Order Code RL32546

Title VII Health Professions Education and Training: Issues in Reauthorization

Updated December 21, 2005

Bernice Reyes-Akinbileje
Analyst in Life Sciences
Domestic Social Policy Division

Sharon Kearney Coleman
Technical Information Specialist
Domestic Social Policy Division

Title VII Health Professions Programs: Issues in Reauthorization

Summary

In 1963, responding to projections of an impending physician shortage, Congress passed the Health Professions Educational Assistance Act (P.L. 88-129). This act was the first comprehensive legislation to address the supply of health care providers. Relevant programs, authorized in Title VII of the Public Health Service Act (PHSA), have evolved in subsequent reauthorizations, to provide grants to institutions for primary care curriculum and faculty development, scholarships and loans to individuals training in certain health professions, and other programs. Title VII programs are administered by the Bureau of Health Professions in the Health Resources and Services Administration (HRSA), in the Department of Health and Human Services (HHS). These programs are intended to counter market forces that encourage specialization, and instead aim to alleviate particular provider supply shortages, improve the placement of providers in underserved areas, and improve the racial and ethnic diversity of providers.

The most recent reauthorization of HRSA Title VII programs was in the Health Education Partnerships Act of 1998 (P.L. 105-392), which added authority for geriatrician training, and health workforce analysis, among others. Though authority for these programs expired in 2002, Congress continued to fund most of them each year since then, and appears on track to continue funding in FY2006.

The effectiveness of Title VII health professions programs has long been a subject of debate. Evaluating program effectiveness is complicated by differing perspectives on the ultimate program goals, by continuous evolution of the programs, and by the influence of other federal and private sector programs on provider supply and demand. The unresolved debate about Title VII program effectiveness has resulted in recommendations from the Administration to eliminate many of these programs, recommendations which have persisted for many years.

This report will examine the legislative, programmatic and funding histories of Title VII health professions programs, and discuss issues including workforce analysis and evaluating program effectiveness. In addition, a number of social or market trends likely to affect the health professions, such as the aging population, will be discussed. Summaries of relevant legislation introduced in the 109th Congress and descriptions of Title VII programs are also provided. This report will be updated as events warrant.

Contents

List of Tables

Title VII Health Professions Programs: Issues in Reauthorization

Introduction

In 1963, responding to projections of an impending physician shortage, Congress passed the Health Professions Educational Assistance Act (P.L. 88-129) to support the training of health professionals. This act, which authorized grants for the construction of new teaching facilities, was the first comprehensive legislation to address health care provider supply. Relevant programs, authorized in Title VII of the Public Health Service Act (PHSA), have evolved in subsequent reauthorizations. Beginning in the 1980s, funding for these programs became more focused on alleviating geographic and speciality maldistribution of health professionals, rather than increasing their overall supply. In addition, student assistance and other programs to recruit disadvantaged/ minority students were funded. Today, Title VII programs include grants for primary care curriculum and faculty development, scholarships and loans to assist individuals in financing health professions training, workforce analysis programs, and others. These programs are administered by the Bureau of Health Professions in the Health Resources and Services Administration (HRSA), in the Department of Health and Human Services (HHS).

HRSA also administers two related programs in health workforce development. The National Health Service Corps (NHSC), authorized in Title III of the PHSA, is a scholarship and loan repayment program for certain health care workers who commit to future service in shortage areas. Eligible providers include primary care physicians (doctors of medicine or osteopathy), primary care nurse practitioners, physician assistants, dentists and dental hygienists, certified nurse midwives, social workers, psychologists, and other mental health providers.[1] The NHSC is administered by the HRSA Bureau of Primary Health Care. In addition, programs authorized in Title VIII of the PHSA focus exclusively on nursing workforce development, and are administered by the HRSA Bureau of Health Professions.[2]

A variety of other federal programs also provide support for health professions training, including graduate medical education (GME) programs administered through Medicare and Medicaid in HHS, clinical research training supported by the National Institutes of Health in HHS, and training programs in the Departments of Defense and Veterans Affairs. These other programs may or may not provide

---

[1] See Health Resources and Services Administration (HRSA), National Health Service Corps Web page, at [http://nhsc.bhpr.hrsa.gov/].

[2] See HRSA, Bureau of Health Professions Nursing Web page at [http://bhpr.hrsa.gov/nursing/].

training that is targeted toward clinical specialization. The HRSA programs in Titles III, VII and VIII of the PHSA are the only federal programs intended to counter market forces that encourage specialization, and instead aim to improve the placement of providers in underserved areas, improve the racial and ethnic diversity of providers, and push back against market forces favoring specialization by encouraging "generalist" providers, those in primary care, family medicine, and geriatrics.

The most recent reauthorization of HRSA Title VII programs was in the Health Education Partnerships Act of 1998 (P.L. 105-392). In the act, Congress extended authority for many Title VII programs through September 2002. Congress created new authority for programs in geriatrician training and health workforce analysis. In order to provide administrative flexibility, Congress consolidated 44 existing or new programs into seven clusters of related programs (described in the next section) and established advisory committees for two of the clusters. Though authority for Title VII programs expired in 2002, Congress continued to fund most of them in each fiscal year since then, and appears on track to continue funding in FY2006 (see the section on "Funding for Title VII Programs").

The effectiveness of Title VII health professions programs in meeting a variety of stated objectives has long been a subject of debate. This has resulted in recommendations from the Administration to eliminate many of the programs, recommendations which have persisted for many years.

This report will examine the legislative, programmatic and funding histories of Title VII health professions programs, and discuss issues including workforce analysis and evaluating program effectiveness. In addition, a number of social or market trends likely to affect the health professions, such as the aging population, are discussed. Title VII programs are described in the appendix. This report will be updated as events warrant.

Legislative History of Title VII Programs

In 1963, responding to a projected nationwide shortage of physicians, Congress passed the Health Professions Educational Assistance Act (P.L. 88-129, amending the Public Health Service Act, or PHSA). The act authorized grants for the construction of new teaching facilities and loans to support students in the study of medicine, dentistry, and osteopathy. In the 1970s, when studies indicated that a physician shortage was no longer looming, the emphasis of Title VII programs shifted. Through several reauthorizations in the 1970s and 1980s, Title VII programs were seen as a means to improve maldistributions of health professionals. Programs were authorized to increase the numbers of health professionals in underserved (mostly rural or inner-city) areas, and to improve the racial and ethnic diversity of the health care workforce. In addition, programs were developed to counter the nationwide trend toward specialization by supporting training and curriculum development in primary care.

In 1998, Congress reauthorized and consolidated health professions programs in the Health Education Partnerships Act (P.L. 105-392), creating new authority for programs in geriatrician training and health workforce analysis. To provide administrative flexibility, Congress consolidated multiple existing or new programs into *clusters* of related programs. The current clusters of Title VII programs are: (1) training of minority and disadvantaged professionals; (2) training in primary care medicine and dentistry; (3) interdisciplinary, community-based linkages, to establish training centers in remote areas; (4) health professions workforce information and analysis; (5) public health workforce development; and (6) student financial assistance. Congress also established advisory committees for two of the clusters, primary care medicine and dentistry, and interdisciplinary, community-based linkages. Behavioral and mental health providers were made eligible for participation in certain Title VII programs. The Health Education Assistance Loan (HEAL) program was reauthorized, but since 1998 no new loans have been issued. Still, HEAL receives annual appropriations to liquidate existing loans.

Authority for Title VII programs expired in September 2002, though most programs have continued to receive funding through annual appropriations.

Health Professions Supported by Title VII Programs

The health workforce comprises those who provide hands-on medical care, those who provide ancillary technical and patient-care services, and public health workers who study and address health problems in populations rather than individuals. Generally, workers providing direct medical care or patient-specific technical services have specialty training and certification, and are licensed by states and territories as a condition of their practice. These requirements do not generally apply to the public health workforce.

A wide range of health professionals is eligible to receive support for the education and training activities offered through Title VII programs. Education and training requirements vary for each profession and are reflected in the period of academic study, residency requirements, licensure requirements, and other prerequisites for practice. Title VII support is also available to institutions that train health professionals. Groups of health professionals that are eligible for Title VII support include physicians, dentists, mental and behavioral health professionals, environmental health professionals, dental assistants, and medical assistants.

Some Title VII programs for training providers emphasize support for primary care, those health care services rendered in general medicine and dentistry, family practice and pediatrics. These fields, which emphasize a breadth of skills and care for the whole patient, contrast with specialty care, which is often focused on specific organs or systems. Primary care providers, who may include physicians, dentists, nurses or physician assistants, provide primary care through integrated, accessible health care services. The American Academy of Family Physicians, representing primary care physicians, defines its members as those who:

> [function] as the patient's means of entry into the health care system ... [and are] the physician of first contact in most situations and, as the initial provider, [are]

> in a unique position to form a bond with the patient ... [to evaluate] the patient's total health needs, and [to provide] personal care within one or more fields of medicine.[3]

Title VII also supports training of the public health workforce. This workforce may include nurses and physicians, though they may or may not render direct patient care in the course of their work. Public health workers may also be administrators, technicians, veterinarians, animal control specialists, environmental engineers, sanitarians, educators and community outreach workers.[4] The national public health workforce has been estimated at roughly 450,000 to 500,000 employed workers, employed in health departments at the local, state, or federal levels, in health care institutions, in academia, and in other settings. Considerable overlap exists among providers of primary care and those in public health, as both are strongly oriented toward prevention of illness and injury. Individuals in both fields often move between them, or work in both concurrently, during the course of their careers.

