	Tenure of office	
	From	To
ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION:		
Kenneth M. Endicott	Aug. 1973	Present
DIRECTOR, BUREAU OF HEALTH RESOURCES DEVELOPMENT: (note b)		
John C. Greene (acting)	Sept. 1973	Present
Kenneth M. Endicott	Nov. 1969	Aug. 1973
Leonard D. Fenninger	Jan. 1967	Nov. 1969

[a]Title of office was changed from Assistant Secretary for Health and Scientific Affairs, November 1972. Position created November 1965.

[b]The Bureau of Health Manpower was created in January 1967 from a number of ongoing programs. It was a separate operating bureau of the Public Health Service until April 1968, when it was transferred to the National Institutes of Health. The Bureau's name was changed to the Bureau of Health Professions Education and Manpower Training in January 1969 and to the Bureau of Health Manpower Education in September 1970. In July 1973, the Bureau was transferred to the newly organized Health Resources Administration where its name was changed to the Bureau of Health Resources Development.

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programs. These include Federal assistance in construction of teaching facilities, federally insured loans, and the Shortage Area Scholarship Program.

If the program is continued, the Congress should consider (see p. 63):

--Whether its goals could be served as well if scholarship funds were added to loan funds and the scholarships eliminated. This may be warranted in view of the difficulties experienced in equitable distributions of scholarship funds and the excellent potential of all medical and dental students to repay loans upon graduation.

--The necessity of continuing to provide loans at interest rates lower than those available to the Government in view of the very high earning potential of medical and dental school graduates.

--Whether the goal of increasing the number of health professions students from low-income families could be better served if HPSAP were directed to a specifically defined income group.

--The need for providing overall coordination of the various Federal programs providing aid to health professions students.

CHAPTER 1

INTRODUCTION

In 1963 the Congress initiated the Health Professions Student Assistance Program (HPSAP) as part of an overall program designed to meet anticipated national shortages of doctors, dentists, and other health professionals. Other facets of the overall program assist health professions schools in constructing or renovating teaching facilities and in advancing educational programs. HPSAP is authorized under title VII of the Public Health Service Act (42 U.S.C. 294 and 295g).

HPSAP provides long-term, low-interest loans to students in need and scholarships to students with exceptional needs and pays or cancels portions of the principal and interest on educational loans of graduates who practice in designated shortage areas.

Although HPSAP's objectives are not specified in the legislation, committee reports and appropriation hearings indicate that the Congress was concerned with the need to

--increase the number of qualified applicants to health professions schools,

--attract more health professions students from low-income families, and

--encourage physicians and dentists to practice in shortage areas.

To evaluate HPSAP as it relates to the medical and dental professions, we reviewed the National Institutes of Health's (NIH's) implementation of HPSAP at 7 medical and 6 dental schools. The scope of our review is in chapter 8.

LEGISLATIVE HISTORY

HPSAP has evolved through various laws over the past 10 years. Initially, the Health Professions Educational Assistance Act of 1963 (Public Law 88-129) established a 3-year program of loans of up to $2,000 a year to students of medicine, dentistry, and osteopathy. Students of optometry

were added to HPSAP by a 1964 amendment to the Public Health Service Act (Public Law 88-654). Loans were to be made at a rate of interest determined annually on the basis of market prices of long-term Federal obligations--but not lower than 3 percent a year--and repayable within 10 years beginning 3 years after graduation.

The Health Professions Education Assistance Amendments of 1965 (Public Law 89-290) extended the loan program for an additional 3 years and increased the maximum loan amount to $2,500 a year. It also extended the provisions to students of pharmacy and podiatry and established a program of scholarships for low-income health professions students of up to $2,500 a year. The amendments further provided that physicians, dentists, and optometrists, who practiced in areas having a shortage of their professional skills, could have portions of their HPSAP loans forgiven.

The Health Manpower Act of 1968 (Public Law 90-490) extended for 2 years the appropriation authority for the loan and scholarship programs, fixed the interest rate at 3 percent, and required repayments to begin 1 year after completion of studies. Postponement of repayment was allowed for students engaged in advanced professional training, including internship and residencies. The 1968 act also redefined student eligibility for scholarship assistance as "students of exceptional financial need."

The Comprehensive Health Manpower Training Act of 1971 (Public Law 92-157) extended the HPSAP an additional 3 years, increased the maximum annual loan or scholarship to $3,500, and added a loan-forgiveness provision for students from low-income or disadvantaged families who fail to complete their studies. Appropriation authority expires June 30, 1974, except for the 3 additional years where they are authorized in amounts necessary to enable students who received aid before July 1, 1974, to continue or complete their education.

PROGRAM ADMINISTRATION

Until the middle of 1973 the Bureau of Health Manpower Education, NIH, Department of Health, Education, and Welfare (HEW), centrally administered HPSAP. Operating reports, information requests, questions from participating schools and

all applications for participation were directed to the Bureau's Division of Physician and Health Professions Education.

In July 1973 HEW began to reorganize and decentralize some of its health agencies and established the Health Resources Administration. HPSAP was transferred from NIH to the Bureau of Health Resources Development of the Health Resources Administration. HEW regional offices will administer the program on a decentralized basis, and participating schools will report program results to the regions. The Health Resources Administration will determine centrally the amounts participating schools are to be awarded and will be responsible for centralized data collection, planning, and policy development and analysis.

PROGRAM ACTIVITY

HPSAP funds totaling almost $300 million have been allocated to health professions schools for student assistance through fiscal year 1973 as follows:

Fiscal year	Loans	Scholarships
	(millions)	
1965	10.2	-
1966	15.6	0.1
1967	25.3	3.9
1968	26.7	7.2
1969	26.4	11.2
1970	15.9	15.5
1971	24.8	15.5
1972	30.0	15.5
1973	36.0	15.5
Total	210.9	84.4

The following amounts were allocated for academic year 1972-73.

Type of school	Loans	Scholarships	Total	Percentage
Medicine	$19,496,071	$ 6,785,696	$26,281,767	51.0
Dentistry	7,580,961	2,655,543	10,236,504	19.9
Pharmacy	3,939,145	4,204,680	8,143,825	15.8
Optometry	1,298,612	513,708	1,812,320	3.5
Osteopathy	1,161,258	367,722	1,528,980	3.0
Podiatry	621,468	187,931	809,399	1.6
Veterinary	1,902,485	784,720	2,687,205	5.2
Total	$36,000,000	$15,500,000	$51,500,000	100.0

Grants to schools of medicine and dentistry accounted for about 71 percent of the total grants awarded.

The following table shows that an estimated 97,454 students were enrolled in participating health professions schools in the United States for the 1971-72 academic year,[1] and 35,438 received assistance from HPSAP.

Type of school	Total enrollment	Number of students assisted	Percentage
Medicine	43,946	16,397	37.3
Dentistry	17,331	7,543	43.5
Pharmacy	24,335	6,561	27.0
Optometry	3,068	1,325	43.2
Osteopathy	2,302	1,167	50.7
Podiatry	1,267	561	44.3
Veterinary	5,205	1,884	36.2
Total	97,454	35,438	36.4

PROGRAM OPERATION

Health professions schools wishing to participate in the loan portion of HPSAP must establish a Federal Capital Contribution Fund for making loans to eligible students. These

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[1]As of April 25, 1974, figures for academic year 1972-73 were not available from HEW. During this period 283 schools participated in HPSAP.

schools are also required to contribute 10 percent of the total moneys placed in the fund; HEW contributes the remaining 90 percent. Principal and interest collected on loans are returned to the fund to be reloaned to other students.

In 1968 and 1969 health professions schools could also participate in the loan program by establishing a Federal Capital Loan Fund. No contributions from the schools were required for participation in this Fund; advances of funds were made to the schools on promissory notes, and collections of principal and interest from student loans were remitted to HEW in payment of the notes.

Federal grants for the health professions student scholarship program are awarded annually to participating schools. A school receives either $3,000 multiplied by the number of its full-time students who are from low-income families, or $3,000 multiplied by one-tenth of the total school enrollment, whichever is greater. NIH developed the following schedule of low family incomes which schools can use for requesting scholarship funds for school year 1972-73.

Size of family	Income (before taxes)
2	$3,600
3	4,200
4	5,400
5	6,400
6	7,200
7 or more	8,800

The schools may transfer up to 20 percent of the total amount of scholarship funds they receive in any fiscal year to a Federal Capital Contribution Fund and may make similar transfers from the Federal Capital Contribution Fund to the scholarship fund. However, no transfers can be made to or from a Federal Capital Loan Fund.

The law prescribes that financial assistance may be provided only to health professions students (dentistry, medicine, optometry, osteopathy, pharmacy, podiatry, and veterinary) who need aid to pursue a full-time course of study.

A school is given flexibility in providing a student with loans and/or scholarships; but to qualify for scholarship assistance, a student must have exceptional financial need, be nationals of the United States or intend to become permanent residents, and be enrolled in or accepted by the school as full-time students.

The regulations make the schools responsible for determining a student's need. In determining need, the schools are to consider the costs reasonably necessary for attending the school, the financial resources available to the student, and the total financial situation of the student and his parents.

According to NIH information published in October 1973, medical students' estimated annual expenses during school year 1970-71 averaged $5,500, and dental students' annual expenses averaged $6,200. A medical student's estimated expenses ranged from $4,300 for a single student to $7,800 for a married student with two or more children, and a dental student's, from $4,600 to $8,100.

CHAPTER 2

PROBLEMS IN DETERMINING FINANCIAL NEED

NIH has not adequately instructed schools on how to determine student need. As a result, schools' methods in determining such need are often divergent and inconsistent. More specific criteria are needed for determining the (1) type of student expenses which are includable, (2) amount of expenses allowable, (3) student's resources, and (4) circumstances under which a student may be properly considered self-supporting.

Increased emphasis on documenting the basis for awards is also required to insure that HPSAP funds are properly and equitably distributed.

DETERMINING NEED

Of the 13 schools we reviewed, 9 subscribed to the College Scholarship Service to assist them in determining student need. Colleges and universities that were members of the College Entrance Examination Board[1] inaugurated the College Scholarship Service in 1954 to provide a standardized method of determining financial need. The College Scholarship Service measures family financial strength in relation to anticipated educational expenses and computes the amount of financial support that parents can contribute to a student's education.

The College Scholarship Service defines financial need as the difference between the cost of an education at a particular institution and the amount of money a student and his family can reasonably make available from their income and assets to meet the expenses of that education. At the schools we reviewed, students' costs were usually estimated on the basis of a budget which included tuition, fees, books, supplies, and such living expenses as food, rent, transportation, and entertainment. The student's resources were usually determined from a financial statement prepared by the student and/or his parents and included such

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[1]A nonprofit membership organization that provides tests and other education services for schools and colleges.

items as savings, earnings from summer and part-time employment, spouses' earnings, scholarships, loans or gifts from other sources, and support from the student's parents.

Estimating student expenses

NIH instructions state that the costs to be allowed in computing a student's need are those "which directly affect the student's ability to attend the school on a full time basis." Of the 13 schools we reviewed, 9 had developed standard budgets for estimating costs necessary for a student to attend the school. Although these budgets were not always adhered to, they usually considered whether the student was a resident or nonresident of the State, his marital status, and number of children. The remaining schools used the expenses estimated by the student in his aid application.

Officials at some schools using standard budgets said without standard budgets those students who chose a higher standard of living would receive more aid than the students who lived more modestly. They also stated that the amount of aid funds available were not sufficient to support students at more than a modest level. Officials at schools without standard budgets indicated that (1) they did not have sufficient staff resources and time to develop budgets and (2) standard budgets might be too rigid and preclude student aid officers from judging individual cases.

NIH has not specified how to determine whether amounts claimed for allowable types of expenses are reasonable and the types of expenses which are properly includable in school budgets. As a result, we found that expenses allowed by the schools were sometimes questionable and at other times, proper but excessive. Below are examples of questionable expenses.

--At the Baylor school of medicine a student was allowed a $1,000 health profession loan[1] to pay for his girl friend's abortion.

[1]After we discussed this loan with school officials, it was canceled. The school awarded the student a replacement loan from a private source.

--At the Illinois dental school some students' budgets included items such as, contributions of up to $250 to community organizations, life insurance of up to $369, $1,100 to repay a loan from parents, and $600 for feeding a spouse's horses.

--At the University of California, Los Angeles (UCLA), medical school, a student was allowed a $1,000 loan to partly pay for a summer European tour. Three other students received loans from $400 to $1,000 shortly before graduation to defray costs of moving to new locations or setting up practice.

Following are examples of proper but excessive expenses.

--At the University of Illinois dental school, the budgets of 30 out of 56 students sampled included amounts for books, equipment, and supplies that were from $300 to $1,500 more than the actual costs; 27 of the 30 ranged from $300 to $700.

--One dental student at Illinois included in his school year budget $850 for clothing, laundry, and cleaning (about $95 a month) and $390 for toiletries and personal grooming (about $43 a month); another included about $225 a month for automobile maintenance and transportation.

--At the University of Southern California (USC) medical school, one student was allowed a budget for the school year of $18,680, which included about $360 a month for housing and about $300 a month for transportation. The standard student budget at that school provides $125 a month for housing and $75 a month for transportation.

--At Howard, one dental student was allowed a budget of $11,219 which included--in addition to allowances for tuition, books, instruments, food, lodging, clothing, and travel--$250 for personal expenses, $301 for insurance, $1,740 miscellaneous, and $2,208 (about $250 per month) for automobile operation; another student with a $13,191 budget was allowed $6,523 for unexplained "miscellaneous" expenses. The chairman of the financial aid committee could not explain what the miscellaneous expenses represented.

Types of expenses allowed by one school might be disallowed by another school. For example:

--At Emory a medical student was allowed $790 for airplane and automobile trips for internship interviews; UCLA does not allow these types of expenses.

--The Baylor school of medicine bases increased living expenses on the number of children in the student's family, whereas the school of dentistry does not.

Student resources

NIH's Manual of Information, Policies, and Procedures, states that the system used for determining need must:

--Be based on the total financial situation of the student and his parents; however, a student's need may be determined on the basis that he is self-supporting, if justified.

--Yield detailed information on both the parents' and the student's current income, assets, and other resources.

--Provide auditable documentation of the basis for approval or disapproval of any student application for assistance.

The manual does not specify, however, how parents' contributions are to be computed, or under what circumstances the student is to be considered self-supporting. As a result, schools varied on the amounts parents were expected to contribute to a student's support and under what circumstances a student was considered self-supporting. Also, the schools' treatment of resources was not adequately documented.

Variances in expected parental contributions

Of the 13 schools we reviewed, 10 (9 College Scholarship Service subscribers and 1 nonsubscriber) used, in varying degrees, the College Scholarship Service's system of measuring family financial strength. For example, USC[1] and

[1]Names of Universities only are indicated when both the medical and the dental schools follow the same procedures.

the UCLA medical school[1] used the parental contribution as computed by the Service while the University of Illinois used it only as a guide. Emory, although a subscriber, did not use the contribution computed by the Service unless the student indicated his parents were willing to provide support. The Georgetown dental school used the expected parental contribution reported by the student on the College Scholarship Service application.

Other schools in our review used their own systems of determining expected parental contributions. The Georgetown medical school had used the service but discontinued it for the 1972-73 school year in favor of its own system. The Baylor medical school did not subscribe to the service but used its tables in computing expected parental contribution. The Howard medical school did not compute this expected contribution but used whatever the student reported, and the dental school did not consider parental contributions at all.

Because of the different systems in use, parents of similar financial and family circumstances, with children in different schools, could be required to contribute widely differing amounts. For example, the following table shows the parental contributions some of the schools expected for selected single students.

	Student A USC medical school	Student B Howard medical school	Student C USC dental school	Student D Georgetown dental school
Number of dependent children in family, including student	3	3	2	2
Parental income	$ 9,620	$11,136	$11,000	$11,150
Parental net assets	28,600	24,000	25,400	27,000
Expected parental contribution	1,810	200	1,580	770

[1]The UCLA dental school was not included in our review.

The Georgetown medical school considered parents' income in determining the parental contribution but considered net assets only if they exceeded $50,000. In some cases the school did not use this criterion. For example:

--Student A reported parental net assets of $145,000 which were disregarded because a large portion of the assets were farm holdings.

--Student B reported parental net assets of $60,615 which were disregarded, according to the financial aid administrator, because that amount was not significantly greater than $50,000.

Self-supporting students.

Whether a student will receive aid under HPSAP often depends on whether he is considered dependent or self-supporting. Need determinations for self-supporting students usually do not consider the parents' income or assets, whereas dependent students' need determinations consider the resources of both the student and his parents. Students who have been declared independent, therefore, often receive aid they would not have received if their parents' assets and income had been considered.

The schools we reviewed had differing methods for distinguishing between self-supporting and dependent students. The UCLA medical school, for example, considered students 25 years of age or under to be dependent unless it could be demonstrated that the student was not receiving parental support and was not being claimed as a dependent by the parents for income tax purposes. USC treated as independent those students who submitted notarized affidavits of nonsupport from their parents. The University of Illinois considered students who provided a notarized statement of parental nonsupport, veterans, and students who had been married more than 2 years, or who have children, to be independent. Three other schools--Georgetown dental school, Emory dental school, and Emory medical school--made subjective decisions on each case.

The College Scholarship Service lists among its principles of student financial aid that

--parents are expected to contribute according to their means,

--financial aid should be offered only after family resources are determined insufficient to meet the student's educational expenses, and

--the amount of aid should not exceed the amount needed to meet the difference between the student's total educational expenses and the family's resources.

