TESTIMONY SUBMITTED IN SUPPORT OF CONTINUATION OF THE POSTGRADUATE HEALTH PROFESSIONS PROGRAM by the ADVISORY COMMITTEE ON MEDICAL EDUCATION

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I. SUMMARY STATEMENT

THE POSTGRADUATE HEALTH PROFESSIONS PROGRAM (MAINE COMPACT)

Purpose:

The primary objective of the compact is to provide educational opportunities in the health professions including allopathic, osteopathic, dental and veterinary medicine, and optometry to Maine students without incurring the inordinately large expense related to sponsorship of schools in these disciplines. Support of access to these professional schools may be considered an extension of the educational opportunities that the state sponsors for its residents in law, engineering and other programs through the University of Maine. The well qualified student from a state which has no health professions schools is at a significant disadvantage in competing against the national pool for admission to health professions schools. All states in this country without allopathic medical schools, including Maine, do have such contractual arrangements with health professions schools in other states.

Allopathic:

It is clear that the compact legislation has been instrumental in providing opportunities in health professions schools to well qualified Maine students. The impact is especially notable in allopathic medicine. In 1968-69, Maine's national rank in terms of entering students to allopathic medical schools per 100,000 population was 49th. In 1979-80, it was 35th. Its rank in terms of percentage of applicants who succeeded in being admitted rose from 51st in 1973-74 to first in 1977-78 despite a decrease in the number of applications between these years. The number of applicants per 100,000 population was lower, however, than any other state in the nation. The high percentage of successful applicants in the presence of a decreasing applicant pool reflects a highly developed guidance and pre-selection process in Maine colleges. Our 35th position nationally, in terms of entering students per 100,000 population, would then suggest the need for continued funding of access at current levels and certainly not a decrease.

Veterinary Medicine:

Access continues to be a problem for students aspiring to a career in veterinary medicine. Veterinary schools are state-supported and do not generally consider students from states other than their own despite academic qualifications and financial ability, unless that student's state has a contractual agreement providing access with the school. Reference is made to a study which documents a relatively small number of applicants to schools of veterinary medicine from the State of Maine in one particular year, suggesting no further need of support of access to these schools. This particular year was an exception. Few students applied because during the previous year only two of a large number of applicants were admitted and students were generally discouraged from applying. The number of applications has increased to previous levels as demand continues to be great.

Osteopathic:

Maine students do have access to positions in the School of Osteopathic Medicine.

The significant need of the student in osteopathic medicine continues to be support in the form of loan monies.

Dentistry:

In dental medicine, because of high tuition and market influences, it is likely that entering class size will be decreased. Without access through the compact, Maine students would be required to compete for this decreased number of seats with the national pool. Funding should continue to support access in part but should also be used to make available loans to qualified students.

Optometry:

There is continued need of support of access in optometry, especially with an aging population of optometric practitioners.

Finally, it is important to note that the program has provided access to students from all walks of life and from all parts of the state, as documented in the appendices. Its continuation would obviate the possibility that access to health professions schools would become limited to one particular class and to the very wealthy.

Tuition Assistance:

While providing access to seats in the various health professional schools, the program has also provided substantial tuition assistance to the students enrolled under its aegis. Each of the schools returns a variable but significant degree of Maine money to the student to defray tuition expenses. Discontinuation would have a very serious impact on the ability of our students to consider a career in the health professions and would result in substantial increases in tuition paid by Maine students in the affected schools.

The program is extremely cost effective when one considers the cost of providing such educational opportunities through development and continued support of health professions schools by the State of Maine. Furthermore, the relationship with medical schools developed through the compact resulted in an estimated $3,299,634 return to the State of Maine during four years of the present compact. It is anticipated that flow of monies back to the state will continue.

Medical Education in Maine:

The compact legislation has had a significant impact on medical education in the State of Maine. Relationships with the medical schools have fostered development of postgraduate medical education programs at four centers throughout the State which programs have played a significant role in providing physician manpower, including primary care physicians to rural areas, for the entire State of Maine. These relationships and the availability of house officers have played a major role in supporting development of tertiary patient care programs at the Maine Medical Center and at other hospitals and have facilitated recruitment of physicians for the state. Medical school faculties have played an integral role in the development and maintenance of continuing medical education programs for the state's physicians. Compact schools, as well as other schools, have made a major commitment to training medical students in the State of Maine. Tufts and Vermont students spent a total of 274½ student

months at two centers in the state during their third years. Compact school students and students from other medical schools throughout the country spent over 194 student months in elective preceptorships in the state, many of them in rural areas, at no additional cost to the state.

Manpower:

Exposure of these students to practice in the State of Maine should have a significant influence on recruitment of physicians to the state in the future since such experiences are a well known determinant of practice site selection.

It is too early to assess the impact of the compact on return of Maine students to the state to practice. It takes medical students seven to nine years following entrance to medical school to complete training, military obligation, if necessary, and to enter practice. Under the current legislation, the first class graduated in 1979. They are still all in training; however, as of May 1980, ten of 14 graduates of the dental medicine program have returned to the State of Maine. Three are reported in residency training; one is in practice elsewhere. None of three veterinary graduates has returned to the state to practice; one is still in postgraduate training.

However, there is substantial experience with graduates of the University of Vermont School of Medicine. The contractual obligation with that school goes back to the late 1950s. Twenty-eight of 63, or 44.4 per cent of Maine compact students graduating from the University of Vermont School of Medicine between the years 1962 and 1975, are currently practicing in the State of Maine. This return is especially significant because these students returned to practice in Maine voluntarily before pay-back provisions requiring return to Maine to forgive an indebtedness to the state were legislated. Twenty-two of 28, or 78.6 percent of these physicians, are practicing in areas of the state other than Greater Portland. Finally, it is important to note that 68 per cent of Maine compact students in graduating medical school classes of 1981 are applying to the Maine Medical Center to return for postgraduate medical training.

RECOMMENDATIONS

1. Continue funding of the program at the current level of enrollment.

2. Funding in support of educational opportunities in allopathic medicine should continue to be in the form of access or purchase of seats.

3. Since access is not a problem for students interested in osteopathic medicine, funding should be in the form of a loan fund.

4. Veterinary Medicine. Access continues to be a problem. Funding should be in support of the purchase of seats at current levels.

5. Dental Medicine. Funding should continue to support access in part but should also be used to make available loans to qualified students.

6. Optometry. Funding should continue to support access through purchase of seats.

II. APPENDIX A

Questions and Answers Relating to the Maine Compact.

Data in Support of Answers, Conclusions.

QUESTIONS

1. HAS THE COMPACT LEGISLATION IMPROVED ACCESS TO ALLOPATHIC MEDICAL SCHOOL?

2. WHAT HAS HAPPENED TO THE APPLICANT POOL TO ALLOPATHIC MEDICAL SCHOOLS AND THE CHANCES OF BEING ADMITTED UNDER THE COMPACT?

3. DOES THE INCREASED PERCENTAGE OF ACCEPTANCES SUGGEST THAT THE COMPACT IS MAKING IT EASIER FOR POORLY QUALIFIED STUDENTS TO ENTER MEDICAL SCHOOL?

4. IS THE COMPACT SUPPORTING ACCESS TO PROFESSIONAL SCHOOLS FOR CHILDREN OF PHYSICIANS?

5. DOESN'T THE COMPACT SUPPORT ACCESS TO STUDENTS FROM THE LARGER CITIES AND TOWNS IN THE STATE AS COMPARED WITH SMALLER TOWNS AND RURAL AREAS?

6. WHAT MIGHT IT HAVE COST THE STATE OF MAINE TO DEVELOP A NEW SCHOOL OF MEDICINE AS PROPOSED IN THE MID-1970S BY THE LEGISLATURE AND VETOED BY THE GOVERNOR?

7. HAVE THE RELATIONSHIPS DEVELOPED WITH HEALTH PROFESSIONAL SCHOOLS RESULTED IN A RETURN OF MONEY TO THE STATE OF MAINE?

8. HAS SUPPORT OF THE MAINE STUDENT THROUGH THE COMPACT RESULTED IN ANY SIGNIFICANT NUMBER OF STUDENTS RETURNING TO PRACTICE IN MAINE TO SATISFY OUR HEALTH MANPOWER REQUIREMENTS?

9. HAVE MOST OF THESE PHYSICIANS ESTABLISHED PRACTICE IN PORTLAND?

10. WHAT OF MEDICAL STUDENTS IN OTHER SCHOOLS?

11. WHAT IMPACT HAS THE COMPACT RELATIONSHIP HAD ON BRINGING MEDICAL STUDENTS FROM THE AFFILIATED MEDICAL SCHOOLS TO MAINE FOR CLINICAL EXPERIENCE WHICH MIGHT INFLUENCE THEIR SELECTION OF MAINE TO PRACTICE?