Allied health professionals support or assist in the delivery of public health services or primary health care. They are involved with the delivery of health or related services pertaining to the identification, evaluation and prevention of diseases and disorders; dietary and nutrition services; rehabilitation and health systems management, and others. Dental hygienists, diagnostic medical sonographers, dietitians, cardiovascular technologists, medical technologists, occupational and physical therapists are some examples.[5] These practitioners provide many kinds of services, and they work in all types of settings, including managed care, hospitals, laboratories, health departments, long-term care, and home care settings.

Funding for Title VII Programs

In FY2002, the Administration proposed elimination of most Title VII programs, while continuing most funding for the National Health Service Corps and Title VIII nursing programs, saying

> These (Title VII) training grants were created almost 40 years ago when a physician shortage was looming. Today, a physician shortage no longer exists. To reflect changing priorities, the budget will recommend focusing resources on the Health Professions grants that address current health workforce supply challenges, such as the impending nursing shortage.[6]

---

[3] American Academy of Family Physicians, *Policy and Advocacy*, "Family Practice," at [http://www.aafp.org/x6809.xml].

[4] Institute of Medicine, *Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century*, at [http://www.iom.edu/report.asp?id=4307], p. 263.

[5] The Association of Schools of Allied Health Professions, at [http://www.asahp.org/definition.html].

[6] HHS, *Budget for Fiscal Year 2002*, p. 24, at [http://www.hhs.gov/budget/pdf/hhs2002.pdf].

For fiscal years 2003, 2004, 2005, and 2006, the Administration requested funds for only two Title VII programs: Scholarships for Disadvantaged Students (Section 737) and Health Professions Workforce Information and Analysis (Section 761). Congress continued to appropriate funds for these and most other Title VII programs, though, after years of steady increases, the overall appropriation has remained below the level that was appropriated in FY2003 (See **Table 1**, below).

Table 1. Annual Budget Requests and Appropriations for Title VII Programs, FY2001-FY2006

(dollars in millions)

	FY01	FY02	FY03	FY04	FY05	FY06 Conf.
Budget request	152.4	58.2	11.0	10.9	10.9	10.5
Appropriation	276.4	295.1	308.4	294.2	299.5	Pending

Source: HHS annual budget request documents and tables at [http://www.hhs.gov/budget/06budget/documents/HRSABudget06.pdf].

On June 21, 2005, Representative Regula introduced H.R. 3010 (FY2006 Appropriations bill, Labor, HHS, Education). In July, the bill was passed in the House (H. Rept. 109-143; Yeas and Nays: 250-151). In October, the amended bill was passed in the Senate (S.Rept. 109-103; Yeas and Nays: 94-3). The first conference agreement, in H. Rept. 109-300, proposed a total of $94 million for Title VII programs (or 68 percent less than the FY2005 appropriation). The Senate passed it, but on November 17, the House rejected it.[7]

On December 13, a second conference bill was filed. The next day it was passed by the House (H. Rept. 109-337; Yeas and Nays: 215-213). Senate consideration of the bill is pending. The second agreement proposed a total of $146.7 million for Title VII programs (or 51 percent less than the FY2005 appropriation). A funding history for selected Title VII programs is provided in **Table 2.**

[7] For updates on the status of the LHHS Ed appropriations bill, see CRS Report RL32952, *Labor, Health and Human Services, and Education: FY2006 Appropriations*.

Table 2. Funding for Title VII Programs, FY2001-FY2006 (est.)

(dollars in thousands)

Program	FY01	FY02	FY03	FY04	FY05	FY06 Pres.	FY06 House[a]	FY06 Senate[b]	FY06 Conf. [c]	FY 06 Conf II[d]
Centers of Excellence, Section 736	30,388	32,788	34,088	33,657	33,09	9,831	12,000	33,609	12,000	12,000
Scholarships for Disadvantaged Students (SDS), Section 737	44,473	46,216	47,795	47,510	47,129	—	35,128	47,128	35,128	47,128
Faculty Loan Repayment Program and Minority Faculty Fellowship Program, Section 738	1,330	1,330	1,321	1,313	1,302	—	—	1,302	700	1,302
Health Career Opportunity Program, Section 739	33,044	34,611	36,153	36,160	35,646	—	—	35,647	4,000	4,000
Primary Care Medicine and Dentistry, Section 747	91,048	93,002	92,432	81,917	88,816	—	—	90,000	28,173	41,264
Area Health Education Centers, Section 751	33,125	33,346	32,946	29,206	28,971	—	—	28,971	2,000	28,971
Health Education and Training Centers, Section 752	4,640	4,400	4,371	3,851	3,819	—	—	3,819	—	—
Geriatric Education Centers, Section 753	12,410	20,400	27,818	31,805	31,548	—	—	29,548	—	—
Quentin N. Burdick Program for Rural Interdisciplinary Training, Section 754	5,988	6,996	6,954	6,125	6,076	—	—	6,076	—	—
Allied Health and Other Disciplines, Section 755	8,422	9,495	11,922	11,674	11,753	—	—	11,758	4,000	4,000

Workforce Information and Analysis, Section 761; Health Professions Data System, Section 792	824	824	819	722	716	712	—	712	—	0
Public Health Training Centers and Traineeships, Sections 766 and 767; Preventive Medicine, Dental Public Health, Section 768	9,478	10,473	10,600	9,170	9,097	—	—	9,097	8,000	8,000
Health Administration Traineeships and Special Projects, Section 769	1,231	1,230	1,222	1,078	1,070	—	—	1,070	—	0
Total Appropriations	**276,401**	**295,111**	**308,441**	**294,188**	**299,552**	**10,543**	**47,128**	**298,732**	**94,001**	**146,665**

Sources: HHS/HRSA, Justification of Estimates for Appropriations Committees for Fiscal Years 2000-2006.

[a]H. Rept. 109-143 (H.R. 3010), Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2006, June 21, 2005.

[b]S.Rept. 109-103, July 14, 2005.

[c]H. Rept. 109-300, Nov. 16, 2005.

[d]H. Rept. 109-337, Dec. 13, 2005.

Health Workforce Analysis

An essential tool in assuring an adequate and capable health workforce is the ability to describe workforce strength in the present, and to accurately project future needs. Federal leadership for health workforce analysis rests in the HRSA Bureau of Health Professions, National Center for Health Workforce Analysis (NCHWA).[8] In reauthorizing Title VII and VIII programs in 1998, Congress stated three purposes for programs in Health Professions Workforce Information and Analysis:

> (1) Provide for the development of information on the health professions work force and for the analysis of work force related issues; (2) Provide for the development of necessary information for decision-making regarding future directions in health professions and nursing programs; (3) Provide for continued analysis of issues affecting graduate medical education.[9]

To meet these purposes, HRSA provides grants to state or local governments, health professions schools, schools of nursing, academic health centers, community-based health facilities, and other public or private nonprofit entities in order to: conduct targeted information collection and analysis; research high priority work force questions; develop a non-federal analytic and research infrastructure; and conduct program evaluation and assessment.

Difficulties in measuring the health workforce are discussed below, and represent something of a first hurdle in meeting the Title VII goals of improving the numbers, distribution and diversity of non-specialized health practitioners. When it is not possible to count an existing workforce with confidence, it may not be possible to proceed to next steps: projecting future workforce needs, in total or as a percentage of a population served; defining shortage areas; determining whether market trends in workforce sectors will assure an appropriate future supply; and, evaluating whether specific Title VII programs are effective.

Defining and Enumerating the Health Workforce

Each year, NCHWA enters into cooperative agreements with six Regional Centers for Health Workforce Studies to collect, analyze and disseminate information and to monitor trends in the national, state and local health workforce. NCHWA also

---

[8] See HRSA, National Center for Health Workforce Analysis Home Page, at [http://bhpr.hrsa.gov/healthworkforce/].

[9] U.S. Congress, *Health Professions Work Force Information and Analysis, Section D*, in "Health Professions Education Partnerships Act 1998," Senate Rept. 105-220, June 23, 1998, 105th Congress, Second Sess.

supports efforts to describe the health workforce state by state, and has published in-depth and summary state profiles on its web page.[10]

A census of health workers starts with consistent terminology. The U.S. Department of Labor, Bureau of Labor Statistics (BLS) uses a system of Standard Occupational Classification (SOC) to collect, calculate, and disseminate data about the American workforce. SOC categories provide a consistent format for use in the decennial census, for federal agencies enumerating private-sector workforces relevant to their missions, and for private entities interested in studying the American workforce. Workers are classified into one of over 820 occupations based on similar job duties, skills, education, or experience. Health care workers whose disciplines are supported by Title VII programs are classified in category 29-0000 — "Health care Practitioners and Technical Occupations," which is further divided into "Diagnosing and Treating Practitioners" such as physicians, pharmacists and dentists, and "Health Technologists and Technicians," which includes, among others, laboratory and radiology technicians, and dental hygienists. The suffix in category 29 allows for finer designations. For example, therapists are coded in the 29-1120 series, and a respiratory therapist in particular is coded as 29-1126.[11]

Despite its overall utility, the SOC system falls short when applied to Title VII programs in at least two important ways. First, only eight subcategories of physicians are available, including "other," a category likely to become progressively less helpful if trends toward specialization persist. Second, public health workers, a target group for Title VII programs which has grown in importance with the national emphasis on homeland security, are not described in the SOCs. They are likely to be counted as physicians, nurses, technicians, or other practitioners, depending on which degrees they may hold (if any), but the classification scheme misses the fact that their "practice" is on populations rather than individuals. An analysis of efforts to enumerate workers in the nation's local health departments found that the SOC system did not correspond in meaningful ways with actual workers and their roles, and concluded that "no state or national system is in place to track local public health workers in any way."[12] One of the few attempts to enumerate the national public health workforce estimated it at about 448,000 individuals, though the effort raised as many questions as it answered: What types of training do these individuals have? What proportion of their time is spent solely on public health practice, versus

---

[10] See HRSA, National Center for Health Workforce Analysis, State Health Workforce Profiles website, at [http://bhpr.hrsa.gov/healthworkforce/reports/profiles/default.htm].

