would you think this would be proper without any guidance?

Mr. GOLDBERG. I think if you are dealing in the subject of obscenity or X-rated movies or the like, that there are State and Federal laws already governing that particular area. You don't need another set of regulations overlaid upon the presentation of such material on cable or on hotel or motel pay TV.

There are ways of dealing with these problems without creating another whole code of regulations by a Federal agency.

Mr. MACDONALD. You might be hurting the industry you are trying to help because Massachusetts has all kinds of laws dealing with indecency and they might be a good deal tougher, say, than New Hampshire or Rhode Island who are serviced by the same company.

I am not really clear as to OTP's thinking. If someone down there could get a little memorandum out just on that subject——

Mr. EGER. On the obscenity question?

Mr. MACDONALD. No, not obscenity because they are all going to scream First Amendment anyway. I am not trying to get behind the First Amendment protection as to OTP's thinking why the FCC regulatory feelings should not be expressed to the cable people as well as the broadcast people.

Mr. GOLDBERG. There is one section——

Mr. MACDONALD. First, I would like to get an answer. Will somebody do it?

Mr. EGER. We can provide that.

Mr. MACDONALD. If you get them up in time I can get them in the record.

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[The following letter was received for the record:]

OFFICE OF TELECOMMUNICATIONS POLICY,
EXECUTIVE OFFICE OF THE PRESIDENT,
Washington, D.C., April 3, 1975.

Hon. TORBERT H. MACDONALD,
Chairman, Subcommittee on Communications, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. MACDONALD: Draft cable legislation prepared by the Office of Telecommunications Policy to implement many of the recommendations of the Cabinet Committee on Cable Communications is now in the Executive Branch clearance process and will soon be submitted to the Congress.

This bill will afford the Congress an opportunity to address the fundamental and complex issues presented by the emergence of cable and establish a national cable policy that is consistent with both the public interest and the particular characteristics and potentials of the cable medium. Comprehensive Congressional consideration of cable policy is necessary to define the relationship between cable and other media and to allocate jurisdictional responsibilities among Federal, state and local interests. Indeed, the Supreme Court has noted in recent cable and copyright cases that the growth of cable virtually has exceeded the statutory direction afforded the Commission and the courts by the Communications Act of 1934.

In the absence of specific Congressional direction, Federal regulation of cable communications has been premised on cables' retransmission of broadcast signals and has evolved though *ad hoc* determinations of the Commission and the courts. Under the retransmission rationale a cable or other broadband communications system carrying no broadcast signals would not fall under the provisions of the Communications Act; a result that may not be consistent with the public interest.

Cable is too important, both as a medium of expression and as an industry, to subject it to the vagaries of *ad hoc* regulation absent statutory direction. The articulation of a comprehensive, coherent, and objective policy is needed if the abundant channel capacity of cable is to be given an opportunity as stated in the President's Cabinet Committee Report to prove its worth to the American public in the marketplace of goods and services, and in the marketplace of ideas.

The OPT cable bill would create a considered, systematic regulatory framework that is designed and intended to achieve certain, well-defined policy goals: (1) prescription of the monopolistic power of the cable operator; (2) allocation and definition of regulatory jurisdiction, and reduction of government economic and program content regulation of a medium of communications; and (3) enhancement of free expression and maximization of consumer choice.

Given the probable evolution of cable as a natural monopoly within its service area, provision must be made for protecting the public from potential abuses of monopoly power. In securing the public interest, government may, as the FCC has done with respect to cable, regulate the *use* of power; or as the OTP bill proposes, Congress can act to limit the *extent* and nature of monopoly power, and thus substitute competition in the marketplace for continuing governmental regulation.

By applying the broadcast model to the regulation of cable, the FCC has perpetuated many of the problems incident to the former medium—such as the limitation of the number of outlets in a community, the denial of access to those without a "license", and the application of regulatory doctrines restricting program content—without regard to cable's fundamental and distinguishing characteristics. If instead, Congress were to adopt the ultimate separation of the ownership of cable transmission and programming functions as a policy goal, and provide that adequate system capacity must be made available to all who would use it, the free flow of diverse views and information would be assured without, for example, application of the broadcast-oriented fairness or equal time type doctrines, and without detailed regulatory oversight.

By separating the distribution function of cable, which is a natural monopoly, from the programming functions, which can be competitive, the potential for the monopolistic abuse of private power and the concomitant dangers of governmental interference in program content can be avoided. With an abundance of communications capacity open to all who would use it to promote their ideas, or sell their goods and services, the public's choice to receive entertainment, information, and services will be limited only by natural market force constraints. These objectives can be achieved only through legislation.

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It is also necessary for Congress to address the constitutionally and politically sensitive issue of the proper Federal-state relationship concerning the regulation of cable. In the absence of such direction, the FCC has continued the preemption of state and local regulatory authority begun with promulgation of the 1972 cable rules. Thus, in recent proceedings, the Commission has preempted cable television technical standards, limited local authority over line extension policies, and has proposed additional limitations on local authority in the areas of transfers of control, the processing of subscriber complaints, the selection of operators and the renewal and cancellation of licenses, and the duration of franchises, despite the absence of any compelling Federal interests. More importantly, all of these actions have been taken without Congressional guidance.

The regulatory plan in the OTP bill, to the contrary, establishes clear lines of jurisdictional responsibility. It provides a policy, heretofore lacking, based on the principle that non-Federal governments, subject to the general guidelines and standards established by Congress, should be delegated primary responsibility over cable; not as "agents" of the FCC limited to execution and enforcement of detailed Federal regulation, but as independent governmental bodies, whose substantial interests in cable originate in cable's use of public rights of way and its provision of service to local communities.

This is a decentralized approach to regulation that offers a continuation of the experiment in creative federalism that has been manifested in revenue sharing efforts and the establishment of joint Federal regulatory plans in the health, safety and environmental areas. As these recent efforts recognize, the imposition of nationally uniform regulation without regard to the presence or preponderance of Federal interests, unnecessarily substitutes consistency for the flexibility and creative diversity inherent in our Federal form of government.

With your assistance, we hope the OTP bill will provide a vehicle for the discussion of the problems attendant to the emerging cable industry and the development of national policy with respect thereto. I am looking forward to working with you and your Subcommittee on cable legislation.

Sincerely,

JOHN EGER,
Acting Director.

Mr. GOLDBERG. There is one section in the draft cable bill that perhaps speaks to this point. It is one that would give the FCC authority to require the cable systems to identify the nature of the program that is being sent out. If it is an X rated movie then the cable subscriber or homeowner ought to know that an X rated movie is coming down the cable at a given time.

Mr. MACDONALD. The movie could be called "Angel in Paradise." If you haven't seen it you don't know what is in it.

Mr. GOLDBERG. I haven't seen that particular film.

Mr. MACDONALD. I haven't. I just made up the title. It seems to me a fairly typical title.

Mr. EGER. The notice would have to give some notion to the subscribers as to what the content of the picture is and perhaps there could be something similar to the rating system which is used with theatrical films.

Mr. MACDONALD. You mean you are putting that burden on the FCC?

Mr. EGER. The FCC would adopt regulations making that a requirement of distribution of cable programing.

Moreover, the FCC under this legislation would adopt regulations that would say that the cable operator has to provide the subscriber, at the subscriber's option, with a device, whether it is a locked channel or scramble channel or whatever.

Mr. MACDONALD. You are talking about pay cable now?

Mr. EGER. I am talking about originations.

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Mr. MACDONALD. But you are talking about pay cable.

Mr. HOMET. Not necessarily.

Mr. MACDONALD. What scramblers do they have on just regular cable? I have never seen one. I have cable in my own house. It does not have a scrambler. It just helps pull in more clearly some of the other New England stations. The only scrambler I ever saw was in San Diego where a gentleman running a pay TV outfit has a little card, like a credit card, which gets inserted. Then you are billed at the end of the month. That is not regular cable. That is pay cable.

The broadcasters will want you to think that all cable is pay cable, and it is, up to an extent, but I am talking about straight pay cable. Otherwise there are no scramblers in use. Or if there are I would be happy to learn. I don't know of any.

Mr. GOLDBERG. There would be no technical problem in putting a code or scrambler on any cable channel.

Mr. EGER. That is the only point. We might only do that for pay, but what you are talking about, Henry, is technically——

Mr. MACDONALD. It is not here. It may never get here.

Mr. HOMET. Mr. Chairman, I am thinking in terms of controversy channels, whether they are X rated movies or inflammatory speeches, or what have you, that are generally removed from the broadcast system.

It would be technically possible to lock and scramble channels of that sort so that those who wished to see it could do so.

Mr. MACDONALD. How much would it cost the general public?

Mr. HOMET. It would be the same technology that is used in the pay-TV system you have seen.

Mr. MACDONALD. It would be pay cable?

Mr. HOMET. It could be pay cable or one of the things that this cable system is going to offer you is controversy channels for no extra charge. It is a selling point.

Mr. MACDONALD. Controversy channel?

Mr. HOMET. Soapbox channel, yes.

Mr. MACDONALD. You are talking about public access channels to me?

Mr. HOMET. That would be included. People who now feel it is necessary to burn down a building in order to get press attention would have an alternative.

Mr. EGER. We are not advocating any of these things, Mr. Chairman.

Mr. MACDONALD. I don't propose you are. But the controversial channel thing is intriguing. They are all controversial to some people. You would have to scramble all of them.

Mr. EGER. We are not advocating any of these things in particular.

Mr. MACDONALD. Then why raise them?

Mr. EGER. I don't know. It appeared to be of some interest at least as the conversation drifted that way.

Mr. MACDONALD. It is of interest but this is a hearing about what the OTP is doing or planning to do.

Mr. GOLDBERG. The rationale for having a limited access channel, whether you want to lock the channel with a key or scramble it in some way, is for some homeowners to be able to set a higher standard for themselves and their own families as to what they want coming in the home than what the general community might wish to have. As long as you provide real notice of what the content of an offered program is——

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Mr. MACDONALD. Do you foresee the cable taking the place of public broadcasting and putting on superior programing when all that pay cable is interested in, up until now at least, are movies and sports? The rest, they don't bother with a filler.

Mr. GOLDBERG. Up to now most pay cable has been more mass appeal programing in terms of movies and sports. In the future as a larger audience for cable and pay-TV develops, you can see more specialized audiences develop.

I would just offer one example. The Lincoln Center in New York City is experimenting with ways to extend their box office for the opera and ballet by selling subscription services to cable subscribers.

Mr. MACDONALD. I have heard about opera and ballet from the public broadcasting people for so long that it just rolls off me.

Mr. GOLDBERG. I am not talking about public broadcasting. I am talking about Lincoln Center extending their box office.

Mr. MACDONALD. I am talking about this being offered by the cable people to the general public.

Mr. GOLDBERG. Offered mainly by Lincoln Center, leasing a channel on a cable system.

Mr. MACDONALD. Yes, but then they have to have an outlet. How much money do you think that would take?

Mr. GOLDBERG. The Lincoln Center people think they can get out of the red using a scrambler system.

Mr. EGER. The point is that there is abundance of channel capacity in cable. Whoever uses it or not ought to be able to make the decision themselves.

Mr. MACDONALD. I agree that anyone should be able to view what he wants. There is a place for cable, especially pulling in long-distance signals that some areas cannot get now.

You say you are working with FCC. Why do they oppose your bill so strongly?

Mr. EGER. Obviously they have a philosophical difference.

Mr. MACDONALD. What is the philosophical difference?

Mr. EGER. I think they are probably reasonably content with their own performance and the way in which they feel they are regulating cable now.

Mr. MACDONALD. They have not even promulgated the rules for sure.

Mr. EGER. We are talking about the difference in philosophy on legislation.

Mr. MACDONALD. Nobody has discussed pay cable except for the Lincoln repertory which I think has an exaggerated view of how many people would stay home because they would rather stay home to watch ballet and opera, and they may be right.

Just talking about cable per se, why are they opposed to your cable bill? What are the philosophical differences?

Mr. EGER. Our bill is basically deregulatory. They, being a regulatory body, find that some of the powers they now have, they would not have.

Mr. GOLDBERG. For example, in our legislation there would be no fairness doctrine, no equal time provisions applied to cable originations. You don't have the channel scarcity. There would be no requirement for minimum channel capacity in construction of a cable system. There are a lot of other features like this where the legislation would cut back on FCC regulation.

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Mr. MACDONALD. Does OTP take the position that they think the fairness doctrine should be abolished in regular broadcasting?

Mr. EGER. We have not taken that.

Mr. MACDONALD. Your position is that it might be modified to everybody's benefit?

Mr. EGER. Yes, sir, I think as we have more outlets. If there is much more choice, there is not the same necessity to have pervasive regulatory oversight in the form of a fairness doctrine or some other mechanisms.

Mr. MACDONALD. The fairness doctrine hits a raw nerve on the hill. We are not always talking about the same thing that you are.

I think you are well advised to drop that until you see how the rest of it flies if it flies at all.

Mr. EGER. We don't consider ourselves expert on fairness, children's television, or violence. We are particularly mindful of the philosophy of this as it affects our longer range thinking. We hope to reflect some of that thinking in the bill and really more than anything else to lay something on Congress' agenda where the great debate can begin.

Mr. MACDONALD. I don't know that we will have any great debate about it. But philosophical differences seem to me to be rather historic because the philosophy of the Commission changes over a period of different appointments, and I would guess there would be a change in some respects—it has happened every place else in Washington. I don't know why it would not hit OTP—in the personnel at OTP.

So, I think you are taking a large mouthful when you say this is a philosophical difference because they have never really outlined what their philosophy is. I have never seen them grabbing for more regulation of anything really.