12. DON'T MOST OF THE MEDICAL STUDENTS WHO COME TO MAINE IN THE 4TH YEAR PRECEPTORSHIP GO TO THE MAINE MEDICAL CENTER?

13. DEVELOPMENT OF INTERNSHIP AND RESIDENCY TRAINING PROGRAMS AT MAINE HOSPITALS HAVE BEEN DIRECTLY RELATED TO MEDICAL SCHOOL AFFILIATIONS WITH COMPACT SCHOOLS. WHAT INFLUENCE HAVE THESE RESIDENCIES HAD ON SUPPLYING PHYSICIANS TO PRACTICE IN MAINE?

TABLE 1

Has the compact legislation improved access to allopathic medical school?

TOTAL NUMBER OF ENTERING ALLOPATHIC MEDICAL STUDENTS
NUMBER OF COMPACT STUDENTS, AND
MAINE'S NATIONAL RANK - ENTERING STUDENTS/100,000 POPULATION

Year	Total Maine Entering Students	Compact Students	% of Total	National Rank/ 100,000 Population
1968-1969	28	7*	(25%)	49
1972-1973	28	7*	(25%)	
1974-1975	41	18*	(43%)	
1975-1976	35	13**	(36%)	
1976-1977	45	26	(58%)	
1977-1978	42	34	(81%)	34
1978-1979	49	35	(71%)	34
1979-1980	52	37	(71%)	35

* UVM Compact Students
** New Compact Begun - 10 Students UVM
3 Students Tufts

The legislation has improved Maine's national position in terms of number of entering students per 100,000 population from 49th to 35th. We are still 35th, which would imply that access is still a problem for well qualified Maine students.

TABLE 2

What has happened to the applicant pool to allopathic medical schools and the chances of being admitted under the compact?

TOTAL NUMBER OF MEDICAL SCHOOL APPLICANTS/
NUMBER OF APPLICANTS ADMITTED

	No. of Applicants	No. Admitted	%	Maine's National Rank - % of Applicants Admitted
1972-73	81	28	(34.6)	43
1973-74	106	28	(26.4)	51
1976-77	97	47	(48.5)	7
1977-78	75	47	(59.0)	1*

* While raw percentage of applicants admitted puts Maine in Number 1 position nationally, the number of applicants per 100,000 population (6.91) was lower than any other state in the nation. This may in part reflect the recognized low level of aspiration of Maine students, but also reflects active guidance and pre-selection of student applicants by counsellors at Maine colleges.

Acceptances per 100,000 population is 4.06/100,000, putting Maine in the 35th position nationally. This figure is compared to a low for New England, 2.94 for New Hampshire, and 8.70 for Vermont. Wyoming which also ranks high nationally with 58% of its applicants admitted, has 9.36 acceptances/100,000 population, over double those for Maine. This state also has a compact arrangement, no medical school.

In the two years prior to implementation of the compact, an average of 11.8% of Maine applicants gained admission to Tufts Medical School in competition with 6178 applicants nationally. In the five years of the compact, acceptance rate doubled to 23.7% while applicant pool remained high, averaging 7556.

Elimination of compact support of access would significantly impair chances of well-qualified Maine students.

Does the increased percentage of acceptances suggest that the compact is making it easier for poorly qualified students to enter medical school?

No

The pre-admissions characteristics of students in the Class of 1979 and 1980 at the University of Vermont showed Maine students to be equal to or higher than the class average in grade point average and performance in the Medical College Admissions Tests.

Furthermore, in terms of performance while in medical school, an analysis of 45 graduates of University of Vermont Classes of 1979, 1980, 1981 showed that:

> 30% of Maine students were elected to the National Medical Honor Society on the basis of academic performance as compared to a class average of 12%.
>
> Maine students class rank:

Top 1/3	50%
Middle 1/3	30%
Bottom 1/3	20%

Maine students, therefore, performed substantially better than the average.

Is the compact supporting access to professional schools for children of physicians?

PARENTAL OCCUPATIONS: UVM COLLEGE OF MEDICINE
STUDENTS CURRENTLY ENROLLED (CLASSES 1981-1984)
37/77 Have Thus Far Responded

	Number-Maine	% of Students-Maine	% of Applicants Nationally *
Physician	4	10.8	11.8
Other Health Profession (Nurse, Social Worker, Dentist)	4	10.8	4.4
Other Profession (Teachers, etc.)	10	27.	22.4
Owner, Manager, Administrator	9	24.3	24.6
Clerical or Sales Worker	0	0	5.3
Craftsman or Skilled Worker	3	8.1	9.4
Unskilled Worker (Non-farm)	5	13.5	4.3
Farmer, Farm Worker	0	0	2.8
Homemaker	0	0	0.2
Other	2	5.4	11.5
	37		

Twenty of 37 mothers (54%) held a job.

* Class of 1976-1977 applicants from Journal of Medical Education

The answer is obviously No! Based on this partial survey, the compact supports access to children of Maine's unskilled workers at a significantly higher percentage than national experience. Access for physicians/ children is comparable to the national experience.

Doesn't the compact support access to students from the larger cities and towns in the State as compared with smaller towns and rural areas?

NUMBER OF STUDENTS FROM MAINE - UNIVERSITY
OF VERMONT SCHOOL OF MEDICINE FROM
TOWNS UNDER 10,000 POPULATION*

85 of 215 or 39.5%

See attached lists for actual place of residence.

* Figure includes towns below a population of 10,000 which are not a part of a metropolitan area (Portland, Waterville, Lewiston, Bangor).

No. The attached list documents place of residence of Vermont Medical students in the Classes of 1958-84 inclusive. 85 of 215, or 39.5% have been from towns under 10,000 population that are <u>not</u> a part of a metropolitan area.

PLACES OF RESIDENCE

UNIVERSITY OF VERMONT
COLLEGE OF MEDICINE

1958 to 1984

Graduating Class
Residents of Maine

Class of 1984

Adams, Charles F., Jr.	Brewer
Austin, David	Pittsfield
Baker, Ronald E.	Madawaska
Coco, John F.	Brewer
Cole, Linda S.	Portland
Frye, Kathleen A.	Portland
Khoury, Douglas A.	Bangor
Kronholm, Penelope J.	East Winthrop
Millette, Leo A.	Old Orchard Bch
O'Meara, Thomas M.	Bangor
Poulin, Eileen M.	Winslow
Poulin, Lucille	Winslow
Richards, Audrey L.	Yarmouth
Riker, Richard R.	Lewiston
Shiro, Brian C.	Waterville
Taylor, Connie E.	S. Portland
Wagner, Lansing	Winterport
Wing, Randall B.	Bath
York, Gary L.	Cumberland Fsde

Class of 1983

Campbell, Robert J.	Biddeford
Frewin, Paul R.	Waterville
Heilner, David P., Jr.	Blue Hill
Humper, Brian M.	Bath
LaFleur, Joel D.	Auburn
Lavoie, Frank W.	Lewiston
Meserve, John P.	Randolph
Mills, Brian P.	Augusta
Mills, Scott D.	Auburn
Orloff, John J.	Waterville
Pouravelis, George T.	Biddeford
Rose, James Gary	Orono
Schwartz, Bennett	Portland
Soncrant, Cheryl B.	Bar Harbor
Sprague, Richard S.	Orono
Taylor, William F.	Orono
Thompson, Benjamin M.	S. Portland
Varadi, Kathleen F.	Waterville

Class of 1982

Benoit, Joseph L.	Bangor
Briggs, Dana G.	Bangor
Caldwell, Christopher B.	Cumberland
Couser, Jr., James I.	Farmington
Foster, James C.	Scarborough

Class of 1982 (Cont.)