[11] U.S. Dept. of Labor, Bureau of Labor Statistics, Standard Occupational Classification System Home Page, at [http://www.bls.gov/soc/home.htm].

[12] Michael R. Fraser, "The Local Public Health Agency Workforce: Research Needs and Practical Realities," *Journal of Public Health Management and Practice*, vol. 9, no. 6, 2003, pp. 496-499.

personal health care, teaching or research? Have they also been counted erroneously toward some other health workforce?[13]

Attempts by professional associations to enumerate workers in their disciplines sometimes yield results that conflict with BLS findings. For example, in 2000, BLS data indicated that there were 598,000 physicians in the United States, while a study of the same year by the American Medical Association indicated almost 814,000, or 36% more.[14] This shows the difficulty in using different data sources (such as BLS data and state license rolls) both in conducting the count itself, and in the variety of determinations that must be made to answer a given question. If one is interested in the strength of a full-time workforce practicing a specific discipline, then correction must be made for those holding licenses and practicing in multiple states, those engaged in employment other than practice, (including those in administration or who are retired), and those practicing part-time or not at all.

Projecting Future Workforce Strength and Needs

Each year, NCHWA grantees prepare ten-year projections of national health workforce strength based on analysis of data from the BLS Office of Occupational Statistics and Employment Projections.[15] The most recent analysis, based on BLS projections for 2002-2012, projected a trend toward growth in health sector jobs exceeding overall growth in the workforce.[16] Ambulatory care, home-based and office-based (versus hospital-based) practitioners are those for which the largest growth is predicted.

NCHWA supports ongoing research to project workforce needs for specific health professions in greater depth. These reports generally use BLS data, and frequently comment on the same dominant trends in supply and demand, such as aging of both the population and the health care workforce, and the growing opportunities for women in higher-paying fields and their attrition from lower-paying health care jobs. Specific trends are also noted for certain health professions, such

---

[13] HRSA, National Center for Health Workforce Analysis, *The Public Health Workforce: Enumeration 2000,* Dec. 2000, at [http://cpmcnet.columbia.edu/dept/nursing/institutes-centers/chphsr/publications.html].

[14] Karen Matherlee, *The U.S. Health Workforce: Definitions, Dollars and Dilemmas,* National Health Policy Forum Background Paper, Apr. 11, 2003, at [http://www.nhpf.org/pdfs_bp/BP%5FWorkforce%5F4%2D03%2Epdf].

[15] U.S. Department of Labor, Bureau of Labor Statistics, Employment Projections Home Page at [http://www.bls.gov/emp/home.htm#data].

[16] R. Martiniano, E. Salsberg, S. McGinnis, and D. Krohl, *Health Care Employment Projections: An Analysis of Bureau of Labor Statistics Occupational Projections, 2002-2012.* Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany, Mar. 2004, at [http://chws.albany.edu/].

as the growth of outpatient prescription drug use and the projected growth in demand for pharmacists.[17]

The Association of State and Territorial Health Officials (ASTHO) recently reported on the status of the national public health workforce.[18] Lacking relevant BLS data, ASTHO used the results of a survey of state government agencies conducted by the Council of State Governments and the National Association of State Personnel Executives, augmented by its own survey of its members, the senior health officials of the 57 states and territories (including the District of Columbia). The report's key findings include an aging public health workforce, retirement rates as high as 45% over the next five years, current vacancy rates of up to 20% in some areas, and prolonged high turnover in some areas. The report notes that the educational status of public health workers is not always clear, and that prevailing wages at the state and local level may serve as impediments to enhancing educational requirements.

Shortage Designations and Diversity

The Shortage Designation Branch in the HRSA Bureau of Health Professions, National Center for Health Workforce Analysis, develops shortage designation criteria and uses them to decide whether or not a geographic area or population group is a *Health Professional Shortage Area* or a *Medically Underserved Area or Population*. HRSA reports that more than 34 federal programs depend on these shortage designations to determine eligibility or as a funding preference, and that about 20% of the U.S. population resides in primary medical care Health Professional Shortage Areas.[19] The HRSA Bureau of Health Professions, Diversity Program, designates underrepresented minorities and disadvantaged students eligible for certain programs.

Health Professional Shortage Areas. A health professional(s) shortage area (HPSA) is designated when the Secretary of Health and Human Services (HHS) determines there is a shortage of health professional(s) in an urban or rural area (which need not conform to political subdivisions), a population group or a public or nonprofit private medical facility.[20] Areas are given "HPSA Scores" that take into account several factors, including ratios of population to primary care physicians,

---

[17] See listing of National Center for Health Workforce Analysis reports at [http://bhpr.hrsa.gov/healthworkforce/reports/default.htm].

[18] Association of State and Territorial Health Officials, *State Public Health Employee Worker Shortage Report: A Civil Service Recruitment and Retention Crisis*, May 2004, at [http://www.astho.org/pubs/Worker-Shortage-Booklet.pdf]

[19] HRSA, Bureau of Health Professions, Shortage Designations Branch Home Page, at [http://bhpr.hrsa.gov/shortage/index.htm].

[20] The basis for the Secretary's designation authority rests in Section 215 of the Public Health Service Act, 58 Stat. 690 (42 U.S.C. 216); Section 332 of the Public Health Service Act, 90 Stat. 2270-2272 (42 U.S.C. 254e).

poverty rates, infant mortality/ low birth weight, and travel distance to sources of care.

Medically Underserved Areas and Populations. HRSA defines a Medically Underserved Area (MUA) as "a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services," and a Medically Underserved Population (MUP) as "groups of persons who face economic, cultural or linguistic barriers to health care."[21]

Minority and Disadvantaged Designations. With respect to health professionals, HRSA defines an underrepresented minority as " ... racial and ethnic populations that are underrepresented in the health professions relative to the number of individuals who are members of the population involved. This definition would include Black or African American, Hispanic or Latino, American Indian or Alaskan Native."[22] It is worth noting that individuals who are Asian or Pacific Islanders are not designated in this case. These groups are not underrepresented in the health professions relative to the U.S. population, though they may be designated as underrepresented minorities in other contexts.

HRSA defines a "disadvantaged" individual as someone who

> (a) comes from an environment that has inhibited the individual from obtaining the knowledge, skill, and abilities required to enroll in and graduate from a school (environmentally disadvantaged); or (b) comes from a family with an annual income below a level which is based on low-income thresholds according to family size published by the U.S. Bureau of the Census, adjusted annually for changes in the Consumer Price Index, and adjusted by the Secretary of HHS for adaptation to this program (economically disadvantaged).[23]

Trends Affecting the Health Workforce

Key social and market trends affect demand for and supply of individuals in the health workforce. Aging of the population and the health care workforce, requirements for emergency preparedness, access to health insurance, growth in minority populations, reliance on international medical graduates and other concerns could shape programmatic and funding decisions that influence the health workforce.

---

[21] HRSA, Bureau of Health Professions, Shortage Designations Branch Home Page, at [http://bhpr.hrsa.gov/shortage/index.htm].

[22] HRSA, Bureau of Health Professions, *Health Careers Opportunity Program Definitions*, at [http://bhpr.hrsa.gov/diversity/definitions.htm#hcop].

[23] HRSA, Bureau of Health Professions, *Answers to Frequently Asked Questions: Scholarships for Disadvantaged Students (SDS) Program*, at [http://bhpr.hrsa.gov/DSA/sds04/pages/faq.htm#disadvantageddef].

The Aging Population

In 2003, in the United States, there were 35.9 million persons 65 years and older, 12.3% of the U.S. population. This group is expected to grow to 71.5 million (about one in every five people) by 2030.[24] Health services utilization (e.g., office visits, hospital discharges, length-of-stay, and out-of-pocket health care costs) is generally greater for this group than for younger individuals. Compounding the problem of growing numbers of older individuals who will require care, are reports that groups of health professionals are also aging into retirement. The average age of nurses and public health workers, among others, exceeds the average age of the American workforce overall, and large proportions of these groups are expected to retire within the next five years.

Almost 97% of those over 65 (who are eligible for Medicare) reported in 2003 that they had "a usual place to go for medical care," a proportion much larger than for younger age groups. But while access to care may be a lesser problem for seniors, quality of care may be of concern. The American Geriatrics Society has testified on the nationwide shortage of trained geriatricians, and of training programs for them. The Society describes geriatric care as follows:

> Geriatric medicine promotes wellness and preventive care, with emphasis on care management and coordination that helps patients maintain functional independence in performing daily activities and improves their overall quality of life. ... geriatricians commonly work with a coordinated team of nurses, geriatric psychiatrists, physician assistants, pharmacists, social workers, physical and speech therapists and others. The geriatric team cares for the most complex and frail of the elderly population. Geriatricians are primary care-oriented physicians who are initially trained in family practice or internal medicine and who are required to complete at least one additional year of fellowship training in geriatrics.[25]

The Society further notes that in 1998, of the approximately 98,000 medical residency and fellowship positions supported by Medicare, only 324 were in geriatric medicine and geriatric psychiatry. In 2002, the Alliance for Aging Research reported that there were approximately 9,000 certified geriatricians in the nation, when 20,000 were needed. The Alliance projects a need for 36,000 geriatricians by 2030.[26] They also recommend enhanced training of a variety of other health professionals (e.g.,

---

[24] Unless otherwise noted, information for this section was taken from HHS, Administration on Aging, "Statistics on the Aging Population," at [http://www.aoa.gov/prof/Statistics/statistics.asp].