The student aid officer at Baylor dental school indicated that parental contributions should be based on the family's ability, rather than their willingness, to contribute. He indicated that a student should be required to seek assistance from his own family before turning to the Government. The Georgetown medical school includes a parental contribution, based on the parents' ability, in computing each student's need. The aid officer at the Georgetown medical school stated that it is not equitable to base the requirement for parental assistance on the student's age or marital status. He indicated that the parents' obligation should be just as great for a student who waits until he is older to attend medical school as it is for a younger student. He also believed the parents' obligation should not be relieved just because the student decides to get married.

Other schools did not always determine parental contributions on the ability of the student's family to contribute to his education. For instance:

--A single fourth-year UCLA medical student requested to be treated self-supporting: "I am 25 years old and I no longer feel it's my parents' responsibility to support me * * *." This student's parents had an annual income of $24,500 and net assets of about $26,000. The College Scholarship Service had computed a parental contribution of $6,020 which the school disregarded in determining the student's need.

--A self-supporting medical student at the University of Illinois received a $2,100 health professions loan and a $900 health professions scholarship. In a document to the school the student indicated her parents had a net income, after taxes, of $11,000 a year, and net assets totaling about $100,000 including over $23,000 in cash.

--A UCLA medical student received HPSAP loans totaling $1,600 and scholarships totaling $800 because he was considered self-supporting; he was 26 years old, married, and had two children. His financial statement showed that his father received income of about $31,000 per year and owned net assets of almost $820,000, including $7,000 in cash and more than $450,000 in common stock. The school's estimate of expenses for this student was $6,710. The College Scholarship Service analysis showed an expected parental contribution of $12,050 which would have exceeded total student expenses.

Treatment of student resources not adequately documented

Because individual cases were not adequately documented, we could not determine in some cases which resources schools had considered in computing students' needs; the adjustments, if any, made to the resources; or whether students met the schools' self-supporting criteria. In many of the undocumented cases, the schools' explanations seemed inadequate.

At the University of Illinois, Emory University, and Baylor College of Medicine, most of the cases we examined were not documented to show the basis for the amount of the award. The associate dean of student affairs at the University of Illinois said he mentally adjusted the student's financial data in determining how much aid to award. At the Baylor College of Medicine, the loan and scholarship committee determined subjectively any support expected from parental assets; these determinations were not documented for any of the approved awards we reviewed.

At the Baylor dental school, the student aid officer adjusts student resources at his discretion but does not document the bases for the adjustments. In one instance the College Scholarship Service had computed a parental contribution of $2,500 which the student aid officer reduced to $1,300. He said he made the adjustment because the student's parents had another child attending college. However, the College Scholarship Service computations had already been adjusted to account for the second child attending college.

Officials of the Howard medical school were not certain why the school disregarded certain resources (ranging from $200 to $10,350) which some students reported. They said the individual who determined the need must have intended to disregard student resources and base need on expenses only.

The financial aid committee chairman at the Howard medical school said he disregards resources reported by freshman students (parental contributions, spouses earnings, etc.) if he thinks the students might not actually obtain those resources. He said he also disregards any financial aid from outside sources reported by freshmen because (1) such aid is usually what the student anticipates receiving, not what the student has already obtained, and (2) the sources usually notify the school when they make awards to students. However, the student often fails to identify the source of the loans or scholarships on his application for aid, and not all sources notify the school of their awards. (See ch. 3.)

At the Howard medical school, 50 of the 59 students whose files we reviewed claimed to be self-supporting, but only 26 of these had parental oaths of nonsupport on file as required by the school. At the UCLA medical school, 29 students of the 52 sampled were considered independent, but 9 did not have the certification on file required by the school. Similarly, at USC 12 of 71 independent students in our samples had no affidavits on file verifying their status.

At the Baylor medical school one student had been considered "partially" independent of parental support. The chairman of the loan and scholarship committee said that, although the parents were not contributing the full amount expected, intangible factors, such as another child in medical school, justified treating the student as partially independent. The student's application showed parental taxable income of about $22,000 and net assets of about $60,000, not including their home. There was no letter or statement in the files to substantiate his independence.

At Emory a medical student was treated as independent because he said he could not ask his parents for help. His father's income was about $27,500 and the College Scholarship Service had computed an expected parental contribution of $7,380. There was no written evidence of the parents' refusal to support the student. He was awarded a $1,000 scholarship and a $2,000 loan.

CONCLUSIONS

The lack of specific NIH program guidance to participating schools has resulted in widely differing methods and criteria in determining student need. Because schools' approaches varied and were not always sound or properly administered, HPSAP funds were not always used for the types of student expenses which, in our opinion, directly affect the ability of a student to attend a school full time. In addition, the types of expenses which did appear proper were often excessive. Also, because of the different systems in use, the support expected from parents could vary depending on which school a student chose to attend.

HPSAP should have guidelines to insure that students' needs are appropriately determined and to provide for a degree of uniformity among and within schools concerning

--the type of student expenses which should be properly includable,

--the methods for determining the amount of expenses allowable,

--the resources to be considered,

--the circumstances under which a student may properly be considered self-supporting, and

--the verification of student resources.

Increased emphasis on documenting the basis for awards is also required to insure that HPSAP funds are properly and equitably distributed.

CHAPTER 3

PROBLEMS IN AWARDING AID

Criteria has not been provided to the schools to carry out the provisions of the HPSAP legislation for awarding loans to students with need and scholarships to students with exceptional financial need. The schools in our review had adopted a variety of methods and criteria for awarding scholarships, and some had not consistently applied the criteria adopted. Decisions to award scholarships sometimes appeared arbitrary and were often inconsistent, both between schools and within schools, and did not necessarily benefit students with the greatest computed need or from the lowest income families.

Aid is available to health professions students from a number of sources, not all of which are subject to control or coordination by the schools. The schools in our review were often unaware, when awarding aid from HPSAP, that the student had received or applied for aid from other sources, including other Federal programs, such as federally insured loans. Consequently, students' aid sometimes exceeded their computed needs.

IMPROVED CRITERIA NEEDED FOR AWARDING SCHOLARSHIPS

The HPSAP legislation does not provide criteria for distinguishing "exceptional financial need" from "need." HEW regulations delegate this responsibility to the schools, allowing them to give priority to students from economically, culturally, or educationally deprived backgrounds. HEW regulations and NIH instructions specify only that determinations of need and exceptional financial need must consider the financial resources available to the student and the costs reasonably necessary for his attendance at the school.

Public Law 89-290 made scholarships to students from low-income families a part of HPSAP in 1965. HEW regulations implementing the 1965 law did not define "low-income families." The regulations said scholarships were to be awarded to students "from families whose income is such that the student, without such financial assistance, would be unable to pursue

a full-time course of study at the school." The school was responsible for determining whether a student was from a low-income family.

The Health Manpower Act of 1968 redefined students eligible for scholarship assistance as "students of exceptional financial need who need such assistance to pursue a course of study." The Senate and House reports stated that this change would make scholarship assistance available to students in the health professions on about the same basis as are educational opportunity grants--established under title IV of the Higher Education Act of 1965 (20 U.S.C. 1061-1079)--to undergraduate students in almost all fields. HEW guidelines for the Educational Opportunity Grant program defined "exceptionally needy students" as those whose families' adjusted gross incomes are not more than $9,000 a year and who could not contribute more than $625 a year to the student's educational expenses as determined by an approved needs-analysis system. The HEW regulation did not adopt this or similar criteria for the HPSAP.

In 1971 the Congress enacted the Comprehensive Health Manpower Training Act of 1971 (Public Law 92-157). In passing the legislation, the Congress considered redefining scholarship eligibility. The House bill provided that students who received scholarships after July 1, 1972, were to be students of exceptional financial need who were from low-income backgrounds. The Senate amendment to the bill provided that scholarships were to be awarded only to students of exceptional need and to students from low-income or economically disadvantaged families. The House and Senate conference substitute, however, omitted specific reference to low-income or disadvantaged families and provided that students who received scholarships would be those with exceptional financial need.

In 1972 the HEW Assistant Secretary for Planning and Evaluation proposed that HEW establish regulations requiring scholarships to be awarded first to students from the lowest income families and that the maximum family income for scholarship eligibility be established at $10,000. The Director of NIH responded that this would unnecessarily recentralize decisionmaking and limit the ability of institutional financial aid officers to make the most effective use of the funds available to them. He believed that, before awarding scholarships, a

student's need should be carefully analyzed, including his resources and the costs necessary to attend the school.

Commenting on the proposed regulations in August 1972, the HEW General Counsel took the position that the language substituted in the 1971 act during the House and Senate conference indicated that the Congress recognized a difference between exceptional financial need and low family income. He stated that, although not prohibited by the statutory language, defining exceptional financial need solely in terms of family income was not the intent of the Congress. The General Counsel suggested that a study be undertaken of the feasibility of deriving a formula to measure need which would be used to determine student eligibility for scholarships. NIH correspondence indicated exceptional financial need might be defined in terms of the amount of a student's need and/or his family income background. No further instructions or criteria have been issued to the schools.

Examples of different criteria and methods for awarding scholarships

In the absence of NIH criteria for distinguishing exceptional financial need (required for scholarship awards) from need (applicable to loan awards), participating schools have taken a variety of approaches to awarding scholarship aid.

The University of Illinois has interpreted exceptionally needy students to include minority students, married students, and students whose fathers are deceased, retired, or are near retirement; the UCLA and Baylor medical schools have not specifically defined exceptional financial need but give priority in awarding scholarships to students from families with annual incomes under $15,000.

The Baylor and USC dental schools have developed methods for distributing available scholarship funds on the basis of computed need levels. At the Baylor dental school, for example, the student aid officer identifies scholarship needs each year on the basis of the amount of scholarship money available. The need level established for school year 1972-73 was $3,000; students whose needs exceeded $3,000 received scholarships in the amount of the excess. They obtained loans for needs of $3,000 or less.

USC dental school allocated health professions funds in 1972-73 so that students with computed needs under $1,000 received no scholarship funds; freshmen and sophomores with computed needs between $1,000 and $3,500 received a $400 scholarship and a $900 loan; juniors and seniors with computed needs between $1,000 and $3,500 received a $300 scholarship and a $500 loan; freshmen and sophomores with computed needs over $3,500 received a $600 scholarship and a $1,000 loan; and juniors and seniors with computed needs over $3,500 received a $500 scholarship and an $800 loan.

USC officials commented that juniors and seniors were awarded less HPSAP aid because they were closer to graduation and should have less difficulty in obtaining aid from other sources. The UCLA medical school also gave senior students less HPSAP scholarship money and more loans, because the seniors would be able to repay loans sooner than other students. The USC medical school did not give senior students any HPSAP aid.

Of the available HPSAP money at the Georgetown dental school, one-eighth is distributed to the freshman class, two-eighths each to the sophomore and junior classes, and three-eighths to the senior class. A faculty advisor for each class distributes the money among the students. In the sophomore, junior, and senior classes, school officials award scholarships judgmentally. The scholarship money allocated to the freshman class during the 1972-73 school year was divided equally among those applying. School officials said seniors are allocated larger scholarships because unexpected expenses are more likely to occur in the senior year.

At the Howard dental school, available HPSAP scholarship money is first distributed to sophomores, juniors, and seniors who received scholarships in prior years. These students are usually awarded at least as much scholarship assistance as they received in their freshman year. Any remaining funds are then distributed to freshmen. The financial aid committee judgmentally decides which freshmen will be awarded scholarships and how much they will receive. Awards are made until funds are exhausted.

Emory University officials said they had not defined exceptional financial need nor established criteria for deciding which students should receive scholarships and which should receive loans. Emory requires students to submit separate applications, for loans and scholarships, and awards scholarships only to those students who apply for them.

Scholarships not always awarded to students with greatest need

Because the schools included in our review were not sure about the definition of "exceptional financial need" and because the systems and criteria adopted for distributing scholarship funds were often imprecise and ambiguous, health professions scholarships were not always awarded to students with the greatest computed need.

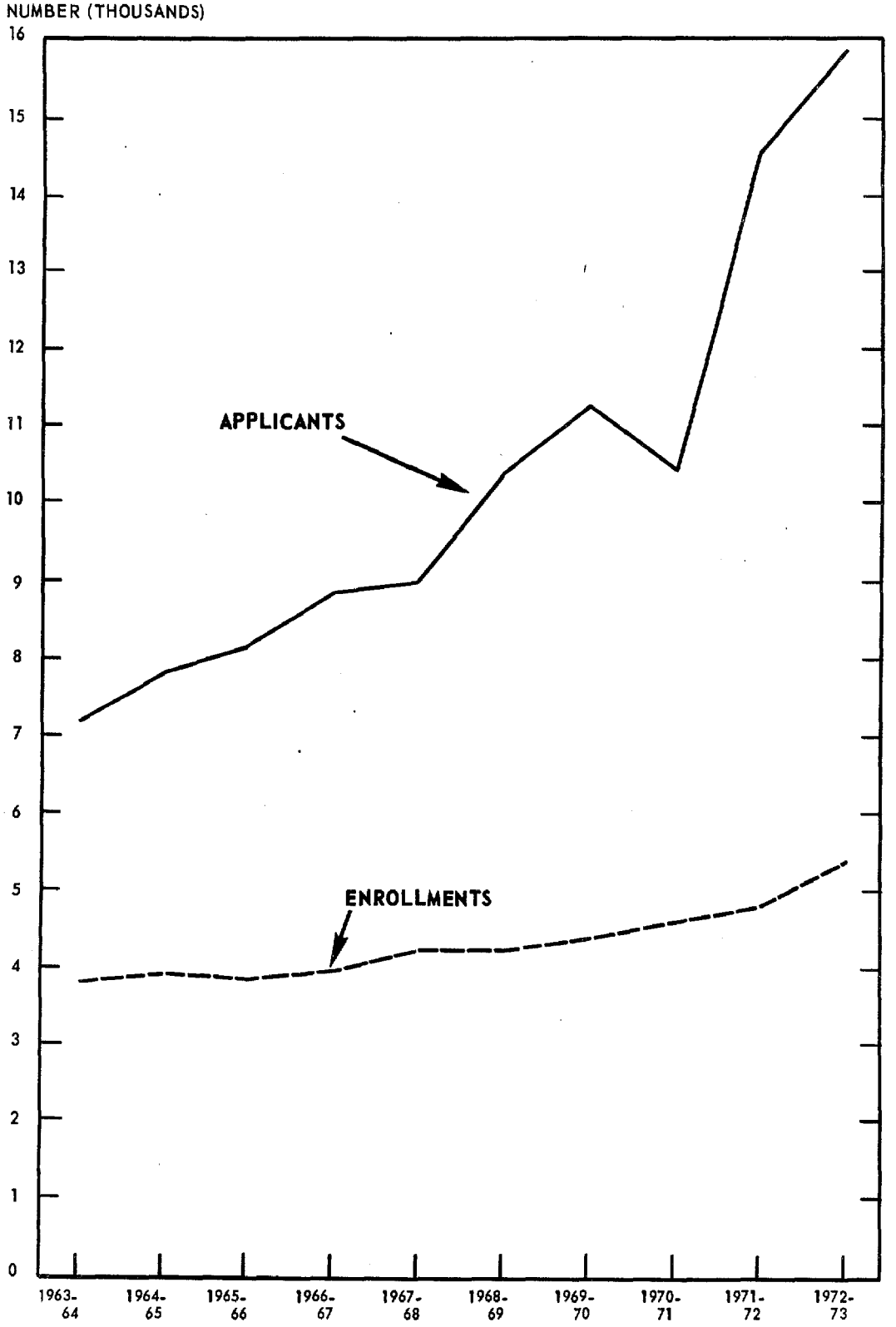
Freshmen who were awarded scholarships in school year 1972-73 at the Georgetown dental school each received a $200 scholarship even though their individual needs, according to the College Scholarship Service, ranged from zero to $8,460.

At the Howard University dental school one student from our sample of those receiving scholarships indicated that he expected to incur costs of $6,872 and had $500 in resources; he was awarded a scholarship of $1,450. Another student indicated that he expected to incur costs of $6,388 and that he had resources amounting to $11,600; he was awarded a scholarship of $2,500.

At the USC school of medicine, four students with needs from $7,000 to $8,100 each received a $500 scholarship. Two other students with needs of $3,900 and $4,800 received scholarships of $1,800 and $1,400, respectively. At the Baylor medical school one student needing $6,400 received a $1,500 health profession scholarship, whereas another student needing $3,865 received a $3,500 health professions scholarship.

The Emory medical school awards scholarships only to those students who apply for scholarships instead of loans. All applicants are ranked from 1 to 5 according to scholastic achievement and need (a ranking of 1 being the highest and 5 being the lowest). The scholastic achievement ranking and the need ranking are then averaged for an overall rating. Students with the highest overall rating are usually given the most

According to the American Dental Association, similar increases have taken place at dental schools throughout the Nation, as shown below.



The percent of applicants accepted has decreased over the 10-year period. In school year 1963-64, medical schools accepted 48.5 percent of the applicants, as new entrants, and in school year 1972-73, 36.9 percent. Correspondingly, in school year 1963-64, dental schools accepted 52.7 percent of the applicants, and in school year 1972-73 they accepted 33.7 percent.