Gagan, Jamie L.	Westbrook
Hanlon, Ann M.	Augusta
Hayward, Thomas D.	Cape Elizabeth
Jaccoma, Edward H.	Kennebunk
Kilgour, James B.	Rockland
McCarty, Martha E.	Fairfield
O'Meara, John R.	Waterville
Poole, Lindsay	Cape Elizabeth
Pritham, Robin M.	Greenville Jct.
Puls, Wendie M.	Freedom
Shapiro, Deena J.	Lewiston
Shaw, Robert L.	Veazie
Sowerwine, Margaret E.	Columbia Falls
Strater, William T.	Ogunquit
Towle, Deborah I.	Portland
Treworgy, Scott W.	Calais
Young, Michael P.	Orono

Class of 1981

Carbonneau, Robert J.	Lewiston
Cooper, Mark S.	Gardiner
Hall, David G.	Freeport
Jillsen, Ann Elizabeth	Rockland
Kaplan, Lawrence C.	Camden
Larochelle, Jacques G.	Jackman
Leavitt, Bruce J.	Waterville
Lemire, Ann Marie	Old Orchard Bch
Logan, Theodore F.	Scarborough
Martin, Priscilla S.	Lewiston
Millard, Peter S.	S. Windham
Millay, David G.	Bowdoinham
Smith, Jr., Clifton D.	Westbrook
Smith, Donald D.	Old Town
Stitham, Sean	Dover-Foxcroft
Torrey, Susan P.	Brewer
Tripp, Leslie N.	Saco
Violette, E. Jeffrey	Augusta

Class of 1980

Paul Balzer	Brunswick
Sarita Brouwer	Camden
Cheryl Coffin	Bangor
Kerry Crowley	Corea
Joel Cutler	Bangor
Jeryl Dansky	Hallowell
Linda Hermans	Kennebunk

Class of 1980 (Cont.)

Mark Kandutsch	Bar Harbor
Roland Larrabee	Brownville Jct.
Thomas Lever	Mexico
Denise L'Heureux	Sanford
Rebecca Chagrasulis McGee	Casco
Mark McGovern	Portland
Paul Morin	Fort Kent
Lori Radke	Orono
Jim Sensecqua	N. Windham
Norman Sturtevant	Waterville

Class of 1979

Karen Gershman	Orono
Eve Inchardi	Brunswick
Gary Keller	Bangor
Ralph Manchester	Waterville
Cynthia Christy Manchester	Waterville
Michael McKee (dec)	Eustis
Nancy Plourde	Auburn
Alan Rogers	Waterville
James Sensecqua	N. Windham
Laurie Woodard	Lewiston
Evangeline Lausier	Freeport

Class of 1978

Sherry Dickstein	Portland
Jonathan Hayden	Yarmouth
Edwin Heffernan	Wells Beach
Mark Helms	Portland
Michael Hermans	Kennebunk
Barbara James	Auburn
Thomas Judd	Ellsworth
Jeffrey Lovitz	Waterville
David Lynch	Augusta
Wallace McGrew	Cape Elizabeth
Philip Peverada	Portland
Paul Plourde	Orono
Paul Poulin	Waterville
Mark Rolerson	Lewiston
John Scamman	Cape Elizabeth
Christopher Snow	W. Scarborough
John Thomas	Dover-Foxcroft
Brooke Thorner	Portland

Class of 1977

Samuel Broaddus	Westbrook
Allan Freedman	Orono
James C. Hebert	Waterville
William Hickey	Houlton
Alan McLean	Falmouth

Class of 1977 (Cont.)

Guy Raymond	Frenchville
John Redmond	Augusta
Karen Reeves	Auburn
Maya Chatterjee Rogers	Brunswick
Kenneth Stevens	South Portland
Jane Wolf	Portland
Howard Yeaton	Winthrop

Class of 1976

Marilyn Clark	Yarmouth
Douglas Dennett	Dixfield
George Eypper	Bethel
John Georgitis	Orono
Paul McBrearity	Allagash
Matthew Zetumer	Harrison

Class of 1975

Allen Fongemie	Van Buren
Steven Johnson	Kennebunk
John Murphy	Augusta
Stephen Rowe	South Portland
Christopher Selvage	Cape Elizabeth
Robert Turner	Bowdoinham
Robert LeGendre	Brunswick

Class of 1974

Brian Gardner	Richmond
Albert Hebert	Mars Hill
Richard Lampert	Brunswick
Frederick Perkins	Kennebunk
Douglas Sewall	Orono

Class of 1973

Ralph L. Berry III	Cornish
Cressey Brazier	Brooks
David Bronson	Bath
David Flavin	Biddeford
Nicola Miragliuolo	Bangor
Irwin Paradis	Fort Kent
Bernard Price	South Portland
Stephen D. Reed	Newcastle
Susan Shubert Buchwald	Bangor
Richard J. Taylor	Bangor

Class of 1972

William Bennett	Lincoln
James Bress	Portland
Douglas Brown	Waterville

Class of 1972 (Cont.)

Mark Dubay	Old Town
Donald Levi	Portland
Donald Murinson	Portland
Gary Towle	Portland

Class of 1971

Alan Ayer	S. Portland
Charles Belisle	Biddeford
Ernest Brown	Eliot
David Haskell	Houlton
Lester York	Portland

Class of 1970

Preston Carter	Etna
Richard Gendron	Saco
David Staples	Brewer

Class of 1969

Duane Record	Livermore Falls
William Thurlow	Brunswick

Class of 1968

Thomas Hallee	Pittsfield
Park Harris	Presque Isle
Robert Madrell	Ellsworth
Jon Pitman	N. Vassalboro

Class of 1967

Jeanine Berry	Unity
Norman Bress	Portland
Peter Colley	Farmington
David Martin	Falmouth
Otis Tibbetts	Auburn
Roger Wilson	Jefferson

Class of 1966

Paul Jabar	Waterville
George Morrissette	Augusta
Robert Vigue	Berwick

Class of 1965

James Butler	Augusta

Class of 1964

Prescott Cheney	Briston
Theodore Hallee	Pittsfield
Willis Ingalls	N. Windham

Class of 1963

Ann Tompkins Dvorak	Island Falls
Philip Villandry	Biddeford
Houghton McClellan White	Biddeford

Class of 1962

Daniel Day	Yarmouth
John Richard Dooley	Portland
Richard Haskell	Orono
Paul Marshall	Waterville

Class of 1961

Donald Morton	Presque Isle

Class of 1960

Henry Curley	S. Portland
Richard Dillihunt	Winthrop
Edward Greco	Cape Elizabeth

Class of 1959

Patricia Ann Adams	W. Scarboro
William Hodgkin	Auburn
Bernard Passman	Portland

Class of 1958

Peter Goodhue	Fort Fairfield
Daniel J. Hanson	Calais
Paul Stevens	Westfield
Peter Webber	Portland

Have the relationships developed with health professional schools resulted in a return of money to the State of Maine?

OUT-OF-STATE MEDICAL SCHOOLS

FINANCIAL RETURN TO MAINE

DURING FOUR YEARS OF THE PRESENT COMPACT

I.	CAPITAL OUTLAY (Source: RHA; MMC)	157,555
II.	STUDENT FINANCIAL ASSISTANCE (Source: RHA; Tufts University)	79,300 *
III.	ON SITE (In Maine) PROGRAM RESOURCES (Source: Tufts University; Maine Dartmouth Family Practice Residency; Central Maine Medical Center; Maine Medical Center)	2,816,519 **
IV.	ON SITE (In Maine) EDUCATION OF PRACTICING PROFESSIONALS, EXCLUDING TRAVEL EXPENSES (Source: Tufts University; Maine Dartmouth Family Practice Residency; University of Maine AHEC)	220,172
V.	OTHER (Estimate of Travel Expenses; Administration Support for CMMC) (Source: Tufts University; CMMC; Maine Dartmouth Family Practice Residency)	26,088
	TOTAL	$3,299,634

* Does not include a dollar amount reflecting that Maine Compact students at the University of Vermont pay Vermont's in-state tuition as opposed to out-of-state tuition -- a difference of $2,970 per student per year.

** Includes AHEC funds. Those funds, however, were not available to Maine without the partnership of an out-of-state medical school.

The figures presented above, when compared to the biennial expenditures under the compact (currently proposed at 1.7 million per year) document a substantial direct return on the investment.

Has support of the Maine student through the compact resulted in any significant number of students returning to practice in Maine to satisfy our health manpower requirements?

Yes:

28 of 63 (44.4%) of Maine compact students graduating from the University of Vermont School of Medicine between 1962-1975 now practice in Maine! These students returned without being obligated to return for the purpose of debt forgiveness.

Have most of these physicians established practice in Portland?

No:

22 of 28 or 78.6% have established practices outside of Greater Portland.

What of medical students in other schools?

Graduates from Tufts and UVM under the new legislation (effective in 1975) are still in post-graduate training and cannot have been expected to enter practice as yet.

However, 68% of the Maine students in graduating medical school classes of 1981 are applying to the Maine Medical Center to return to Maine for post-graduate training.

As of May 1980

0 of 3 veterinary graduates returned to Maine.
10 of 14 dental graduates returned.

TABLE 3

What impact has the compact relationship had on bringing medical students from the affiliated medical schools to Maine for clinical experience which might influence their selection of Maine to practice?