[25] Charles E. Cefalu, statement on behalf of the American Geriatrics Society before the Senate Special Committee on Aging, hearing regarding "Patients in Peril: Critical Shortages in Geriatric Care," Feb. 27, 2002, 107th Cong., second sess.

[26] Alliance for Aging Research, "Medical Never-Never Land: Ten Reasons Why America Is Not Ready for the Coming Age Boom," 2002, available at [http://www.agingresearch.org/bookshelf_details.cfm?id=38].

family physicians, mental health providers and nurses) in the special needs of older patients.

In the Health Professions Education Partnerships Act of 1998, Congress created a new Section 753 in the PHSA to provide support for professional training, re-training, and faculty development for geriatric practice. Funding for this program has grown from $10.6 million in FY2000 to $31.5 million in FY2005. The Administration budget proposal for FY2006 does not fund this and most other Title VII programs, saying that a federal assessment determined that these programs have not demonstrated an impact on placing health professionals in underserved areas.[27] The House recommends no funding for geriatric training in FY2006. The Senate Committee on Appropriations recommends $29.5 million for FY2006. The Conference agreement recommended no funding (see the previous section on funding).

Emergency Preparedness

Since the terror attacks of 2001, the need for a responsive public health workforce is more evident. GAO reported in 2002 that "shortages of personnel existed in state and local health departments, laboratories, and hospitals and were difficult to remedy."[28] Federal, state and local governments may be in competition for a finite group of workers, as CDC Director Julie L. Gerberding has noted, saying, "We're competing over the same group of talented people. It takes time to hire and train people and our pipeline in our schools is not a torrent. It's more like a trickle."[29] The Partnership for Public Service has reported that the federal government has been unable to match salary growth in the private sector since 2001, resulting in migration of talent away from public service, and that nearly half of all federal employees in biodefense-related positions will be eligible for retirement within five years.[30]

In 2002 the Institute of Medicine proposed a plan for educating public health professionals for the 21st century, recommending degree programs in schools of public health, medicine, and nursing.[31] In a subsequent workshop, the Association of State and Territorial Health Officials (ASTHO) posited that training programs

---

[27] HHS. *Budget in Brief*, Fiscal Year 2006, p. 20, available at [http://www.hhs.gov/budget/06budget/FY2006BudgetinBrief.pdf].

[28] U. S. General Accounting Office, *Bioterrorism: Preparedness Varied Across State and Local Jurisdictions*, GAO-03-373, Apr. 2003, p. 17.

[29] Testimony of CDC Director Julie L. Gerberding in the U.S. Congress, Senate Committee on Health, Education, Labor and Pensions, *Federal Biodefense Readiness*, 108th Cong., first sess., July 24, 2003. (Hereafter cited as Testimony of CDC Director, *Biodefense Readiness*.)

[30] Partnership for Public Service, *Homeland Insecurity: Building the Expertise to Defend America from Bioterrorism*, at [http://www.ourpublicservice.org/].

[31] Institute of Medicine, *Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century*.

alone will not remedy public health worker shortages, and that the problem requires a strategy that takes into account the human resources systems, salary structures, and incentives in governmental public health.[32] ASTHO urged consideration of distance-learning, education debt forgiveness programs for state and local public health workers, and funding support for on-the-job training.

CDC maintains a public health workforce program that looks broadly at the problem from a "pipeline" perspective.[33] Its most recent strategic plan for public health workforce development pre-dates the 2001 terror attacks, though activities are ongoing to bolster the workforce in the context of terrorism and emergency preparedness. CDC Director Julie L. Gerberding notes:

> A competent and sustainable workforce is one of the strategic imperatives within CDC's National Strategy for Terrorism Preparedness and Emergency Response. CDC's support to address this imperative will focus on: increasing the number and type of professionals that comprise a preparedness and response workforce; delivery of certification and competency based training; recruitment and retention of the highest quality workforce; evaluation of the impact of training on workforce competency; (and) support for Schools of Public Health, Medicine and other Academic partners to increase the number of individuals entering the field and trained throughout their career. Currently, CDC funds Academic Centers for Public Health Preparedness at Schools of Public Health to address workforce training and 'workforce pipeline' issues. ... we are developing a strategic framework for workforce development throughout the entire public 41health system, which includes going way back to junior highs and high schools.[34]

Though HRSA has conducted analyses of the health workforce, its emphasis has historically been on primary health care rather than in public health functions such as surveillance, outbreak investigation and facility inspections. More recently HRSA is funding studies of the public health workforce in several states.[35] In addition, HRSA supports a number of programs to train public health professionals on the job.[36] Following the terror attacks of 2001, HRSA provided grants in FY2002 and FY2003 through a new Bioterrorism Training and Curriculum Development Program, for training in recognition and treatment of diseases related to bioterrorism to health care providers in training and on the job. FY2004 funding completed the

---

[32] Institute of Medicine, *Who Will Keep the Public Healthy?*, workshop summary, Aug. 4, 2003, at [http://www.iom.edu].

[33] See the CDC Office of Workforce Policy and Planning Home Page at [http://www.phppo.cdc.gov/owpp/].

[34] Testimony of CDC Director, *Biodefense Readiness*.

[35] For more information, see HRSA Regional Centers for Health Workforce Studies at [http://bhpr.hrsa.gov/healthworkforce/centers/default.htm].

[36] See descriptions of HRSA public health workforce programs at [http://bhpr.hrsa.gov/publichealth/index.htm].

awards for prior-year grantees.[37] The FY2005 appropriation for this program was $27.520 million.[38]

Despite these efforts, there have been repeated calls for a national strategy aimed at defining and providing a skilled, sustainable workforce for public health preparedness, without it coming at the expense of routine public health activities. The Gilmore Commission recommended in 2002 that "DHHS fund studies aimed at modeling the size and scope of the health care and public health workforce needed to respond to a range of public health emergencies and day-to-day public health issues."[39] With the release of its fifth and final report one year later, the Commission noted that this recommendation was one of few that had yet to be implemented. The Association of Public Health Laboratories has said that "the nationwide shortage of skilled laboratorians cannot be addressed through short-term funding support, but requires a long-term national strategy."[40] And the Partnership for Public Service noted, "There is no government wide planning effort that develops a coordinated recruitment plan for the numerous federal agencies responsible for biodefense....We have seen no analysis that identifies the numbers and types of employees needed in response to the most likely bioterrorist threats."[41]

Congress may wish to consider whether federal leadership to develop a national strategy for a prepared public health workforce should properly reside at CDC, at HRSA, or elsewhere, and whether this matter should be considered in reauthorizing Title VII programs.

Health Insurance

In 2004, the U.S. Census Bureau reported the third consecutive annual increase (for the prior year) in the share of the American population without health

---

[37] See HRSA Bioterrorism and Emergency Preparedness Programs at [http://www.hrsa.gov/bioterrorism.htm].

[38] HRSA, "Justification of Estimates for Congressional Committees, FY2006," *Budget*, vol. I, p. 183.

[39] Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction, *Fourth Annual Report to the President and Congress*, p. 55, at [http://www.rand.org/nsrd/terrpanel/terror4.pdf]. Commonly known as the Gilmore Commission after its chair, former VA Governor James S. Gilmore III, the Panel was established in the National Defense Authorization Act for FY1999 to assess the federal, state and local capabilities for responding to terrorist incidents in the United States.

[40] Association of Public Health Laboratories, "Public Health Laboratory Issues In Brief: Bioterrorism Capacity," at [https://www.aphl.org/docs/BTIssuebrief%20final%20Oct02.pdf].

[41] Partnership for Public Service, *Homeland Insecurity: Building the Expertise to Defend America from Bioterrorism*, at [http://www.ourpublicservice.org/].

insurance.[42] An estimated 15.6% of the population, or 45 million people, were uninsured in 2003. The overall decrease in coverage was driven in part by a drop in the number of people covered by employment-based health insurance, from 175.3 million in 2002 to 174.0 million in 2003.

The Institute of Medicine (IOM), in one of a series of reports on the problem of uninsurance, looked at its associated costs, and commented on its effects on provider distribution, saying:

> Uninsurance may affect the availability of health services within communities. In an effort to avoid the burden of uncompensated care or to minimize its impact on the financial bottom line, health care providers may cut back on services, reduce staffing, relocate, or close. Already overcrowded hospital emergency departments may be further strained as they increasingly serve as the provider of first and last resort for uninsured patients. Physicians' offices or even hospitals may relocate away from areas of towns or entire communities that have concentrations of uninsured persons. Especially for institutions that serve a high proportion of uninsured patients such as center-city community hospitals or academic medical centers, a large or growing number of uninsured persons seeking health care may "tip" a hospital's or clinic's financial margin from positive to negative.[43]

In January 2002, the Administration announced a series of actions to assist those without health insurance.[44] The focus of HRSA activities was to be support for Community Health Centers and the National Health Service Corps (in Title III of the PHSA), a strategy proposed in other venues as well, including appropriations testimony. Title VII Health Professions programs were not mentioned specifically, though if they are effective in placing providers in underserved areas, they could serve to push back against the market forces described by IOM in providing care for the uninsured.

International Medical Graduates

A graduate from a medical school outside the United States and Canada is an international medical graduate (IMG).[45] IMGs constitute about one-fourth of

---

[42] U.S. Department of Commerce, U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2003," at [http://www.census.gov/prod/2004pubs/p60-226.pdf].

[43] Institute of Medicine, "Hidden Costs, Value Lost: Uninsurance in America," 2003, p. 90.

[44] U.S. Dept of Health and Human Services, remarks of Secretary Tommy G. Thompson, "President's Plan To Assist The Uninsured," Jan. 30, 2002.