Sometimes Congress has to prod them a little to get them to do some things. They are already overburdened.

Like a committee here, you don't like to have your jurisdiction fussed with. I can't say that you can blame their viewpoint on that either. What are the points of difference which cause the FCC to oppose your bill?

Mr. GOLDBERG. They believe that regulation has a lot of flexibility that would be lost by putting some of the principles and policies in legislation. They would like to have the opportunity in a developing industry to adjust and change their regulations as they go along.

Another principal difference is that they disagree with the split between Federal and non-Federal jurisdiction that our bill represents. They would like more jurisdiction over what our bill would leave to the non-Federal area.

I think those are the principal differences. They may not have articulated a philosophy up to this point, but with our legislative proposal before the Congress and perhaps their legislative proposal——

Mr. MACDONALD. When is it coming? You keep saying it is coming. When is it coming?

Mr. GOLDBERG. I have probably cried wolf too many times on this as to when I think it is coming, but I believe that the OMB clearance process will be completed within the next 2 weeks. I anticipate it would be another 2 weeks of adjusting the various differences of opinion. I would like to see the legislation up here in a month or 5 weeks.

Mr. MACDONALD. Just so long as you are not blaming the Congress

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for not taking any action, We can't act because we have not seen it. You would be amazed how many people blame us for not doing something that we haven't had our hands on.

Somebody makes a speech that it should be here, and it has not arrived. People get hold of us wanting to know what we are doing about it. But we have never seen it.

In any event, thank you very much for coming.

Mr. EGER. Thank you, Mr. Chairman.

[The following material was received for the record.]

RESPONSES TO WRITTEN QUESTIONS POSED BY CHAIRMAN MACDONALD TO OFFICE OF TELECOMMUNICATIONS POLICY, EXECUTIVE OFFICE OF THE PRESIDENT

1. One area which I note you touch on but do not address directly in your statement is the expanding role of telecommunications in the area of economic development, particularly in connection with international and domestic commerce. Isn't there a logical telecommunications role for the Department of Commerce in this area?

The Department of Commerce has the statutory responsibilities, among others, to foster, promote and develop the foreign and domestic commerce of the United States (15 U.S.C. § 1512) and to maintain a clearinghouse for the collection and dissemination of scientific, technical and engineering information for government and industry (15 U.S.C. § 1152). In view of these responsibilities, there is a logical role for the Department of Commerce in the field of telecommunications, just as there is an appropriate role for the Department in transportation, energy, housing, and other fields of economic activity.

2. The 1976 Budget proposes the elimination of the Office of Telecommunications in the Department of Commerce and recommends its merger with the National Bureau of Standards (NBS). This proposal implies that Commerce's role should only be a very limited, technical one, rather than a broader function as the scope of the problem seems to indicate. As the Administration's telecommunications spokesman, what have OTP's recommendations been to OMB on the elimination of OT? Has OTP been continuously consulted since last August when OMB first began to press Commerce for a change? Can you explain the substantial change in the original OMB recommendation (that OT support programs and staff be retained as separate entity) and the final decision made last November (that OT be merged entirely with NBS)?

Executive Order 11556 provides that the Secretary of Commerce shall support the Director of the Office of Telecommunications Policy (OTP) in the performance of his functions. It further provides that in this regard the Secretary shall perform analysis, engineering, and administrative functions responsive to the performance of OTP's responsibilities for spectrum management, and conduct technical and economic research as required by the Director of OTP.

In response to the Executive Order, the Office of Telecommunications (OT) was reorganized in the Department of Commerce (DOC) in September 1970. Certain pre-existing telecommunications activities not related to OTP support were also included as part of OT's role.

In connection with a study conducted in early 1973 in which OMB, OTP, and DOC participated, OTP expressed the view that non-OTP support functions performed by OT should be separated and transferred elsewhere within DOC. Among the principal factors contributing to this conclusion were (1) excessive OT overhead unrelated to OTP support activities and (2) the lack of a clear distinction regarding allocations of resources within OT as beween OTP support and other OT activities.

OTP, OMB, and DOC have maintained a continuing dialogue regarding the control of resources and personnel in connection with OTP support activities. Some of these problems were resolved when the budget for the OTP support functions performed by OT was transferred to OTP's own budget. Subsequent to the budget transfer, OTP has continued its discussions with DOC and OMB regarding various means to achieve a clearer separation between the OTP support functions performed by OT and OT's telecommunications technology programs. In August 1974, OMB advised both OTP and Commerce that because of the similarity between OT's technology programs and the programs conducted by

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the National Bureau of Standards (NBS), these activities should be consolidated under NBS management and that OT, as such, would be eliminated. OMB also suggested that the OTP support functions be assigned directly to the Assistant Secretary for Science and Technology and receive all program guidance and funding from OTP in FY 76. OMB advised that these changes would be reflected in the President's budget in FY 76.

The Administration's budget for FY 76 recommends that the technology programs of OT be consolidated with those of the National Bureau of Standards. In addition, funds for DOC activities in support of OTP are included in the OTP budget, as was the case last year. The question concerning the precise location of the OTP support programs within the Department of Commerce, (e.g., whether attached to the Secretary's office, the Office of the Under Secretary, or the Assistant Secretary for Administration), remains to be resolved and is the subject of continuing discussion among OTP, OMB, and the Department of Commerce.

RESPONSES TO WRITTEN QUESTIONS POSED BY CHAIRMAN MACDONALD TO OFFICE OF TELECOMMUNICATIONS, DEPARTMENT OF COMMERCE

QUESTION 1

Question. What are the considerations on which the proposal to consolidate the programs of the Office of Telecommunications (OT) with those of the National Bureau of Standards (NBS) is based? Would you supply copies of all correspondence, memoranda, and documents concerning the consolidation.

The proposal is based on the following considerations:

Recommendations from an OMB review of the programs of the Office of Telecommunications and the telecommunications activities of NBS were intended to improve the OTP-Commerce working relationships and result in generally greater effectiveness and efficiency of the telecommunications technology programs at Commerce. (Letter from Frederic V. Malek to Frederick B. Dent dated August 15, 1974.)

The Assistant Secretary for Administration asked to discuss with Assistant Secretary Ancker-Johnson the OMB recommendations, together with similar recommendations developed by his staff. (See memorandum from Henry B. Turner for Assistant Secretary Ancker-Johnson dated August 19, 1974, with attachment, "FY 1976 Secretarial Submission, Analysis of Recommendations, Office of Telecommunications, Policy Issue".)

Dr. Betsy Ancker-Johnson, Assistant Secretary for Science and Technology together with Dr. Richard W. Roberts, Director, National Bureau of Standards and Dr. John M. Richardson, Acting Director, Office of Telecommunications, forwarded a paper on this issue prepared for the budget "Policy Review" of the Assistant Secretary for Administration. They recommended that the Department respectfully decline the OMB recommendations and resume the Department's study of the issue after experience had been gained under the FY 1975 arrangement. (See "FY 1976 Budget Policy Review of Science and Technology, Office of Telecommunications", by Betsy Ancker-Johnson, John M. Richardson, and R. W. Roberts, hand delivered on August 27, 1974.)

Analysis by the Assistant Secretary for Administration recommended transfer of all OT functions to the National Bureau of Standards because of (1) apparent similarity of technical work, (2) co-location of NBS and OT laboratories in Boulder, (3) provision of administrative services for OT at Boulder by NBS already, (4) retention of telecommunications responsibilities under the Assistant Secretary for Science and Technology, and (5) possible lower costs of administration. (See FY 1976 Secretarial Submission, Analysis and Recommendations, Office of Telecommunications, Policy Issue—Assistant Secretary for Administration Position, Undated, approximately September 3, 1974.)

The Assistant Secretary for Science and Technology endorsed OMB's objectives but argued for continuing the new FY 1975 funding/management arrangement as the soundest way to secure the desired objectives. (See Abstract of Secretarial Correspondence from Assistant Secretary for Science and Technology to the Secretary dated September 5, 1974.)

The Secretary intended to review the matter with Secretary Morton and Governor Scranton before any further action was taken. (See memorandum from Henry B. Turner for Assistant Secretary Ancker-Johnson dated September 9, 1974.)

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The Secretary suggested that we await the outcome of current reviews of the Executive Office of the President before deciding on the final organizational arrangements for OT. (See letter from Frederick B. Dent to Roy L. Ash dated September 20, 1974.)

The recommendation from OMB in November, 1974, was that the telecommunications functions now performed by OT were to be consolidated in NBS in order to consolidate the telecommunications technology programs of OT.

The Assistant Secretary for Science and Technology unsuccessfully appealed this recommendation on the basis of (1) greater estimated administrative costs and (2) functional and managerial incompatibility of the OT and NBS activities. (See memorandum from Betsy Ancker-Johnson for Guy Chamberlin dated November 25, 1974.)

It was determined that the Office of Telecommunications is to be abolished, and its programs will be consolidated in the National Bureau of Standards. (See letter from Roy L. Ash to Frederick B. Dent dated February 3, 1975.)

QUESTION 2

Question. Has a final decision been made to carry out the consolidation of functions? If so, when and by whom?

Answer. Yes, a final decision has been made to carry out the consolidation, as stated by the President in his budget submission of February 3, 1975.

QUESTION 3

Question. In view of the fact that OT was established to support the operations of the Office of Telecommunications Policy (OTP), was OTP consulted regarding the proposed consolidation? If so, how would you characterize the attitude of OTP toward the proposed consolidation? Would you please supply copies of correspondence with OTP regarding the consolidation.

Answer. I do not know whether OTP was consulted; however, the letter from Frederic V. Malek to Frederick B. Dent dated August 15, 1974, at Tab 1a, states in part:

"Mr. Whitehead, Director of OTP, has been informed of these recommendations."

I am not able to characterize the attitude of OTP toward the proposed consolidation.

There is no correspondence with OTP from my office regarding the consolidation.

QUESTION 4

Question. After the proposed consolidation takes effect, will OT remain in existence?

Answer. No, the Office of Telecommunications will be abolished and its functions will be performed elsewhere. (See letter from Roy L. Ash to Frederick B. Dent dated February 3, 1975.)

QUESTION 5

Question. Where will all the functions now performed by OT be carried out after the proposed consolidation takes effect?

Answer. The telecommunications functions now performed by OT will be carried out within the National Bureau of Standards.

QUESTION 6

Question. What activities have been carried out by the Office of Telecommunications (OT) at the direction of the Office of Telecommunications Policy (OTP) since OTP was created? During that period, has there been any change in the type of activities OT has been directed to carry out by OTP? How was OTP directed those activities to be carried out by OT? Describe the method of funding OT activities carried out in support of OTP.

Answer. Activities carried out in the Spectrum Management Program since its inception in FY 1971 are broadly categorized as follows:

1. *Spectrum Management and Information*: Provides administrative and routine technical support in the review and processing of some 50,000–60,000 frequency assignments or assignment adjustments annually, provides similar support in the review of spectrum-related aspects of new radiocommunications systems and for technical and Ad Hoc committees and planning groups engaged

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in National and International spectrum planning activities. Maintains a computerized master file of some 125,000 assignment records.

2. *Spectrum Analysis*: Supports both the day-to-day and long-term management functions. Spectrum sharing situations among individual stations and among major systems are analyzed. Gives particular attention to proposed new systems to insure spectrum availability and compatibility of operation. Selected frequency bands and radio services are investigated to determine the effectiveness and efficiency of spectrum sharing arrangements and for identification of problems and alternatives.

3. *Spectrum Engineering Development:* Improves existing and develops new analytical capabilities for use in the two preceding categories of activities, giving due consideration to the inherently statistical nature of electromagnetic compatibility problems. Makes field and laboratory measurements of spectrum usage and emission characteristics. (See spectrum management support tasks and activities FY 1973, FY 1974, and FY 1975.) Work for FY 71 and FY 72 was essentially similar.

Activities carried out in the research and analysis for policy formulation program are generally characterized as follows:

1. *Data Base*: Acquires and maintains the economic business, regulatory, and technical information base needed to support policy analysis of Federal, Domestic, and International issues. Determines the probable data base information and format requirements and periodically updates the information to maintain current files.

2. *Analyses*: Supports OTP with both quick reaction capability, planned policy statements, correspondence, and docket participation, and preparation and defense of legislative initiatives. Industry structures are analyzed to determine where competition is appropriate and how regulatory incentives may be utilized (1) to improve industry performance for effectiveness in meeting the public's and government's communications needs, (2) to foster the introduction of innovative services, (3) to improve the competitive position of our import and export telecommunications market, and (4) to reduce the regulatory burden.

3. *Methodologies:* Develops new and improves existing techniques for organizing and analyzing issues related to policy formulation. Establishes their benefits, limitations, and data base requirements, including computer modeling. Provides technical representatives for supervision and monitoring of OTP and OT(PSD) contracts.

[See "Activities of Office of Telecommunications (OT), (Policy Support Division), Department of Commerce, as Directed by Office of Telecommunications Policy (OTP), Period August, 1971 through February 1975.]

Since OTP was created to the present, there has been no fundamental change in the type of activities OT has been directed to carry out by OTP. However, when an issue becomes resolved, emphasis is turned to other topics; for example, domestic satellite effort has given way to study of common and specialized carriers. Furthermore, responsive to OMB guidance to OTP and OT, greater reliance is being placed on private sector contracts, where competence can be found. This change parallels proposed reductions in the staffing of the Policy Support Division.

OTP has directed the activities mainly by week to week interaction between OTP Assistant Directors (Wilfred Dean, Walter Hinchman, Walt Sutter, Bromley Smith, William Fishman, and Charles Joyce) and OT Program Managers (S. I. Cohn and Scott Lothrop) and staff. The OTP Assistant Directors and the OT staff work together to produce work statements and scheduling for tasks.