MEDICAL STUDENT EXPOSURE TO PRACTICE IN THE

STATE OF MAINE - 1980-81

	Student Months
Third Year Clerkships:	
Maine Medical Center - UVM College of Medicine (Medicine, Surgery, Obs/Gyn, Pediatrics, Psychiatry)	252
Eastern Maine Medical Center - Tufts (Pediatrics)	22.5
TOTAL:	274.5
*Fourth Year Elective Preceptorships (1980-81) (No specific funding required)	
University of Vermont (34 outside of Greater Portland)	47
Tufts	26
Boston University	24
Maine Medical Center (Non-Tufts Students)	82
Eastern Maine Medical Center (Non-Tufts Students)	15
TOTAL	194

* Not all preceptorships listed.

This very substantial number of students includes students from other states and schools as well. This exchange would not occur without the compact relationship. This program of preceptorships does not cost the state additional dollars in support.

TABLE 4

Don't most of the medical students who come to Maine in the 4th year preceptorship go to the Maine Medical Center?

No.

18 Maine compact students from UVM are spending 47 student months in Maine this year. All but 13 of these student months will be spent outside of Greater Portland, as shown on the attached list.

EXTERNSHIPS IN MAINE
SCHEDULED BY
MAINE CONTRACT STUDENTS, CLASS '81

TABLE 4

Student	Physician & Site	Date	Specialty
Robert Carbonneau	Dr. David Walter, Lewiston, ME	3/80	PEDS
	Dr. Stephen Sokol, Mt David Clin Assoc, Lewiston, ME	1/81	MED
Mark Cooper	Dr. Arlene Cenedella, Presque Isle, ME	1/80	OB/GYN
	Augusta General Hospital, Augusta, ME	3/80	RAD
	Dr. Jeanne Arnold, Family Med Institute, Augusta, ME	8/80	F.P.
	Dr. Shelby Brammer, St. Mary's Hosp, Lewiston, ME	1/81	EMER ME!
David Hall	Dr. Robert Beekman, Hulls Cove, ME	6/80	MED
	Dr. Paul Parker, Maine Med Ctr, Portland, ME	7/80	NEPHROL
Ann Jillson	Dr. Shrier, Penobscot Bay Med Ctr, Rockland, ME	5/80	OB/GYN
	Dr. Richard Burton, Maine Med Ctr, Portland, ME	12/80	SURG
Lawrence Kaplan	Dr. George Hallett, Maine Med Ctr, Portland, ME	8/80	PEDS
	Dr. Robert Scarlata, Pineland, Ctr, Pownal, ME	9/80	
	Dr. Charles Burden, Coastal Peds, Bath, ME	"	PEDS
	Dr. Richard McFaul, Maine Med Ctr, Portland, ME	11/80	CARDIOL
	Dr. Paul LaMarche, Eastern Maine Med Ctr, Bangor, ME	12/80	PEDS
	Dr. Robert Scarlata, Pineland Ctr, Pownal, ME	"	
~~Jacques~~ Larochelle	Dr. Philip Kimball, Eastern Maine Med Ctr, Bangor, ME	6/80	ORTHOPED
	Dr. Richard Britton, Maine Med Ctr, Portland, ME	9/80	SURG
	Dr. Paul Brinkman, Jr., Farmington, ME	12/80	SURG
Bruce Leavitt	Dr. Albert Aranson, Maine Med Ctr, Portland, ME	4/80	MED
	Dr. Mark Dubay, Bath, ME	7/80	OB/GYN
	Dr. John Towne, Med-Maine Med Ctr, Waterville, ME	12/80	SURG
Ann Lemire	Dr. Arlene Cenedella, Presque Isle, ME	6/80	OB/GYN
	Dr. Wise, Eastern Maine Med Ctr, Bangor, ME	10/80	MED
Theodore Logan	Dr. Robert Roy, Mid-Maine Med Ctr, Waterville, ME	3/80	MED
	Dr. Harold Burnham, Gorham, ME	5/80	MED
Priscilla Martin	Dr. William Ervin, Portland, ME	7/80	MED
	Dr. J. Edward Martin, Mexico, ME	12/80	MED
Peter Millard	Dr. Richard McFaul, Maine Medical Ctr, Portland, ME	7/80	PEDS
David Millay	Dr. Arnold, Central ME Fam. Prac. Res., Augusta, ME	9/80	F.P.
	Dr. George, Hallett, Maine Med Ctr, Portland, ME	11/80	PEDS
	Dr. Peterlein, Central ME Fam Prac Unit, Lewiston, ME	12/80	F.P.
	Maine Med Ctr, Portland, ME	1/81	RAD
	Dr. Peter Mason, Richmond Area Hlth Ctr, Richmond ME	2&3/81	F.P.
Clifton Smith	Dr. Jeanne Arnold, Family Med Institute, Augusta, ME	4/80	F.P.
	Dr. C. Irving Meeker, Maine Med Ctr, Portland, ME	6/80	OB/GYN
nald Smith	Dr. John Mackin, Mid-Maine Med Ctr, Waterville, ME	3/80	MED
	Dr. P. Emmett, Eastern Maine Med Ctr, Bangor, ME	4/80	EMER RM
	Dr. Albert Lantinen, Penobscot Bay Med Ctr, Rockland	9/80	OB/GYN
	Dr. Timothy Richardson, Mi Maine Med Ctr, Waterville	12/80	MED

1/19/81

SCHEDULED BY
MAINE CONTRACT STUDENTS, CLASS '81

TABLE 4 - Cont.

Student	Physician & Site	Date	Specialty
Sean Stitham	Dr. F. Lawrence, Maine Med Ctr, Portland, ME	3/80	EMER RM
	Dr. H. Gary Parker, Mayo Reg Hosp, Dover-Foxcroft, ME	6/80	MED
Susan Torrey	Dr. Parrot, Eastern Maine Med Ctr, Bangor, ME	9/80	MED
Leslie Tripp	Dr. Peter Emmett, Eastern ME Med Ctr, Bangor, ME	9/80	EMER RM
	Dr. Walter Peterlein, Central ME Med Ctr, Lewiston	10/80	F.P.
	Dr. Jeanne Arnold, Me-Dartmouth Fam. Prac Res, Augus	11/80	F.P.
	Dr. John Gibbons, Maine Med Ctr, Portland, ME	12/80	RAD
Jeffrey Violette	Dr. William Toggart, Mid-Maine Med Ctr, Waterville	5/80	EMER RM

TABLE 5

What might it have cost the State of Maine to develop a new school of medicine as proposed in the mid-1970s by the legislature and vetoed by the governor?

COST OF UNIVERSITY OF MASSACHUSETTS SCHOOL OF MEDICINE - WORCESTER

1st Class Accepted	1970	
Hospital Opened	1976	
Capital Costs:		
Physical Plant, Construction Medical School and Hospital		$160,000,000
65-70 Acres of State-Owned Land - Cost Not Available		
Furnishings and Equipment 1-2 Million Dollars/Year x 10 Years		$ 10-20,000,000
Operating Budget:		
Medical School		$ 18,000,000/Year
Hospital - Educational Subsidy		$ 3-4,000,000/Year
	1976-1979	
	$1,000,000/Year at Present	

The compact legislation has provided access and many of the advantages of medical school affiliation, as well as providing educational opportunities in veterminary medicine, dental medicine, optometry and osteopathic medicine, all at a small fraction of the cost of supporting just one of these schools as suggested above.

TABLE 6

Development of internship and residency training programs at Maine hospitals have been directly related to medical school affiliations with compact schools. What influence have these residencies had on supplying physicians to practice in Maine?

MAINE MEDICAL CENTER RESIDENCY GRADUATES, 1965 - 1975 (INCLUSIVE)

Program	Total Trainees	No. in Maine	%	Of Those Remaining in Maine, % in Portland
Anesthesiology	15	7	47%	57%
Cardiology	15	7	47%	29%
General Practice	14	10	71%	30%
Internal Medicine	31	16	51%	37%
Internship Only	54	13	24%	54%
Nephrology	1	1		100%
Pathology	5	1	20%	100%
Pediatrics	14	11	79%	45%
Psychiatry	12	10	83%	60%
Radiology	14	9	64%	78%
Surgery	34	25	74%	32%
TOTAL	209	110	(53%)	

FAMILY PRACTICE RESIDENCY GRADUATES

Central Maine Medical Center	4	3	75%
Maine Dartmouth Residency	24	16	67%
Maine Medical Center	21	17	81%
Eastern Maine Medical Center	17	10	59%
Waterville Osteopathic	2	1	50%
Osteopathic Hospital of Maine	13	10	77%

These residencies have been instrumental in supplying the medical manpower needs for the State of Maine.