[45] Information in this section is derived from: HRSA, National Center for Health Workforce Analysis, *Globalization and the Physician Workforce in the United States*, April 2002 at [http://bhpr.hrsa.gov/healthworkforce/reports/default.htm]; James A. Hallock, et al., "The International Medical Graduate Pipeline," *Health Affairs*, vol. 22, no. 4, July-Aug. 2003, pp. 94-96 and CRS Report RL31460, *Immigration: Foreign Physicians and the J-1 Visa Waiver*

(continued...)

physicians in graduate medical education in the United States. The Educational Commission for Foreign Medical Graduates at [http://www.ecfmg.org] certifies IMGs to enter residency or fellowship programs at accredited U.S. institutions. About one-fourth of IMGs entering U.S. residency programs are on exchange visitors' status (J-1) visas, and must either return to their home countries for two years following training, or obtain a waiver by committing to three years of service in an underserved area in the United States. As a result, in 2002 IMGs with visa waivers constituted about 60% of all underserved-area service commitments in the United States. However, in December 2003, HHS expanded restrictions on its J-1 visa waiver application, limiting waived physicians to working in Federally Qualified Health Centers, Rural Health Clinics or Indian Health Service Clinics in areas with high HPSA scores. This new policy substantially reduced the number of areas that qualified for J-1 visa waiver status in a number of primarily rural states.

HRSA notes that three times as many minorities live in HPSAs as compared with the general population. While IMGs serve an important role in plugging health care gaps in these underserved areas, about 40% of IMGs come from just four Asian countries, India, the Philippines, Pakistan and South Korea. Black and Hispanic IMGs are under-represented not only relative to the patient population, but also compared with the provider population. IMGs do not, therefore, contribute to improving overall racial and ethnic diversity in the health care workforce.

The Effectiveness of Title VII Programs

The effectiveness of Title VII health professions programs in meeting a variety of stated objectives has long been a subject of debate. On the one hand, Administrations have proposed to eliminate many of the programs, recommendations which have persisted for many years. On the other hand, Congress has continued to fund these programs, and they continue to evolve, complicating the task of evaluating program effectiveness. Numerous views on program effectiveness and ways to improve program evaluation are discussed below.

Differing Views on Program Goals

In general, evaluating program effectiveness depends on linking performance to pre-determined goals. This simple maxim has proved troublesome when applied to HRSA Title VII programs; different parties, from stakeholders to the Administration to the Congress, have articulated different goals ranging from the very broad to the very specific, and sometimes in conflict. This has led to a wide swath of official determinations of effectiveness and an historical difference of opinion between Congress and the Executive Branch regarding the merits of these programs. In addition, the evolution of program goals over time adds to the script of stated purposes. For example, the advisory committee for Section 747 Primary Care

---

[45] (...continued)
Program, by Karma A. Ester.

Medicine and Dentistry programs recounted a chronology of purposes in authorizing legislation, beginning in 1963 with support for school construction, the most basic bricks-and-mortar foundation of long-term capacity-building. With each reauthorization the stated purposes evolved, bringing in support for minority training and geographic distribution, expanding residency slots, and incorporating family medicine and dentistry along the way.[46] To some, the moving goalpost of program objectives stymies efforts to evaluate the effectiveness of any one step. To others, this simply represents the natural progression of successful programs.

In 1997, in preparation for the 1998 reauthorization of HRSA Title VII programs (P.L. 105-392), GAO testified that "the effectiveness of Title VII ... programs will remain difficult to measure as long as they are authorized to support a broad range of health care objectives without common goals, outcome measures, and reporting requirements."[47] The following sections will examine program goals from a variety of perspectives. The cluster of Section 747 Primary Care Medicine and Dentistry programs will be cited frequently as an example; these programs have a reasonable evidence base upon which to consider the question of effectiveness, as well as a rich history of debate. It is assumed that many of the elements of this controversy will apply equally well to the other program clusters.

Congressional Views. In reauthorizing Title VII programs in 1997, Congress consolidated the existing 44 health workforce programs into seven *clusters*. Legislative language generally articulated objectives only for specific components within each cluster, but the accompanying Senate Report (105-220, June 23, 1998) provided a glimpse of congressional intent toward broader goals for each cluster, as follows:

- *Minority and Disadvantaged Health Professionals Training*: Purposes: (1) Provide for the training of minority and disadvantaged health professionals to improve health care access in underserved areas and to improve representation in the health professions.
- *Primary Care Medicine and Dentistry*: Purposes: (1) Provide for the training of family physicians, general internists, general pediatricians, physician assistants, general dentists, and pediatric dentists to improve access to and quality of health care in underserved areas.
- *Interdisciplinary, Community-Based Linkages*: Purposes: (1) Provide support for training centers remote from health professions schools to improve and maintain the distribution of health providers

---

[46] U.S. Dept. of Health and Human Services, HRSA, Advisory Committee on Training in Primary Care Medicine and Dentistry, *Comprehensive Review and Recommendations: Title VII, Section 747 of the Public Health Service Act*, Nov. 2001.

[47] Testimony before the U.S. Congress, Senate Committee on Labor and Human Resources, Subcommittee on Public Health and Safety, *Health Professions Education: Clarifying the Role of Title VII and VIII Programs Could Improve Accountability*, 105th Congress, first sess., GAO/T-HEHS-97-117, Apr. 25, 1997.

in rural and urban underserved areas; (2) Provide support for geriatric education and geriatric faculty fellowships; (3) Provide support for interdisciplinary training projects.

- *Health Professions Workforce Information and Analysis*: Purposes: (1) Provide for the development of information on the health professions work force and for the analysis of work force related issues; (2) Provide for the development of necessary information for decision-making regarding future directions in health professions and nursing programs; (3) Provide for continued analysis of issues affecting graduate medical education.
- *Public Health Workforce Development*: Purpose: Provide for an increase in the number of individuals in the public health work force and enhance the quality of such work force.
- *Nursing Workforce Development*: (Not applicable. These programs are found in Title VIII.)
- *Student Financial Assistance:* Purposes: (1) Continue certain loan programs which do not require federal appropriations or that guarantee the availability of loan sources in the market for health professions students; (2) Continue a loan program for the disadvantaged.[48]

Most of the clusters carry statements of purpose that causally link an activity (e.g., "provide for the training of minority and disadvantaged health professionals") to an outcome (e.g., "to improve health care access in underserved areas and to improve representation in the health professions"). While Congress has funded each cluster in each fiscal year since reauthorization, the Administration has not always concurred with these assumptions of causality, or with the assumption that these programs are effective in general.

Despite the Administration's annual budget proposals (discussed below), Congress provided continued funding for all program clusters in Title VII for FY2004, though at a level below the FY2003 appropriation. The House Appropriations Committee noted in its report on FY2004 appropriations that:

> The Committee was unable to restore completely the ... reduction in health professions funding proposed by the Administration, but intends to continue all the programs at manageable operating levels with the funds provided. The Bureau of Health Professions provides both policy leadership and support for health professions workforce enhancement and educational infrastructure development.[49]

---

[48] Most of the clusters also have the stated purpose of administrative simplification, an overarching goal behind creating the clusters.

[49] U.S. Congress, House Committee on Appropriations, *Making Appropriations for the Departments of Labor, Health and Human Services and Education, and Related Agencies*, report to accompany H.R. 2660, 108th Cong., first sess., H.Rept. 108-188 (Washington: GPO, 2003), p. 23.

Administration Views. In the FY2006 Administration budget proposal, as in prior years, HRSA health workforce programs are slated for near-elimination. Following an FY2005appropriation of nearly $300 million spread across the seven clusters, the Administration's FY2006 proposal calls for about $11 million, going to only two clusters; $10 million for Scholarship for Disadvantaged Students and $1 million for health workforce information and analysis.[50] In its Program Assessment Rating Tool (often called a PART assessment) for FY2003, the White House Office of Management and Budget (OMB) found a lack of clarity of purpose in Title VII programs, giving them collectively a 13% (out of 100) rating for results/accountability, and recommending continued phase-out of most health professions grants with redirection of funds to more effective options, though none were stated.[51] In specific, the assessment found:

> 1. There is disagreement regarding the purpose of the program and a clear and focused purpose is not found in the authorizing legislation, external views and program documents. For example, the agency believes the purpose is to address the failure of the market to distribute health providers to all areas of the country and to serve all population groups. Others believe the purpose is to primarily to help rural areas or to subsidize schools.
>
> 2. While the program has been managed well overall, it has not regularly used performance data to improve program outcomes. The (GAO) noted in 1997 that effectiveness has not been shown and the impact will be difficult to measure without common goals, outcome measures and reporting. The program has adopted new performance benchmarks, but lacks data to demonstrate progress.

In her testimony to congressional appropriators regarding the FY2005 budget proposal, HRSA Administrator Elizabeth Duke expanded on the Administration's rationale for cutting back or eliminating the health professions programs, stating that:

> ... the preference of the Administration is to put more money into direct health care delivery and less money into some of the programs that have been historically used. ... only 30 percent of the graduates of these programs actually end up in care to the underserved, and ... the Administration's position is that a better way to go would be to fund direct care (through the National Health Service Corps).[52]

Views of Formal Advisors. The Advisory Committee on Training in Primary Care Medicine and Dentistry was created by Congress in 1998 to provide advice and recommendations to the Secretary of HHS regarding Section 747 programs. As expected, in order to provide tangible experience in program

---

[50] See previous section, on "Funding for Title VII Programs."

[51] U.S. Office of Management and Budget, *Performance and Management Assessments, Fiscal Year 2004,* Budget of the U.S. Government, 2003.