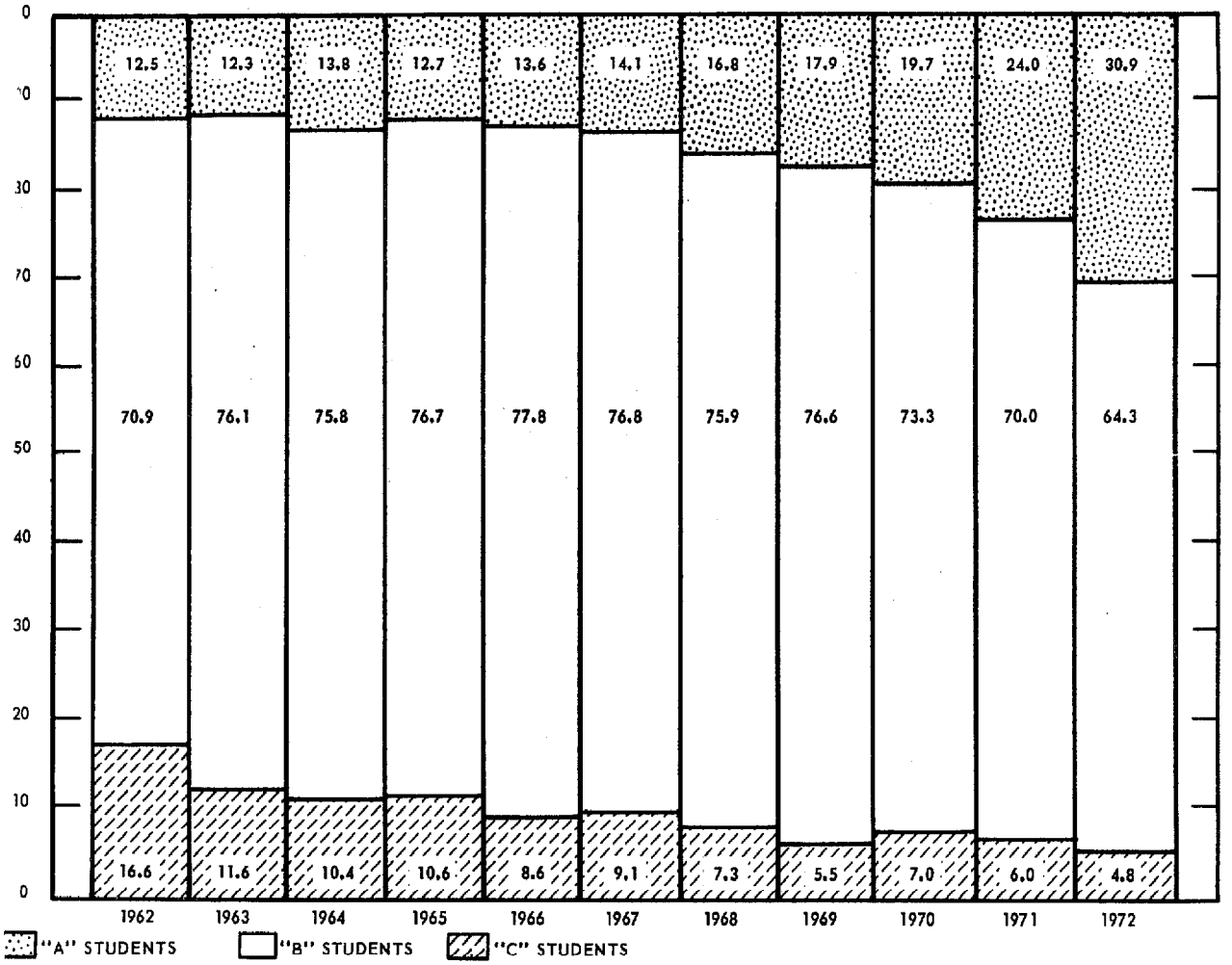
At any given school the applicant rate is much higher than the national statistics because students seeking admission usually apply to more than one school. For example, the applications for first year openings for school year 1972-73 were:

	Medical schools			Dental schools		
	Applicants	Admissions	Percent accepted	Applicants	Admissions	Percent accepted
Baylor	3,270	168	5.1	817	130	15.9
Emory	3,003	104	3.5	913	103	11.3
Georgetown	7,014	205	2.9	1,592	140	8.8
Howard	3,038	134	4.4	[a]500	97	19.4
UCLA	3,854	144	3.7	(b)	-	-
Illinois	1,627	280	17.2	515	130	25.2
USC	3,848	112	2.9	[a]1,500	120	8.0

[a]Estimated.

[b]The UCLA dental school was not included.

Since 1963 the quality of applicants to medical and dental schools nationally has also increased. For example, applicants' mean scores on the Medical College Admissions Test for school year 1972-73 were about 5.3 percent higher than the scores in school year 1963-64. According to the American Medical Association, college grade point averages of entering classes between 1962 and 1972 have improved; a larger percentage of the entering classes are "A" students and a smaller percentage are "C" students as shown in the following chart.



Source: Information extracted from The Journal of the American Medical Association, November 19, 1973, with the permission of the American Medical Association.

Officials at Georgetown medical school estimated that the grade point average for students who entered in school year 1963-64 had increased from 2.93 (on a scale of 4) to 3.32 for those who entered in school year 1972-73. The grade point average of students entering UCLA medical school in school year 1972-73 was 3.51.

Dental schools have had similar increases in quality students. Academic averages on the Dental Aptitude Test have increased as have predental grade point averages.

Officials at most of the schools we reviewed did not attribute the increases to the number or quality of applicants to HPSAP. Some of the officials pointed out that medicine and dentistry were enjoying great popularity because they are humanitarian professions and provide opportunities for high earnings and security.

For example, an official at the University of Illinois attributed the increased demand for admission to the following factors:

--Schools are employing counselors to recruit students from particular social environments.

--The employment outlook is more optimistic in medicine and dentistry than in other science fields.

--The profession provides social prestige and lucrative economic rewards.

--The general increase in population correspondingly increases the demand for admissions to medical and dental schools.

Officials at Howard believed that the increased demand was the result of a combination of population increases, recruiting programs, and increased awareness of the opportunities of these professions.

HPSAP NOT AN IMPORTANT FACTOR IN STUDENTS' DECISIONS TO ENTER MEDICINE OR DENTISTRY

The availability of HPSAP aid apparently has had little influence on students' career selection decisions because they either were unaware of it at the time they made their decision or they would have entered medical or dental school even if HPSAP aid had not been available.

We sent questionnaires to 719 students who had received HPSAP loans or scholarships in school year 1972-73, and about 88 percent of the 635 who responded said they did not know about HPSAP until they had applied for admission to the medical or dental school or until after they were already enrolled. Only 7 of the 75 students who were aware of the program indicated they would not have entered school without HPSAP.

MOST STUDENTS BENEFITING FROM PROGRAM NOT FROM LOW-INCOME FAMILIES

About 63 percent of the students we sampled who had received HPSAP aid were from families with incomes above $8,800, the highest level considered to be low income. (See

p. 5.) The average parental income reported was about $11,500. Students reported parental incomes as high as $49,000.

Of the 719 students in our samples, about 40 percent of those who reported parental assets said their parents had net assets exceeding $20,000. Net parental assets up to $820,000 were reported.

We asked graduates who had received HPSAP loans (see app. X) if they thought they would have been able to complete their medical or dental studies without HPSAP assistance. Of the 305 graduates who responded to the question, 167 said they would. The American Medical Association told us that information it compiled for the 1964-68 school years showed that only 26 of 2,654 students who withdrew from medical school--about 5.9 percent of all enrollees--did so for financial reasons. Of these, 10 also cited another reason.

Because of the possibility that the situation presented by the American Medical Association data may have been influenced somewhat by the availability of HPSAP funds during this period, we checked into the schools' experiences before the advent of the program and obtained data from 11 of the 13 schools reviewed. Officials at nine schools indicated that the number of medical and dental students who withdrew for financial reasons had been about the same before HPSAP began. Officials at the other two schools said they had no such information.

Although several of the schools we reviewed had a program for recruiting minority students, none were specifically directed to students from low-income backgrounds. Some school officials felt that minority students, for the large part, represented students from low-income families and that efforts to attract them were, in effect, efforts to attract financially disadvantaged students. However, these officials also commented that increases in minority enrollments were primarily attributable to recruiting efforts rather than HPSAP.

At the Georgetown school of dentistry, if an applicant needs aid it will lessen his chance for admission.

School officials indicated that, if an applicant has superior academic ability, the fact that he is economically disadvantaged will not hinder his chances for admission. But,

if an applicant has only average academic ability, and states he needs $3,000 to $6,000 at the outset, the school will reject his application because it cannot give him that much aid, and without the aid it believes he would fail.

CONCLUSIONS

Although conclusive evidence to support the programs' impact is not available, HPSAP does not appear to have had a significant impact on increasing the number of medical and dental graduates in the United States. Over twice as many students are demanding admission to medical and dental schools as the schools can admit; increasing the number of applicants will not increase the ability of these schools to admit students. Further, HPSAP apparently has had no significant impact on increasing the number of applicants. The schools have attributed increases to other factors.

HPSAP aid is being given to students who would probably attend medical or dental schools even if such aid was not available. To this extent, it does not appear to be effective in attracting students from disadvantaged family backgrounds who could not otherwise afford to attend medical or dental schools. The program could be more effective in increasing the number of disadvantaged students in medical and dental schools if it were limited to such students.

CHAPTER 5

INFLUENCE OF LOAN-FORGIVENESS PROVISIONS ON PHYSICIANS' AND DENTISTS' DECISIONS TO PRACTICE IN SHORTAGE AREAS

A number of areas in the country have shortages of physicians and dentists. Portions of loans from HPSAP can be canceled if, upon graduation, the recipient practices in a designated shortage area for a specified time. The cancellation provisions, however, have had negligible impact on medical and dental school graduates' decisions on the location of their practices because

--most of the students have not been made aware of the provisions before graduation and

--the provisions have not been considered sufficiently attractive to offset the undesirable aspects.

More liberal loan cancellation provisions were enacted in 1971 but their impact is unknown because they did not become operative until fiscal year 1974.

LOAN CANCELLATION PROVISIONS

The Health Professions Educational Assistance Amendments of 1965 initially authorized the cancellation of loans for shortage area practice. (See p. 1.)

The amendments provided that borrowers who practiced in areas certified by the State health authority as having a shortage of the borrowers' professional skills could have up to 50 percent of their health professions loans forgiven at a rate of 10 percent a year of practice. The Allied Health Professions Personnel Training Act of 1966 (Public Law 89-751) authorized, in addition to the cancellation provisions, that physicians, dentists, and optometrists practicing in poor rural areas could have their health professions loans forgiven at a rate of 15 percent a year, up to a total of 100 percent of such loans.

Under both provisions, the appropriate State health authority determined the student's eligibility for cancellation. Upon completion of each 12 consecutive months of eligible practice, the State health authority certified to the school that the borrower had met all requirements for entitlement to cancellation. The school determined the amount of principal and interest to be canceled and credited it to the borrower's account.

In 1971 the Comprehensive Health Manpower Training Act replaced these provisions with new authority intended to provide greater incentives. Under the new provisions, the Secretary of HEW would repay portions of all educational loans obtained by a student in exchange for an agreement by that student to practice for at least 2 years in a designated shortage area. Upon completion of the first year of practice, the Secretary would repay 30 percent of the principal and the interest on each loan which was outstanding on the date the individual began practice. An additional 30 percent would be paid at the end of the second year of practice, and, if the individual chose to practice in the area for a third year, another 25 percent of each loan would be paid. Initial funding of $400,000 was appropriated for the new provisions in fiscal year 1974.

Student awareness of provisions

To determine how many borrowers were aware of the loan cancellation provisions, we sent questionnaires to 30 randomly selected former students whose loans were being repaid or were due for repayment, from each of the 13 schools we reviewed. The questionnaire included the question:

> "Have you been advised that portions of your loan could be canceled if you practiced in an area identified as having a shortage of physicians or dentists?"

Of the 315 who responded, 224 answered no to this question, 87 said yes, and 4 did not answer the question. Of those who answered yes, 29 said they did not learn of the cancellation provisions until after they had graduated.

The 13 schools had various methods for informing borrowers of the cancellation provisions.

--Nine of the schools indicated their procedure was to conduct individual exit interviews with departing students.

--Howard did not conduct exit interviews but sent exit questionnaires to seniors before their graduation.

--Georgetown conducted a general meeting to which it invited all seniors who received aid.

In many cases though, the method adopted was not thoroughly implemented. For example:

--Emory had no record of an exit interview for 25 out of 60 former students whose loan files we reviewed.

--Illinois had advised only 28 of 60 sampled borrowers of the cancellation provisions.

--Howard had no exit questionnaires on file for 13 of the 60 graduates in our sample.

--At the Georgetown medical school only 34 of the 71 graduating seniors who received HPSAP loans attended the exit meeting.

Incentive not sufficiently attractive to offset other considerations

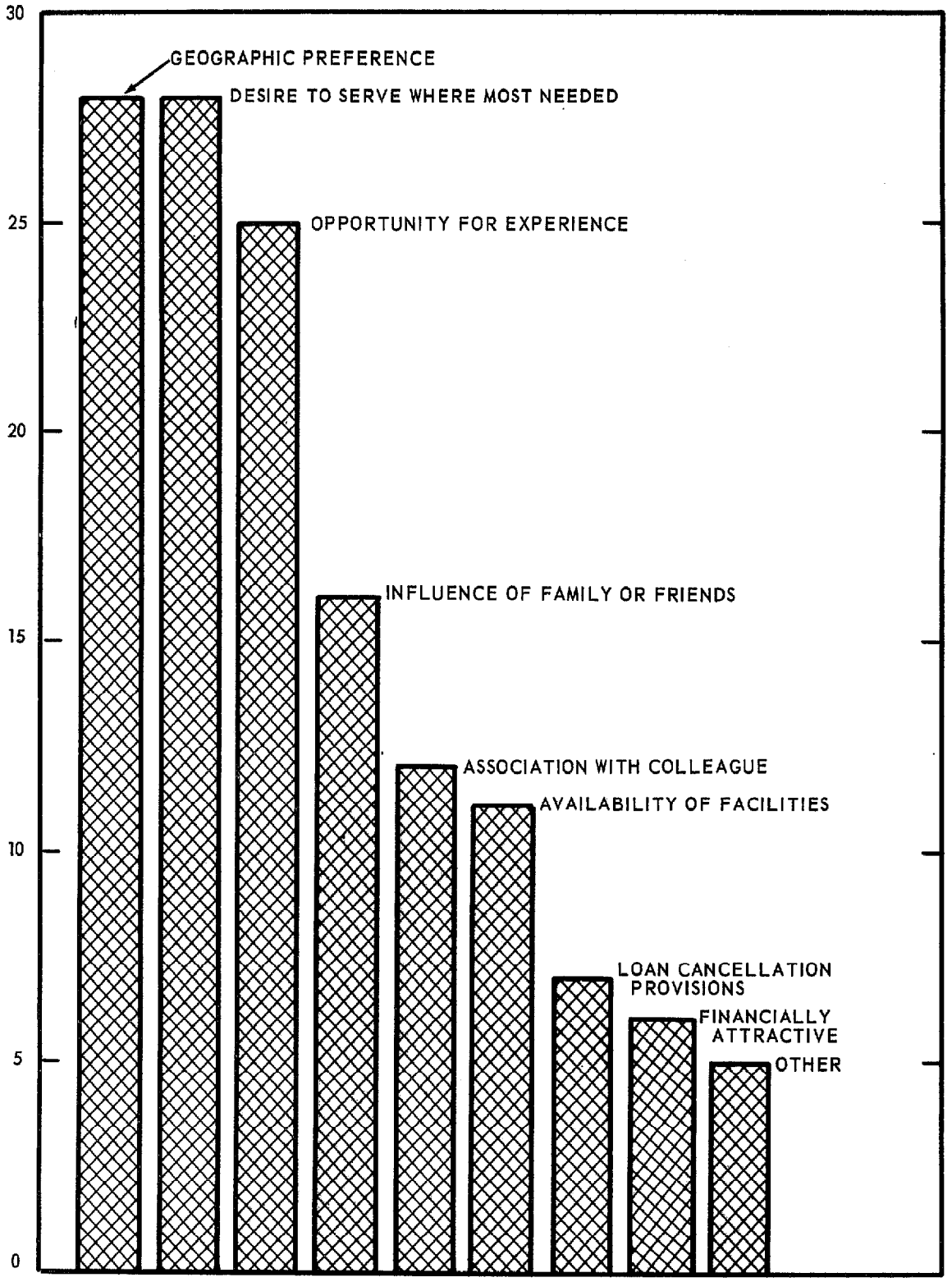
We estimate that about 30,000 of the approximately 93,800 medical and dental students who graduated from U.S. schools from 1965 to 1972 received loans from HPSAP. As of October 1973 only 86 physicians and 133 dentists had obtained cancellation of a portion of their loan for practicing in a designated shortage area.

Most of those who applied for loan cancellations apparently were not motivated to locate in a shortage area by the loan cancellation provisions. We sent questionnaires to the 183 physicians and dentists who had obtained cancellations as of May 1973. (See app. XI.)