III. APPENDIX B.

DETAILED STATEMENTS RELATING TO EACH INDIVIDUAL PROFESSIONAL DISCIPLINE

DENTAL MEDICINE

The Maine Dental Association supports continuation of the Maine Post-Graduate Professions Program which provides opportunities for Maine students in the fields of allopathic and osteopathic medicine, dentistry, optometry and veterinary medicine.

The purpose of this Legislation was to gain access for Maine students in professional education programs not available in the State of Maine. This purpose is no less valid today. It is imperative that Maine students have equal opportunities to pursue education in these vital professions.

The MDA recognizes that nationally over the past several years there has been a gradual decline in the number of applicants for dental seats. Although the reasons for this decline are varied, multifaceted and complex, it is, at least in part, attributable to the rising cost of a dental education.

Faced with steadily decreasing Federal assistance and constantly rising inflation, dental schools have been forced to raise tuition rates. The tuition increases have, in turn, resulted in lowering the applicant pool. Caught in this critical situation, the dental schools have been forced into making major changes to remain financially viable.

Tufts University School of Dental Medicine has plans to reduce class size from 150 to 125 students. They also have under consideration several methods of increasing the applicant pool. Highly qualified junior undergraduate students may be accepted for admission.

Whatever changes are adopted will undoubtedly serve to increase the pressure on Maine applicants and students will again face fierce competition for the available seats.

Under the Maine compact agreement, a specified number of seats are assured for Maine students. Without the compact, Maine applicants would be forced to compete as part of the national applicant pool.

If the Post-Graduate Health Professions Program is terminated, students from low and middle income families may be denied access for financial reasons. Maine's dental students come from all socioeconomic levels. In fact, eight of this year's contract dental students come from families whose annual income is $16,500 or less. Without the subsidy program, many of these deserving students may be unable to find the funding needed to complete their education.

The State of Maine has contractual obligations with these students in the health professions and with the schools in which they are enrolled. The Maine Dental Association feels that these obligations must be honored.

VETERINARY MEDICINE

It is now possible for qualified Maine students to enter the veterinary profession. Access is via the contract arrangement with Tufts, University of Pennsylvania, and Cornell. Other schools in the U.S. usually do not consider Maine students because there are no contract arrangements. If the Contract arrangement were ended, it would be very difficult for any individual from Maine to pursue a career in veterinary medicine.

OPTOMETRIC MEDICINE

Studies on optometric manpower indicate that indeed age distribution of optometric practitioners in the State of Maine is skewed, indicating a disproportionate number of older practitioners. A study done in 1975 indicated that 70 of 124 practicing optometrists were 50 years of age or over and would be expected to retire by the late 1980's. This phenomenon which is nationwide resulted from the high number of doctors educated following WWII. The whole country will experience this attrition. Maine requires an average of 9 new optometrists per year through the 1980's. In the last five years the New England College of Optometry, where 85% of Maine Doctors of Optometry are educated, has admitted 4 to 6 Maine students each year. It has been brought to my attention by the Dean of NEWENCO that as their contract program develops for states outside of New England, those states from which the college has qualified applicants are being told that those applicants, if capitated, will be given priority over non-capitated students. This will tend to greatly restrict opportunities for non-capitated students.

It is strongly felt that a greater number of students from Maine at NEWENCO are accepted as a direct result of those admitted under the compact. This tends to dilute the per student costs to bargain levels.

Our legislators must realize that taxpayers from other states supporting medical schools will become reluctant to allow Maine students to get a "free ride" at their expense. At some point, as competition for these seats increases, it will be more beneficial for the medical schools to accept most of their students from the compact pool. The other alternative would be to increase tuition costs for out of state students to a level that only the wealthy could afford. This would put the middle and low income students at a disadvantage.

It should also be noted that seven (7) of the 10 colleges that Maine contracts with apply all or part of the grant to the students tuition costs. This, in effect, satisfies a form of student aid to help defray the ever increasing costs of medical education.

Capitation, as demonstrated by the national experience, provides an equitable means for the New England States to contribute to the support needed to provide for the region's increasing needs for medical care. The amount committed by the State of Maine is only a small portion of what our costs would be to "float" a medical school.

OSTEOPATHIC MEDICINE

The University of New England College of Osteopathic Medicine was established in response to a need for more osteopathic physicians in New England. The primary goal of the college is to produce osteopathic physicians who will practice family medicine in under-served areas of New England. The College of Osteopathic Medicine's

curriculum emphasis is on health promotion and illness prevention. Over 75% of osteopathic physicians, nationally, practice family medicine, and over 90% practice primary care. Osteopathic physicians are more likely to practice in rural areas than other types of physicians.

The New England College of Osteopathic Medicine, located in Biddeford, Maine, has a commitment to Maine, and gives preferential admission to applicants from Maine. The college does not link admissions to state capitation or loans and, in fact, the majority of Maine students at the University of New England College of Osteopathic Medicine choose not to accept state funds. Some Maine students need loan support, and on their behalf, we feel this bill should receive support.

The College of Osteopathic Medicine expects to participate in Chapter 304 postgraduate education in the fields of medicine, optometry, veterinary and dental medicine during the 1982-83 biennium. One-fifth of the funds allocated for allopathic and osteopathic contract seats is to be used at the New England College of Osteopathic Medicine. Principally, Maine residents will use these loan funds to help pay their tuition. The money loaned to each osteopathic student is to be no more than the average cost to the state for capitation at the allopathic schools. The decision as to student need is to be at the discretion of the New England College of Osteopathic Medicine. In addition, one fourth of the loaned monies will be forgiven for each year that the graduate practices in the state. The University of New England College of Osteopathic Medicine expects to play an increasing role in the health science education of Maine students, and thus will be requesting more support in future years.

All students at the college receive over three years of their education at the Biddeford Campus and at the three Maine osteopathic hospitals in Portland, Waterville, and Bangor. The teaching program is one of the most economical and cost effective in existence.

In addition to the medical school, the university has created a new school of health science to train physical therapists, occupational therapists and other health care providers. In this rapidly growing school, over 50% of the first physical therapist class was from Maine. The total budget for the university is now in excess of 5 million dollars. The University of New England hopes to develop a mutually beneficial relationship with the people of Maine.

ALLOPATHIC MEDICINE*

The Postgraduate Health Professions Program (Maine Compact or Maine Contract Program), as currently authorized by the Legislature, establishes contractual relationships with ten health professions schools for the purpose of providing preferential access to these schools for Maine students. Seats are contracted for in four schools of allopathic medicine, one school of osteopathic medicine, one school of dental medicine, three schools of veterinary medicine and one school of optometry. The contract program originated with the University of Vermont School of Medicine with the class entering in 1958 (graduating class of 1962).** In 1975-76 it was

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* For all tables referenced in this section, please refer to Section II, Appendix A.

** See Footnote, page 7.

expanded to include the Tufts Medical School and the other schools noted above. Therefore, there is ample information relevant to access of Maine students to schools of allopathic medicine entering classes between 1958 and 1979 and significant data relating to practice patterns and locations of graduates of the University of Vermont in the graduating classes of 1962 through 1975. The majority of the students entering medical school under the expanded 1975-1976 compact have still not graduated or are in postgraduate training. Therefore, no valid analysis can be made relating to type of practice or location. The agreement has had a number of effects on the practice of medicine in the State of Maine. These include the availability of continuing medical education through the faculty and programs of the compact medical schools, development of the Area Health Education Center (AHEC), approval of residency training programs for graduate physicians, and development of major medical school affiliations with hospitals in Maine.