[52] Testimony of Elizabeth Duke before the House Committee on Appropriations Subcommittee on Labor, Health and Human Services, and Education regarding the Health Resources and Services Administration FY2005 appropriation, 108th Congress, second sess., Mar. 24, 2004.

performance, the committee is comprised of individuals who either work for institutions or represent professions that benefit from Title VII programs. The committee has issued two reports. In the first, published in November 2001, the committee concluded that these programs are effective in improving the numbers and distribution of targeted providers, though much of the evidence cited is anecdotal and a causal link between the program and outcomes is not always demonstrated.[53] The committee acknowledges this, though, in several statements about the difficulty in evaluating these programs, saying

> Several factors make it difficult to obtain direct evidence relevant to the influence of Title VII, Section 747 programs on its primary goals. First, the program has continued to evolve since it began. With these changes, reporting methods have been modified and have not necessarily provided data relevant to the supply, distribution, and composition of primary care providers.[54]

Ironically, the committee adds to the debate about Title VII programs serving as counterweights to the market-driven specialization trend, suggesting that public funds as well as private sector forces may work against program outcomes and hamper their actual or perceived effectiveness. The committee notes:

> Judgments about (the effectiveness of these programs) are further muddied because these programs represent only a minor fraction of overall funding for medical education and training. ... The billions of dollars in support of other national priorities such as biomedical research through the National Institutes of Health and the support through Medicare graduate medical education in subspecialty areas have been powerful influences toward specialty rather than primary care training that dwarf the amounts expended to support Title VII, Section 747 incentives.[55]

Stakeholder Views. Responding to OMB's unfavorable performance ratings for Title VII programs, the American Academy of Family Physicians (AAFP) has testified that:

> OMB criticized all of the Title VII Health Professions programs as lacking a focused objective. However, Section 747 ... in particular, has a clear purpose and has been successful in achieving its goals. The OMB evaluation lumps all of the programs together and does not evaluate them individually. By definition, these programs will have different goals, different levels of effectiveness and different histories, making the PART evaluation unsophisticated, at best.[56]

---

[53] U.S. Dept. of Health and Human Services, HRSA, Advisory Committee on Training in Primary Care Medicine and Dentistry, *Comprehensive Review and Recommendations: Title VII, Section 747 of the Public Health Service Act*, Nov. 2001.

[54] Ibid., p. 9.

[55] Ibid., p. 9.

[56] American Academy of Family Physicians, "Statement for the Record to the House and Senate Appropriations Subcommittee on Labor/HHS/Education in Support of Various (continued...)

The Section 747 cluster does have a stated purpose in authorizing legislation, as noted above. With respect to the apparent assumption by Congress that subsidized training programs will lead to improved access and quality of care in underserved communities, AAFP points to the findings, published in 2002, of a comprehensive analysis of Title VII programs between 1978 and 1993 in which 180,000 medical school graduates were followed to evaluate their practice specialty and location in the year 2000. Students who attended schools that received no family medicine Title VII funding during their tenure chose family practice at a rate of 10.2%. Students who attended schools that received Title VII funding of any type for one or more years of their enrollment chose family practice at a rate of 15.8%. Additionally, Title VII funding was associated with higher rates of practice in primary care health personnel shortage areas and with practice in a rural area. The authors concluded that Title VII programs resulted in an additional 6,968 family physicians involved in active patient care *who would otherwise not have been,* with an aggregate input of $290 million in Title VII funds to Section 747 programs, over the 15-year study period.[57]

Resolving the Effectiveness Debate

Comprehensive studies such as the one about family physicians described above are few, though some would argue that a lack of evidence to demonstrate successful performance does not mean that Title VII programs are ineffective. The disagreements in evaluating Section 747 programs highlight the difficult position in which Congress finds itself. What are the parameters of a meaningful evaluation, in terms of the timespan studied and the length of followup in an ever-changing landscape? Should these evaluations be conducted by stakeholders? Is OMB the best evaluator for a process intended to "aim" a freshman medical student at whatever shortages may exist eight years hence? What is the societal value of a well-placed provider who would not otherwise be there?

Adding to the challenge of evaluating effectiveness, even if one concludes that Title VII programs led to improved provider distributions, what does that mean for access to care, or to actual health outcomes for the population? GAO has noted that:

> ... geographic measures of physician supply can be a very rough measure of the actual accessibility of physician services in a given area. ... many people lack access even in an area with a large number of physicians. This lack of access is often due to economic facts; lack of insurance, Medicaid coverage or low income in general may prevent many residents from receiving care from many of the

---

[56] (...continued)
Programs for FY2005," Apr. 21, 2004, at [http://www.aafp.org/x27256.xml?printxml].

[57] George E. Freyer et al., "The Association of Title VII Funding to Departments of Family Medicine with Choice of Physician Speciality and Practice Location," *Family Medicine*, vol. 34, no. 6, 2002.

> physicians in the area. In addition, there may be language and cultural barriers that keep the residents from seeking or receiving appropriate care.[58]

Many seek an end to the annual debate in which the Administration, Congress and stakeholders propose eliminating or restoring budgets for Title VII programs, while evaluation methods continue to satisfy no one. The Society of Primary Care Policy Fellows has called for a new evaluation model, saying:

> Over the 25-year history of these programs, extensive data have been collected but have not been effectively used to scientifically assess their impact. For a decade, the Office of Management and Budget and the General Accounting Office have repeatedly criticized (HRSA) for failing to perform regular, objective, comprehensive evaluations. Evaluation of the programs has also been hampered due to a lack of legislated outcome measures and their reliance on the prevailing Administration's priorities. When it has been possible to collect data relevant to Administration priorities, for example, to assess (Title VII's) ... impact on access to care in either health centers or through the National Health Service Corps, these data have not been collected. For Title VII, this evaluation failure has meant a decade of Administration budget recommendations for no funding.[59]

The Society recommends that an evaluator directly accountable to the Congress be designated, that the evaluator establish outcomes-based benchmarks, and that there be routine data analysis to measure workforce production and distribution, and population health. The Society also recommends that data be gathered to evaluate the impact of Title VII programs on the distribution and deployment of the health care workforce in federally qualified health centers and other underserved communities.

The GAO has noted limitations in the PART assessment process, saying in particular:

> Some agency officials claimed that having multiple statutory goals disadvantaged their programs. Without further guidance, subjective terminology can influence program ratings by permitting OMB staff's views about a program's purpose to affect assessments of the program's design and purpose.[60]

This limitation may help to explain the PART findings for Title VII programs; despite several statements in the assessment narrative itself that data for evaluation

---

[58] U.S. General Accounting Office, *Physician Workforce: Physician Supply Increased in Metropolitan and Nonmetropolitan Areas but Geographic Disparities Persisted,* GAO-04-124, Oct. 2003, p. 29.

[59] Lynette A. Ament et. al., *Reauthorizing Title VII and Title VIII: Options for Outcomes and Evaluation,* Primary Health Care Policy Fellowship, Fellows Policy Paper, 2003, at [http://www.primarycaresociety.org/papers.htm].

[60] U.S. General Accounting Office, *Performance Budgeting: Observations on the Use of OMB's Program Assessment Rating Tool for the Fiscal Year 2004 Budget,* GAO-04-174, Jan. 2004, p. 20.

were limited, suggesting a finding of "Results Not Demonstrated," the programs were instead rated "Ineffective." GAO noted that the PART assessment process is being revamped for FY2005 to reflect lessons learned, and GAO recommended, among other things, closer coordination of OMB with Congress to improve the likelihood that future PART assessments will accurately capture congressional intent in measuring program performance.

OMB itself notes the limitations of its Performance Assessment Rating Tool, saying:

> ... information provided by performance measurement is just part of the information that managers and policy officials need to make decisions. Performance measurement must often be coupled with evaluation data to increase our understanding of why results occur and what value a program adds. Performance measurement cannot replace data on program costs, political judgments about priorities, creativity about solutions, or common sense. A major purpose of performance measurement is to raise fundamental questions; the measures seldom, by themselves, provide definitive answers.[61]

OMB then describes six types of obstacles to good performance measurement and ways to mitigate them. Four of the descriptions apply to Title VII programs, as follows:

- *The program's outcomes are extremely difficult to measure*: This problem can result when the program purpose is not clear, when the beneficiary or customer is not clearly defined, when stakeholders and programs managers have different views of the program, and when good data are not available. OMB suggests using qualitative information such as expert panel reviews when quantitative measures are lacking.
- *The program is one of many contributors to the desired outcome*: This problem results when several federal programs, programs from various levels of government (federal, state, local), and private-sector or non-profit activities all contribute to achieving the same goal. OMB recommends, as one approach, developing broad, yet measurable, outcome goals for the collection of programs, while also having program-specific performance goals.
- *Results will not be achieved for many years*: To address this issue, OMB suggests defining specific short- and medium-term steps or milestones to accomplish the long-term outcome goal. These steps are likely to be output-oriented interim goals.
- *The program has multiple purposes and funding can be used for a range of activities*: This problem occurs with federal programs that must offer some degree of local flexibility while still aiming toward

---

[61] U.S. Office of Management and Budget, "Performance Measurement Challenges and Strategies," June, 2003, at [http://www.whitehouse.gov/omb/part/challenges_strategies.html].

> national goals. OMB suggests developing both performance measures and national standards to provide "joint accountability" for programs, and setting local targets for aggregation into national targets.

The national goal-setting agenda for health, the decennial Healthy People project, emphasizes health targets for individuals. The current set of goals, Healthy People 2010, articulates two national goals directly related to Title VII programs in its section on Access to Quality Healthcare Services, namely to "increase the proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention," and "(in) the health professions, allied and associated health profession fields, and the nursing field, increase the proportion of all degrees awarded to members of underrepresented racial and ethnic groups."[62]

In its most recent Annual Performance Report under the Government Performance and Results Act (GPRA, for FY2003), HRSA reports on efforts to transition from older goals which are being phased out, to new short and long-term goals.[63] A general trend is the elimination of goals to increase the *number* of providers and substitution of goals to increase the *proportion* of funded providers actually serving in the desired situation. The shifting parameters, while intended to provide more pertinent measures, again reflect the difficulty in evaluating these steadily-evolving programs.