From fiscal years 1971 through 1974, funding for the activities carried out in support of the Office of Telecommunications Policy (OTP) was provided for in the Department of Commerce (DOC) appropriations made available to the Office of Telecommunications (OT).

In response to the recommendations of the Appropriations Committee, the FY 1975 budget request proposed that funds be appropriated directly to OTP rather than OT. The 1975 Appropriations Act reflects this arrangement. OT now performs the activities, in support of OTP, and charges the costs against funds advanced in accordance with an Interagency Agreement. (Interim Memorandum of Agreement Between OTP and DOC, July through December, 1974.)

QUESTION 7

Question. Is there any understanding as to what activities will be carried out within the Department of Commerce at the direction of OTP in support of its activities after the programs of OT are consolidated with those of NBS?

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Answer. It is my understanding that NBS is to carry on the same general kind of spectrum management support activities and policy research activities as OT has been doing, in support of OTP.

QUESTION 8

Question. On what basis does OT carry out work for Federal departments and agencies other than OTP?

Answer. Pursuant to 15 U.S.C. 271 *et. seq.* and delegation of authority in Department Organization Order 30-5A, OT provides technical advisory services to other Federal agencies. *The agencies pay for the cost of these services by advance or reimbursement.* The cost includes directly related expenses and overhead charges for indirect and administrative expenses.

A client agency usually approaches OT with a research problem. A formal work statement is drawn up, either by the client agency or by the client agency and OT. Costs and schedules are proposed by OT. The client agency then prepares a work order or other form of interagency agreement for formal acceptance by OT. OT manages and performs the work under its own line direction and delivers the work product. The work product is usually a report covering the findings.

QUESTION 9

Question. Please supply a copy of each annual report made by OT and all documents and orders of the Department of Commerce relating to the functions and operations of OT.

Answer. The annual reports for fiscal years 1971, 1972, 1973 and 1974 are enclosed.

QUESTION 10

Question. We note that OT has had an acting director for the last several years. How do you justify retaining him in this status?

Answer. When I became Assistant Secretary (April 16, 1973), Dr. Richardson was Acting Director of OT. Early during my tenure I became aware that Dr. Richardson would not be approved for Director by the White House staff. I retained him as Acting Director because I was (and am) completely satisfied with his performance and hoped that approval could be obtained eventually for his appointment as Director. The issue was largely mooted by Mr. Malek's letter of August 15, 1974, and subsequent events.

RESPONSES TO WRITTEN QUESTIONS POSED BY CONGRESSMAN JOHN M. MURPHY TO OFFICE OF TELECOMMUNICATIONS POLICY, EXECUTIVE OFFICE OF THE PRESIDENT

QUESTION 1

Question. Mr. Eger, in your role as spokesman for the Executive Office that makes or suggests policies, both short and long term, for the United States in the telecommunications field, you have had occasions to make speeches, and your office has submitted positions and statements on a subject that was explored to some degree with the FCC on Tuesday when the Commission was before this Committee for Overview hearings. I refer to the subject of competition in the telephone industry. In your speeches and statements, you have come out strongly in favor of competition in the telephone business. My question to you is: Have you or your office been able to evaluate the benefits that have occurred, or will be derived, from competition for intercity services and terminal equipment markets? If there are benefits expected or benefits already derived, have you quantified these? To whom have these benefits accrued and to what extent?

Answer. This Office is continually in the process of assessing the effects of competition in the intercity transmission and terminal equipment markets. Innovations in private branch exchange (PBX), key telephone systems, and computer terminals and modems for large and small businesses as well as automatic answering devices for residential subscribers are only a sample of the benefits that can be and are attributed to liberalized interconnection. In the intercity communications area, innovations in all-digital transmission systems and tariff structures (e.g., minimum billing time) that are more responsive to the needs of the burgeoning data communications/computer market are examples of benefits. Certain aspects of the value of these developments are difficult to quantify in an economic sense, but they are real nevertheless. For example, an airline is better able to provide telephone reservation service to the traveling public; an automobile manufacturer is able to offer better service to its dealers and their customers

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through better inventory control of repair parts; a homeowner may have better burglary protection; and a customer may get a better, more individualized response from a communications carrier when there are alternative sources of supply.

QUESTION 2

Question. There is a strong suggestion that competition in the telephone industry will drive down the price of business services for large users, and consequently other groups, such as the residence customer or small businessman, will pay higher charges. Has this suggestion been studied and quantified by your office?

Answer. We are now in the process of addressing this very question in a Federal Communications Commission proceeding entitled, "Economic Implications and Interrelations Arising From Policies and Practices Relating to Customer Interconnection, Jurisdictional Separations and Rate Structures." The central concerns of this proceeding, referred to as Docket 20003, are (a) the possible impact of competition on local exchange rates and (b) the adjustments to traditional cost allocation and pricing practices that may be necessary or appropriate to minimize any adverse effects on residential ratepayers. A copy of our submission is enclosed. To summarize our findings, the impact of competition on the charges for residential or small business service is demonstrably almost nil at the present time. Whatever future impacts could occur appear to be within the capacity of the regulatory system to dispel, through changes in separations procedures and the like. In general, the pressures toward cost-based pricing that competition has produced are healthy and deserve objective scrutiny as we move into the information era where the telephone system is used for a myriad of purposes besides ordinary voice communications.

QUESTION 3

Question. In espousing the benefits of competition in the Telecommunications Industry, Mr. Eger, is your position based on studies that show what the benefits will be or have been? If you have studies showing the benefits of competition, is your position then based on philosophical grounds "that competition is good and in the public interest?" Has your office completed any studies on the relative cost of one nationwide telephone network versus the cost of several networks to furnish the same services? If you have, do these studies tend to show that it was more economical to have one network or several networks?

Answer. The fundamental premise of our free enterprise system is that competition will promote product and service innovation leading to greater consumer choice and/or decreasing costs and prices. This is exemplified by what has happened in recent years to pocket calculators, minicomputers, and computer terminal devices. The same thing has also been taking place in the market for telephone terminal equipment. See, for example, the March 24 and March 31, 1975, issues of *Telephony*.

Regulated monopoly, in our judgment, should be seen as the exception to the general rule of competition, and should be accepted only when justified by the presence of extensive economies of scale or very high entry costs that preclude effective competition. We have made studies of these matters, and concluded for example in 1972 that the economies of synchronous satellites were such as to warrant a policy of "open entry" into the provision of domestic satellite services—a policy generally accepted and followed by the FCC.

This past year, we conducted analyses of the economies of long-haul terrestrial transmission using two independently conducted studies employing different means and data. These studies indicate that there would be a cost penalty associated with multiple terrestrial voice telephone networks. Of course, cost is only one aspect of the customer-choice equation and, in many cases, we are dealing with specialized non-voice applications that may be susceptible to being handled more efficiently outside a single network. Nevertheless, the existing carriers should be able to draw on whatever cost advantages they may possess; and if the new entrants are to overcome such a cost penalty, they must develop genuinely differentiated service options.

On a closely related issue, we have urged the FCC to liberalize the rules regarding the resale and shared use of established common carrier plant in order that specialized "value-added" services can be supplied by non-carrier entrepreneurs. This would preserve and make use of economies of scale of long-haul carriers while allowing specialized service vendors to choose between constructing their own transmission facilities or using those of an established carrier.

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RESPONSES TO WRITTEN QUESTIONS POSED BY CONGRESSMAN LOUIS FREY, JR., TO OFFICE OF TELECOMMUNICATIONS POLICY, EXECUTIVE OFFICE OF THE PRESIDENT

ROLE OF OTP

1. Since its organization in 1970, OTP has performed three basic functions: (1) serving as Presidential advisor and advocate in telecommunications; (2) managing Federal Government telecommunication resources; and, (3) undertaking long-range planning and research in policy and technology. Do you see OTP roles or emphases changing? Which of these roles do you plan to concentrate on?

Answer. The basic functions assigned to OTP are set forth in Reorganization Plan No. 1 of 1970 and Executive Order 11556, copies of which are included as Attachments 1 and 2. OTP will continue to concentrate on all of the responsibilities and functions assigned by the Reorganization Plan and the Executive Order.

2. Do your recent efforts in consolidating agency resources in navigation and weather warning signal an increased concentration on this type of role, i.e., identifying duplication among agencies and consolidating telecommunication systems and resources?

Answer. The results of OTP's efforts in the navigation and warning fields are the fruit of three to four years of planning and investigation. We have directed similar efforts more recently through OTP Circular 12 (the Government Communications Planning Program, copy of which is included as Attachment 3), to four new areas, namely, Environment, Law Enforcement, National Security, and Transportation, each of which involves a number of agencies. The goal of this program, as in the navigation and warning areas, is to identify and eliminate duplicative systems and to encourage integrated planning of systems to increase the overall communications effectiveness of agencies and departments.

3. Since the Federal Government spent over $14 billion in FY 1974, shouldn't we have an agency in the Executive to seek greater efficiency, resolve interagency disputes, etc.? ($14 billion in telecommunications).

Answer. In view of the Federal Government's substantial expenditure for telecommunications, there is a clear need for an Executive Branch agency to coordinate telecommunications activities and to assure effective allocation of resources. This need, which was recognized repeatedly over the last two decades in various studies by Congressional Subcommittees and Executive Branch agencies, resulted in the creation of the Office of Telecommunications Policy in 1970.

4. What mission has President Ford defined for OTP? What does the Administration think your principal roles should be?

Answer. OTP's principal roles are those set forth in Reorganization Plan No. 1 of 1970 and Executive Order 11556.

5. A few weeks ago, the news media reported that President Ford, OMB Director Ash, and others in the White House had decided to abolish OTP and had stricken its funds from the budget. The President then appeared to reverse his decision, and OTP was reinstated. Why did the Administration seek to abolish OTP originally? For what reasons was the office then reinstated into the budget? Have you talked with the President or his staff about the future role of OTP?

Answer. The Office of Management and Budget had considered the transfer of OTP's budget and functions to the Department of Commerce, presumably as part of an overall effort to reduce the size of the Executive Office of the President.

Following a review of the background and history of the telecommunications function within the Executive Branch and a review of the previous recommendations of the Congress, OMB and GAO for a strengthened Executive telecommunications capability (which led to OTP's creation in 1970), a decision was made to retain the Office as it was originally constituted.

6. Does the U.S. need an OTP? Why?

Answer. Under Reorganization Plan No. 1 of 1970 and Executive Order 11556 (Attachments 1 and 2), OTP performs two essential functions:

(1) Formulates policies and coordinates cost effective operations for government communications systems, including assigning and managing frequencies used by Federal agencies, exercising the President's statutory responsibilities under the Communications Act of 1934 and the Communications Satellite Act of 1962, and providing policy direction for the National Communications System and emergency communications.

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(2) Serves as advisor to and spokesman for the President on communications policy, covering a wide range of domestic, international, government and private sector issues.

The Communications Act of 1934 vests in the President broad authority over telecommunications in times of war or national emergency, and reserves to him the responsibility for assigning radio frequencies for government use. These responsibilities, together with the President's constitutional responsibilities for foreign policy and national security, which require rapid, reliable and secure communications, necessitate the existence of an expert telecommunications capability in the Executive Branch.

Moreover, proper coordination and planning of the Federal Government's own vast telecommunications systems requires that there be an independent and authoritative telecommunications entity within the Executive Branch, capable of overseeing the communications systems and activities of the various departments and agencies.

Finally, the economic and societal impact of new technologies in communications is growing rapidly. The far-reaching implications of new developments, such as cable and satellite communications and computer teleprocessing, require sound, long-range policy planning at the national level and effective dialogue on communications policy issues among the Executive Branch, the Federal Communications Commission and the Congress.

PRESIDENTIAL CONSULTATION

1. Does OTP now advise the President on telecommunication policy issues? On what basic issues does the Administration intend to submit legislation? Express, advocate policy?

Answer. Pursuant to the responsibilities set forth in Reorganization Plan No. 1 of 1970 and Executive Order 11556, the Office of Telecommunications Policy advises the President on telecommunications policy issues. The Administration has submitted to the present Congress, or will submit in the near future, legislation on long-range financing for public broadcasting, cable television and international satellite communications. As stated in detail in the current report entitled "Activities and Programs: 1974–1975", copies of which were provided for the record, OTP is presently engaged in developing and implementing policies in numerous areas in addition to those which are addressed by the above-mentioned legislation. These areas include common carrier regulation, competitive communications services, government communications coordination, international telecommunications planning and spectrum allocation and management.

2. Have you recently consulted with the President on such issues? How often do you communicate with President Ford? Has he indicated issues or positions he wants OTP to pursue?

Answer. Consistent with its role as the President's principal adviser on telecommunications, OTP consults regularly with White House staff personnel, and with the President when appropriate. A recent example of the President's expression of his position on a particular communications issue was his statement of February 13, 1975, urging the Congress to enact promptly the Administration's long-range funding bill for public broadcasting.

3. Who is the President's principal spokesman on telecommunication policies and issues?

Answer. Pursuant to § 2(c) of Executive Order 11556, the Director of the Office of Telecommunications Policy has the responsibility to assure that the views of the Executive Branch are effectively presented to the Congress and the Federal Communications Commission on telecommunications policy matters.

PUBLIC BROADCASTING

1. The Administration recently sent up a long-range financing bill for public broadcasting with certain funding ceilings ($70–$100 million over five years). Last year, the Senate passed a similar bill, but with higher ceilings ($88–160 million over five years). Will you recommend the President veto a bill with ceilings that are higher than those the Administration recommended?