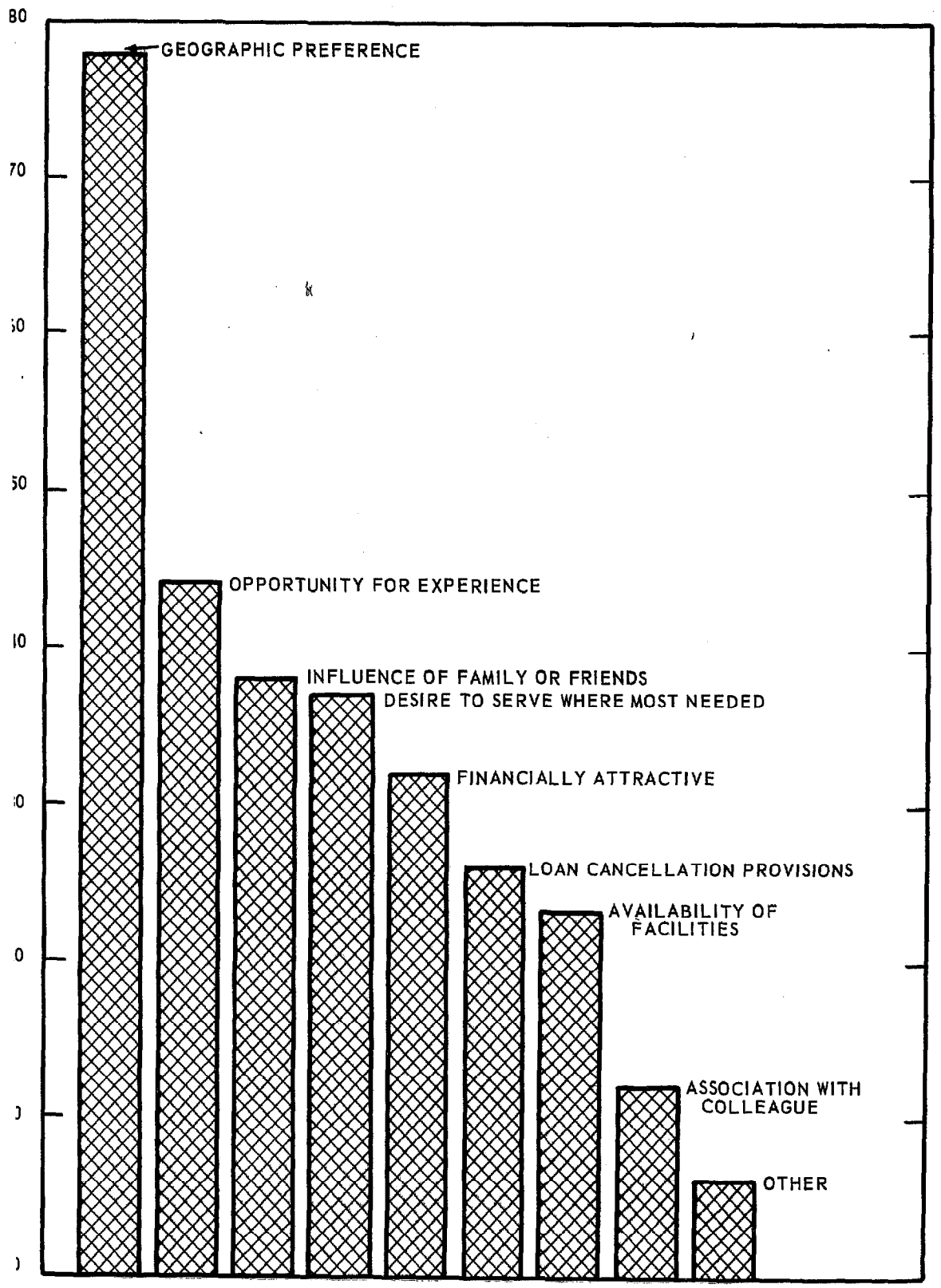
The questionnaire asked whether they would have chosen the same location for practice even if loan cancellation provisions had not been available to them; 137, or 82 percent, of the 167 who responded said they would have.

The questionnaire also asked the respondents to rank from 1 to 9, in order of importance, the factors which influenced them in selecting their practice location. Their responses are summarized in appendixes III and IV. To show the relative importance of each of the influencing factors, we compared the number of physicians and dentists who ranked each factor first, second, or third in importance. Those comparisons are shown in the following charts.

NUMBER OF RESPONSES INDICATING MOST IMPORTANT FACTORS INFLUENCING PHYSICIANS TO LOCATE IN SHORTAGE AREAS



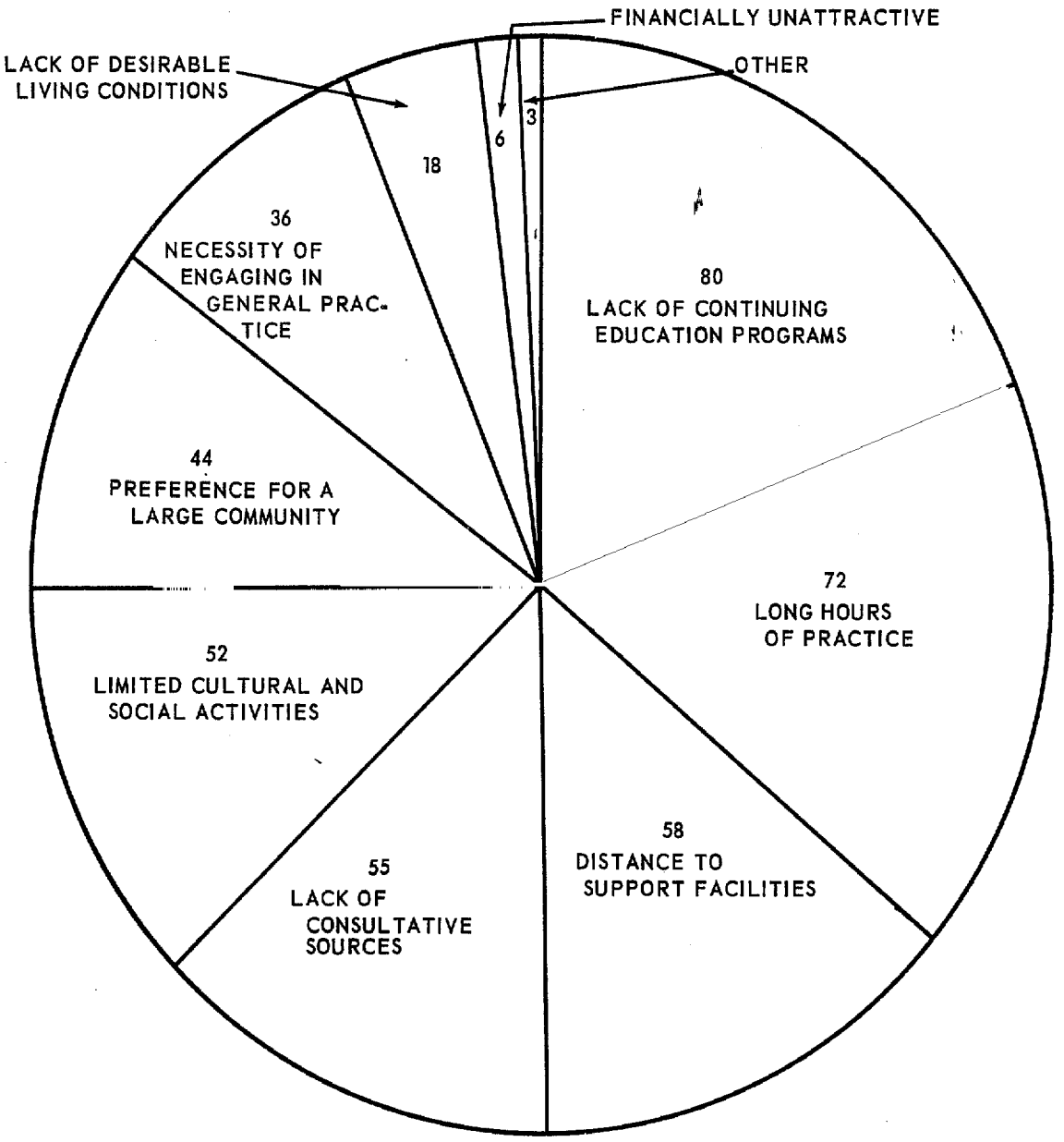
NUMBER OF RESPONSES INDICATING MOST IMPORTANT FACTORS INFLUENCING DENTISTS TO LOCATE IN SHORTAGE AREAS



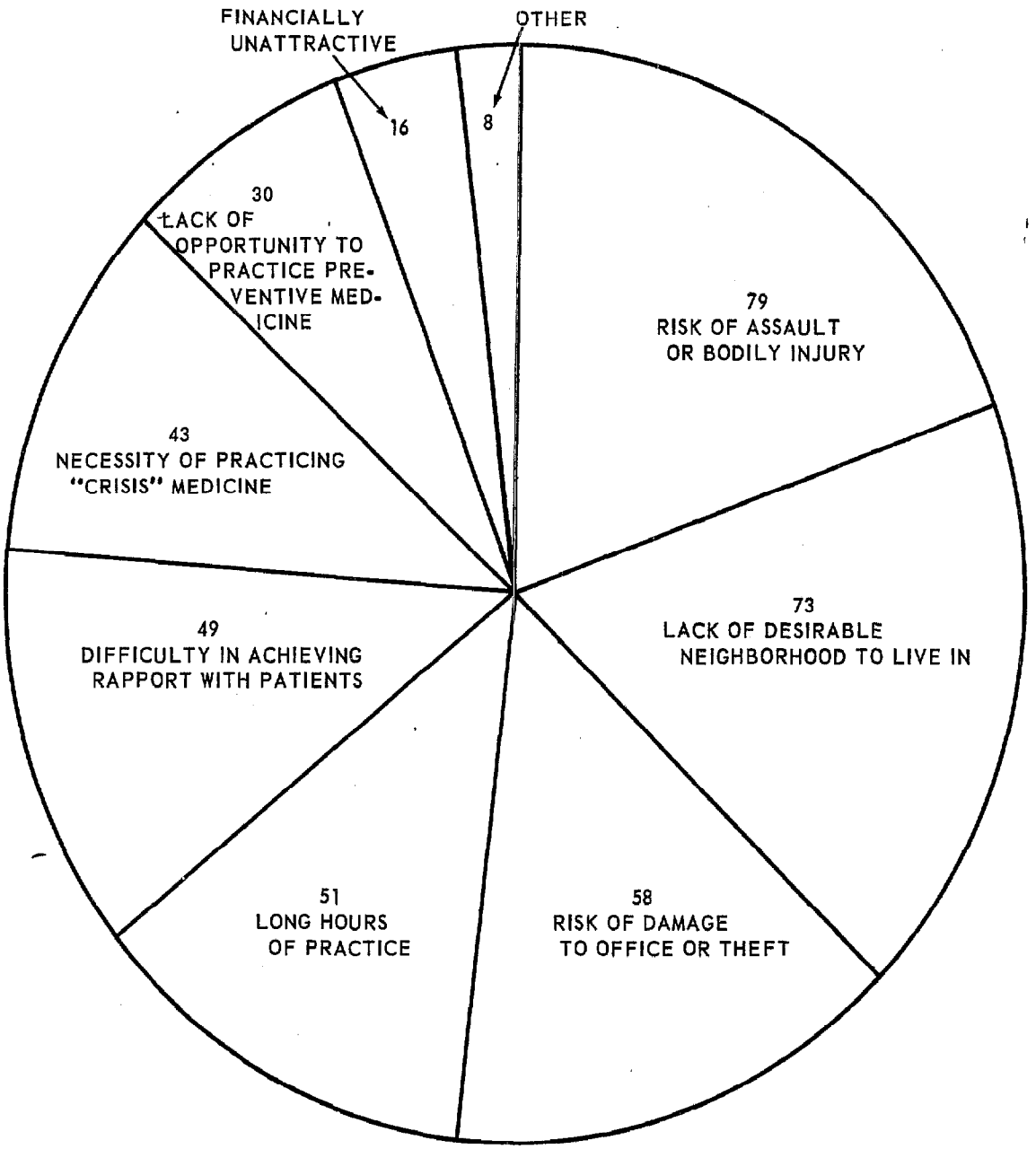
Our randomly selected sample of 390 graduates whose loans were being repaid or were due for repayment (see p. 39) included 87 who indicated they were aware of the loan cancellation provisions. Of these, eight had applied for loan cancellation. We asked the 87 graduates to rate the effect of the cancellation provision in influencing them to consider practicing in a shortage area; 58 of the respondents indicated that the provisions attracted them very little or not at all; 22 were somewhat attracted; 6 were highly attracted; and 1 did not respond.

We asked the sampled graduates to rank, in order of importance, several conditions which they considered unattractive about practice in rural shortage areas and inner-city shortage areas. We developed these conditions on the basis of applicable literature and with advice from the former Bureau of Health Manpower Education, NIH, and the Congressional Research Service. Some of the respondents checked some of the factors as being important without ranking them. Summaries of the responses are shown in appendixes V through VIII. See the following charts for the number of respondents who ranked these conditions first, second, or third in importance.

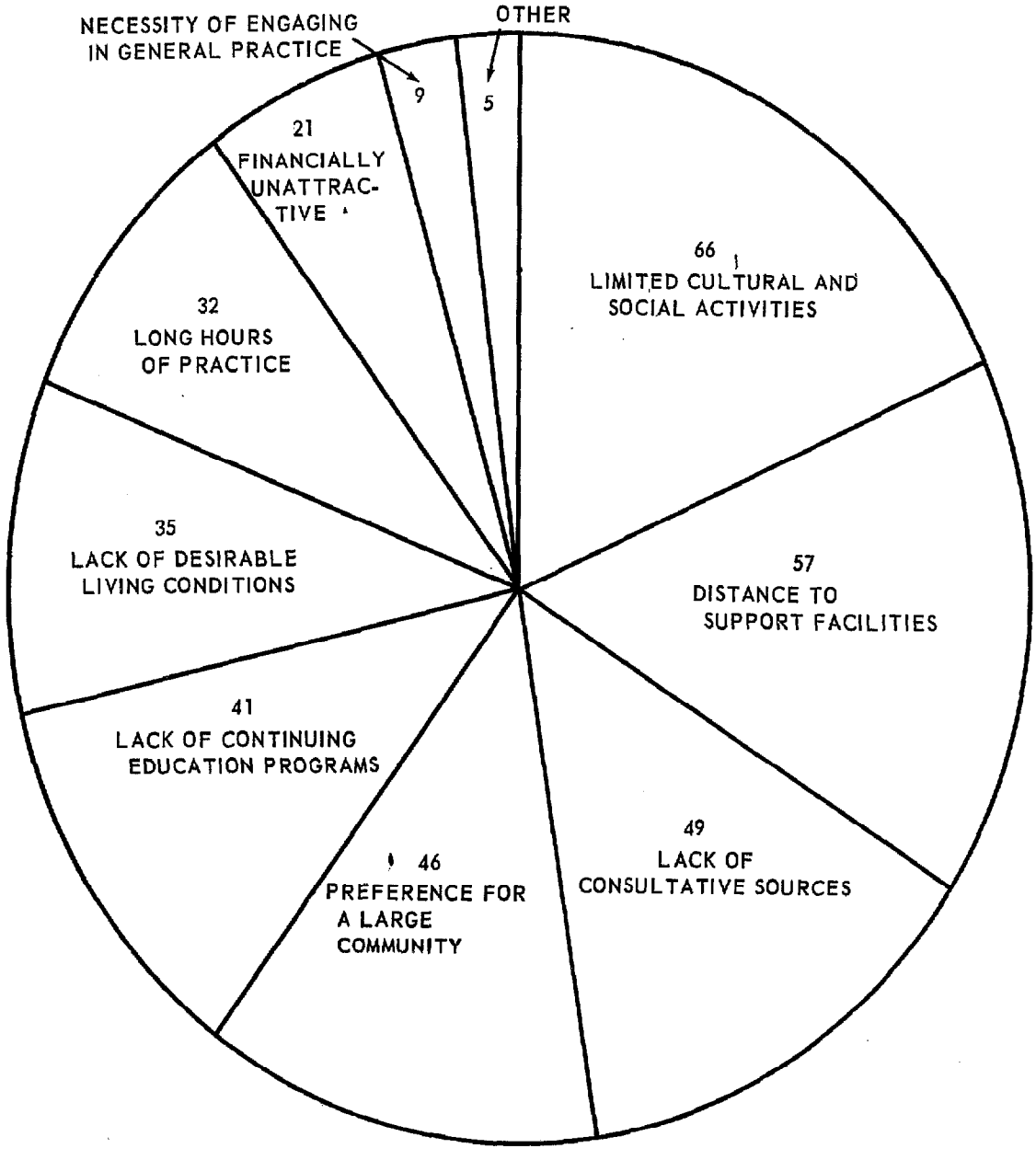
MEDICAL GRADUATES' RANKING OF UNDESIRABLE ASPECTS OF RURAL AREA PRACTICE



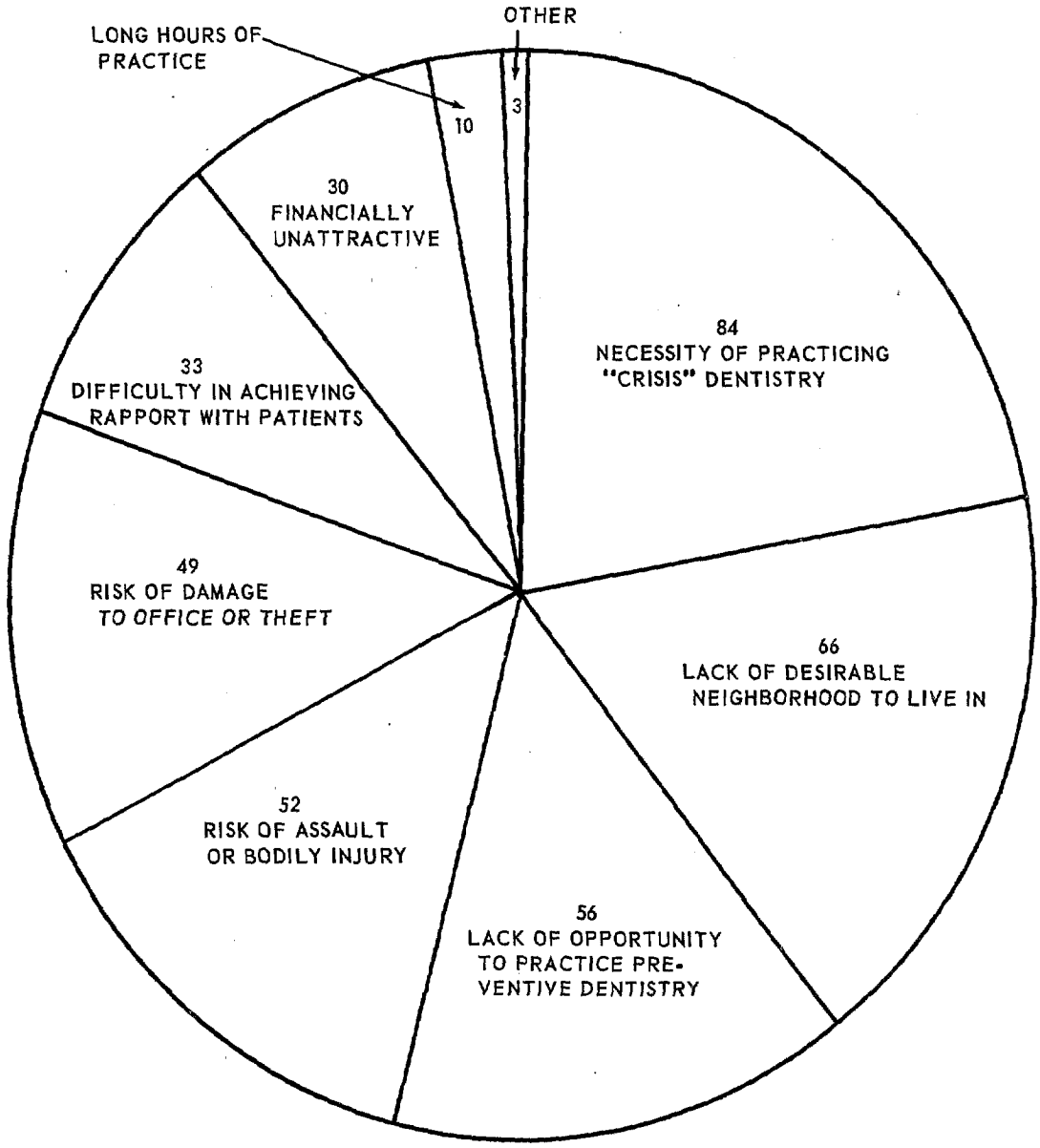
MEDICAL GRADUATES' RANKING OF UNDESIRABLE ASPECTS OF INNER-CITY PRACTICE



DENTAL GRADUATES' RANKING OF UNDESIRABLE ASPECTS OF RURAL-AREA PRACTICE



DENTAL GRADUATES' RANKING OF UNDESIRABLE ASPECTS OF INNER-CITY PRACTICE



The responses of both medical and dental graduates regarding the undesirable aspects of inner-city practice call attention to certain continuing social problems. Respondents were highly concerned about personal safety and property damage, establishment of rapport with inner-city patients, and desirable locations in which to reside. The extent that certain biases and prejudices--such as the effect of racial beliefs and of the socioeconomic status of the population to be served--may have consciously or unconsciously influenced such responses is unknown.