Options for Congress

While Congress has continued to fund Title VII programs despite recent budget proposals for elimination, reduced amounts put forward in budget proposals may affect budget ceilings — the so-called 302(b) allocations for appropriations bills — putting pressure on appropriators who wish to maintain Title VII funding to offset the funds from elsewhere. In reauthorizing Title VII programs, Congress may wish to consider whether the annual funding cycle and evaluation process for these programs could be clarified through explicit authorizations for appropriations; through specific statements of program purpose or outcomes in legislation or report language; through requirements for expanded dialogue with officials at HRSA and OMB to bridge the gaps between congressional and administrative priorities for these programs; through evaluation demonstration projects to develop the type of baseline and ongoing data collection and analysis needed to meet the needs of OMB and other evaluators; and other measures.

---

[62] U.S. Dept. of Health and Human Services, "Objectives for Improving Health (Part A): Access to Quality Health Services," *Healthy People 2010*, vol. 1, goals 1.7 and 1.8, Jan. 30, 2001, at [http://www.healthypeople.gov/publications/default.htm]

[63] U.S. Dept. of Health and Human Services, HRSA, "FY2005 Justification of Estimates for Congressional Committees," *GPRA Performance Plans and Reports*, vol. 2, Feb. 2004, pp. 124-178.

Legislation

109th Congress

The following is a list of bills introduced in the 109th Congress which propose to amend Title VII of the Public Health Service Act or otherwise direct activities related to the domestic health workforce. Comprehensive legislation to reauthorize Title VII health professions programs has not been introduced as of this writing.

H.R. 3010 (Regula) Health and Human Services FY2006 Appropriations bill. On June 21, 2005, Representative Regula introduced H.R. 3010 (FY2006 Appropriations bill, Labor, HHS, Education). In July, the bill was passed in the House (H.Rept. 109-143; Yeas and Nays: 250-151). In October, the amended bill was passed in the Senate (S.Rept. 109-103/H.R. 3010; Yeas and Nays: 94-3). The first conference agreement, in H.Rept. 109-300, proposed a total of $94 million for Title VII programs (or 68 percent less than the FY2005 appropriation). The Senate passed it, but on November 17 the House rejected it.

On December 13, a second conference bill was filed. The next day it was passed by the House (H.R. 3010/H.Rept. 109-337; Yeas and Nays: 215-213). The second agreement proposed a total of $146.7 million for Title VII programs (or 51 percent less than the FY2005 appropriation). Senate consideration of the bill is pending. (See the section on "Funding for Title VII Programs.")

H.R. 215 (Stearns) To amend the Public Health Service Act to provide for the education and training of allied health professionals in exchange for a service commitment, and for other purposes. Introduced January 14, 2005.
Referred to Subcommittee on Health.

S. 89 (Inouye) To amend title VII of the Public Health Service Act to make certain graduate programs in professional psychology eligible to participate in various health professions loan programs. Introduced on January 24, 2005.
Referred to Committee on Health, Education, Labor, and Pensions.

S. 473 (Cantwell) To amend the Public Health Service Act to promote and improve the allied health professions. Introduced February 28, 2005.
Referred to Committee on Health, Education, Labor, and Pensions.

S. 823 (Conrad) To provide for the establishment of summer health career introductory programs for middle and high school students. Introduced April 18, 2005).
Refereed to Committee on Health, Education, Labor, and Pensions.

Appendix

Description of Title VII Programs

Programs are administered by the Bureau of Health Professions (BHPr) of the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (HHS). A brief description of each program follows.

Part A: Student Loans. Subpart I: Insured Health Education Assistance Loans to Graduate Students (Sections 701-720). The health education assistance loan (HEAL) program authorizes federal guarantees for educational loans obtained by graduate students in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, public health, pharmacy, chiropractic, or programs in health Administration and clinical psychology. Students borrow funds from commercial lenders, educational institutions, state agencies, insurance companies, and pension funds at the prevailing market interest rates. The federal government insures the loan's principal and interest. Student borrowers pay an insurance premium to contribute to a Student Loan Insurance Fund from which payments are made for defaults, death, and disability of borrowers. Borrowers have from 10 to 25 years to repay loans.

Loan amounts are limited to $20,000 for an academic year for a student in medical, osteopathy, dentistry, veterinary medicine, optometry, or podiatry school ($80,000 aggregate). For students enrolled in schools of pharmacy, public health, chiropractic, or graduate programs in health administration or clinical psychology, the loan amount is limited to $12,500 for an academic year ($50,000 aggregate). Since the program's inception, $4 billion has helped 156,000 students pay for their education in the health professions.

Citing a decline in the need for the HEAL program, the FY1996 appropriation for Labor, Health and Human Services, and Education included provisions to phase out the program (P.L. 104-208). Subsequently, new HEAL loans to student borrowers were discontinued as of September 30, 1998. However the program exists to provide loan insurance for students who have obtained loans prior to 1998. The Secretary reports that FY2004 goals for the program are (1) an orderly phase-out of the outstanding loan portfolio and (2) reduction in the amount of HEAL claims to be paid from the liquidating account.

In FY2004, the HEAL program had an outstanding portfolio of $2.1 billion, down from $2.3 billion in FY2003. There are 108,561 HEAL borrowers who have not yet fully repaid their loans.[64] These loans will require management for at least the

---

[64] HHS. *Performance and Accountability Report Fiscal Year 2004*, available at [http://www.hhs.gov/of/reports/account/acct04/sect3/PARsection3.html].

next 25 years, when the last loan is expected to be repaid. In FY2005, the program received $3.2 million. The request for FY2006 is for $2.9 million.[65]

Subpart II: Federally-Supported Student Loan Funds (Sections 721-735). This subpart authorizes three programs for loans to students in the health professions: student loan (HPSL) program; the primary care loan (PCL) program; and the loans for disadvantaged students (LDS) program. Students must demonstrate financial need to be eligible for the programs. For all three programs, loans must not, for any school year, exceed the cost of attendance. This includes tuition, other reasonable educational expenses, and reasonable living costs for that year. For medical students in their third and fourth years of schooling, loans may be increased to pay balances from other loans that were made for attendance at the school.

HPSL provides loans to students in schools of medicine, osteopathy, dentistry, pharmacy, podiatry, optometry, or veterinary medicine. Students must meet financial need criteria and agree to complete requirements for residency training and subsequent practice in primary care. The PCL program permits schools of allopathic and osteopathic medicine to make loans to students who agree to enter and complete a residency training program in primary health care and to practice primary care medicine through the life of the loan. The LDS program provides loans to students who study allopathic or osteopathic medicine and are from disadvantaged background. In fiscal years 2003 and 2004, aggregate support from these programs supported approximately 3,700 students. For FY2004 and FY2005, estimated obligations are $26 million and $24 million, respectively.[66]

Part B: Health Professions Training for Diversity (Sections 736-741). Programs in this part aim to address the lack of minority representation among faculty and practicing clinicians in the health professions. Currently, an array of assistance is provided in the form of scholarships, loan repayment programs, and training programs.

The Centers of Excellence (COE) program provides grants to health professions schools to support programs of excellence in health professions education for under-represented minority individuals. Among other requirements, the schools must use the grant to train students in providing health services to a significant number of underrepresented minorities through community-based health facilities located at remote sites. Schools may use funds to provide stipends. However, eligible health professions schools must: (1) have a significant number of underrepresented minority enrollees; (2) effectively assist minority students in completing the education program; (3) effectively recruit minority students and provide them with financial support, and (4) make significant recruitment efforts to increase the number of

---

[65] U.S. Senate. Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2006, July 14, 2005, S. Report 109-103.

[66] Health Professionals Student Loans, Including Primary Care Loans/Loans for Disadvantaged Students, Catalog of Federal Domestic Assistance at [http://www.cfda.gov].

faculty and administrators who are from minority groups.[67] Schools designated as Centers of Excellence may include certain historically black colleges and universities, schools with large enrollments of Hispanic or Native American students, or, other health professions schools with a large enrollment of underrepresented minorities. In FY2004, COE supported 34 projects, 1,067 underrepresented minority students, and 1,850 underrepresented faculty participants, which is the same level of support for the FY2005 appropriation. No funding is requested for this program in FY2006.

The Scholarships for Disadvantaged Students program (SDS) authorizes grants to institutions for expenses related to tuition and other reasonable living expenses for the purpose of assisting full-time financially needy students. Priority is given to institutions based on the proportion of graduating students going into primary care, the proportion of underrepresented minority students, and the proportion of graduates working in medically underserved communities. Eligible entities include schools of medicine, osteopathy, dentistry, nursing, pharmacy, podiatry, optometry, veterinary medicine, public health, chiropractic, or allied health, a school offering a graduate program in behavioral and mental health practice, or an entity providing programs for the training of physician assistants. In addition, the school must carry out a program for recruiting and retaining students from disadvantaged backgrounds, including racial and ethnic minorities. In FY2004, approximately 13,022 disadvantaged students participated in the program. In FY2005, budget projection show little change. However, FY2006 budget estimates would decrease program capacity to result in service to about 1,560 disadvantaged students.