Answer. The Administration's long-range funding bill for public broadcasting (H.R. 4563) proposes a five-year authorization and appropriation, based on a matching formula whereby each $2.50 of non-Federal revenue received by public broadcasting would be matched by $1.00 in Federal funds. The matching appropriation is not open-ended, however, in that the bill includes ceilings on the permissible appropriation for each fiscal year, beginning at $70,000,000 in FY 1976

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and reaching $100,000,000 in FY 1980. As we stated in our transmittal letter accompanying the bill, we believe that these ceilings are sufficiently high to permit continued growth of public broadcasting, while comporting with sound fiscal policy in view of the fact that this would be Congress' first venture in multi-year appropriations for public broadcasting.

2. If the concept of long-range (five-year) *appropriations* is rejected in the House or Senate in the 94th Congress, what is the Administration's recommendation for an alternative to the funding scheme in the present Administration bill?

Answer. Long-term Federal financing for public broadcasting is a goal which has long been sought by the Administration, the Congress and the public broadcasting industry. The concept actually precedes the Public Broadcasting Act of 1967, having been first expressed by the Carnegie Commission on Educational Television. At the very outset, it was recognized that there was a sensitive relationship between broadcast programming and Federal funding, and that some form of insulated, long-term funding was a necessary condition to a Federally-supported public broadcasting system.

In the years following enactment of the Public Broadcasting Act, numerous government and private groups have studied various alternatives for long-range, insulated funding. The Administration's bill represents the best collective judgment of the Executive Branch, the Corporation for Public Broadcasting (CPB), the Public Broadcasting Service (PBS) and the Association for Public Radio Stations (APRS) as the most appropriate way to achieve the long-sought goal of long-term, insulated funding for public broadcasting.

3. Why should we approve a five-year authorization and appropriations bill for CPB? Does Congress have the obligation to keep a closer check on the expenditures of public funds?

Answer. Clearly, Congress has an obligation to hold public broadcasting accountable for the expenditure of public funds. On the other hand, strict accountability by public broadcasting, tied to the annual budgetary and appropriations processes, can lead to government direction of programming, which is contrary to fundamental principles of free expression. A five-year authorization and appropriation strikes a balance between the government's obligation to evaluate how public funds are spent and the goal of insulating the program judgments of public broadcasters from the annual financial control of the government.

4. What is the rationale behind the five-year funding concept?

Answer. The five-year funding approach removes public broadcasting from the annual appropriations and budgetary process of the Congress and the Executive Branch, thus eliminating direct annual financial control by the Federal Government. In short, it frees public broadcasting from direct Federal financial control for an extended period of time, while still allowing oversight during the five-year term, and enabling a thorough evaluation at the expiration of the five-year appropriation.

5. When the CPB was created in 1967, one of its principal missions was to develop a strengthened system of educational broadcasting. In view of our needs in education today, do you think public broadcasting has adequately addressed need in education and instruction?

Answer. Much remains to be accomplished by way of strengthening public broadcasting's role in education and instruction. In the past, a great deal of energy and attention within the public broadcasting community was properly devoted to resolving fundamental questions such as the appropriate role of CPB vis-a-vis other organizations and the local stations, and resolving basic issues as long-range funding for public broadcasting.

Now that many of the organizational questions have been resolved and a long-range funding program agreed upon, it is appropriate for public broadcasting to focus more attention on developing its role in the fields of education and instruction. It appears that CPB has already begun to move in this direction. The CPB Annual Report for 1974, for example, states that the Corporation funded a major study in 1974 to evaluate its role in the four areas of early childhood, elementary/secondary, postsecondary and adult education. In addition, the Corporation has created a new Office of Educational Activities designed to develop CPB's educational activities and programs. These are commendable first steps in defining and addressing the educational needs that can be met by public broadcasting.

6. Would you recommend that we designate a certain proportion of CPB funds for educational-instructional uses?

Answer. The system of public broadcasting created by the Public Broadcasting Act of 1967 is premised on autonomy of local, noncommercial broadcasting

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stations. Under the Administration's bill, a substantial portion of CPB's appropriation would be channeled through the Corporation to the stations. The Communication Act of 1934 requires local stations to serve the needs of their local audiences. Thus, the decision as to whether public broadcasting should devote more of its resources to educational/instructional uses is one that is most appropriately made at the local station level.

7. Often we think of public broadcasting as consisting only of public *television*. How does your long-range financing bill address the needs of radio?

Answer. The Administration's bill would require that a certain proportion of Federal funds be distributed by CPB to local television as well as radio stations. The bill reserves for consultation among CPB and representatives of station licensees the decision regarding the division of funds as between radio and TV. It also provides that the amount that is to be distributed among radio stations be apportioned according to a formula, the precise terms of which are left to the stations and the Corporation, which is designed to provide for the financial needs of stations in relation to the audiences they serve, and to stimulate non-Federal financial support for station activities.

EDUCATIONAL BROADCASTING FACILITIES LEGISLATION

1. Only a few days ago, HEW recommended a bill to us to (a) extend the educational broadcasting facilities program, and (b) set up a new demonstration grants program for pilot projects using satellite and other communications technologies to distribute health, education resources. Does OTP support this legislation as submitted?

Answer. OTP supports the extension of the Educational Broadcast Facilities Program, as well as the proposal to encourage the development and use of new communications technologies for the more effective transmission and delivery of educational, health care and other public service information.

2. Do you think this bill should be considered along with the long-range funding bill? Or, should we consider them as separate issues?

Answer. The proposed five-year extension of the authorization for the Educational Broadcast Facilities Program coincides with the duration of the CPB long-range funding plan and in a sense complements it. For this reason, and because many of the witnesses for each bill would be the same, it may be convenient for the Subcommittee to consider the two bills together. On the other hand, since the long-range funding bill poses some novel and fundamental issues, not the least of which is the multi-year appropriation provision itself, it may be advisable to consider this bill separately. In any event, OTP defers to the judgment of the Subcommittee on this matter.

3. The Administration has proposed we authorize $35 million (over five years) for this educational facilities bill. If this amount were authorized and appropriate, what percentage of coverage would this amount give us in the U.S.:

(a) for public TV?

(b) for public radio?

4. Can you provide us with an analysis of what funds are necessary to attain varying levels of population coverage:

(a) for public TV?

(b) for public radio?

5. What percentage of U.S. population is now being covered by:

(a) public TV?

(b) public radio?

Answer. The following information is responsive to Questions 3, 4 and 5, *supra*. This information was provided to OTP by the Office of Education, Department of Health, Education, and Welfare, which administers the Educational Broadcast Facilities Program.

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EDUCATIONAL BROADCASTING FACILITIES PROGRAM

PERCENT OF U.S. POPULATION WITHIN ACCEPTABLE SIGNAL RANGE OF NONCOMMERCIAL STATION (FISCAL YEAR 1976–80)

Year	EBFP funds	Noncommercial radio (estimate)	Noncommercial TV (estimate)
At $7,000,000 authorization:			
Utilizing $6,000,000 for EBFP and $1,000,000 for demonstrations:			
1974	$15,675,000	63.0	78.5
1975	12,000,000	66.0	80.0
1976	6,000,000	68.0	81.0
1977	6,000,000	69.0	81.2
1978	6,000,000	70.0	81.4
1979	6,000,000	71.0	81.5
1980	6,000,000	72.0	81.5
With gradual phaseout of EBFP activities by Federal Government:			
1976	6,000,000	67.0	80.5
1977	5,000,000	67.5	80.6
1978	4,000,000	68.0	80.8
1979	3,000,000	68.0	81.0
1980	2,000,000	68.5	81.0

The above estimates take into consideration the following factors:

1. 47USC392 provides for grant awards up to 75% of the eligible project cost.
2. 47USC392 stipulates that no State can receive more than 8.5% of the amount appropriated for the Program in that fiscal year. Unless a community could raise from 50 to 75% of the cost of the apparatus, most projects to activate or expand an ETV station could not be funded.
3. 45CFR153 establishes facilities "priorities" to be considered in awarding grants.
4. The average Federal grant in FY 1974 (funded at 68.5% of the total project cost) follows:

ETV activation	$479,134
ETV expansion/improvement	270,241
ER activation	83,965
ER expansion/improvement	60,191

EDUCATIONAL BROADCASTING FACILITIES PROGRAM

ANALYSIS OF FUNDS NEEDED FOR VARIOUS RATES OF NONCOMMERCIAL BROADCAST COVERAGE

[In millions of dollars]

Percent of population within acceptable signal range	ETV activations	ETV expand/improve	Total
82	17	21	38
84 [1]	34	42	[2] 76
86 [1]	51	63	[2] 114
88 [1]	68	84	[2] 152
90 [1]	85	105	[2] 190

	ER activations and/or power increased to become full-service station	ER expand/improve	Total
68 [3]	1.75	1.58	3.3
70 [3]	3.50	3.16	[2] 6.6
72 [3]	5.25	4.74	[2] 10.0
74 [3]	7.00	6.32	[2] 13.3
76 [3]	8.75	7.90	[2] 16.6
78 [3]	10.50	9.48	[2] 20.0
80 [3]	12.25	11.06	[2] 23.3
82 [3]	14.00	12.64	[2] 26.6
84 [3]	15.75	14.22	[2] 30.0
86 [3]	17.50	15.80	[2] 33.3
88 [3]	19.25	17.38	[2] 36.6
90 [3]	21.00	19.00	[2] 40.0

[1] For each 2 percent of the population to receive noncommercial television, an average of 9 originating and/or repeater stations will need to be activated, and 9.6 stations will need to increase their effective radiated power to provide additional coverage as well as an acceptable signal to many within the signal range.

[2] Estimated at fiscal year 1975 cost; inflation over the period necessary to reach 90 percent coverage not included.

[3] For each 2 percent of the population to receive noncommercial radio service, an average of 11.6 full-power stations will need to become operative as well as a number of existing stations in metropolitan areas will need to expand to provide additional coverage.

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Projected ETV facility needs—90 percent population coverage [1]

	Dollars required (millions)
45 Station activations (19 originating; 26 repeater)	85
48 Expansions of ETV stations to reach effective power, et cetera	*18
Needed improvements of existing stations to minimum state-of-the-art	[2]87
Total	190

Bases for Projection:
1. Estimates based upon 1975 dollar value and 1975 costs of equipment.
2. Average cost of fully activating a noncommercial ETV station is approximately $2.8 million, excluding land and buildings.

Projected ER facility needs—90 percent population coverage [1]

	Dollars required (millions)
140 station activations and/or stations upgraded (10 watt to full power)	21
Improvements of existing radio stations to minimum state-of-the-art	[2]19
	40

Bases for Projection:
1. Estimate based upon 1975 dollar value and 1975 costs of equipment.
2. Based upon current and projected priorities, emphasis will be placed on activating public radio stations in major metropolitan areas not now served.
3. The average cost of activating a noncommercial radio station capable of fully serving its community will be $150,000 excluding land and buildings necessary to the operation.

*Also include funds for translators.

[1] Approximately 80% of the population of the U.S. is within the range of an existing ETV station, and 66% is within the range of a noncommercial radio station. It is recognized that not all residents within the coverage area can presently receive the station's signal. No valid information could be located as to the extent the signals are being received throughout the country. Applicants under the Educational Broadcasting Facilities Program frequently report need for increased power required to eliminate signal deficiencies caused by terrain, shadows from tall buildings, etc. UHF stations most frequently require assistance to expand power. To alleviate this problem, it may be necessary for some stations to relocate their antenna as well as increase power.

[2] The equipment in a number of stations is outmoded and renders them incapable of providing quality programing to the people they are charged with serving. When such is the case, these stations usually find it quite difficult to secure from the people the kind of financial support needed.

LICENSE RENEWAL

1. OTP strongly advocated a license renewal bill during the 93rd Congress. Do you plan to reintroduce the same legislation? If not, what changes will you advocate?

Answer. Numerous broadcast license renewal bills have now been introduced in the 94th Congress and several additional ones are likely to be introduced in the near future. OTP is evaluating these bills in light of the provisions of the former Administration's license renewal legislation proposed to the 93rd Congress, and will make its views known when this evaluation is complete.

2. The FCC is reportedly planning to implement an expedited renewal consideration procedure in which uncontested renewal applicants would be judged by quantitative standards. That is, if such a broadcaster had programmed certain percentages of local, public affairs, news, etc., programming, he would be renewed. Would OTP favor or oppose such a procedure?

Answer. OTP is opposed to a broadcast license renewal procedure whereby uncontested renewal applicants would be judged by predetermined quantitative program standards. In fact, the license renewal bill prepared by OTP and submitted to the 93rd Congress on behalf of the Administration would have specifically precluded the FCC from using predetermined categories, quotas, formulas or guidelines for evaluating the program performance of license renewal applicants.

Our views on this matter are premised on the need to insulate the broadcast medium of expression from undue governmental influence or control. Broadcasters have a built-in incentive to render the type of program service that will most readily assure renewal of their licenses. If the FCC sets out to renew the licenses of those whose programming meets government-imposed standards and criteria, broadcast performance will conform to the government's notion of good program service, rather than reflect the broadcasters' independent judgments or

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their perceptions of the needs and interests of the communities they serve. This result would be clearly at odds with the First Amendment interests of both broadcasters and the public.

CABLE LEGISLATION

1. As a result of OTP efforts and those of the Cabinet Committee on Cable, you have circulated a comprehensive cable bill within the Administration. When will it be sent to Congress?