I. ACCESS

The primary objective of the compact agreement has been to provide access to Maine students who would otherwise not have the opportunity to go to medical school. The data herein presented documents the success and the role that the compact has had in doing so. (Table 1). The figures on this table are compiled from the "Annual Reports on Medical Education in the United States," as published in the Journal of the American Medical Association, State of Maine Department of Education data, and class lists from Tufts University School of Medicine and the University of Vermont School of Medicine. In 1968, 28 Maine students entered allopathic medical schools. The State ranked 49th nationally in terms of entering medical students per 100,000 population. Even at this point, seven students, or 25 percent of the entering total, gained access to medical school through reserved seats at the University of Vermont. In 1974, two years before the new compact legislation was enacted 41 Maine students entered allopathic medical schools in the United States, with the increase from previous years being largely accounted for by the increase in the access provided by reserved seats at the University of Vermont. The number increased further under the new compact legislation so that in 1979, 52 allopathic medical students were admitted nationally from the State of Maine and 37, or 71 percent of these were admitted through reserved seats at compact medical schools. At this point the State ranks 35th nationally in terms of medical school students admitted per 100,000 population. It is clear from these figures that fewer students from Maine are entering allopathic medical schools outside of the compact at this time than in 1968 and previous years. The increase in admissions to medical schools is clearly a direct reflection of the availability of reserved seats in these schools. Data from Tufts University School of Medicine make possible an analysis of the success of Maine applicants competing for admission to Tufts with the national pool of students and the effect of the compact. In the two years prior to the implementation of the contract an average of 11.8% of applicants from Maine gained admission to Tufts while in competition with an average of 6178 applicants. In the five years following initiation of the contract, the acceptance rate doubled to an average of 23.7% while the total applicant pool remained high, averaging 7,556. It appears that the majority of students applying to schools of medicine, once accepted, elect to enter under the compact agreement rather than outside of the agreement despite the payback provisions since there are substantial tuition benefits which accrue to the student accepted under the compact agreement. Tufts University School of Medicine returns part of the money that it receives from the State of Maine to the

student as tuition assistance. ($1500.00 to each student in the 1980 entering class against a tuition of $10,580.) The University of Vermont School of Medicine charges the Maine compact student a lower tuition rate rather than that required of out-of-state students. ($6,210.00 for Maine compact students as compared to $9,180.00 for other out-of-state students.) Finally, the success rate of Maine students in gaining acceptance to medical school when compared to students from other states is still another indicator of the success of the compact agreements. (Table 2). In 1977, 59 percent of the 75 students from the State of Maine who applied to medical school were admitted.

While raw percentage of applicants admitted puts Maine in number one position nationally, the number of applicants per 100,000 population (6.91) was lower than any other state in the nation. This may in part reflect the recognized low level of aspiration of Maine students, but also actual guidance and pre-selection of student applicants by counsellors at Maine colleges.

Therefore, reserved seats through the compact agreement have made available allopathic medical education for students from the State of Maine who would otherwise have to compete for acceptance to medical schools in the national pool. Students who have been admitted to non-compact medical schools in the United States have opted to accept a compact position despite the pay-back obligation since compact schools, as noted above, offer significant tuition assistance to the Maine student accepted under these agreements. Without the compact, these students would have to pay out-of-state tuition or seek tuition assistance through another source or perhaps not be able to attend medical school.

II. MANPOWER

Although satisfaction of the health manpower needs of the State of Maine was not an initial objective of the legislation, it has become an area of interest and concern for legislators and others in the State over the course of the last few years. Discussions have centered about reallocation of monies now used for the purpose of reserving seats to the development of rural preceptorships which would expose students to practice in the State of Maine and, hopefully, attract them to return to practice in Maine, especially in underserved areas. The experience under the existing compact agreement supporting access has already had a significant impact on the State in this regard. Twenty-eight of 63 (44.4 percent) of Maine compact students graduating from the University of Vermont School of Medicine between the years of 1962 and 1975, are currently practicing in the State of Maine. This is a substantial return to the State of physicians who have gained access to medical school through the compact agreement. It is especially significant because these students elected to return to practice in Maine voluntarily, before payback provisions requiring return to Maine to forgive indebtedness to the State. Twenty-two of 28, or 78.6 percent of these physicians are practicing in areas of the State other than Greater Portland. Exposure to practice through student experiences in rural preceptorships is said to exert a positive influence on a student's subsequent choice of a rural primary practice location. In 1972, an affiliation was developed between the Maine Medical Center and the Tufts University School of Medicine under an Area Health Education Center Federal Grant Award. This agreement resulted in the rotation of third year medical students from Tufts through the Maine Medical Center for clinical clerkships. Until 1977-78 relatively few Maine students rotated through the MMC because relatively few were accepted at Tufts Medical. However, because of the

1975-1976 compact agreement with Tufts, there were 16 Tufts students at the Maine Medical Center for an entire year of clinical clerkships in 1979. This figure rose to 18 in 1980, the last year of the affiliation between Maine Medical Center and Tufts. Beginning in July of 1980 and because of the existence of the compact agreement between the State of Maine and the University of Vermont, an agreement was reached between the Maine Medical Center and The University of Vermont to provide clinical clerkship experiences for third year Vermont medical students. As noted in Table 3, the number of medical students from compact schools who will be exposed to practice in the State of Maine in both third and fourth years is impressive. Without major affiliations, third year medical students would not come to Maine hospitals for clerkships. Furthermore, it is unlikely that medical students, especially those from other states, would elect fourth year rotations in the State of Maine unless these affiliations existed. Finally, it is important to note than 18 fourth year Maine compact students from the University of Vermont have scheduled a total of 47 months of elective internships in the State of Maine during 1980-81, for an average of 2.6 months each, in a variety of clinical settings and disciplines.[1] As mentioned in the introductory remarks, evaluation of the rate of return of allopathic medical school graduates under the new compact legislation is premature. The first students under the new legislation graduated in 1979 and are in postgraduate medical training. However, it is impressive to note that of 34 Maine compact students graduating from Tufts, Vermont, and Dartmouth Medical Schools in the class of 1981, 23 or 68 percent have applied to the Maine Medical Center for postgraduate medical training beginning in July of 1981.

In summary, a significant number of physicians who have been educated under the compact agreement have returned to practice in the State of Maine. A large number of medical students are being exposed to medical practice in the State of Maine as a direct result of the affiliation between the Maine Medical Center with Tufts University School of Medicine in the past and now with the University of Vermont School of Medicine. This relationship and its continuation is directly dependent upon the continuation of the compact agreement. Furthermore, the University of Vermont has placed all 18 of the Maine compact students in the class of 1981 in preceptorship programs in the State for an average of 2.6 months each during the senior year. Seventy-two percent of these experiences are outside of Greater Portland, many of them in rural sites. This is taking place under the existing legislation without reallocation of funds to support of these preceptorships. Sixty-eight percent of the Maine compact students in the Class of 1981 are applying to return to the State of Maine in postgraduate medical education at the Maine Medical Center beginning in July of 1981.

III. COST

The alternative to providing access to allopathic medical education for Maine students, as provided by the compact, would be the development of an allopathic medical school in the State of Maine. This alternative was considered in the past and found to be excessive in cost. During the period when this possibility was being considered, the State of Massachusetts accepted this alternative in developing the

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[1] Only 13 of these months, or 38 percent of the experiences are in Portland. (Table 4.)

new University of Massachusetts School of Medicine in Worcester. The costs of building and operating this school are shown in Table 5. Therefore, it is clear that the current Maine compact agreements which provide access to students interested in the study of allopathic medicine are very clearly cost effective in comparison with the other alternative. The total available in support of allopathic seats in Fiscal 1981 is $1,105,300. Monies have returned to Maine in support of undergraduate medical education, postgraduate and continuing medical education not only in Portland, Bangor, and Lewiston, but also through the AHEC contract as a result of medical school affiliation to Biddeford, Rockland, Waterville, Skowhegan, Farmington, Presque Isle, Millinocket, Bar Harbor and Machias. This amounted to 5.7 million dollars from 1972 through 1980.

SECTION IV: LETTER TO THE HONORABLE JOSEPH E. BRENNAN, GOVERNOR -

Critique Of Facts And Conclusions In The Report Prepared
For The Governor By The Department Of Human Services
As The Basis For His Recommendation To Discontinue
His Support Of The COMPACT

February 26, 1981

The Honorable Joseph E. Brennan, Governor
State of Maine
State House
Augusta, Maine 04333

Dear Governor Brennan:

I have been asked by members of the Advisory Committee on Medical Education, as its Chairman, to provide you with a document that reflects some of the special knowledge available from our Committee that is pertinent to the Maine Postgraduate Health Professional Education Program. We understand, on good authority, that the Executive decision to propose cancelling this program has been largely based upon a report prepared by the Department of Human Services. We have recently been able to review this report in detail and are dismayed at its many inaccuracies and its flagrant, negative bias. We hope that providing you with a point by point critique of this report you will reconsider your position on the issue. This critique was based upon a response by Mr. Donald Nicoll to a request from a member of the Legislature. It drew upon the most up to date information available 1) from the schools participating in the COMPACT, 2) from The Board of Registration in Medicine, 3) from the work of the Health Manpower Subcommittee, and 4) other members and staff of the Advisory Committee on Medical Education.

GENERAL OBSERVATIONS:

The report focuses initially and dominantly on the Health Manpower issue as it relates to the alleged oversupply of physicians. This focus ignores the fact that the basic reason for the program is to provide access to a spectrum of postgraduate health professional education programs for Maine's young people. Recent changes in the Act were designed to strengthen incentives for graduates of these programs to return to Maine to practice their professions. These changes did not and should not obscure this basic objective. A statement concerning these basic objectives of the COMPACT program does not appear until page 20 long after much heralded alarm about the projected national oversupply of physician manpower.