The faculty loan repayment program (FLRP) and minority faculty fellowship program (MFFP) authorizes contracts with individuals who agree to serve as members of the faculty in health professions schools in return for federal repayments of up to $20,000 in educational loans for each year of service. Eligible individuals must be from disadvantaged backgrounds who: (1) have a degree in medicine (allopathic or osteopathic), dentistry, nursing, or another health profession; (2) are enrolled in an approved graduate training program in medicine, dentistry, nursing, or other health profession, or (3) are enrolled as a full-time student and in the final year of course work at an accredited school. Health professions schools can provide minority faculty fellowships with such grants to increase the number of underrepresented minority faculty members. Fellowships include stipends and allowances for other expenses, such as travel and specialized training. Schools are required to provide matching funds for the fellowship program. In FY2004, 44 faculty participated in the FLRP program. In FY2004, the MFFP supported 4 awards. In FY2005, budget projections show little change. No funding is requested for these program in FY2006.

The Health Careers Opportunity Program (HCOP) provides grants to health professions schools, academic health centers, state or local governments, or other appropriate entities to train and educate health professionals in order to reduce

---

[67] U.S. Dept. of Health and Human Services, HRSA, *Justification of Estimates*, FY2005, p. 117.

disparities in health care and in the provision of culturally competent health care. In FY2004, a total of 8,120 post-secondary, and 3,891 secondary minority/disadvantaged students received support. In the same year, a total of 1,850 matriculants in health and allied health professions schools received support, and a total of 84 grants were issued. In FY2005, 7,500 post-secondary, and 3,400 secondary minority/disadvantaged students received support. Also, in FY2005, a total of 1,500 matriculants in health and allied health professions schools are planned, and a total of 80 grants are expected to be issued. No funding is requested for this program in FY2006.

Part C: Training in Family Medicine, General Internal Medicine, General Pediatrics, Physician Assistants, General Dentistry, and Pediatric Dentistry (Sections 747-748). This subpart consists of four components: (1) Family Medicine; (2) General Internal Medicine and Pediatrics Training; (3) Physician Assistant Training, and; (4) General Pediatric Dentistry Training. The goals of these programs are to improve access to and quality of health care in underserved areas and to improve the diversity of primary care medical and dental providers.

The programs provide grants and contracts to public or nonprofit private groups, including hospitals, schools of medicine (allopathic or osteopathic). Funds must be used to: (1) plan, develop, operate, or participate in an approved professional training program (including a residency or internship program) in the field of family medicine, internal medicine, or pediatrics for medical students, interns, residents, or practicing physicians that emphasizes training for the practice of family medicine, general internal medicine, or general pediatrics; (2) provide financial assistance (through traineeships and fellowships) to needy medical students, interns, residents, practicing physicians, or other medical personnel who plan to specialize or work in family medicine, general internal medicine, or general pediatrics; (3) train physicians who plan to teach in family medicine (including geriatrics), general internal medicine, or general pediatrics; (4) provide financial assistance (traineeships and fellowships) to physicians in such program who plan to teach in a program for family medicine (including geriatrics), general internal medicine or general pediatrics; (5) meet the costs of training physician assistants, and for the training of individuals who will teach in such programs; and (6) meet the costs of planning, developing, or operating programs, and provide financial assistance to residents in general dentistry or pediatric dentistry.

In FY2004, the program supported 3,029 residents and graduates in clinical training in underserved areas; 483 residents and graduates entered practice in underserved areas; 1,826 residents and graduates provide and support primary care programs; 818 minorities/individuals from disadvantaged backgrounds completed training; and 856 minorities/individuals from disadvantaged backgrounds were in training.

Part D: Interdisciplinary, Community-Based Linkages (Sections 750-757). The Area Health Education Center (AHEC), Health Education and Training Center (HETC), Geriatric Education Center (GEC), and the Quentin N. Burdick Program for Rural Interdisciplinary Training, and grants for allied health programs comprise this part.

AHECs provide grants to schools of medicine for projects to increase and improve health personnel services in medically underserved communities. A grant may be awarded to a school of nursing in any state that does not have an AHEC. Each center is required to encourage the regionalization of health professions schools through partnerships with community-based organizations and specifically designate a geographic area or medically underserved population to be served by the center that is remote from school facilities. In FY2004, funding supported a total of 300,000 local providers for continuing education training on bioterrorism response, cultural competence, women's health and related topics; 300,000 elementary/high school students for health career guidance and information; 24,000 minority/disadvantaged students to enhance health careers; 80 health professions students trained at community sites; 20 training projects in medically underserved areas. Budget projections anticipate or no change in FY2005. No funding is requested for this program in FY2006.

The HETC program provides grants to entities that address the persistent and severe unmet health care needs in border states between the U.S. and Mexico and in the state of Florida, and in other urban and rural areas with serious unmet health care needs. The HETC must establish an advisory board, conduct health professions training and education programs, and conduct training in health education services, and support health professionals (including nurses) practicing in such areas through educational and other services. In FY2004, HETC supported training for a total of 330 minority/disadvantaged students in health careers; 300 local providers or health professions students in medically underserved areas; 140 local residents trained as community health workers; 100 health professions students trained at new sites; and 25 new sites for health professions training in medically underserved areas. In FY2005, these numbers are expected to decrease for some training activities resulting in: 330 minority/disadvantaged students in health careers; 300 local providers or health professions students in medically underserved areas; 140 local residents trained as community health workers; 80 health professions students trained at new sites; and 20 new sites for health professions training in medically underserved areas. No funding is requested for this program in FY2006.

The Geriatric Education Center (GEC) program authorizes: (1) grants and contracts for improved training of health professionals and allied health professionals in geriatric health care; (2) grants and contracts for geriatric training projects to train physicians and dentists and behavioral and mental health professionals who plan to teach geriatric medicine, geriatric behavioral or mental health, or geriatric dentistry; and (3) geriatric academic career awards to promote the career development of eligible individuals as academic geriatricians. In FY2004, funding supported a total of 61,350 health providers receiving training in geriatrics; 66 geriatric fellowship trainees; 47 Geriatric Education Centers (GECs); and, 90 Geriatric Academic Career

Awards Programs (GACAs). In FY2004, HHS budget projections for these numbers are unchanged. No funding is requested for this program in FY2006.

The Quentin N. Burdick Program for Rural Interdisciplinary Training makes grants to eligible entities for interdisciplinary training programs to provide health services in rural areas. The funds can be used to provide stipends to students, establish post-doctoral fellowship programs, train faculty in rural health care delivery systems, or purchase or rent needed transportation or telecommunication equipment. In FY2004, this program supported a total of 900 students and rural health care providers trained in rural settings and 35 interdisciplinary training sites in rural areas. In FY2005, these numbers are expected to remain the same, according to HHS estimates. No funding is requested for this program in FY2006.

The Allied Health and Other Disciplines Program consist of the following three components: (1) Allied Health Special Projects; (2) Chiropractic Demonstration Projects; and, (3) Podiatric Primary Care Residency Training Projects. Grants may be awarded to assist entities in increasing the number of individuals trained in allied health professions; plan and implement projects in preventive and primary care training for physicians of podiatry; and carry out demonstration projects in which chiropractors and physicians collaborate to provide the most effective treatments for spinal and lower back treatments. In FY2004, funding supported 2,388 allied health graduates and three chiropractic demonstration projects; 68 residents/graduates that provide and support podiatric primary care; 18 minority/disadvantaged residents graduates in training for podiatric primary care; and, five residents/graduates who entered and practiced podiatric primary care in underserved areas. No funding is requested for this program in FY2005

Part E: Health Professions and Public Health Workforce (761-770).

Subpart 1: Health Professions Workforce Information and Analysis (Sections 761-763). Grants are awarded to entities in order to develop analysis of and information on the health workforce. Grants may be awarded to support the development of information for decision-making strategies pertinent to the health workforce.

This part is carried out in programs administered in the National Center for Health Workforce Analysis of BHPr. Specific goals of the program are to: (1) provide health workforce information and analyses to national, state and local policymakers and researchers on a broad range of issues such as graduate medical education, Medicaid/SCHIP, and health care workforce planning; (2) conduct federal-state collaborative efforts directed at assessing the adequacy of the current and future local health care workforce, and 3) develop strategies for improving the diversity and distribution of the workforce. In FY2004, the program supported one regional center for health workforce studies, health workforce databases for 18 health

disciplines and medical specialities. In FY2004, HHS published 21 reports, and in FY2005, it anticipated publishing and additional 74 reports.[68]

Subpart 2: Public Health Workforce (Sections 765-770). Grants may be awarded to eligible entities to increase the number of individuals in the public health workforce, to enhance the quality of such workforce, and to enhance their ability to meet national, state, and local health care needs. Preference for such grants is given to entities serving individuals from disadvantaged backgrounds and those entities that graduate large proportions of individuals that serve in underserved communities.

The public health training center program makes grants to accredited schools of public health, or other accredited institutions so that the latter may plan, develop, operate, and evaluate projects in various areas of interest. These areas include preventive medicine, health promotion and disease prevention, or improving access to and quality of health services in medically underserved communities.

Public health traineeship grants are made to accredited schools of public health and other institutions for graduate or specialized training for health professions fields in which there is a severe shortage of health professionals (including epidemiology, environmental health, biostatistics, toxicology, nutrition, and maternal and child health).

Grants are awarded to schools of medicine, osteopathic medicine, public health, and dentistry to meet the costs of projects to plan and develop new residency training programs, to maintain or improve existing residency programs, and to provide financial assistance to residency trainees. Also, grants are awarded to the health administration traineeship and special programs related to hospital administration or health policy analysis and planning to provide student traineeships and to prepare students for employment. In FY2004, this program supported 2,070 public health traineeships, and 32 traineeship awards to schools. No funds are requested for this programs in FY2006.

[68] Fifty of these reports are published every 2-3 years in the *State Health Workforce Profiles*.