Answer. Draft cable legislation prepared by the Office of Telecommunications Policy to implement many of the recommendations of the Cabinet Committee on Cable Communications is now in the Executive Branch clearance process. Extensive comments and suggestions regarding the provisions of the bill have been received from the FCC and Department of Justice and are under consideration by OTP. Necessary changes will be made in the present draft during the next few weeks, and it is anticipated that the bill will be made available for Congressional consideration by the end of April.

2. Has this legislation been sent to the FCC for comment? Did you work with the FCC in developing the bill? Is the FCC also authoring its own legislation?

Answer. By letter dated April 2, 1974, the Director of OTP requested the cooperation, assistance and advice of the Chairman of the FCC regarding implementation of the Committee's legislative proposals. Accordingly, key staff of the Commission's Cable Bureau were delegated responsibility to confer with, advise and assist OTP staff, and several meetings were held during the drafting stages. In addition, the Commission has been of invaluable assistance during the clearance process and has twice filed extensive and analytic comments which have facilitated significant improvements in subsequent drafts.

3. What was the impetus for OTP development of a cable bill?

Answer. In the 1974 State of the Union Address, the President directed OTP to prepare draft legislation to implement the proposals of the Cabinet Committee on Cable Communications, whose report was published in January of that year. In creating the Cabinet Committee several years earlier, the President noted that a comprehensive review of cable policy was necessary in order to avoid the social, economic and regulatory instability that could be caused by the absence of a sound national policy framework for cable development. During course of its investigation, the Committee found that integration of cable into our national communications system, in a manner consistent with traditional principles of competition and freedom of expression, required articulation of a new and different policy approach to cable.

4. What are its principal provisions? Does it address the pay-cable questions? Siphoning question? Division of state and federal regulations?

Answer. Although the OTP cable bill is still in draft stage and is subject to further modification in response to comments submitted by agencies participating in the clearance process, the essential provisions of the bill are consistent with the "transitionary stage" recommendations of the Cabinet Committee on Cable Communications. Thus, the primary purpose of the bill is to create an evolutionary plan for the integration of cable into our present system of communications.

To this end, the bill divides and describes the limits of Federal and non-Federal regulation of cable in relation to the interests of the respective levels of government. Within this framework, the FCC would be authorized to regulate only those aspects of cable communications which call for enforcement by an administrative agency at the national level. Recognizing the substantial non-Federal interests in cable development, primary responsibility for the day-to-day regulation of cable, subject to certain limitations and Federal guidelines, would be granted to non-Federal entities.

While the bill in general provides that cable should develop as a medium of communications in its own right and be allowed to compete in the marketplace with other media for audience, programming and profits, there is at present no specific reference to the question of "pay cable" or "siphoning". These matters involve fundamental First Amendment issues which are now in litigation and which would be more appropriately addressed in the first instance by the courts.

FURTHER LEGISLATIVE PROPOSALS

1. Does OTP plan to submit any further legislation for the 94th Congress? In what areas?

Answer. OTP has submitted a bill to provide long-range funding for the Corporation for Public Broadcasting and plans to submit legislation on cable television regulation, as discussed above. In addition, we are planning to resubmit

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the proposed amendments to the Communications Satellite Act of 1962 that were introduced in the last Congress.

COMMON CARRIER REGULATION

1. OTP has recently undertaken studies of FCC's Uniform System of Accounts for Common Carriers, and of Usage-sensitive pricing for common carriers. Could you tell us the nature and results of these studies, and what you have done with such information? Have the results been sent to the FCC? Do you plan further action in this field?

Answer. The study of the FCC's Uniform System of Accounts was conducted under contract to OTP by Peat, Marwick, Mitchell and Co. The resulting report, entitled "Study of Common Carrier Accounting and Depreciation Practice and Policy," was designed as a broad overview of the subject of making the system of accounts more responsive to regulatory needs in a competitive market. The report and Executive Summary were transmitted to the FCC on September 23, 1974. It is publicly available through the National Technical Information Service, Accession Nos. PB236201 and PB236202. We plan to continue our efforts in this area, concentrating on possible reforms to the accounting system that would produce incentives for higher productivity in the use of common carrier plant.

The question of Usage Sensitive Pricing (USP) is currently receiving wide industry, regulatory, and public attention. Development of a theoretical economic model has been completed and we are working closely with the industry to (a) develop the necessary data for the model, and (b) gain information on the practical aspects of the problem, especially consumer reaction. It is anticipated that the results of these studies of USP will be formally transmitted to the FCC in connection with its economic inquiry in Docket No. 20003.

2. OTP has also conducted inquiries into cost structures, economies of scale, pricing, and level of demand of competitive communications services and equipment. What has been the outcome of these studies?

Answer. The nature of economies of scale in telecommunications was investigated by two independently conducted studies employing different means and data. The Policy Support Division of the Office of Telecommunications, Department of Commerce, conducted an econometric study using a production function approach based largely on available published FCC data. The results were published as "Econometric Analysis of Returns to Scale in the Bell System," by Leroy H. Mantell. It is publicly available through the National Technical Information Service, Accession No. PB231513. Under contract to OTP, Systems Applications, Inc., conducted a study based on engineering cost data supplied by AT&T and other firms in the industry. Where the former study employed conventional statistical techniques, the contractor's analysis tested each functional physical component of a telephone system: long haul transmission link, network, switch and local loop. The two-volume contract study is also available from the National Technical Information Service, Accession Nos. S23820 and S238019, and is entitled "The Domestic Telecommunications Industry: Economic Behavior, Competition, and Public Policy."

The statistical analysis confirms previous estimates of increasing returns to scale in large-scale telephone systems. Both studies indicate significant returns to scale in long haul transmission and networks while pointing to the strong likelihood of modest to little better than constant returns to scale in the local distribution function.

GOVERNMENT COMMUNICATIONS

1. You mentioned that OTP had embarked on a Government Communications Planning Program to facilitate long-range planning, avoid duplication, share facilities, etc., among agencies of the Federal Government. What has been the nature of OTP *action* in implementing this program?

Answer. OTP formally established the Government Communications Planning Program with the issuance of OTP Circular 12 in October, 1973. The Circular identifies four broad mission areas and establishes goals, objectives, and methods of implementing the planning program, (a copy of Circular 12 is included for reference as Attachment 3).

OTP representatives are liaison members of and provide guidance to the various interagency planning committees, which meet periodically to review progress and assign new planning tasks to various agencies and departments. The results of the work within each mission area are formally reported to OTP

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once each year. The submissions are analyzed and evaluated by an OTP coordinating group and findings reported back to the various agencies, together with guidance for the ensuing work efforts during the fall quarterly meeting of the lead agencies with OTP staff.

The first round of reports, which focused on identifying existing or planned communications systems, has been received, evaluated, and OTP guidance has been reported back. The inventory of communications programs resulting from this initial effort will provide a foundation for future long term planning. Next reports are due in August, 1975.

2. Can you give us examples of where OTP identified unnecessary duplication among agencies, and acted to remedy it?

Answer: The most significant examples to date of the identification and elimination of unnecessary duplication are in the areas of navigation and home warning discussed below.

3. You cited OTP involvement in coordinating and consolidating agencies' (1) navigation and (2) warning systems. Exactly what did OTP do in these areas? What is the status of U.S. navigation, and warning systems?

Answer. In 1972 OTP initiated an effort aimed at establishing a coordinated government radio navigation program and providing better planning information for the users of government-provided radio navigation aids. Early in this effort we found that there was considerable confusion among government and private users as to what navigation aids would be available to marine users.

Initially, four different systems were under consideration: The Department of Transportation was requesting funds to expand LORAN C as the system for the Coastal/Confluence Region; it was developing a high accuracy system for use in harbors and estuaries; it was supporting the OMEGA System for high seas; and it was also operating the LORAN A System. OTP felt that the LORAN C expansion should not be funded until the total marine navigation problem had been considered, and so recommended to OMB.

In 1973, OTP concluded that if LORAN C was deployed for the Coastal Region, differential techniques within that system could provide a high accuracy capability within the harbors and estuaries area. We also concluded that if LORAN C was expanded and OMEGA was implemented, LORAN A could be phased out, thus eliminating two of the four competing systems. We so informed OMB, DOT, and the House Subcommittee on Coast Guard and Navigation.

In March, 1974, the OMEGA and LORAN C systems were designated as the two systems for maritime radio navigation needs. As a result, the plan for a separate system for harbors and estuaries was cancelled and a schedule for phasing out LORAN A was published. This action resulted in considerable cost savings to the government and to private users. We have estimated that the program which was cancelled would have cost the government between $43 and $200 million in investment, $10 to $50 million annually, and would have cost the private sector about $450 million in duplicative navigation equipment.

These efforts, together with the establishment of a lead agency to coordinate navigation in the context of the overall Planning Program, have resulted in steps toward better management of navigation resources both within and between agencies. For example, the Department of Defense has established a Navigation Steering Group which is reviewing all Defense navigation programs with the goal of consolidation or elimination of duplicative programs. OTP and the lead agency group, which includes DOD, will continue to develop a coordinated interagency navigation program.

With regard to warning systems, OTP noted in 1971 that there were at least four systems in various stages of development or use capable of transmitting warnings directly to the public by means of radio. OTP undertook a review of the matter, and later in 1971 established a policy of relying on the voluntary purchase of home warning receivers by the public. By mid-1974, OTP felt that the evidence was conclusive that the direct broadcast of warnings to the home by radio could serve at most as a supplement to other warning capabilities, and that only one federally supported system for direct broadcast was warranted. In addition, we concluded that, of all the alternative systems, the NOAA weather radio system would be the most effective and economical choice for this capability. As a result, in January, 1975 OTP updated its original warning policy by specifying that the NOAA weather radio would be the only federally sponsored system for broadcast of radio warnings direct to the public in their homes. Copies of the OTP policy statement and support paper on home warning are included as Attachment 6.

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Having settled the question of which radio system should be used for home warning, we are now working to establish a consolidated Federal/local warning program. Thus far it appears that the major problem in disseminating warning is not technological, but rather lies in the coordination of the communications controlled by the various groups and agencies into a comprehensive program. We are now working with Federal agencies and representatives of State and local governments to develop such a program, and expect to complete this effort in FY 76.

4. Are the involved agencies cooperating with your policies in this area?

Answer. We feel that, in general, the agencies are cooperating. However, from time to time we encounter some reluctance among agencies which heretofore have been accustomed to almost complete autonomy in communications planning.

5. Does OTP need additional authority or executive tools to insure interagency compliance with administration telecommunications policy?

Answer. If additional authority is needed in any area of our government coordination responsibilities as our planning and evaluation processes become more extensive, we will seek it from the President or Congress, as appropriate.

6. You also mentioned OTP plans to identify all Federal agency uses of communications satellites. Do you plan coordination and consolidation initiatives in this area? When?

Answer. OTP's present effort in the field of communications satellites is centered on the potential interest in high powered satellite services. An interagency committee has been formed to determine the potential level of Federal use for such technology, and to determine if R&D funds exist within agencies. Such funds could be appropriately applied to foster the availability of this capability.

7. What success is OTP having in obtaining compliance with its policy encouraging reliance on the private sector for telecommunications services? (As opposed to government agencies developing their own.)

Answer. The policy has influenced a number of major procurements in a direction toward greater reliance on the private sector, including the Defense Department's AUTODIN II, the Coast Guard's Vessel Traffic Safety System, and NASA's Tracking and Data Relay Satellite System. In addition, noncompliance with this policy was a factor in the cancellation of GSA's FEDNET procurement and in the decision to defer implementation of the IRS tax administration system.

8. There is an OTP in Commerce and in HEW. What are their functions? Are they extensions of the White House OTP?

Answer. The Office of Telecommunications Policy in the Department of Health, Education and Welfare, reporting to the Assistant Secretary for Planning and Evaluation, is designed to coordinate the use of communications technologies involved in the implementation of the Department's programs and activities, principally in the areas of health care and educational services. It is not an extension of the White House Office of Telecommunications Policy.

The Office of Telecommunications in the Department of Commerce performs several functions, two of which are directly related to the activities of OTP. In addition to conducting research and development in communications technology, principally in the area of radio wave propagation, it provides economic and engineering policy support for OTP and provides technical support for OTP's frequency assignment and spectrum management functions.

9. Should all major agencies and departments have such offices for coordinating communications activities and resources, and for implementing White House OTP policies?

Answer. The overall investment in communications within most agencies of the government is quite sizeable today and is growing each year. We believe that more management attention within agencies, directed to telecommunications requirements, development and use, will result in more efficient control and utilization of this important resource.

10. Could you explain how OTP responsibilities differ from those of the FCC?

Answer. The Federal Communications Commission is an independent regulatory agency which has the statutory responsibility under the Communications Act of 1934 to regulate communications in the private sector. Its jurisdiction is broadly divided into two categories: (1) it regulates the rates and services of domestic and international communications common carriers, and (2) it assigns radio frequencies used in the private sector for such purposes as radio and television broadcasting, microwave transmission and citizens band radio, to name only a few.

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The Office of Telecommunications Policy is an Executive Branch agency, located in the Executive Office of the President, which has no regulatory jurisdiction over the private communications industry. The functions of the Office are set forth in Reorganization Plan No. 1 of 1970 and Executive Order 11556. Summarized briefly, its responsibilities are to advise the President on communications policy matters; to allocate and manage that portion of the radio spectrum used by the Federal Government; to maintain plans for mobilizing the Nation's communications resources in an emergency; and to coordinate the planning and evaluate the operation of the communications activities of the Executive Branch.

11. Your report notes OPT's intention of insure that issues of individual privacy are considered in interagency computer networking. How do you intend to do that? What progress has been made to insure individual rights of privacy in establishing government computer hook-ups? In what areas other than law enforcement are agencies merging computer facilities?