Assuming the validity of the responses, however, they point out types of problems that are not addressed by HPSAP, which only provides a financial incentive in the form of loan forgiveness, and may not be susceptible to being addressed legislatively.

Both groups considered money least important in either rural area or inner-city practice. However, both groups cited incentives needed to encourage practice in shortage areas, such as financial assistance in setting up practice and higher incomes. Medical graduates also cited improved support facilities, continuing professional educational opportunities, and opportunities to share a practice or confer with colleagues. Dental graduates cited special income tax provisions as an incentive to encourage practice in shortage areas. Several graduates commented that a program of scholarship assistance to medical and dental students--such as the Physician Shortage Area Scholarship Program[1]--in exchange for agreements by those students to practice in shortage areas after graduation would effectively relieve the shortages. About 73 percent of the 635 recipients still in school who responded to our questionnaire, stated they would be interested in participating in such a program.

Officials at several schools said the loan cancellation provisions did not provide enough financial incentive to attract physicians and dentists to practice in shortage areas.

Officials at Howard and Georgetown thought loan cancellations could be an incentive if the indebtness of the

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[1] Authorized by Public Law 92-157 (42 U.S.C. 295g), Nov. 18, 1971.

students was considerably higher. The "HEW 1975 Health Program Memorandum," printed in the Congressional Record on July 24, 1973, points out that graduating physicians and dentists are presently about $7,000 in debt, on the average. According to the memorandum, if that level of debt were increased to around $20,000 to $30,000, the possibility of having it forgiven could be a genuine incentive to consider practicing in a shortage area.

CONCLUSIONS

HPSAP's loan cancellation provisions have not effectively attracted physicians and dentists to shortage areas. Although a major problem seems to have been graduates' lack of awareness of the provisions, the comments of graduates who were aware of the program and of school officials indicate HPSAP does not provide enough incentive to offset the aspects of shortage-area practice that are considered undesirable. Both physicians and dentists rated such considerations as personal and family needs and professional development above monetary considerations inherent in the loan cancellation provisions.

More liberal loan cancellation provisions were enacted in 1971 and became operative in fiscal year 1974. It is not known whether they will provide sufficient incentive to overcome the nonmonetary aspects of shortage-area practice physicians and dentists considered undesirable.

CHAPTER 6

NEED FOR IMPROVED PROGRAM MONITORING

HEW has not effectively monitored the schools' administration of HPSAP. Administrative procedures at many of the schools we reviewed were not in accordance with NIH instructions or they needed improvement to insure that

--need determinations and aid awards were properly documented to permit administrative and management review,

--loans were collected promptly and effectively, and

--program assets were properly executed and safeguarded.

INADEQUATE DOCUMENTATION

The NIH manual states that any system may be used for determining student need and awarding aid but that the system used "must provide auditable documentation of the basis for approval or disapproval of any student application for assistance." Some instances of inadequate documentation in the need determination process were discussed in chapter 2. Other examples follow.

At the Baylor dental school the mathematical computations of need (expenses less resources) were documented, but no documentation showed how the estimates of expenses were developed. Also, no documentation supported the aid officers' adjustments of students' resources.

At the Baylor medical school the mathematical computations of need were not documented. The only documented evidence of the loan and scholarship committee's HPSAP loan approvals was the amount of the award, the date, the phrase "demo need" (demonstrates need) and the chairman's signature. Neither the committee chairman nor the financial aid officer could tell us the amount of financial need determined for any student.

At the University of Illinois the financial aid files were not documented in most cases to show the basis for approving or disapproving loan and scholarship awards, nor for

adjusting students' expense estimates. Most of the files we reviewed did not contain sufficient supporting documents to show how the school had determined the students' financial need.

At Howard the lack of documentation extended to the school's request for grant funds. For school year 1972-73, the medical and dental schools chose to base their requests for scholarship funds on the statutory formula of $3,000, multiplied by the number of full-time students from low-income families. The medical school's documentation was inadequate. It was based on a computer printout showing the number of students from various family sizes and income ranges, but the income breakpoints were not compatible with those provided in NIH instructions and could not be reconciled. The dental school did not document the number of students shown on the applications.[1]

INADEQUATE BILLING AND COLLECTION PROCEDURES

NIH instructions require each participating school to exercise diligence in the collection of all loans due. The instructions require the officer in charge of collection to establish a procedure that is prompt and firm. According to these instructions, the school should maintain current lists of delinquent accounts. Except for litigation costs, the school must pay collection costs.

In our opinion a need exists for schools to establish procedures to insure that HPSAP loans are billed and collected regularly and systematically. Many of the schools were not promptly determining the status of their loan accounts and/or were not promptly and appropriately collecting identified delinquent accounts. The Baylor dental school, for example, billed borrowers who were repaying their loans on a monthly repayment plan only for the first payment due. Thereafter, the collections officer billed borrowers irregularly. Borrowers with quarterly, semi-annual, and annual repayment plans were billed for each payment due. In our sample of 30 loans, 11 were on a monthly repayment plan. The loan

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[1]Subsequent to a meeting between HEW, NIH, GAO and Howard officials, Howard prepared and submitted documentation satisfactory to NIH.

collection officer told us in June 1973 that UCLA had made no routine billings on health professions loans since July 1972; statements had been sent to borrowers only at their request.

One former UCLA student wrote to us: "* * * I was on the verge of writing my senator. * * * UCLA * * * does not seem to care whether or not I ever pay my loan; every year we have to beg them to bill me, usually months after the period when I should have been billed. * * *"

Baylor medical and dental schools and UCLA did not keep current lists of delinquent HPSAP accounts. At the Baylor dental school the student aid officer was unable to provide the names of five borrowers he had reported on the 1972 Annual Operating Report to NIH as being delinquent by 120 days or more.

USC's computerized accounting and collection system automatically updated accounts and billed borrowers monthly. The computer was programed to stop sending "past due" notices on accounts after they were 120 days delinquent. USC officials said the system was relatively new and that manpower efforts had been directed toward making it operational. They said that, because of manpower constraints, collection efforts suffered but would improve as the system became operational.

At several schools, the absence of definitive followup procedures has resulted in longstanding delinquent accounts. At Georgetown, for example, 144 borrowers were from 180 days to 5 years behind in their payments. The bank handling Georgetown's collections has recommended that 12 medical and 44 dental accounts be turned over to a collection agency. As of May 1973 none had been turned over. A Georgetown official said one of the reasons for not turning the accounts over to a collection agency was the high collection cost involved.

Costs of collection

Participating schools have often been reluctant to turn over delinquent accounts to collection agencies. An official at the University of Illinois said he did not refer delinquent accounts to collection agencies because the

--Whether its goals could be served as well if the scholarship funds were added to loan funds and the scholarships eliminated. This may be warranted in view of the difficulties experienced in equitable distributions of scholarship funds and the excellent potential of all medical and dental students to repay loans upon graduation.

--The necessity of continuing to provide loans at interest rates lower than those available to the Government in view of the very high earning potential of medical and dental school graduates.

--Whether the goal of increasing the number of health professions students from low-income families could be better served if HPSAP were directed to a specifically defined income group.

--The need for providing overall coordination of the various Federal programs providing aid to health professions students.

CHAPTER 8

SCOPE OF REVIEW

Our review was made at NIH headquarters in Bethesda, Maryland, and at seven medical and six dental schools in California, Georgia, Texas, Illinois, and the District of Columbia. The schools reviewed and the amounts they were awarded under HPSAP for the academic year 1972-73 are shown below.

Medical schools	Loans	Scholarships	Total
Baylor College of Medicine	$ 211,770	$ 75,064	$ 286,834
Emory University	40,500	53,363	93,863
Georgetown University	300,000	96,354	396,354
Howard University	213,477	175,917	389,394
University of Illinois	324,000	143,031	467,031
UCLA	184,000	77,110	261,110
USC	176,918	53,500	230,418
Total	$1,450,665	$674,339	$2,125,004

Dental schools	Loans	Scholarships	Total
Baylor College of Dentistry	$ 90,000	$ 58,686	$ 148,686
Emory University	72,000	49,542	121,542
Georgetown University	175,000	65,511	240,511
Howard University	167,893	133,989	301,882
University of Illinois	175,500	58,140	233,640
USC	223,407	67,557	290,964
Total	$903,800	$433,425	$1,337,225

For the academic year 1972-73 about 2,339, or about 36 percent, of the 6,549 health profession students enrolled at the schools we reviewed received assistance under the program as shown in the following table:

Medical schools	Total enrollment	Total receiving aid	Percentage of enrollment receiving aid
Baylor	542	171	31.5
Emory	396	105	26.5
Georgetown	705	280	39.7
Howard	469	246	52.4
Illinois	956	275	28.8
UCLA	558	177	31.7
USC	395	132	33.4
Dental schools			
Baylor	430	101	23.5
Emory	364	114	31.3
Georgetown	474	235	49.6
Howard	365	223	61.1
Illinois	422	139	32.9
USC	473	141	29.8
Total	6,549	2,339	35.7

We reviewed HPSAP's administration to determine whether it was achieving the results intended by the Congress. We reviewed the legislation, congressional hearings, and the implementing regulations, policies, and guidelines of NIH and the selected schools to determine how well they were administering HPSAP.

We examined NIH records and held discussions with appropriate NIH officials. At each of the 13 schools visited, we randomly sampled 30 students that received a loan during school year 1972-73 and 30 that received a scholarship during that year. We reviewed the school records, including the student aid folders, and held discussions with appropriate school officials. We sent questionnaires to (1) those randomly sampled students who received aid in school year 1972-73, (2) 30 randomly selected former students at each of the 13 schools who, at the time of our review, had loans with payments due, and (3) to all 183 physicians and dentists in the Nation whose loans were partially canceled because they practiced in a shortage area as of May 1973.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

APR 11 1974

Mr. Gregory J. Ahart
Director, Manpower and Welfare Division
United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Ahart:

Thank you for the opportunity to comment on the draft of your Report to the Congress of the United States on the Health Professions Student Assistance Programs, administered by the Health Resources Administration of this Department.

We are enclosing comments as you have requested. Should there be any questions regarding these comments, please contact us.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosures

APPENDIX I

GENERAL ACCOUNTING OFFICE REPORT TO THE CONGRESS OF THE UNITED STATES ON FEDERAL LOANS AND SCHOLARSHIPS TO HEALTH PROFESSIONS STUDENTS: CONGRESSIONAL OBJECTIVE NOT BEING MET (B-164031(2)

General Comments

The Department disagrees with the general conclusion that the Congressional objectives of the Health Professions Student Assistance Program are not being met. However, the Department accepts as valid the criticism for relying too heavily on the schools of medicine and dentistry to administer the student assistance program responsibly and in close adherence to guidelines provided. The report demonstrates that this heavy reliance on the institutions together with minimal monitoring has led to unwise use of student aid funds. Accordingly, the Department proposes to implement corrective measures in response to the report's findings and recommendations.

Congressional Objectives of the Program

The Department questions the conclusion that the Congressional objectives have not been met, especially when as the report recognizes, the legislation does not specify program objectives.

Based on its interactions with the legislative committees of the Congress responsible for the health manpower legislation, the Department is convinced that the Congress did not rely upon student aid as the principal mechanism for resolving the health manpower problems which are generally conceded to be primarily shortages of manpower of the right kind in the right place at the right time to provide adequate health services to the total population.

The medical and dental schools existing at the time the original student aid programs were enacted were not graduating enough students to meet the country's needs. To remedy this situation Congress authorized construction grants which would permit the creation of new schools and the expansion of existing schools in order to increase the output. At the same time, student aid was authorized in order to assure that there would be a sufficient number of qualified students to fill the created new vacancies.

In the course of time these health manpower authorizations expired and the manpower legislation was amended and extended. Other types of monetary awards were authorized such as basic improvement grants, special improvement grants, capitation, special projects, start-up grants, conversion grants, health manpower educational initiative awards, teacher training grants, physician shortage area scholarship grants, etc., all presumably designed to increase the quantity and quality of health manpower and improve distribution and utilization.

In addition to authorizing these various programs, Congress has appropriated increasing funds to implement them and at the same time State and local governments, as well as the private sector, have developed a variety of programs and provided very substantial funds for the same general purposes.

During the decade which has elapsed since enactment of the original Federal health manpower legislation, there has been a substantial change in both the quantity and quality of medical and dental students. The number of medical school graduates increased from 7,264 to 10,391 between 1963 and 1973. Dental school graduates increased 3,230 to 4,082 during the same period of time. The grade point average of entering students both in schools of medicine and dentistry during the same period of time has also increased.

It seems reasonable to conclude then that both the quantity and quality of medical and dental students have increased and to this extent Congressional objectives appear to have been met. The Department is convinced that the HPSAP has contributed to the attainment of these objectives, however, it is impossible to measure the extent to which it has done so, inasmuch as it is part of a multifacted program to increase and improve the manpower pool.

The report also concludes that health professions student assistance programs does not appear to have had a significant impact on influencing dental and medical graduates to locate in shortage areas. The Department agrees with this conclusion and will propose several new approaches to the solution of this problem, in its recommendations for modification of the current health manpower legislation.

Recommendations to the Secretary of Health, Education, and Welfare and DHEW Responses

Recommendation: Establish uniform criteria to be used by participating schools in determining student need. Such criteria should outline the types of costs which may be considered necessary and the resources which should be considered.

Response: The data presented in the report indicate that health professions schools either have not followed or have taken great liberties with Departmental guidelines in determining student financial need. The Department will, therefore, review and revise the guidelines to require all institutions to utilize definitive, uniform criteria for determining student financial need and will indicate specifically what items can and cannot be considered appropriate to determining individual need.

Recommendation: Develop regulations and criteria for determining how scholarship funds are to be awarded to students.

Response: Regulations and operating criteria will be amended as necessary to specify how scholarship funds are to be awarded and will establish the minimal level of need that will determine eligibility of students to receive loans and scholarships.

Recommendation: Develop, to the extent feasible, methods for insuring the consideration and coordination of all available sources of aid, especially Federal sources, in meeting student's needs.

Response: Operating procedures and guidelines will be amended to require each student recipient to make a declaration of need quarterly, and to specify all financial resources including Federal sources and will require the institution to terminate the payment of loans and/or scholarships where new need levels do not warrant continuation of Federal commitments. Schools will be required to audit each student need account at quarterly intervals and document any change in the certification of need. Also, an attempt will be made to make student aid officers in the institutions aware of all Federal funds made available to students, i.e., PHS scholarship funds, DOD scholarship funds, and any other from Federal sources.

Recommendation: Establish procedures to ensure that participating schools make students fully aware of loan cancellation provisions before they graduate.

Response: In responding to this recommendation, it is necessary to point out the difference between loan cancellation and loan repayment. Loan cancellation applies to loans made before November 17, 1971 and provides for cancellation of loans made under the Federal program of loans to health professions students. Very few students have taken advantage of this old provision and it is generally regarded as in effective in persuading students to serve in shortage areas. Loan repayment authorized in the Health Manpower Training Act of 1971 is a much more generous provision in that it provides for repayment of up to 85 percent of any educational loan in return for service in a shortage area. Each school will be required to conduct an exit interview with each student participating in the HPSAP and document in the student's folder that the student is aware of the loan repayment provision as well as loan cancellation provisions.

Recommendation: Encourage participating schools to establish good internal controls, improve operating record, and develop aggressive and thorough collection procedures.