POINT BY POINT COMMENTS:

Beginning on page one is a discussion of the Graduate Medical Education National Advisory Committee (GMENAC) Report. This discussion oversimplifies the report by ignoring the considerable emphasis given in the report to the problem of maldistribution and the need to resolve this problem in parallel with that of the projected physician oversupply.

The GMENAC's call for a reduction in medical school class size, emphasized on page three, has special implications for future access problems for young people in states without a medical school. Opportunities for Maine residents will be drastically reduced without the purchase of contract spaces.

The paper begins a discussion of trends in the supply and distribution of physicians in Maine on page four. There is a great deal of emphasis on the percentage increase in physician supply between 1970 and 1980. This statistic is misleading because Maine started from a very small base. The comparison of the physician growth rate (47%) with the population growth rate (12.4%) is additionally misleading because Maine was improving its physician supply from a starting point of very serious deficit. One should also note the drop in the rate of increase in the years between 1978 and 1980. The 1980 figures probably understate total supply by last fall (since the survey came in July), but the overall increase between 1978 and 1980 probably did not exceed 4½%.

Please note the table at the top of page six. It demonstrates that even with a substantial percentage increase in physicians between 1973 and 1978 Maine was still lowest in New England for the proportion of physicians to population and was substantially below the national ratio. As a matter of fact, Maine's position in comparison with the United States deteriorated between 1973 and 1978. In 1973 we were at 75% of the national ratio of physicians to population. By 1978 we had dropped to 69%. The paper takes note of our poor position in New England on page seven, but immediately asserts that we do not have a "serious shortage of physicians". The table on page seven must be read with great care because one of the report's most serious mistakes is found there. The sentence leading to that table asserts that the table "assesses the number of active physicians in Maine in 1978 against available standards of 'sufficiency'." The hooker in defining "sufficiency" comes under Primary Care. The footnote asserts that the 1:2,000 "Standard of Sufficiency" comes from "State Health Plan for Maine". In the first place, the ratio of one primary care physician to 2,000 persons comes from the proposed State Health Plan for Maine which has not been submitted to public hearing or considered for final adoption by the State Health Coordinating Council. In the second place, that proposed standard and the federal guideline from which it is drawn do not assert that one primary care physician to 2,000 persons is "sufficient". A ratio of one to 2,000 is bare minimum and below that ratio the federal government will now subsidize primary care practice. Distressingly, 25% of Maine's population live in communities which fall below this minimum guideline. The comparable guideline of sufficient supply derived from the GMENAC Report would establish the ratio of one primary care physician per 1,140 persons. Applying this ratio to the state as a whole, the "211 primary care physician surplus" becomes a 210 physician deficit.

From this perspective of an existing primary care physician deficit, and in light of the data showing that in 1978 Maine has actually fallen further behind the national average in total physician to population ratio, the assertion on page eight that "Maine thus appears to be competing successfully in attracting such physicians to the State" has a hollow ring. The observation that the growth of the physician population fell to only 4½% between 1978 and 1980 should be causing us some concern.

The impact of nurse practitioners and physicians assistants on the needs for primary care physician manpower are uncertain at present. The GMENAC ratios for primary care physician needs were based on assumptions that included the effect of physician extenders participating in joint practice with the primary care physicians. At present most of the physicians assistants are in practice in Emergency rooms (less than ideal settings for the cost effective provision of primary care services), and many of the registered nurse practitioners are not participating in joint practice with primary care physicians.

The final section on manpower addressed the distribution of physicians by county, pages nine to fifteen. Several tables are presented which analyze the overall physician to population ratios by county. The most grevious oversight in this analysis is again the use of percent increase in physician numbers as a comparative measure of change. If a county starts with few physicians and gains a few, a large percent increase will occur. This may have very little relevance to the relative improvement in supply as compared to a measure of need. A second methodologic deficiency is the use of total physicians on a county-by-county basis. The county is too large a geographic area for comparison of primary care physicians and too small a geographic unit for many specialties that have a wide geographic referral base.

The Health Manpower Subcommittee of the Advisory Committee on Medical Education has completed a study of primary care physician manpower distribution with the help of members of the Bureau of Health Planning & Development, the BSA, and the Maine Health Information Center. As a part of this study a county-by-county comparison between 1976 and 1978 was done which illustrates the misleading potential of using the percent increase of physicians as a measure of improving maldistribution. Some examples are as follows: Waldo County was found to have the greatest deficit of primary care physicians (7 present in 1976, 17 needed by GMENAC standards). Three physicians were added by 1978 for a 43% increase. This increase fulfilled only 18% of the estimated need. In Kennebec County by contrast, 22 new physicians had arrived for a 34% increase. This increase satisfied 100% of the GMENAC criteria of need. The statewide composite of this different perspective of the trends of new physician distribution shows that the most daficient counties have the least of their needs fulfilled by the new physicians added to the manpower pool (see Column 6 of Appendix 4 of Health Manpower Subcommittee Report appended). This reality in the face of a declining rate of new physician growth between 1978 and 1980 suggests that it is premature to assume our physician manpower distribution problems are over.

Page 15 starts the review of the COMPACT program. The second paragraph on that page has the first of several errors in counting the number of medical school graduates who attended the University of Vermont and returned to Maine to practice. The paper includes the years 1976 and 1977, two years that are not representative because not all of the graduates had concluded their residency program. If one eliminates 1976 and 1977 and looks at the actual figures for 1962 to 1975, the total number of physicians graduating from the program and returning to Maine was 28, not 23, and represented 44% of the COMPACT students, not 28.3%.

There is a misleading statement on the subject of financial need and student costs on page 17. In the middle of that page there are two errors. In most of the schools, students from Maine are accepted only if they are participating in the contract program. In those schools, acceptance and contract enrollment is not based on financial need. In each case, however, the tuition for these students is lower than the usual out of state student tuition because of the contract program's contribution. Thus there is a substantial savings to the students participating in the program. In Optometry, students are accepted with or without contract obligations. In this case participation in the contract program is arranged on the basis of financial need. The statement on page 18 that these tuition discounts are offered in competition for the best students is grossly in error.

The table on page 19 on the cost of the program for selective years 1973-81 appears to be accurate. It rebuts a later assertion that the medical student portion of the program costs $1.6 million a year.

As noted at the beginning of this letter the statement on the major purpose of the program comes on page 20. Even that page contains errors. The paper asserts that "Data are not available at this time to determine if the (other) states without medical schools have contract programs similar to Maine." The states listed in the table on page 21 as not having medical schools all have COMPACT programs and this has been a matter of public record for years. The last sentence on page 20 casually tosses off the central point of the COMPACT by stating "no estimates have been made of the number of Maine students who would have entered medical school had the contract program not been in place." Such estimates are easily provided:

1. Prior to the COMPACT, Maine's position nationally with respect to the percent of applicants to medical school that were accepted was low (51st in 1973-74, 43rd in 1972-73).

2. Much is made (page 22) of the fact that since the start of the current COMPACT, Maine's position nationally has moved to first with respect to the percent of applicants admitted. This statistic is misleading because Maine's acceptance rate into medical school per capita of population is low (34th nationally). The high acceptance/applicant ratio is related to an artifact of the approach of the undergraduate student advisors at our several colleges and the state university. Because of the limited career opportunities for unsuccessful applicants to health professional schools, each of these advisors makes a special effort to discourage potential applicants who have virtually no chance of gaining admission. Hence the applicant pool is kept relatively small.

3. Maine's low acceptance per capita ratio merely reflects the fact that the 40 medical school contract seats available to Maine residents are fewer than the number available in other states with and without medical schools. Reducing this number further will clearly worsen Maine's already poor relative position for educational opportunities for its gifted young people.

4. There are a few students admitted to schools outside of the COMPACT (ranging between 8 and 22, average =16). We can only speculate that federal cutbacks in medical school support and the response to the GMENAC recommendations will shrink these numbers significantly.

The low point of the DHS report on this issue comes on page 27 with the statement, "It is assumed here, but not documented that there must have been an access problem prior to 1962 or the contract program would not have been established. This assumption raises a logical question of whether the access problem still exists." The above data amply support the contention that an access problem exists even with the COMPACT program in place.