Answer. Federal agencies are beginning to share computer facilities in many major areas of the Executive Branch. OTP is concerned primarily with the use of telecommunications to enable consolidation of geographically separate record-keeping systems.

OTP intends to ensure that agency plans for data communications networks are consistent with law and policy relating to privacy. This will be done in two ways.

First, OTP is initiating a study of the relationship between data network sharing and the protection of privacy. Upon completion of the study, policy guidance will be issued.

Second, OTP will consider privacy as one of the critical policy factors when it reviews agency network plans. Although OTP does not have the resources to review of all such plans, it does review them on a selective basis, based upon information received through the annual summary plans submitted under OTP Circular 12, and on information contained in notices received under GSA's interim procurement regulation E–34, which is designed to ensure consideration of privacy issues prior to actual procurement of computer/communications systems and services.

SPECTRUM MANAGEMENT AND MONITORING

1. It seems as if the FCC, OTP, and GSA are all involved in frequency allocation and assignment. Please explain the roles of each.

Answer. The United States has divided the responsibility for management of the radio frequency spectrum resource between the Federal Communications Commission and the President. Specifically, the Communications Act of 1934, as amended, vests in the Federal Communications Commission (FCC) responsibilities for the regulation of non-government interstate and foreign telecommunication, including the assignment of radio frequency spectrum among private users, regulation of the use of those frequencies; and authorization of alien amateur and alien aircraft operators, licensed by their governments, for operation in the United States under reciprocal arrangements.

The Act exempts "Radio stations belonging to and operated by the United States" from the provisions of sections 301 and 303 (the licensing and general powers of the Commission) of the Act, and provides that such stations shall use such frequencies as shall be assigned by the President (47 U.S.C. 305(a)).

The Communications Satellite Act of 1962, in providing for a global commercial communication-satellite system, extended the regulatory authority of the FCC to the U.S. part of that system. At the same time it assigned to the President the responsibility to "so exercise his authority as to help attain coordinated and efficient use of the electromagnetic spectrum and the technical compatibility of the system with existing communications facilities both in the United States and abroad."

Reorganization Plan No. 1 of 1970 transfers functions relating to the assignment of radio frequencies to radio stations belonging to and operated by the United States, or to classes thereof, conferred upon the President by the provisions of the above cited Communications Act, to the Director of the Office of Telecommunications Policy.

The GSA role is confined to its intra-Administration use of frequency spectrum. The GSA, like other Federal Government agencies using radio, has an office to oversee the internal use of frequencies assigned to it by OTP.

In short, (1) the FCC is responsible for frequency allocation and assignment to its non-government licensees, (2) the OTP is responsible for the same func-

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tion as regards the departments and agencies of the Federal Government, and (3) GSA is concerned only as regards use of radio frequencies within that Administration.

2. Your report notes that the FCC and OTP are cooperating in a "study" to determine how future requirements for limited frequency space can be most efficiently assigned and used. What is the status and schedule of this inquiry? When will it provide concrete recommendations?

The "study" has been ongoing since 1970. The schedule was intended originally to be open-ended but it is now expected that most of the substantive results will be available by the end of 1977. The International Telecommunication Union (ITU), with 149 member nations, is planning a General World Administrative Radio Conference in 1979, at which time the entire table of international radio frequency allocations will be reviewed. The greater part of the engineering research in preparation for that Conference will have to be completed by the end of 1977. The "study" will, in fact, serve as an input to two concomitant purposes:

facilitating the joint OTP/FCC review to be used in national planning, and

preparing the spectrum portion of the U.S. proposals for the 1979 Radio Conference.

Thus far, the "study" has been concentrated on the 100–1215 MHz band. Concrete results in this area to date have been:

(a) The assignment on a national basis of VHF and UHF for Emergency Medical Services telecommunications.

(b) The decision has been made to clear several frequencies in the 150 MHz and 450 MHz areas for assignment to maritime communications—primarily for new requirements such as vessel traffic and on-board comunications systems.

(c) OTP released 26 MHz of heretofore exclusive government spectrum at 900 MHz to the FCC for non-government use. This served as a stimulant to FCC Docket 18262 which provided for the new non-government 900 MHz land mobile communications service.

(d) FCC has proceeded also with its Docket 18261 whereby some of the unused UHF TV channels are made available for land mobile communications in several major urban areas.

(e) OTP has revised the frequency assignment structure for government operations in the 162–174 and 406–420 MHz bands to provide substantially more channels.

(f) A government requirement for an additional 100 MHz of space has been identified for accommodating increased communications in the 1980–85 time frame.

(g) A study has been made of VHF Television broadcasting assignment criteria with the result that it has been found that many additional stations could be engineered or "dropped in" the top 100 markets.

3. You indicated that OTP is involved in "monitoring" agency uses of assigned frequencies. Please describe who you monitor and how you conduct this activity.

Answer. Effective management of the spectrum requires reliable information as to the actual extent of its use. Accordingly, in 1973 OTP initiated a spectrum measurement system to support its radio frequency management function. The principal tool for spectrum measurement is a truck mounted van specifically configured for the purpose. Radio emissions are observed and measured to determine electromagnetic characteristics, provide statistical data on usage, and to resolve harmful interference problems.

Spectrum observations and measurement, i.e., monitoring, are confined to radio emissions on frequencies authorized for official telecommunications of agencies of the Federal Government. Agencies are put on advance notice when their radio frequencies are to be subjected to observation and measurement. So far most of this activity has pertained to Federal Government land mobile and radar frequencies.

The work of spectrum measurement is actually conducted by the Department of Commerce (Office of Telecommunications) under the policy direction and guidance of OTP. Included herewith as Attachment 4 is a copy of the relevant OTP Order providing that direction and guidance. As a matter of interest, also included as Attachment 5 is a copy of a letter from Congressman Macdonald commending OTP for the acquisition of a spectrum monitoring and measurement unit.

4. Last year OTP recommended that the FCC approve "dropping in" additional VHF channels in several cities for broadcast use. What prompted such a recommendation? What benefits would be derived from adoption of this recommendation? Who do you recommend furnish programming for these new channels?

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One of OTP's responsibilities set forth in Executive Order 11556 is to "develop in cooperation with the FCC, a comprehensive long-range plan for improved management of all electromagnetic spectrum resources." Pursuant to this responsibility and as part of a continuing effort to find ways of improving the use of the spectrum, OTP issued its first technical report on VHF Television Broadcasting Frequency Assignment Criteria. This study suggested that 67 additional VHF-TV stations could be "dropped-in" in the top 100 television markets by taking advantage of existing technologies and techniques, e.g., directional antennas, precise frequency offset, etc., to reduce current spectrum assignment criteria. This was followed up with a second technical report in May, 1974.

The conclusions reached were basically the same as in the first report, i.e., VHF-TV assignment criteria should be reexamined to assure that effective use is made of the spectrum in light of modern day engineering possibilities. This recommendation, if implemented by the FCC, will result in more broadcast outlets in a spectrum environment that is characterized by inherent scarcity.

OTP does not make recommendations as to who should furnish programs on the new channels that might be made available as a result of our proposal, nor do we believe it appropriate for any government agency to do so. The Federal Government's responsibility in the area of spectrum availability is to assure that this limited resource is used efficiently; beyond this it should be up to the private sector, subject of course to the licensing provisions of the Communications Act, to determine by whom, when and how these frequencies will be utilized.

SATELLITE DEVELOPMENT AND USE

1. Please explain the relationship of OTP to COMSAT, INTELSAT.

Answer. The Communications Satellite Act of 1962 created COMSAT for the purpose of establishing a global commercial communications satellite system. The Act assigned certain responsibilities to the President, some of which have been delegated by Executive Order (E.O. 11191 and 11556) to the Director of OTP. In general, the Director of OTP serves as the chief point of liaison between the President and COMSAT.

COMSAT is the designated operating entity which represents the United States in INTELSAT, now an 89 member organizatioin, which provides the space segment for the global communications satellite network. INTELSAT was created pursuant to two agreements—an Intergovernmental Agreement (signed by the U.S. Government) and an Operating Agreement (signed by COMSAT as the U.S. Signatory). OTP together with other interested agencies formulates policy relating to the U.S. Government's participation in INTELSAT as a Party to the Intergovernmental Agreement. Additionally, OTP, together with the Department of State and the Federal Communications Commission, provides guidance to COMSAT in its capacity as the U.S. Signatory to the Operating Agreement, on matters of interests to the Government.

2. Last year, OTP advocated legislation to amend COMSAT provisions of the Communications Act. Generally, what were these recommendations? Do you intend to recommend this legislation to the 94th Congress?

Answer. OTP submitted legislation in 1974 to amend the Communications Satellite Act of 1962, and intends to submit the legislation in the present Congress following OMB clearance. In general, the legislation would remove several provisions relating to COMSAT's affairs which normally would not be associated with a private enterprise communications carrier, but which were originally included due to uncertainties that existed at the time COMSAT was created. The global satellite system has now been established and COMSAT is a mature commercial common carrier, and it is therefore appropriate to remove a number of the special provisions contained in the 1962 Act.

3. What is the status of the AEROSAT program—the experiment in using satellites for improving air traffic control. Do you see this project moving out of the testing stage soon?

Answer. Following the signing of a Memorandum of Understanding by the FAA, ESRO and Canada in 1974, an AEROSAT co-owners arrangement for provision of the space segment was signed by COMSAT General, ESRO and Canada on December 2, 1974. Present plans call for issuance of an RFP for the space segment in July, 1975 and the first satellite launch is scheduled for late 1978. The experimental AEROSAT system has a five year design lifetime and there are no plans to move beyond the testing stage until the results of the experimental phase have been obtained.

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4. OTP and HEW have been working over the past months to stimulate private enterprise to develop satellite and ground facilities which would distribute educational and health programming to needy areas in the U.S. What progress has been made in this project? Has a user "consortium" been formed?

Answer. OTP has encouraged reliance on the private sector, rather than government-owned systems, for the provision of communications satellite services for distributing health and education programming to outlying areas. Numerous health and educational organizations from across the country have recently joined together to form a Public Service Satellite Consortium to explore the further development and use of this technology.

ATTACHMENT 1

REORGANIZATION PLAN NO. 1 OF 1970

(Prepared by the President and transmitted to the Senate and the House of Representatives in Congress assembled, February 9, 1970, pursuant to the provisions of chapter 9 of the United States Code.)

OFFICE OF TELECOMMUNICATIONS POLICY

SECTION 1. *Transfer of functions.* The functions relating to assigning frequencies to radio stations belonging to and operated by the United States, or to classes thereof, conferred upon the President by the provisions of section 305(a) of the Communications Act of 1934, 47 U.S.C. 305(a), are hereby transferred to the Director of the Office of Telecommunications Policy hereinafter provided for.

SEC. 2. *Establishment of Office.* There is hereby established in the Executive Office of the President the Office of Telecommunications Policy, hereinafter referred to as the Office.

SEC. 3. *Director and deputy.* (a) There shall be at the head of the Office the Director of the Office of Telecommunications Policy, hereinafter referred to as the Director. The Director shall be appointed by the President by and with the advice and consent of the Senate and shall be compensated at the rate now or hereafter provided for Level III of the Executive Schedule Pay Rates (5 U.S.C. 5314).

(b) There shall be in the Office a Deputy Director of the Office of Telecommunications Policy who shall be appointed by the President by and with the advice and consent of the Senate and shall be compensated at the rate now or hereafter provided for Level IV of the Executive Schedule Pay Rates (5 U.S.C. 5315). The Deputy Director shall perform such functions as the Director may from time to time prescribe and, unless the President shall designate another person to so act, shall act as Director during the absence or disability of the Director or in the event of vacancy in the office of Director.

(c) No person shall while holding office as Director or Deputy Director engage in any other business, vocation, or employment.

SEC. 4. *Performance of functions of Director.* (a) The Director may appoint employees necessary for the work of the Office under the classified civil service and fix their compensation in accordance with the classification laws.

(b) The Directors may from time to time make such provisions as he shall deem appropriate authorizing the performance of any function transferred to him hereunder by any other officer, or by any organizational entity or employee, of the Office.

SEC. 5. *Abolition of office.* That office of Assistant Director of the Office of Emergency Preparedness held by the Director of Telecommunications Management under Executive Order No. 10995 of February 16, 1962, as amended, is abolished. The Director of the Office of Emergency Preparedness shall make such provisions as he may deem to be necessary with respect to winding up any outstanding affairs of the office abolished by the foregoing provisions of this section.

SEC. 6. *Incidental transfers.* (a) So much of the personnel, property, records, and unexpended balances of appropriations, allocations, and other funds employed, held, or used by, or available or to be made available to, the Office of Emergency Preparedness in connection with functions affected by the provisions of this reorganization plan as the Director of the Bureau of the Budget shall determine shall be transferred to the Office of Telecommunications Policy at such time or times as he shall direct.

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(b) Such further measures and dispositions as the Director of the Bureau of the Budget shall deem to be necessary in order to effectuate the transfers provided for in subsection (a) of this section shall be carried out in such manner as he shall direct and by such agencies as he shall designate.

SEC. 7. *Interim Director.* The President may authorize any person who immediately prior to the effective date of this reorganization plan holds a position in the Executive Office of the President to act as Director of the Office of Telecommunications Policy until the office of Director is for the first time filled pursuant to the provisions of section 3 of this reorganization plan or by recess appointment, as the case may be. The President may authorize any person who serves in an acting capacity under the foregoing provisions of this section to receive the compensation attached to the office of Director. Such compensation, if authorized, shall be in lieu of, but not in addition to, other compensation from the United States to which such person may be entitled.