Response: Regulations and guidelines will be amended and revised to mandate that schools establish and follow effective operating procedures, including fiscal and management controls, aggressive and thorough collection procedures, and the maintenance of appropriate records.

Recommendation: Closely monitor the operation of the program at participating schools to insure full compliance with program regulations, instructions, and guidelines.

Response: The number of personnel available to monitor this program has been inadequate. The report makes it obvious that DHEW has depended too heavily on the schools to use good management procedures in administering the health professions, student loan and scholarship program. The report clearly documents that some of the schools have abused the freedom of action provided in Department regulations and guidelines and the Department is convinced that in addition to improving our regulations and guidelines, it will be necessary to monitor more aggressively the programs in the schools. Additional monitoring will be shared between headquarters and regional offices. Central office personnel will have responsibility for reviewing and keeping current the regulations, guidelines and operating procedures and communicating these to the regional offices.

In addition, the Bureau will continue to contract with the Education Testing Service to study collection procedures in all health profession schools. New guidelines will be issued to all participating schools requiring them to safeguard all program assets and to execute all notes properly, including the designation of the rate of interest. All schools will be required to keep promisory notes and other critical documents in fire safes and locked files.

APPENDIX II

PARTIAL LIST OF FEDERAL AND NATIONAL AID PROGRAMS AVAILABLE TO MEDICAL AND DENTAL STUDENTS (note a)

Federal programs	Type of aid
Commissioned Officer Student Training and Extern Program (Public Health Service)	Training plus pay
Navy Relief Society Education Fund	Loan
Professional Public Health Personnel Traineeships	Project grant
Armed Forces Health Professions Scholarship Programs	Tuition plus stipend
Air Force Medical Education Program	Scholarship
Training in Family Medicine	Traineeships and fellowships
Navy Senior Medical Student Program	Grant
Physician Shortage Area Scholarship Program	Scholarship
Federally Insured Student Loan Program	Loans
Veteran Benefits	Monthly allowances

National programs	
United Student Aid Fund	Loan
Wiche Student Exchange Program	Supplemental fee
American Dental Trade Association Loan	Loan
American Fund for Dental Education	Scholarship
National Medical Association, Inc. - Loan	Loan
Joseph Collins Foundation	Grant
Higher Education Loan Program	Loan
American Association of University Women Educational Foundation	Fellowship
American Medical Association Educational Research Foundation	Guaranteed loan
Broome County Medical Society Foundation Scholarship Fund	Grant
United Cerebral Palsy Research and Educational Foundation, Inc.	Scholarship

National programs (continued)	Type of aid
Scholarship - U.S. Section	Scholarship
March of Dimes	Scholarship
Elliott Dollar Student Loan Fund	Loan
DAR Scholarship and Fellowship Funds	Scholarship
Indian Health Employees Scholarship Fund, Inc.	Scholarship
Kellogg Foundation	Loan
McFarland Medical Trusts Grants	Grant
American Medical Women's Association Loan Fund	Loan
Minority Scholarship Fund	Scholarship
National Medical Fellowships, Inc.	Grant
Pfizer Laboratories	Scholarship

[a]Partial list compiled primarily from the 1972 Financial Information National Directory for Health Careers of the American Medical Association.

APPENDIX III

PHYSICIANS' RANKING OF FACTORS WHICH INFLUENCED THEM TO PRACTICE IN SHORTAGE AREAS

	Order of importance			Responses not ranked
	1-3	4-6	7-9	
Geographic preference	28	10	4	4
Desire to serve where most needed	28	9	2	6
Opportunity for experience	25	12	3	6
Influence of family or friends	16	10	6	1
Association with colleague	12	7	6	2
Availability of facilities	11	14	6	4
Loan cancellation provisions	7	25	7	4
Financially attractive	6	13	10	4
Other	5	0	1	0

DENTISTS' RANKING OF FACTORS WHICH INFLUENCED THEM TO PRACTICE IN SHORTAGE AREAS

	Order of importance			Responses not ranked
	1-3	4-6	7-9	
Geographic preference	78	14	1	3
Opportunity for experience	44	27	3	1
Influence of family or friends	38	19	18	1
Desire to serve where most needed	37	31	7	4
Financially attractive	32	31	12	2
Loan cancellation provisions	26	37	18	0
Availability of facilities	23	24	20	1
Association with colleague	12	17	24	2
Other	6	2	2	3

APPENDIX V

MEDICAL GRADUATES' RANKING OF UNDESIRABLE ASPECTS OF RURAL AREA PRACTICE

	Order of importance			Responses not ranked
	1-3	4-6	7-9	
Lack of continuing education programs and opportunities for professional growth	80	29	8	6
Long hours of practice and inability to take time off	72	33	10	4
Distance to good support facilities	58	53	5	5
Lack of consultative sources	55	41	14	4
Limited cultural and social activities	52	37	14	8
Aside from consideration of practice, preference for a large community	44	23	28	3
Necessity of engaging in general practice	36	32	27	5
Lack of desirable living conditions for family	18	18	49	4
Financially unattractive	6	15	52	1
Other	3	0	1	2

MEDICAL GRADUATES' RANKING OF

UNDESIRABLE ASPECTS OF INNER-CITY PRACTICE

	Order of importance			Responses not ranked
	1-3	4-6	7-8	
Risk of assault or bodily injury	79	31	8	10
Lack of desirable neighborhood to live in near work	73	33	9	6
Risk of damage to office or theft of property	58	38	11	10
Long hours of practice and inability to take time off	51	35	9	5
Difficulty in achieving rapport with patients due to cultural differences	49	24	20	8
Necessity of practicing "crisis" medicine	43	32	15	6
Lack of opportunity to practice preventive medicine	30	31	25	6
Financially unattractive	16	29	39	7
Other	8	0	0	5

APPENDIX VII

DENTAL GRADUATES' RANKING OF UNDESIRABLE ASPECTS OF RURAL AREA PRACTICE

	Order of importance			Responses not ranked
	1-3	4-6	7-9	
Limited cultural and social activities	66	29	10	10
Distance to good support facilities	57	29	8	9
Lack of consultative sources	49	31	10	7
Aside from consideration of practice, preference for a large community	46	21	15	5
Lack of continuing education program and opportunities for professional growth	41	38	8	8
Lack of desirable living conditions for family	35	20	30	6
Long hours of practice and inability to take time off	32	29	24	7
Financially unattractive	21	19	34	5
Necessity of engaging in general practice	9	11	43	4
Other	5	0	0	1

DENTAL GRADUATES' RANKING OF UNDESIRABLE ASPECTS OF INNER-CITY PRACTICE

	Order of importance			Responses
	1-3	4-6	7-8	not ranked
Necessity of practicing "crisis" dentistry	84	22	7	5
Lack of desirable neighborhood to live in near work	66	34	6	5
Lack of opportunity to practice preventive dentistry	56	36	8	5
Risk of assault or bodily injury	52	28	13	5
Risk of damage to office or theft of property	49	34	8	5
Difficulty in achieving rapport with patients due to cultural differences	33	39	21	5
Financially unattractive	30	48	34	4
Long hours of practice and inability to take time off	10	31	32	4
Other	3	0	1	3

APPENDIX IX

QUESTIONNAIRE SENT TO MEDICAL AND DENTAL STUDENTS WHO RECEIVED AID UNDER THE HEALTH PROFESSIONS STUDENT ASSISTANCE PROGRAM IN SCHOOL YEAR 1972-73

1. Marital status: Single _____ Married _____

2. Type of environment in which you grew up:

Inner-city (low-income urban area)	_____
Urban	_____
Suburban	_____
Small city or town	_____
Rural	_____

Please indicate:

City _____ County _____ State _____

3. What is your ethnic group?

American Indian	_____
Black American	_____
Caucasian American	_____
Oriental American	_____
Spanish Surname American	_____
Foreign student	_____
Other (specify) _____	

4. Approximate annual gross income of your parents at the time you entered medical or dental school:

Less than $ 5,000	_____	$25,001 - $30,000	_____
$ 5,001 - $10,000	_____	$30,001 - $40,000	_____
$10,001 - $15,000	_____	$40,001 - $50,000	_____
$15,001 - $20,000	_____	$50,001 - $60,000	_____
$20,001 - $25,000	_____	Over $60,000	_____

5. When did you first learn of the Health Professions Student Loan and Scholarship program?

   a. While in high school _____
   b. While an undergraduate student _____
   c. During the process of applying or enrolling in medical or dental school _____
   d. After I had entered medical or dental school _____

6. Would you have entered medicine or dentistry even if financial aid from the Health Professions Student Loan and Scholarship program had not been available to you?

   Yes _____ Probably _____ Not likely _____ No _____

7. Approximately how much legal debt would you be willing to incur in order to complete medical or dental school? $_____

8. If the Health Professions Student Aid program consisted only of loans rather than scholarships, would you still have applied for such aid?

   Yes _____ No _____

9. If Health Professions loans were at normal interest rates rather than low interest rates, would you still have applied for such loans?

   Yes _____ No _____

10. Please list by source all financial aid you have received for the current academic year (parents, federally insured loans, Health Professions loans or scholarships, AMA, ADA, State loans or scholarships, private loans or scholarships, etc.).

Source	Amount

11. How difficult do you believe it is for a health professions student to obtain adequate financial aid to complete his education?

    Difficult _____
    Moderately difficult _____
    Not difficult _____

4. Approximate annual gross income of your parents at the time you entered medical or dental school:

Less than $ 5,000	_____	$25,001 - $30,000	_____
$ 5,001 - $10,000	_____	$30,001 - $40,000	_____
$10,001 - $15,000	_____	$40,001 - $50,000	_____
$15,001 - $20,000	_____	$50,001 - $60,000	_____
$20,001 - $25,000	_____	Over $60,000	_____

5. When did you first learn of the Health Professions Student Loan and Scholarship program?

   a. While in high school _____
   b. While an undergraduate student _____
   c. During the process of applying or enrolling in medical or dental school _____
   d. After I had entered medical or dental school _____

6. Would you have entered medicine or dentistry even if financial aid from the Health Professions Student Loan and Scholarship program had not been available to you?

   Yes _____ Probably _____ Not likely _____

   No _____

7. Do you think you would have been financially able to complete your medical or dental education without assistance from this program?

   Yes _____ No _____

8. If the Health Professions Student Aid program had consisted only of loans rather than scholarships, would you still have applied for such aid?

   Yes _____ No _____

9. If Health Professions loans had been at normal interest rates rather than low interest rates, would you still have applied for such loans?

   Yes _____ No _____

10. Please indicate the sources and approximate amounts of aid you received to finance your medical or dental education.

Source	Amount

11. In what kind of work are you engaged?

    Office based private or group practice _____
    Hospital based practice _____
    Teaching _____
    Administration _____
    Research _____
    Other (specify) _____

12. If in practice, where is your practice located?

    City _____ County _____

    State _____

    Is your practice in the same type of environment as your home town or where you grew up (i.e., as in question 2)?

    Yes _____ No _____

What influenced you to practice in the area where you are located? Please rank 1, 2, 3, etc., in order of importance.

Geographic preference _____
Availability of facilities and support services _____
Influence of family or friends _____
Association with established colleague _____
Opportunity for wide range of experience _____
Financially attractive _____
Other (specify) _____

13. Have you obtained any advanced training since you graduated from medical or dental school?

Yes _____ No _____

If so, what is your area of specialization? _____

_____

14. Have you been advised that portions of your loan could be canceled if you practiced in an area identified as having a shortage of physicians or dentists?

Yes _____ No _____

If so, when did you first learn of the provision?

While in medical or dental school _____
During an exit interview with your financial aid advisor _____
While an intern or resident _____
After you were in practice _____

Did this attract you to consider practice in a shortage area?

Very much _____ Somewhat _____

Very little _____ Not at all _____

15. In your opinion, what is undesirable about practice in a rural area? Please rank 1, 2, 3, etc., in order of importance.

Aside from consideration of practice, preference for a large community _____
Lack of continuing education programs and opportunities for professional growth _____
Long hours of practice and inability to take time off _____
Distance to good support facilities _____
Lack of consultative sources _____
Limited cultural and social activities _____
Necessity of engaging in general practice _____
Lack of desirable living conditions for family _____
Financially unattractive _____
Other (specify) _____

16. In your opinion, what is undesirable about practice in a low-income inner-city area? Please rank 1, 2, 3, etc., in order of importance.

Risk of damage to office or theft of property _____
Risk of assault or bodily injury _____
Difficulty in achieving rapport with patients due to cultural differences _____
Long hours of practice and inability to take time off _____
Lack of desirable neighborhood to live in near work _____
Necessity of practicing "crisis" medicine or dentistry _____
Lack of opportunity to practice preventive medicine or dentistry _____
Financially unattractive _____
Other (specify) _____

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

CONGRESSIONAL OBJECTIVES OF FEDERAL LOANS AND SCHOLARSHIPS TO HEALTH PROFESSIONS STUDENTS NOT BEING MET

National Institutes of Health
Health Resources Administration
Department of Health, Education, and Welfare B-164031(2)

D I G E S T

WHY THE REVIEW WAS MADE

Because of widespread concern with health manpower shortages, GAO reviewed the Health Professions Student Assistance Program (HPSAP) which gives long-term, low-interest loans and scholarships to health professions students.

Until mid 1973 HPSAP had been administered by the National Institutes of Health (NIH). It is now administered by the Health Resources Administration. This review evaluated the program relating to the medical and dental professions.

Although the legislation does not specify program objectives, committee reports and hearings indicate that HPSAP was part of an overall congressional effort to alleviate expected shortages of doctors, dentists, and other health professionals. Other efforts included Federal assistance in construction of teaching facilities and in the Shortage Area Scholarship Program.

The Congress also apparently expected the program to

--improve the quality of health professions students by increasing the number of applicants for admission,

--induce health professionals to practice in geographic areas having a shortage of their skills, and

--increase the proportions of health professions students from low-income families.

Under HPSAP the Department of Health, Education, and Welfare (HEW):

--Awarded grants totaling almost $300 million to schools of medicine, dentistry, pharmacy, optometry, osteopathy, podiatry, and veterinary as of June 30, 1973.

--Allocated $51.5 million to health professions schools during academic year 1972-73, of which about 71 percent went to schools of medicine and dentistry.

--Assisted about 35,400 health professions students in academic year 1971-72.

FINDINGS AND CONCLUSIONS

It does not appear that HPSAP has had a significant impact on

--increasing the output of the Nation's medical and dental schools (see p. 28),

--improving the quality of medical and dental students (see p. 33), and

--influencing medical and dental school graduates to locate their practices in shortage areas. (See p. 38.)

Although the program undoubtedly has made the health professions more accessible to students from low-income families, its efficiency and impact in this regard could be greatly improved.

Problems in determining financial need

The law prescribes that financial assistance may be provided only to health professions students needing aid to pursue a full-time course of study. However, HEW has not provided specific guidance.

As a result participating schools often used imprecise, inequitable, and ambiguous methods and criteria for determining financial need. (See p. 7.)

A student's financial need is determined from his expenses and available resources. HEW guidelines do not specify the types or the amounts of expenses that are allowable. GAO found awards based on student expense estimates which included amounts (see p. 8)

--up to $300 monthly for transportation expenses and up to $360 monthly for housing;

--for books, equipment, and supplies that exceeded the actual cost of such equipment from $300 to $1,500; and

--for items such as feed for a spouse's horses, a summer European tour, contributions to community organizations, and an abortion for a girl friend.

HEW guidelines also do not specify how to determine the amount a student's parents are expected to contribute or under what circumstances the student may properly be considered self-supporting.

The seven medical and six dental schools in GAO's review used different methods to determine parents' obligations to contribute and the circumstances in which a student was considered independent. As a result, parental contributions expected could vary widely among parents in similar family and financial circumstances. GAO found instances of students receiving aid with parental earnings as high as $49,000 a year or, with net assets of as much as $820,000. (See pp. 14 and 35.)

Problems in awarding aid

The legislation provides for loans to students with financial "need" and for scholarships to students with "exceptional financial need."

Possible criteria for distinguishing between "need" and "exceptional financial need" include the parents' income and/or the dollar amount of a student's need. (See p. 19.)

HEW has not provided specific guidance or criteria to the schools. Scholarship awards have often been inconsistent or arbitrary and have not necessarily benefited students with the largest financial needs or from the lowest income families. (See pp. 21 and 22.)

Distribution of scholarships on the basis of computed financial needs will not be equitable until all schools have developed appropriate and consistent systems for determining students' financial needs. However, even distribution of scholarships primarily to students from low-income families does not address the fact that such students, upon graduation, have earning potential equal to that of other students. Comments of school officials and students suggest that program objectives might be served just as well if loans were substituted for scholarships.

Failure to coordinate various sources of aid available to health professions students, including such Federal sources as federally insured loans, has caused duplication. Some students received more aid than their computed needs. (See p. 24.)

Impact on the quantity, quality, and mix of students

According to school officials the lack of teaching facilities and teachers--not students--has primarily limited output of medical and dental schools. (See p. 29.)

The quantity and quality of medical and dental students has increased significantly since HPSAP began. It appears that these increases, however, are not primarily attributable to HPSAP but to other factors, such as prestige and potential earnings of the medical and dental professions.

The number of medical and dental school graduates from low-income families could be increased with available funds if the program was limited to students from this economic level.

Influence of loan-forgiveness provisions on decisions to practice in shortage areas

Almost 94,000 medical and dental students graduated in the United States from 1965 to 1972. About one third of these received HPSAP loans. As of October 1973, 86 physicians and 133 dentists had obtained cancellation of a portion of these loans for practicing in "a designated shortage area."

Further, 167 physicians and dentists that had obtained loan cancellations responded to a GAO questionnaire, and 137 stated that they would have chosen the same location for their practice even if the cancellation provisions had not been available. (See p. 40.)

Lack of awareness of the availability of cancellation provisions appears to be a major problem. Comments of school officials and graduates aware of this said the program has not provided sufficient incentive to offset aspects of shortage area practice considered undesirable by graduates.

Both physicians and dentists rated considerations, such as personal and family needs and professional development, above the monetary incentives provided by the program.

Need for improved program monitoring

Administrative procedures at many schools need improvement to insure

--adequate documentation of students' need determinations to permit administrative review,

--prompt and effective collection of loans, and

--proper safeguarding of program assets.

Many of the 13 schools GAO reviewed were not promptly determining the status of their loan accounts or were not taking appropriate actions to collect identified delinquent accounts on time.

At most schools, promissory notes--the evidence of loans made to students--were not safeguarded against fire or theft. (See p. 54.)

HPSAP has been audited at only 3 of the 13 schools. Monitoring contacts with 283 schools participating in the program consisted primarily of telephone conversations between NIH and school officials and participation yearly in about 25 regional meetings of national and collegiate financial aid organizations.

In mid 1973, HEW was reorganized and responsibility for monitoring the program was delegated, in part, to HEW regional offices. (See p. 56.)

RECOMMENDATIONS

The Secretary of HEW should direct the Administrator of the Health Resources Administration to (see p. 60):

--Establish uniform criteria to be used by participating schools in determining student need.

--Develop regulations and criteria for determining how scholarship funds are to be awarded to students.

--Develop, to the extent feasible, methods for insuring consideration and coordination of all available sources of aid, in meeting students' needs.

--Establish procedures to insure that participating schools make students fully aware of loan repayment and cancellation provisions before they graduate.

--Encourage participating schools to establish good internal controls, improve operating records, and develop aggressive and thorough collection procedures.

--Closely monitor HPSAP operation at participating schools to insure full compliance with regulations, instructions, and guidelines.

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW concurred with GAO's recommendations and advised GAO of the actions it planned to take to improve HPSAP's administration and effectiveness.

HEW agreed with GAO's conclusion that HPSAP has not had a significant impact on influencing medical and dental graduates to practice in shortage areas.

It generally disagreed with GAO's views on the impact HPSAP has had on increasing the output of medical and dental schools and improving the quality of medical and dental students. HEW's comments and GAO's evaluation are in chapter 7. (See p. 61.)

MATTERS FOR CONSIDERATION BY THE CONGRESS

Appropriation authority (Public Law 92-157) for loans and scholarships to health professions students expires June 30, 1974.

Recognizing HPSAP's minimal impact on the original congressional goals, and availability of other Federal and national aid programs for health professions students, the Congress should consider whether the goals can better be accomplished through other existing

scholarship money. As a result, some students with less need, but higher scholastic status, may receive more scholarship money than students with greater need. For example, the following four students at Emory received scholarships in school year 1972-73.

Student	Overall scholastic and need rating	Need	HPSAP scholarship award
A	1.44	$4,375	$2,250
B	1.66	620	1,500
C	2.06	5,100	1,000
D	2.55	6,450	0

Scholarships not always awarded to students from low-income families

As mentioned earlier, NIH provided participating schools with criteria for defining low-income families as a basis on which the school may request grants for awarding scholarships to students. Although the schools could use this criteria in requesting grants from NIH, the schools were cautioned that they were not to use it for determining eligibility of scholarship recipients. The law does not require students to be from low-income backgrounds to receive scholarships.

Of the 388 students in our sample who had received scholarships in school year 1972-73, 308 had reported parental income to the school. Of those, about 59 percent came from families whose income was above $8,800--the maximum considered low income. (See p. 5.) The schools did not have information on parental income for about 21 percent of the students in our sample. These students received about $92,000 in scholarships.

On the basis of our random sample of HPSAP recipients, there was no significant relationship[1] between family income reported by the students to the schools and the amount of

[1]At the 95-percent confidence level.

scholarship students received at 11 of the 13 schools we reviewed. At the Baylor medical school and the Emory dental school, our test showed that students from lower income families might receive more scholarship money, although this appeared to be coincidental and not the result of the procedures in use.

At 5 of the 13 schools the average scholarship received by students from families with incomes above $8,800 was greater than, or equal to, that received by students from families with incomes less than $8,800.

Some school officials said there is no really equitable basis for awarding scholarships. They pointed out that, regardless of the student's family income or his financial situation while he is a student, his earning potential and his ability to repay a loan should be equal to any other student's upon graduation. They said students who graduate should have no difficulty in repaying loans under HPSAP because of the high average income of medical and dental professions. HEW reported that the median net income for physicians and dentists in 1970 was about $40,000.

In response to our questionnaire sent to about 30 loan recipients and 30 scholarship recipients at each of the 13 schools, students indicated they were willing to share the cost of their education. (See app. IX for a copy of the questionnaire.) Of the 618 students who responded to the question of how much debt they were willing to incur, about 34 percent said $15,000; about 88 percent said $5,000; and about 10 percent said they would borrow whatever they needed to graduate. Also, about 94 percent of the 950 students and graduates who responded to the questionnaire indicated they would have applied for assistance from this program if only loans and no scholarships had been available. In addition, 58 percent of the students and graduates responding to our questionnaire said they would have applied for loans even if the interest rate was higher than the 3-percent rate in effect for HPSAP loans.

At October 31, 1973, the average interest rate on outstanding marketable obligations of the Federal Government was 6.322 percent, or more than double the 3-percent rate required to be repaid by doctors and dentists on their HPSAP loans.

AWARDS CAN EXCEED STUDENT NEEDS

Numerous Federal and national aid programs are available to medical and dental students. (See app. II.) In addition, each school has a number of private loan or scholarship funds and some States aid health professions students as well. Some of these organizations do not allow the schools to administer and award the aid. As a result, the school is often not aware of all the aid a student receives from outside sources.

At UCLA for example, over one-half of the 52 students in our sample received more aid than the school had determined they needed; 7 of these students received about twice as much as they needed. An aid official stated that, in almost all cases where a student received more aid than needed, it was because he received outside aid. The average amount of aid UCLA awarded to students in our samples--both HPSAP and other school administered--amounted to about 80 percent of their computed need. The school awarded 7 of the 52 students more aid than they needed. However, in addition, about 67 percent obtained outside aid.

In many cases, students received aid both from the school and from different Federal programs. For example, of the 33 UCLA students who got aid exceeding their needs, 23 had done so by obtaining federally insured loans in addition to the school aid.

Two different Federal programs paid the tuition for a dental student at Emory University. The student had a computed need of $2,710. He was awarded a $1,500 health professions loan and a $1,000 health professions scholarship which paid the full cost of his tuition ($2,450). He subsequently obtained a $1,500 federally insured loan and also joined the Navy under the Uniformed Services Health Professions Revitalization Act (USHPRA) (10 U.S.C. 2120). According to this act, the military service pays for a student's tuition, fees, books, equipment, and supplies, and also pays the student a $400 per month stipend.

In this case, the Navy sent the school a check for $1,825 covering the prorated tuition and fees from the time the student entered the program. We estimated that the stipend the student received amounted to $2,773. Thus, his

total aid from Federal sources was almost $5,900 more than his computed need. A university official informed us that Emory used the check they had received from the Navy to reimburse the HPSAP fund.

One USC dental student needing only $2,965 received $10,836, all but $750 of which was from Federal programs as follows.

Veterans educational assistance	$ 2,760
Methodist Church	750
HPSAP loan	900
HPSAP scholarship	300
Federally insured loan	2,000
USHPRA tuition payments	1,353
USHPRA stipend payments	2,773
Total aid received	$10,836

The Navy reimbursed another USC dental student for tuition which had been paid by a State fellowship rather than by the student. The school computed this student's need at $4,080. In September 1972 he was awarded a $1,000 health professions loan, a $600 scholarship, and obtained a California State Fellowship for the full amount of his tuition ($3,207). In December 1972 he joined the Navy under USHPRA. The sequence of events relating to his tuition payments was as follows.

--September 11, 1972--first trimester tuition of $1,072 paid by California State Fellowship to USC.

--January 8, 1973--second trimester tuition of $1,072 paid by California State Fellowship to USC.

--February 28, 1973--student billed the Navy for total tuition, books, and fees of $3,607 for the 1972-73 school year.

--May 1, 1973--student received reimbursement of $2,609 for tuition, books, and fees from the Navy for the entire year (prorated from date of enlistment).

--May 4, 1973--third trimester tuition of $1,064 paid by California State Fellowship.

In addition, the student received periodic stipend checks amounting to $2,120 between December 1972 and June 1973 and obtained a $1,500 federally insured loan. The total amount of his aid was about $11,036, about $6,956 more than his need.

An official at the office of student and alumni affairs was aware of the student's enrollment in USHPRA but had not advised the student aid office. An aid office official said they would try to get the student to return the health professions scholarship. Officials at the Department of Defense told us that apparently USHPRA enlistment does not prevent a student from receiving aid from other sources. The Department of Defense aids a student under this program in exchange for his commitment for future service; accordingly, it is not concerned with need, family resources, or aid the student obtains from other sources.

CONCLUSIONS

The Congress has specified that HPSAP scholarships be awarded to students of exceptional financial need. NIH has not provided additional criteria or guidance to the schools concerning how to distinguish exceptional financial need from other need. As a result, distributions of HPSAP scholarship funds often have been based on imprecise or arbitrary criteria resulting in inconsistent and inequitable awards.

Possible criteria for exceptional financial need include the income level of the student's parents and/or the dollar amount of his determined need. The HEW Counsel has ruled, however, that using family income as the sole criterion for scholarship awards is not in accord with congressional intent.

Awards based on need cannot be equitable until appropriate and consistent need-determination systems have been developed at all the schools. Even a system that provides scholarship funds solely to students from low-income families, although recognizing current inability to finance educational costs, does not adequately consider future earning potential. If students from low-income families are provided enough aid to allow them to meet their educational expenses and maintain the same standard of living as other

students, it would not appear unreasonable to require them to repay the aid on graduation because their earning potential is the same as other students.

Most of the students indicated they would be willing to participate in an all-loan program. Officials of several of the schools believed that the program could be just as effective and more easily and equitably administered if scholarship awards were eliminated. Because of the anticipated repayment capability of doctors and dentists, there may not be a need to subsidize their education through scholarships and/or loans with an interest rate which is lower than the interest rate the Federal Government must pay to borrow funds.

The failure to coordinate the sources of aid available to students, including the various Federal programs, has resulted in awarding many students more than what they need. In our opinion, this practice could deprive other students who have unmet needs and result in unnecessary expenditures.

CHAPTER 4

IMPACT OF PROGRAM ON CHANGES IN QUANTITY, QUALITY, AND MIX OF MEDICAL AND DENTAL STUDENTS

Congressional hearings and reports indicate that HPSAP was one facet of an overall congressional strategy to increase the number of medical and dental graduates in the United States. The Congress apparently intended that the program stimulate demand for admissions to medical and dental schools so that (1) the additional places in medical and dental schools created by other facets of its overall program could be filled and (2) the quality of medical and dental students could be improved by enabling the schools to be more selective in their admissions.

The hearings and reports also indicate that the Congress intended that the increased demand come from students whose families previously had not been able to afford the high cost of such education.

Although the number of students accepted by medical and dental schools has increased and the quality has improved since HPSAP began, it does not appear to have been a significant factor in these increases. The increases have been attributed primarily to such factors as additional teaching facilities and the prestige and earning potential of the medical and dental professions. Also, students generally were unaware of HPSAP before deciding to pursue medical or dental educations.

Although HPSAP has undoubtedly assisted some students through medical and dental schools who otherwise would not have been able to attend, it has not been specifically directed to students from low-income families. Some HPSAP aid has gone to students who probably would have attended even if such assistance had not been available.

CONGRESSIONAL OBJECTIVES

Congressional hearings in 1963 on HPSAP indicated that, although the number of college graduates had greatly increased in the preceding 10 years, the proportion applying for admission to medical and dental schools was diminishing. The

testimony indicated that, to keep the then current ratios of physicians and dentists to population, the number of physician graduates would have to be increased by half by 1975 and the output of dental schools would have to be doubled. The Congress was told that, despite these needs, medical and dental educators were finding it increasingly difficult to find enough well qualified students to fill existing places.

The Congress was also given data on the high cost of obtaining a medical or dental education. Reportedly, students from low-income families were precluded from entering these fields because of the investment required. The Senate Report on the initial 1963 HPSAP legislation indicated that about 40 percent of all medical students and a third of all dental students came from the 12 percent of the nation's families whose incomes were above $10,000. Only 15 percent of the medical students came from the 40 percent of the nation's families whose incomes were less than $5,000, and only a third of the dental students came from the 63 percent of the nation's families whose incomes were $6,500 or less.

The Congress hoped that, in establishing HPSAP, capable students from all economic levels would be able to attend medical or dental school. This would significantly increase the number of applicants and allow schools to be more selective in the quality of students admitted.

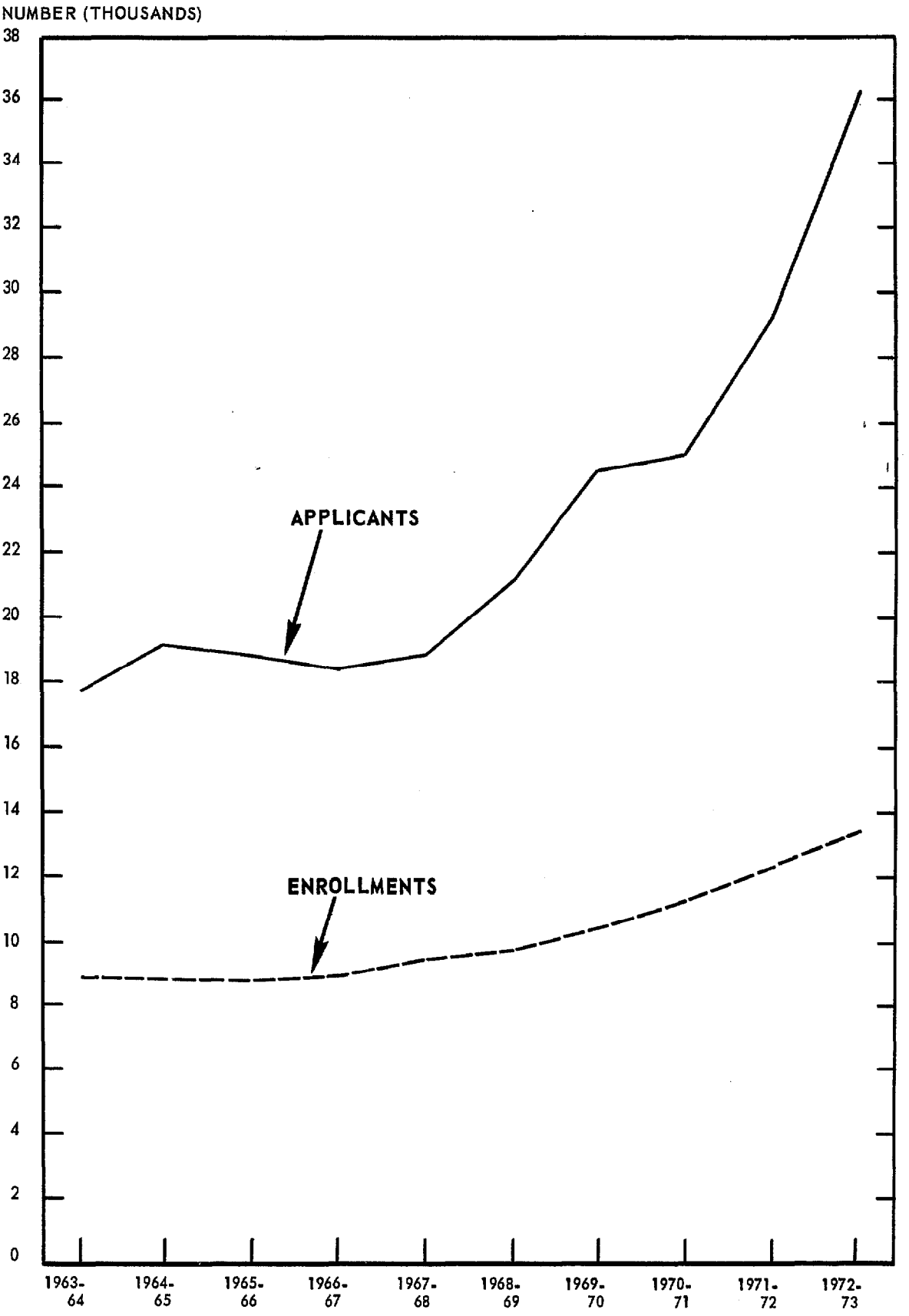
ENROLLMENTS NOT LIMITED BY LACK OF APPLICANTS

Officials at most of the schools we reviewed believed that the demand for admission exceeded the capacity of the schools to such an extent that HPSAP had no impact on the number of graduates the school could produce. Lack of faculty, classrooms, and facilities--not applicants--has primarily limited enrollment at each school and any increase has been attributed to new construction or expansion of facilities, not increased applicants.

Officials at Georgetown, Baylor College of Dentistry, UCLA, and USC, for example, said full enrollment could easily be attained without HPSAP; enough qualified applicants can afford to pay for their education to keep the schools filled to capacity. At Howard, officials also said the school could be kept full, but they believed that minority students might suffer from an absence of Federal aid.

Demand for admission to medical and dental schools

According to information published by the Association of American Medical Colleges, the total number of applicants to medical schools in the United States more than doubled since academic year 1963-64, while the number of first-year enrollments increased by about 50 percent, as shown in the following graph.


NUMBER (THOUSANDS)
38
36
34
32
30
28
26
24
22
20
18
16
14
12
10
8
6
4
2
0
APPLICANTS
ENROLLMENTS
1963-64
1964-65
1965-66
1966-67
1967-68
1968-69
1969-70
1970-71
1971-72
1972-73

program does not provide for collection fees. If an agency charges one-third for collecting a loan, the university must reimburse the loan fund for that cost.