ATTACHMENT 2

Executive Order 11556

ASSIGNING TELECOMMUNICATIONS FUNCTIONS

By virtue of the authority vested in me by section 301 of title 3 of the United States Code, and as President of the United States, and in consonance with the intention expressed in my message to the Congress transmitting Reorganization Plan No. 1 of 1970, it is hereby ordered as follows:

SECTION 1. *Amended and superseded orders.* Executive Orders Nos. 10705 of April 17, 1957, 11051 of September 27, 1962, 11191 of January 4, 1965, and 11490 of October 28, 1969, and the President's Memorandum of August 21, 1963, headed "Establishment of the National Communications System" (28 F.R. 9413) are amended as provided herein. Executive Orders Nos. 10695–A of January 16, 1957, 10995 of February 16, 1962, and 11084 of February 15, 1963, to the extent not heretofore made inapplicable, are hereby revoked.

SEC. 2. *General functions.* Subject to the authority and control of the President, the Director of the Office of Telecommunications Policy (hereinafter referred to as the Director) shall:

(a) Serve as the President's principal adviser on telecommunications.

(b) Develop and set forth plans, policies, and programs with respect to telecommunications that will promote the public interest, support national security, sustain and contribute to the full development of the economy and world trade, strengthen the position and serve the best interests of the United States in negotiations with foreign nations, and promote effective and innovative use of telecommunications technology, resources, and services. Agencies shall consult with the Director to insure that their conduct of telecommunications activities is consistent with the Director's policies and standards.

(c) Assure that the executive branch views are effectively presented to the Congress and the Federal Communications Commission on telecommunications policy matters.

(d) Coordinate those interdepartmental and national activities which are conducted in preparation for U.S. participation in international telecommunications conferences and negotiations, and provide to the Secretary of State advice and assistance with respect to telecommunications in support of the Secretary's responsibilities for the conduct of foreign affairs.

(e) Coordinate the telecommunications activities of the executive branch and formulate policies and standards therefor, including but not limited to considerations of interoperability, privacy, security, spectrum use and emergency readiness.

(f) Evaluate by appropriate means, including suitable tests, the capability of existing and planned telecommunications systems to meet national security and emergency preparedness requirements, and report the results and any recommended remedial actions to the President and the National Security Council.

(g) Review telecommunications research and development, system improvement and expansion programs, and programs for the testing, operation, and use

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of telecommunications systems by Federal agencies. Identify competing, overlapping, duplicative or inefficient programs, and make recommendations to appropriate agency officials and to the Director of the Office of Management and Budget concerning the scope and funding of telecommunications programs.

(h) Coordinate the development of policy, plans, programs, and standards for the mobilization and use of the Nation's telecommunications resources in any emergency, and be prepared to administer such resources in any emergency under the overall policy direction and planning assumptions of the Director of the Office of Emergency Preparedness.

(i) Develop, in cooperation with the Federal Communications Commission, a comprehensive long-range plan for improved management of all electromagnetic spectrum resources.

(j) Conduct and coordinate economic, technical, and systems analyses of telecommunications policies, activities, and opportunities in support of assigned responsibilities.

(k) Conduct studies and analyses to evaluate the impact of the convergence of computer and communications technologies, and recommend needed actions to the President and to the departments and agencies.

(l) Coordinate Federal assistance to State and local governments in the telecommunications area.

(m) Contract for studies and reports related to any aspect of his responsibilities.

SEC. 3. *Frequency assignments.* The functions transferred to the Director by section 1 of Reorganization Plan No. 1 of 1970 include the functions of amending, modifying, and revoking frequency assignments for radio stations belonging to and operated by the United States, or to classes thereof, which have heretofore been made or which may be made hereafter.

SEC. 4. *War powers.* Executive Order No. 10705 of April 17, 1957, headed "Delegating Certain Authority of the President Relating to Radio Stations and Communications", as amended, is further amended by:

(a) Substituting for subsection (a) of section 1 the following: "(a) Subject to the provisions of this order, the authority vested in the President by subsections 606 (a), (c) and (d) of the Communications Act of 1934, as amended (47 U.S.C. 606 (a), (c) and (d)), is delegated to the Director of the Office of Telecommunications Policy (hereinafter referred to as the Director). That authority shall be exercised under the overall policy direction of the Director of the Office of Emergency Preparedness."

(b) Substituting for the text "subsections 305(a) and 606(a)" in subsection (b) of section 1 the following: "subsection 606 (a)".

SEC. 5. *Foreign government radio stations.* The authority to authorize a foreign government to construct and operate a radio station at the seat of government vested in the President by subsection 305(d) of the Communications Act of 1934, as amended (47 U.S.C. 305(d)), is hereby delegated to the Director. Authorization for the construction and operation of a radio station pursuant to this subsection and the assignment of a frequency for its use shall be made only upon recommendation of the Secretary of State and after consultation with the Attorney General and the Chairman of the Federal Communications Commission.

SEC. 6. *Office of Emergency Preparedness.* (a) Executive Order No. 11051 of September 27, 1962, headed "Prescribing Responsibilities of the Office of Emergency Planning in the Executive Office of the President", as amended, is further amended by:

(1) Deleting subsection 301(4) and renumbering subsection 301(5) as subsection 301(4).

(2) Substituting for section 306 the following:

"SEC. 306. *Emergency telecommunication.* The Director shall be responsible for providing overall policy guidance to the Director of the Office of Telecommunications Policy in planning for the mobilization of the Nation's telecommunications resources in time of national emergency."

(3) Deleting section 406.

SEC. 7. *Emergency preparedness.* Executive Order No. 11490 of October 28, 1969, headed "Assigning emergency preparedness functions to Federal departments and agencies," as amended, is hereby further amended (1) by substituting "Policy (35 F.R. 6421)" for "Management (OEP)" in section 401 (27), and (2) by substituting the number of this order for "10995" in section 1802 and in section 2002(3).

SEC. 8. *National Communications System.* The President's Memorandum of

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August 21, 1963, headed "Establishment of the National Communications System" (28 F.R. 9413), is amended by:

(a) Substituting the following for the first paragraph after the heading "Executive Office Responsibilities":

"The Director of the Office of Telecommunications Policy shall be responsible for policy direction of the development and operation of the National Communications System and shall:"

(b) Substituting the term "Director of the Office of Telecommunications Policy" for the term "Special Assistant to the President for Telecommunications" wherever it appears in said memorandum.

SEC. 9. *Communications Satellite Act of 1962.* Executive Order No. 11191 of January 4, 1965, headed "Providing for the Carrying Out of Certain Provision of the Communications Satellite Act of 1962", is amended by:

(a) Substituting the following for subsection (c) of section 1:

"(c) The term 'the Director' means the Director of the Office of Telecommunications Policy.", and

(b) Substituting the following for the catchline of section 2: "*Director of the Office of Telecommunications Policy.*"

SEC. 10. *Advisory committees.* As may be permitted by law, the Director shall establish such interagency advisory committees and working groups composed of representatives of interested agencies and consult with such departments and agencies as may be necessary for the most effective performance of his functions. To the extent he deems it necessary to continue the Interdepartment Radio Advisory Committee, that Committee shall serve in an advisory capacity to the Director. As may be permitted by law, the Director also shall establish one or more telecommunications advisory committees composed of experts in the telecommunications area outside the Government.

SEC. 11. *Rules and regulations.* The Director shall issue such rules and regulations as may be necessary to carry out the duties and responsibilities delegated to or vested in him by this order.

SEC. 12. *Agency assistance.* All executive departments and agencies of the Federal Government are authorized and directed to cooperate with the Director and to furnish him such information, support and assistance, not inconsistent with law, as he may require in the performance of his duties.

SEC. 13. *Functions of the Secretary of Commerce.* The Secretary of Commerce shall support the Director in the performance of his functions, shall be a primary source of technical research and analysis and, operating under the policy guidance and direction of the Director, shall:

(a) Perform analysis, engineering and administrative functions, including the maintenance of necessary files and data bases, responsive to the needs of the Director in the performance of his responsibilities for the management of the radio spectrum.

(b) Conduct technical and economic research upon request to provide information and alternatives required by the Director.

(c) Conduct research and analysis on radio propagation, radio systems characteristics, and operating techniques affecting the utilization of the radio spectrum in coordination with specialized, related research and analysis performed by other Federal agencies in their areas of responsibility.

(d) Conduct research and analysis in the general field of telecommunication sciences in support of other Government agencies as required and in response to specific requests from the Director.

(e) Conduct such other activities as may be required by the Director to support him in the performance of his functions.

SEC. 14. *Retention of existing authority.* (a) Nothing contained in this order shall be deemed to impair any existing authority or jurisdiction of the Federal Communications Commission. In carrying out his functions under this order, the Director shall coordinate his activities as appropriate with the Federal Communications Commission and make appropriate recommendations to it as the regulator of the private sector.

(b) Except as specifically provided herein, nothing in this order shall be deemed to derogate from any existing assignment of functions to any other departments or agency or officer thereof made by statute, Executive order, or other Presidential directives.

RICHARD NIXON.

THE WHITE HOUSE,
September 4, 1970.

[F.R. Doc. 70-12017; Filed, Sept. 4, 1970; 4:58 p.m.]

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ATTACHMENT 3

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF TELECOMMUNICATIONS POLICY,
Washington, D.C., October 12, 1973.

To the heads of executive departments and establishments
Subject: Government Communications Planning Program

1. *Purpose.* This Circular sets forth policies and establishes procedures for a coordinated Government planning program for telecommunications systems and services required by Government agencies in the conduct of their activities.

2. *Objective.* The objectives of the coordinated Government planning program established by this Circular are:

To promote more effective use of communications technology, resources, and services by Government agencies;

To permit better evaluation of existing and planned communications systems;

To help achieve the optimum degree of coordination, compatibility, and resource sharing in Federal communications programs; and,

To promote economy in the Government's use of communications.

3. *Approach.* The communications services used by the Government can be divided into two general classes.

One is the class of services which are widely used and common to many agencies, where the efficiency or cost-effectiveness of the service is a paramount consideration. These services are most economically provided on a common user basis. The General Services Administration is responsible for planning such services.

The other class of services supports operational functions in support of particular agency missions, in which cost considerations must yield to performance or security factors. These services have some characteristics in common, but often cannot be adequately satisfied by general purpose systems designed to provide the most economical bulk services. These services are most efficiently provided by systems or services planned by those responsible for the mission.

4. *Mission Area Planning.* Many communications systems have unique operational reasons for their existence, but there are areas in which agencies with similar missions have separate but similar systems. In each of these areas, a greater degree of coordinated communications planning is desirable.

Four broad mission areas have been identified, which require such treatment:

National Security.

Transportation.

Environment.

Law Enforcement.

To achieve the necessary improvements in Government-wide planning in these mission areas, the following agencies are designated to take leading and participating roles in coordinated communications planning:

National Security. Lead Agency: Department of Defense as Executive Agent, National Communications System—Participants: Departments of States, Defense, and Transportation, Central Intelligence Agency, General Services Administration.

Transportation, Lead Agency: Department of Transportation, Participants: Departments of Defense and Commerce, National Aeronautics and Space Administration.

Environment, Lead Agency: Department of Commerce—Participants: Environmental Protection Agency, Departments of Defense, Interior and Transportation.

Law Enforcement, Lead Agency: Department of Justice—Participants: Departments of Treasury and Interior.

Other Executive branch agencies not identified above may be invited by Lead Agencies to participate as appropriate for specific purposes.

5. *Implementation.* Each Mission Area Group will develop an annual summary plan for its area of responsibility including appropriate treatment of requirements, system plans, alternatives, cost, performance, standards, interconnections, and other relevant aspects. The General Services Administration will prepare a comparable plan for general-purpose Government systems. OTP will provide pertinent planning guidance at the beginning of each planning cycle. These summary plans should cover five years from the date of submission and should be transmitted to the Office of Telecommunications Policy, Executive Office of the President, Washington, D.C. 20504, no later than August 15th of each year. OTP will review these plans to determine compliance with overall Federal Govern-

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ment telecommunications policy, including evaluation of whether an appropriate degree of compatibility and resource sharing is represented in the plans. The determinations made by OTP on such plans will be reported to the agencies involved and to the Office of Management and Budget for their consideration with respect to planning, programming, and budgeting, and to GSA as appropriate for consideration with respect to their planning and procurement actions.

6. *Effective Date.* This Circular is effective immediately.

CLAY T. WHITEHEAD, *Director.*

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF TELECOMMUNICATIONS POLICY,
Washington, D.C., March 4, 1974.

Transmittal Memorandum No. 1

To the heads of executive departments and agencies

Subject: Relationship of GSA FPMR 101-35 to OTP, Circular No. 12

1. *Purpose.* This Transmittal Memorandum clarifies the intent of the Circular as a planning document and amplifies procedures for submission of annual summary plans by Mission Area groups.

2. *Revised instructions.*

(a) Paragraph 1 is changed to "Purpose and Scope" and is revised to add the following: It is not intended to affect existing procurement authorities.

(b) Paragraph 5 is amended to add in the 12th line after "each year," the following sentence: Services, facilities and systems reported in these plans need not be reported to the GSA under the reporting requirements of the applicable FPMR's.

Paragraph 5 is further amended to put a period after "budgeting' 'in the 19th line and to change the remainder to a new sentence reading: Copies of the plans will be made available by OTP to GSA for consideration with respect to their planning and procurement actions, and for appropriate recommendations to OTP with respect to interconnection, sharing, or cost savings.

CLAY T. WHITEHEAD.