Loan officers at Illinois, USC, and UCLA stated that, to effectively collect debts, the Government should provide funds for administering and collecting health professions loans. Without these funds the participating schools have to operate HPSAP on a "time available" basis. A Georgetown official said they plan to start using an attorney for their collections because they have found one that will collect the accounts for a smaller commission than collection agencies demand.

INADEQUATE SAFEGUARDING OF HPSAP ASSETS

NIH instructions state that the promissory note is the legal document which binds the student to his repayment obligations; since it represents a major asset of the school's loan fund, the note must be properly executed and adequately safeguarded. Emory did not properly execute the notes; in 59 of 60 graduates' loan files examined, the promissory notes did not show the interest rate of the loan. The assistant treasurer told us that, in the early years of the program, the interest rate changed from year to year, so at times the school did not know the proper interest rate.

At USC amounts on three promissory notes did not agree with those on other loan records. According to accounting officials, at one time students signed the promissory notes before actually receiving the check. In some cases, the amount of the award was changed in the interim. USC procedures have now been changed to prevent this.

Most of the schools we reviewed did not adequately safeguard promissory notes. For example, USC filed the original notes and copies in student loan folders and, apparently, because of limited space, stored about one-half of the folders in cabinets in public hallways outside the student loan accounting office. Many of these cabinets were readily available to students passing by and were, on occasion, unlocked.

UCLA kept the notes in filing cabinets that were locked at night but unlocked during working hours. When aid office employees removed notes from the cabinets, they would place

them in a folder to be refiled later by work-study students. While checks were being issued to students, the notes remained out of the cabinets for several days at a time, which heightened the possibility of loss or theft. In addition, since the filing cabinets were not fireproof, the notes could be burned.

At Georgetown several promissory notes were kept in an unlocked metal cabinet. At Howard the current year's notes were kept on a table in the office of the student loan officer, which was unlocked during the day. At least one note was missing at each of these schools.

OTHER INSTANCES OF NONCOMPLIANCE WITH NIH INSTRUCTIONS

NIH instructions state that one of the school's most important program obligations is to insure that no borrower is permitted to leave school without having made a definite arrangement to pay his debt. The school should arrange an exit interview with the borrower shortly before he leaves the school to arrange an appropriate repayment plan and to confirm his permanent mailing address. The borrower must be given the option to choose between at least one equal and one graduated periodic repayment plan and should be given a choice of all available repayment schedules offered under each plan (monthly, quarterly, semiannually, or annually). A written record of the interview should be kept.

Repayment arrangements not always adequate

Exit interviews were not always conducted and in some instances schools did not have borrowers' addresses. For example, at Howard University officials did not know the addresses of 7 of 40 delinquent borrowers which we sampled. Of the 30 questionnaires we sent to UCLA graduates, the postal service returned 4 because the borrowers' addresses obtained from the collection office were incorrect.

Although NIH instructions state that borrowers should be given a choice of available repayment schedules, all Baylor medical students are placed on an annual repayment program, and several students were making minimal repayments. The NIH instructions state that for any loans made after June 30, 1969, the school may provide that payments be not less than

$15 a month. Of 60 borrowers at Baylor medical and dental schools, sampled, 14 received HPSAP loans after June 30, 1969. Ten of these had repayment plans of less than $15 a month. One graduate was repaying a $100 loan at the rate of $11.75 a year.

Georgetown told its students not to pay their health professions loans if they though they might practice in a shortage area at some time in the future. An HEW pamphlet advised students contemplating shortage-area practice that prepayment of loans may result in a reduced base amount on which yearly cancellations are calculated, but the pamphlet did not state that loan payments should not be made. The Georgetown financial aid director told us that, by advising students not to pay anything, he was making shortage-area practice more attractive by enabling them to cancel as large an amount of debt as possible. No repayment plans were on file for 21 of 60 graduates sampled at Georgetown, and the plans for 5 other borrowers were incomplete.

Deferments granted without required certifications

NIH instructions provide that interest will not accrue on loans and installments need not be paid when a borrower performs active duty in a uniformed service or serves as a Peace Corps volunteer or while he pursues up to 5 years of advanced professional training, including internships and residencies. The instructions require that to claim a deferment a borrower must file a Certification of Student Status. At UCLA, 3 of 30 graduates sampled were granted deferments, but no certification was on file. At Howard two graduates were granted deferments on the basis of their uniformed service discharge papers. One of these graduates was granted a 2-year deferment although he was only eligible for 4 months; the other student dropped out without graduating and was granted a deferment to work on a master's degree--this is not considered advanced training in a health profession which would make him eligible for deferment of loan repayments.

ADMINISTRATIVE REVIEWS AND AUDITS

HPSAP had been audited at only 3 of the 13 schools in our review; the HEW Audit Agency audited the Baylor school

of dentistry, and the Defense Contract Audit Agency audited the Illinois schools of medicine and dentistry.

The Baylor audit covered the period November 1, 1964, through December 31, 1971. The primary recommendations were that Baylor should (1) improve documentation of the financial need of students who were awarded aid, (2) refund to the Federal Government about $252,000 in scholarship funds, and (3) adjust the loan fund by about $121,000 because students were awarded aid without proper documentation of financial need, and other sources of aid were not exhausted before awarding HPSAP funds. The NIH Bureau of Health Manpower Education concluded that there was no basis for requiring refunds and no adjustment should be made.

The University of Illinois audits covered the 2 years ended June 30, 1970, and June 30, 1971. The auditors' recommendations included (1) a need for written procedures, (2) better documentation of student eligibility for aid, and (3) a mechanized billing and collection system. The school's written procedures did not have standardized budgets for determining student need, and the school was not properly documenting student eligibility and financial need. At the time of our review, it was in the process of computerizing its loan billing and collection procedures.

Between the fall of 1972 and the HEW reorganization, a staff of three professional and six clerical personnel administered HPSAP. Monitoring contacts with the 283 schools participating in HPSAP have consisted primarily of telephone conversations between NIH and school officials and yearly participation in about 25 regional meetings of national and collegiate financial aid organizations. According to the program officer, NIH occasionally visited sites as a result of audits, correspondence, or specific requests, but visits were not normally made because of the schools' flexibility in administering their respective programs.

As a result of the reorganization the present program officer is responsible for national coordination of HPSAP. She said individuals in each of the HEW regional offices would participate in the monitoring of the program. As of October 1973 neither the number of personnel who will have such duties, nor the amount of time they would be required to devote to HPSAP, had been determined.

CONCLUSIONS

The schools' documentation for determining students' financial need and the documentation supporting the schools' request for grant funds did not, in many cases, comply with NIH instructions. In addition, although NIH instructions require schools to exercise diligence in collecting all loans due, many were not promptly determining the status of their loan accounts or taking appropriate actions to collect identified delinquent accounts on time. Also promissory notes were not adequately safeguarded in most cases.

HEW needs to improve HPSAP monitoring to insure that participating schools

--comply with program guidelines and instructions,

--establish prompt and effective loan collection procedures, and

--properly safeguard program assets.

CHAPTER 7

CONCLUSIONS, RECOMMENDATIONS, HEW COMMENTS AND OUR EVALUATION, AND MATTERS FOR CONSIDERATION BY THE CONGRESS

Although the Congress apparently initiated HPSAP as part of an overall program to increase the output of the Nation's health professions schools, it has had no significant impact on this goal.

Secondary goals apparently intended by the Congress for HPSAP were

--to improve the quality of health professions students by increasing the number of applicants,

--to induce health professionals to practice in geographic areas having shortages of their skills, and

--to increase the proportion of health professions graduates who come from low-income families.

HPSAP does not appear to have had a significant impact on the quality of health professions students or on their choices of locations for practice. Although the program has undoubtedly increased the ability of students from low-income families to pursue health professions careers, its impact in this area could be greatly improved.

The program was to have been directed to students in "need" or "exceptional financial need." Ambiguities and imprecision in need determinations by the schools have resulted in a large portion of the aid going to students from middle income or upper income families who may have been able to complete medical or dental school without it. Also, the lack of coordination between the various sources of aid to health professions students--including Federal sources--has resulted in disproportionate or duplicate awards of aid to some students.

The lack of definitive criteria for distinguishing "need" from "exceptional financial need" has caused inconsistent and sometimes inequitable scholarship awards.

Statements by school officials and students suggest that HPSAP goals could be served just as well if the scholarship portion was eliminated and its funds added to the loan portion. Also, questions have been raised about the basic equity and need for subsidizing--through scholarships and interest rates lower than those available to the Government--medical and dental students because they have a very high earning potential upon graduation.

HEW needs to improve its monitoring of the schools' administration of HPSAP to insure compliance with program instructions.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW direct the Administrator of the Health Resources Administration to:

- --Establish uniform criteria to be used by participating schools in determining student need. Such criteria should outline the types of costs which may be considered necessary and the resources which should be considered.

- --Develop regulations and criteria for determining how scholarship funds are to be awarded to students.

- --Develop, to the extent feasible, methods for insuring the consideration and coordination of all available sources of aid, especially Federal sources, in meeting students' needs.

- --Establish procedures to insure that participating schools make students fully aware of loan repayment and cancellation provisions before they graduate.

- --Encourage participating schools to establish good internal controls, improve operating records, and develop aggressive and thorough collection procedures.

- --Closely monitor the operation of the program at participating schools to insure full compliance with program regulations, instructions, and guidelines.

HEW COMMENTS AND OUR EVALUATION

HEW concurred (see app. I) with our recommendations for improving HPSAP's administration and effectiveness and agreed that HPSAP has not had a significant impact on influencing medical and dental graduates to practice in shortage areas. HEW generally disagreed with our views on the impact HPSAP has had on increasing the output of medical and dental schools and improving the quality of medical and dental students.

In commenting on our recommendations, HEW stated that:

--Guidelines would be reviewed and revised to require all institutions to use definitive and uniform criteria for determining financial need and would indicate specifically what items can and cannot be considered for determining individual need.

--Regulations and operating criteria would be amended to specify how scholarship funds are to be awarded and the criteria would establish the minimal level of need that will determine eligibility of students to receive loans and scholarships.

--Operating procedures and guidelines would be amended to require each student recipient to make a declaration of need quarterly and to specify all financial resources.

--Schools would be required to audit each student's need quarterly to document any change in the need certification and to terminate aid when need does not warrant continuation.

--An attempt would be made to make student aid officers in the schools aware of all Federal funds made available to students.

--Each school would be required to conduct an exit interview with each student participating in HPSAP and document that the student is aware of the loan repayment and cancellation provisions.

--Regulations and guidelines would be amended and revised to mandate that schools establish and follow

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HPSAP	Health Professions Student Assistance Program
NIH	National Institutes of Health
UCLA	University of California, Los Angeles
USC	University of Southern California
USHPRA	Uniformed Services Health Professions Revitalization Act

effective operating procedures, including fiscal and management controls, aggressive and thorough collection procedures, and the maintenance of appropriate records.

HEW stated that our report clearly documents that some schools have abused the freedom of action provided in regulations and guidelines. HEW also stated that, in addition to improving the regulations and guidelines, it will be necessary to more aggressively monitor the programs in the schools. HEW stated that it has depended too heavily on the schools to use good management procedures in administering HPSAP and that the number of personnel available to monitor HPSAP has been inadequate.

HEW also stated that (1) additional monitoring of the schools will be shared between headquarters and regional offices, (2) the collection procedures in all health professions schools will continue to be studied, (3) new guidelines will be issued to schools requiring them to safeguard all program assets and to execute all notes properly, and (4) all schools will be required to keep promissory notes and other critical documents in fire safes and locked files.

These actions, if properly implemented, will correct many of the problems identified during our review.

HEW stated that the quantity and quality of medical and dental students have increased since enactment of the HPSAP legislation and congressional objectives appear to have been met. HEW also stated that it was convinced that HPSAP had helped to attain these objectives but that it was impossible to measure the extent it has done so because it is part of a multifaceted program to increase and improve the health professions manpower pool.

We recognize that conclusive evidence supporting the impact of HPSAP on increasing the quantity and quality of students accepted by medical and dental schools since HPSAP began is not available. However, based primarily on discussions with school officials and the answers to the questionnaires that were sent to medical and dental students, it does not appear that HPSAP has been a significant factor in these increases. As stated in chapter 4, officials at the schools we reviewed attributed the increases in the number of

applicants and the quality of these applicants to factors other than HPSAP. They pointed out that medicine and dentistry were enjoying great popularity because they are humanitarian professions and provide opportunity for high earnings and security.

Officials at most of the schools reviewed also believed that the demand for admissions exceeded the capacity of the schools to such an extent that HPSAP had no impact on the number of graduates the schools could produce. Faculty, classrooms, and space limited enrollment at each school. Increases in enrollment that did occur did not result from the increased applicants but from new construction or expansion of facilities--a part of the multifaceted program other than HPSAP. Most of the schools stated that full enrollment could easily be attained without HPSAP.

The schools also indicated that the number of medical and dental students that currently withdraw for financial reasons was virtually as low as before HPSAP. In addition, the vast majority of students that received HPSAP loans or scholarships in school year 1972-73 did not find out about HPSAP until after they had enrolled.

Therefore, it is our view that HPSAP has not had a significant impact on increasing the number and the quality of medical and dental graduates in the United States.

MATTERS FOR CONSIDERATION BY THE CONGRESS

The appropriation authority (Public Law 92-157) for loans and scholarships to health professions students expires June 30, 1974. Recognizing the minimal impact of HPSAP on the original congressional goals and the availability of other Federal and national aid programs for health professions students, the Congress should consider whether the goals can better be accomplished through other existing programs. These include Federal assistance in constructing teaching facilities, federally insured loans, and the Shortage Area Scholarship Program.

If the program is continued, the Congress should consider:

17. What incentives do you think are required to attract more physicians and dentists to shortage areas?

18. Do you have any suggestions for improving the program in general?

APPENDIX XI

QUESTIONNAIRE SENT TO PHYSICIANS AND DENTISTS WHO HAD OBTAINED PARTIAL CANCELLATION OF THEIR HEALTH PROFESSIONS STUDENT ASSISTANCE LOANS BASED ON PRACTICE IN A SHORTAGE AREA

1. In what kind of work are you engaged?

   Office-based private practice _____
   Group practice _____
   Hospital-based practice _____
   Teaching _____
   Administration _____
   Research _____
   Other (specify) _____

2. Is your practice located in your home town or where you grew up?

   Yes _____ No _____

3. In what type of environment is your practice located?

   Inner-city (low-income urban area) _____
   Urban _____
   Surburban _____
   Small City or Town _____
   Rural _____

   Is this the same type of environment in which you grew up?

   Yes _____ No _____

4. Have you obtained any advanced training since you graduated from medical or dental school?

   Yes _____ No _____

   If so, what is your area of specialization? _____

APPENDIX XI

5. When did you first learn that portions of your loan could be cancelled if you practiced in an area identified as having a shortage of physicians or dentists?

While in medical or dental school _____
During an exit interview with your financial aid advisor _____
While an intern or resident _____
After you were in practice _____

6. Did this attract you to consider practice in a shortage area?

Yes _____ Somewhat _____ Very little _____ No _____

7. What influenced you to practice in the area where you are located? Please rank 1, 2, 3, etc., in order of importance.

Loan cancellation provisions _____

Geographic preference _____

Availability of facilities and support services _____

Influence of family or friends _____

Association with established colleague _____

Opportunity for wide range of experience _____

Financially attractive _____

Desire to serve where most needed _____

Other (specify) _____

8. If availability of facilities and support services was ranked in number 7 above, please name or describe such facilities and services.

9. What additional incentives do you think are required to attract more physicians and dentists to shortage areas?

10. Would you have established your practice in the same location even if there were no Federal loan cancellation provisions?

Yes _____ No _____

11. Have you also taken advantage of any state programs which offer loan forgiveness in return for practice in a shortage area?

Yes _____ No _____

APPENDIX XII

PRINCIPAL OFFICIALS OF HEW

RESPONSIBLE FOR ADMINISTERING ACTIVITIES

DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Casper W. Weinberger	Feb. 1973	Present
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
Anthony J. Celebrezze	July 1962	Aug. 1965
ASSISTANT SECRETARY FOR HEALTH: (note a)		
Charles C. Edwards	Mar. 1973	Present
Richard L. Seggel (acting)	Dec. 1972	Mar. 1973
Merlin K. DuVal, Jr.	July 1971	Dec. 1972
Roger O. Egeberg	July 1969	June 1971
Philip R. Lee	Nov. 1965	Jan. 1969
SURGEON GENERAL, PUBLIC HEALTH SERVICE:		
Paul S. Ehrlich, Jr. (acting)	Jan. 1973	Present
Jesse L. Steinfeld	Dec. 1969	Jan. 1973
William H. Stewart	Oct. 1965	July 1969
Luther L. Terry	Mar. 1961	Oct. 1965
DIRECTOR, NATIONAL INSTITUTES OF HEALTH:		
Robert S. Stone	May 1973	Present
John F. Sherman (acting)	Jan. 1973	May 1973
Robert Q. Marston	Sept. 1968	Jan. 1973
James A. Shannon	Aug. 1955	Aug. 1968

REPORT TO THE CONGRESS

Congressional Objectives Of Federal Loans And Scholarships To Health Professions Students Not Being Met B-164031 (2)

National Institutes of Health
Health Resources Administration
Department of Health, Education,
and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(2)

C/

To the President of the Senate and the
Speaker of the House of Representatives

This is our report on the congressional objectives of Federal loans and scholarships to health professions students not being met, as administered by the Health Resources Administration, Department of Health, Education, and Welfare.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Acting Comptroller General
of the United States

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