ATTACHMENT 4

OFFICE OF TELECOMMUNICATIONS POLICY,
EXECUTIVE OFFICE OF THE PRESIDENT,
Washington, D.C., October 19, 1973.

OTP Order No. 9

To: Assistant Secretary of Commerce for Science and Technology,
Assistant Director for Frequency Management, Office of Telecommunications Policy.

Subject: Radio Spectrum Measurement Systems.

1. Purpose and Authority

(a) This Order establishes guidelines which shall be observed by frequency management personnel with respect to the operation and use of radio spectrum measurement systems pursuant to Executive Order 11556 to support this Office's functions relating to the assignment of frequencies to radio stations belonging to and operated by the United States under section 305(a) of the Communications Act of 1934, as amended, 47 U.S.C. § 305(a) and Reorganization Plan No. 1 of 1970, 84 Stat. 2083.

(b) The Assistant Secretary of Commerce for Science and Technology is authorized to operate and use radio spectrum measurement systems only insofar as they are used in support of such functions of this Office, and to promulgate and implement rules and regulations governing the operations and use of such measurement systems provided that such rules and regulations are consistent with the guidelines established herein and have been furnished to this Office's Assistant Director for Frequency Management for his concurrence prior to the time they, or revisions to them, take effect.

(c) Radio spectrum measurement systems operated or used in support of such functions of this Office shall not be operated or used for any purpose or objective other than set out herein.

2. Objective and Scope

A more effective means to ascertain and measure Federal Government occupancy and use of radio frequencies is essential to improved spectrum manage-

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ment. To meet this need, a radio spectrum measurement system has been developed by the Office of Telecommunications, Department of Commerce, which will be used only to—

(a) Determine whether Federal Government radio installations are operating on authorized frequencies and fully in accordance with all applicable regulations.

(b) Provide information necessary to prevent or resolve instances of radio interference between two or more radio frequency users.

(c) Assist in determining whether new usage can be accomplished in a particular frequency band in a particular location.

3. Guidelines

The following guidelines will be observed in the operation or use of radio spectrum measurement systems in support of this Office's responsibilities:

(a) Radio emissions will be observed and measured to determine their electromagnetic characteristics and to provide statistical data as to levels and times of occupancy and usage of the frequency spectrum in selected bands and geographical areas.

(b) Maximum attention shall be directed insofar as practicable towards the observation and measurement of radio emissions on frequencies authorized for official telecommunications.

(c) Reception of actual message content through voice measurement activities shall be restricted to frequencies authorized for official telecommunications; no information so obtained shall be divulged for any purpose other than in support of this Office's spectrum management activities; and there shall be no monitoring of the transmission or reception of the radio emissions of broadcast stations, telephone common carriers, or any other person or entity subject to the jurisdiction of the Federal Communications Commission.

(d) All Government agencies and establishments shall be given notice that their use of radio frequencies is subject to observation and measurement, including reception of message content, in support of this Office's spectrum management activities.

(e) Full recognition shall be accorded the necessity to ensure the integrity and security of measurements and data relating to Federal radio spectrum occupancy and use, in consonance with Executive Order 11654 and applicable OTP and Department of Commerce security regulations.

4. Responsibilities

The Assistant Director for Frequency Management, Office of Telecommunications Policy, shall have primary responsibility for the effective implementation of this Order, and is authorized and directed—

(a) To advise the Assistant Secretary of Commerce for Science and Technology of the requirements of this Office which need to be met through the operation or use of radio frequency measurement systems. The Assistant Director shall maintain appropriate continuing liaison with the Department of Commerce, and receive and evaluate on behalf of this Office the results of the operation of systems conducted in response to this Office's requirements.

(b) To coordinate with appropriate officers and employees of the Department of Commerce in the development of operational rules and regulations pursuant to part 1.(b), above.

(c) To consult with cognizant legal counsel and authority to ensure that the operation of radio frequency measurement systems is fully in accordance with all applicable Federal law.

(d) To establish and maintain continuing liaison with appropriate officials of the Federal Communications Commission so as to ensure the effective coordination of overall national radio frequency measurement and management activities.

5. Retention of Existing Authority

Except as specifically provided herein, nothing in this Order shall be deemed to derogate from any existing assignment of functions to another department or agency or officer thereof made by statute or Executive Order 11556.

6. Effective Date

This Order is effective immediately.

CLAY T. WHITEHEAD, *Director.*

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ATTACHMENT 5

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C., November 6, 1973.

Mr. CLAY T. WHITEHEAD,
Director, Office of Telecommunications Policy,
Executive Office of the President, Washington, D.C.

DEAR CLAY: I read with great interest your letter of October 30th, in which you report the acquisition of a radio frequency spectrum monitoring and measurement unit by the Commerce Department's Office of Telecommunications.

This seems to me a valuable piece of equipment, and perhaps long overdue.

As you well know, I have been on record for several years urging your office to increase your activity in this area of management of Federal telecommunications. I am delighted to see evidence that you are doing this.

Sincerely yours,

TORBERT H. MACDONALD,
Chairman, Subcommittee on Communications and Power.

ATTACHMENT 6

OFFICE OF TELECOMMUNICATIONS POLICY,
EXECUTIVE OFFICE OF THE PRESIDENT,
Washington, D.C., January 13, 1975.

NATIONAL POLICY FOR THE USE OF TELECOMMUNICATIONS TO WARN THE GENERAL PUBLIC

POLICY STATEMENT

In November 1971, the Federal Government completed a review of national policies and programs for use of telecommunications to provide the American public with warning of an enemy attack or of natural disasters. It was established at that time, in a statement of national policy respecting home warning systems, that the acquisition and use of any warning receiver should be a voluntary decision by each citizen. Studies conducted since 1971 now have led the Government to update and reaffirm that policy.

It now has been established that in addition to the voluntary use of a warning receiver, the public interest would be served best by a *single*, Government operated system for warning citizens in their homes of enemy attack or natural disasters. In this regard, the National Oceanic and Atmospheric Administration (NOAA) Weather Radio will be the only Federally sponsored radio transmission of warning information to receivers optionally available to the general public.

The 1971 OTP policy statement committed the Federal Government to pursuing a program that would "establish a rapid, reliable warning capability, and . . . bring the cost of a warning receiver within the reach of every American citizen." To this end, a series of tests and studies were initiated to explore several proposed home warning systems and market demands for home receivers. During 1974, the results of these studies were reviewed by the Warning Steering Committee, an interagency group chaired by the Office of Telecommunications Policy, and including representatives of NOAA, the Defense Civil Preparedness Agency (DCPA), the Federal Communications Commission (FCC), the Office of Preparedness (OP), and the Department of Transportation (DOT).

The studies focused primarily on two alternative home warning systems. The first is the Decision Information Distribution System (DIDS) of the Department of Defense. Designed originally for enemy attack warning, its scope could be expanded to include warning citizens of natural disasters. The system is in the experimental stage. The second system is the National Weather Service's (NWS) VHF/FM Tone Alert System. (The NWS is an agency of NOAA.) This System already is operational for weather forecasting, and incorporates a special tone alert signal permitting receivers to be activated automatically if desired by the owner.

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After analyzing these studies, OTP concluded that the NOAA system is the choice for priority expansion and will serve as the single national home warning system. The reasons for his are:

(1) It provides routine daily weather services, tailored to local areas, thereby enhancing the marketability of receivers;

(2) Federal investment required to complete coverage of most populated areas will be much less than the investment required to complete the DIDS transmitting system, and can be accomplished much sooner; and

(3) Inexpensive commercial receivers for this system are already on the market.

The development of alternative systems, if allowed to continue unchecked, could result not only in a needless proliferation of home warning systems but could also effectively split the market for receivers because of different technologies, which, in turn, might keep the cost of receivers so high as to be a serious obstacle to widespread voluntary purchase. Therefore, in order to avoid duplication, public confusion and unnecessary future financial burden on the public (as consumers and taxpayers), the NOAA Weather Radio will be the only Federally sponsored radio transmission of warning information to receivers optionally available to the general public. Other systems such as the Decision Information Distribution System (DIDS) should no longer be considered candidates for this function.

The market demand studies for home receivers indicated that many citizens would voluntarily purchase receivers capable of receiving home warning (if one were available), but that the total number of households with such receivers would not—for the foreseeable future—constitute a majority of the population. Therefore, this policy recognizes that Government operated home warning systems, with purchase of the receiver on a voluntary basis, can only supplement other existing warning systems.

The Warning Steering Committee, chaired by the Office of Telecommunications Policy, will coordinate efforts for the use of telecommunications for warning dissemination to attain a consolidated national warning capability. In support of this effort, NOAA and DCPA will develop necessary plans to use the NOAA Weather Radio as a supplementary attack warning system, and will further develop plans and procedures to incorporate the civil defense siren systems into the consolidated warning system, as well as to maximize the provision of warning information to radio and television stations.

OFFICE OF TELECOMMUNICATIONS POLICY,
EXECUTIVE OFFICE OF THE PRESIDENT,
Washington, D.C., January 13, 1975.

THE USE OF TELECOMMUNICATIONS TO WARN THE GENERAL PUBLIC

A BACKGROUND PAPER

Federal, State and local government agencies share responsibilities to warn the public of the imminence of emergencies, such as nuclear attack, hurricanes, seismic sea waves, tornadoes, and other natural or man-made disasters. The principal existing means for warning the general public are sirens, news-type announcements by local radio and television stations, and block-by-block canvassing by public safety officials.

Existing warning systems are relatively slow, ineffective at night, and lacking in nationwide coverage. For many years, various Federal agencies have been studying ways to use radio techniques to overcome these deficiencies. From these studies, several proposed systems have emerged which differ in technical details, but which have one element in common—the use of a home radio receiver which would be turned on by a signal from the Federal Government in an emergency. Such a system could be activated in seconds, could be effective in waking people up at night, and could achieve wide coverage of populated areas.

As of 1971, four such radio systems were under active consideration: the Decision Information Distribution System (DIDS) of the Department of Defense; the Weather Radio System of the National Oceanic and Atmospheric Administration (NOAA); a satellite-based system under study by NASA, and the incorporation of a tone signalling capability in local radio and TV broadcast stations which would be utilized as part of the Emergency Broadcast System (EBS).

These and other possible concepts for such a system were reviewed by a Federal interagency task force in 1971. The principal focus of attention at that time was whether some form of legislation should be proposed which would assure

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that a warning receiver would be introduced into virtually every home. (This could be accomplished, for example, by requiring manufacturers to incorporate a radio warning receiver in every new television set.) If such legislation were passed, it would be essential to select the warning system having the highest possible degree of reliability and national coverage, since the participation of the entire American population would be virtually assured. The DIDS system was considered at that time to be the best candidate to meet such a requirement.

After reviewing the policy implications of such legislation, however, it was decided that the government should not pursue a program which would so forcibly inject a government communications capability into every home. Therefore, in November, 1971, a policy was established that public participation in a Federal radio warning program should be by the voluntary purchase of a warning receiver.

Without widespread participation assured by legislative action, it became important to consider the willingness of the public to voluntarily buy warning receivers. Two factors were recognized which would affect the decision to buy: what services would the receiver offer, and how much would it cost? In addition, it became necessary to reconsider the value of Federal investment in radio warning transmitters in light of the additional benefits which would be received from a system of limited penetration. As a practical matter, it was necessary to recognize that many people are warned in time of many emergencies by the existing warning systems. A radio system with the alerting feature (automatic turn-on) represents a certain degree of performance improvement, rather than an all-or-nothing capability.

Following the 1971 policy decision, OTP initiated studies of receiver cost and market penetration. As a result of these studies, we are now convinced that the NOAA Weather Radio is the best choice for a Federal radio warning system. The reasons for this are:

1. It provides routine daily weather services tailored to local areas, enhancing the marketability of receivers;

2. Federal investment required to complete coverage of most populated areas will be much less than the investment required to complete the DIDS transmitting system, and can be accomplished much sooner; and

3. Inexpensive commercial receivers for this system are already on the market.

With respect to other candidates, we find (1) a satellite-based system is more expensive and not feasible in this decade, and (2) the use of private radio and television facilities to broadcast a "turn on" signal in a timely manner suffers from disadvantages in coverage and geographical selectivity. OTP has considered arguments that each agency should implement and promote its own system for broadcasting warning with alerting signals to the public. We believe that this would entail an unacceptable duplication of investments both by the government and by the using public. Only one system should be supported by the Federal Government for direct broadcasting to the public in this manner.

The civil defense community can take advantage of the additional capability inherent in the NOAA Weather Radio by making arrangements to use the system as an additional means of disseminating attack warning information to the general public.

During 1974, the Warning Steering Committee was convened to review the results of studies and the present situation. The Committee is chaired by OTP and includes representatives of the Defense Civil Preparedness Agency (DCPA), Department of Transportation, NOAA, the GSA Office of Preparedness, and the FCC. The Committee considered all facets of the problem, and all participants have advised OTP of their views on the matter. As a result, the national policy issued by OTP in 1971 has been updated to include the government's intention to support only one system for the transmission of warning information to receivers available to the public—the NOAA Weather Radio. A copy of the updated policy is attached.

The Defense Civil Preparedness Agency has considered the DIDS system as a means of performing warning functions other than the transmission of signals directly to the public. The cost-effectiveness of the DIDS system, relative to existing systems for these other functions, has not been evaluated by OTP. The Department of Defense will ultimately decide whether the construction of DIDS transmitters nationwide is warranted for such purposes, and when such construction might proceed. However, this system will no longer be considered as a means for broadcasting warning signals direct to the public by means of home warning receivers.

[Whereupon, at 12:15 p.m., the hearing was adjourned.]

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