The table on page 23 begins a section designed to discredit the physician manpower impact of the COMPACT program. The attempt uses inaccurate data and relies upon the inappropriate assumption that the outcome of the old COMPACT with the University of Vermont (which had no payback provisions and no Maine based rural preceptorships) is a valid measure of the impact of the new COMPACT (whose graduates are still in training). The data in the table on page 23 is in error because it is taken from old data (1978) and included the 1976 and 1977 statistics which would inappropriately include in the denominator students still in residency training. Current data from the Board of Registration was obtained to clarify the point. The individual corrections on that table are as follows: 1968, 4 (not 3) students returned to Maine, and none (not 1) did not return; 1971, 2 (not 1) returned, and 4 (not 7) did not return; 1973, 5 (not 4) returned, and 5 (not 6) did not return; and 1975, 2 (not 1) returned, and 5 (not 6) did not return. The composite of the 1962-1975 data show that 28 out of 63 graduates returned to the state without the stimulus of financial incentives. This is a 44.5% yield, not a 28.4% yield. The errors are carried over in Table VI on page 24. Incidentally, 40% of students now enrolled at the University of Vermont College of Medicine are from towns of less than 10,000 population in Maine. Vermont has worked very effectively on developing a preceptor program for their students in Maine. This year 18 students are spending 47 months in preceptorships, and only 13 of these months will be in the Greater Portland area.

On page 29 the access problems in the other health profession disciplines are summarily dismissed by reference to a mysterious special report of October 22, 1980. The origin of this report, which (like the DHS Report) was withheld from the critique of the Advisory Committee, was recently acknowledged to be MCD. Suffice it to say that this report proposes options to reduce contract seats so as to provide long term support for an MCD program seeking to coordinate rural medical student and family practice preceptorships. It seems both DHS and MCD wish to create funds for their own programs at the expense of the already limited opportunities for health profession careers for Maine's young people. Fortunately, both the existing COMPACT medical schools and the existing family practice residency programs already have established successful rural preceptorship programs and do not need a costly third party broker to intercede on their behalf.

With respect to the access barriers in the non-medical disciplines, the most serious inaccuracy relates to the impression that no barrier to access

exists for veterinary schools. This misconception originated with an earlier MCD report that mistakenly focused on one year that only three students applied for four contract seats in the veterinary schools. The antecedent year 27 students at Orono had applied to four seats - the disappointment of the 23 unsuccessful students discouraged the students from applying the following year. In actual fact, access to non-COMPACT veterinarian schools is far more difficult than for medical school. Only one student in the recent class at Orono was admitted to veterinary school outside the COMPACT.

The paragraph in the middle of page 29 under Legislative Intent is both wrong and misleading. The 1977 amendments have not had an effect on the return rate since the students admitted since then have not even graduated from medical school. The snide question about the "success or extent of the planning" is coupled with the erroneous statistics on the percentage in number of Vermont contract students who returned to Maine between 1962 and 1977. That paragraph is followed by another that is a non sequitur. Of course residency programs have a greater influence on where physicians locate their practices. That point was made on numerous occasions in conjunction with the amendments to the COMPACT legislation when the payback provisions were being advanced as the only way to assure the return of Maine students. The paper fails to note that all of the residency programs in the state are strengthened as an attraction to medical students by affiliations with medical schools and by the involvement of medical school faculty and preceptorships in teaching programs in the state. In fact, of this year's Maine graduates from Tufts and the University of Vermont, 71% are applying for residencies at the Maine Medical Center.

The final paragraph on page 29 tries once more to use the erroneous statistics on the Vermont contract to assert that the COMPACT program is not useful in meeting our manpower needs. Need we say once more that the object of the program was not to meet our manpower needs, except incidentally, but to provide access for Maine students?

The conclusions and recommendations in the paper represent the final triumph of prejudice over facts and logic:

CONCLUSION 1: Restates the GMENAC projection of a national physician surplus. As noted earlier, this projection is not germane to Maine except that it provides a reference point that confirms our primary care physician deficit.

CONCLUSION 2: Restates the erroneous conclusion that Maine already has a sufficient physician supply and restates the misleading statistics based upon percent increases in physician numbers.

CONCLUSION 3: Re-emphasizes the misleading acceptance/applicant ratio and fails to recognize that the low acceptance/population ratio relates to the fact that the number of contract seats is already low by national standards. The misconceptions of the MCD report on the lack of access barriers to veterinary medicine are restated. Finally, the inaccurate statistic underestimating the rate of return of the old COMPACT students is used quite

inappropriately to infer that the current COMPACT will be ineffective with respect to the manpower needs of the state. The correct comparison should be 1962 to 1975, during which time 28 out of 63 students returned to Maine (44%). Early indications from residency applications suggest that the impact of the payback provisions will be significant with the new COMPACT students.

RECOMMENDATIONS:

The rationale for discontinuing the COMPACT (toward the bottom of page 31) is so full of half truths and errors that it is hard to present a temperate rebuttal. The GMENAC projected surplus may have little relevance to Maine's needs for and supply of physicians since it focuses on the national aggregate. The report does not make adjustments for the potential impact of existing market incentives for improving the maldistribution problem. If the GMENAC report is taken seriously and enrollments in medical school are reduced, the opportunities for Maine students will be drastically reduced. Unless we are prepared to shut the door on aspiring young people from Maine, it will be necessary for us to continue the COMPACT program. The reference to the "decreasing ratio of medical school applicants to acceptances nationally" simply underscores that point. The assertion that the program has had an "insignificant impact . . . on the number and distribution of physicians practicing in Maine" is based on erroneous statistics and the willful avoidance of the fact that the payback program is too young to have even influenced one graduate. The final error is in the reference to the cost of the program. $1.6 million is the cost of the total program, including all the health professionals, not just the physicians.

The arguments on Maine's obligations under the COMPACT, starting at the bottom of page 31 and continuing on page 32 are, to put it mildly, appalling. In the first place, the writers display an abysmal ignorance of contract law. The provisions in the contracts that hold the state harmless in the event the legislature does not appropriate funds simply recognize that one legislature may not bind another. That does not remove the obligation from the Executive Branch to make a good faith effort to carry out the provisions of the contract. One can only speculate on what the language used by the Department of Human Services in the paper will do to Maine's reputation for integrity with the schools that have negotiated contracts with us.

There is, in addition, a gross error in fact in the argument. Toward the bottom of page 32 the following sentence appears: "Maine students are treated the same as other students with respect to amounts billed for tuition and room and board." The facts are that the University of Vermont charges Maine students in-state tuition and Tufts University provides a rebate to Maine students under the COMPACT. If Maine terminated the contract with those two schools, tuition for students at the schools under the contract would go up substantially. The net effect of the state action would be to increase the cost of education to those students already enrolled and to selectively limit access to medical career opportunities for the young people from lower income families.

The remedies proposed on page 33 and following would simply increase the cost of education to those students now in the schools and those few who might be lucky enough to get into medical school, veterinary school, optometry school or dentistry in the future. A loan program specifically for osteopathic applicants is already being developed. (It should be noted that the Tufts School of Dentistry, which is not over-burdened with applications, may not be looking for contracts in the same way that the medical schools and the veterinary schools are. A grant or a loan program might make sense for the dental students.) These points notwithstanding, loans and grants won't do students much good if there are not spaces available for them in the out of state schools.

This concludes our point by point critique of the Department of Human Services report on the COMPACT program. We hope we have clarified the reasons why we believe you have been badly misled by its preconceived emphasis and self-serving focus. We believe our talented youth should not be denied access to career opportunities in the health professions. We believe our needs for these professionals in practice in Maine has not disappeared. Furthermore, if the graduates of these programs do not return to Maine the modest investment made by the State will be returned by the payback provisions.

Sincerely yours,

FRANKLIN ROBERTS, Chairman for the
Advisory Committee on Medical Education

FR/pb
Enclosures

COMPARISON OF COUNTY-BY-COUNTY DISTRIBUTION OF ALLOPATHIC PRIMARY CARE PHYSICIANS - 1976 vs 1978

COUNTY	1. 1976 APCP COUNT	2. 1976 RATIO PHYS/ 100,000 POP	3. 1976 RATIO ÷ 83.3	4. # NEW APCP NEEDED 1976	5. # NEW APCP ADDED 1978	6. % OF 1976 NEED MET BY 1978 NEW APCP
Androscoggin	41	43.1	52%	38	21	55%
Aroostook	29	29.7	36%	52	14	27%
Cumberland	117	57.2	69%	53	54	102%
Franklin	9	35.9	43%	12	3	25%
Hancock	20	50.7	61%	13	13	100%
Kennebec	64	62.7	75%	21	22	105%
Knox	23	71.0	85%	4	3	75%
Lincoln	14	58.8	71%	6	3	50%
Oxford	17	37.6	45%	21	3	14%
Penobscot	40	29.5	35%	73	28	38%
Piscataquis	10	59.5	71%	4	-1	Loss
Sagadahoc	10	38.3	46%	12	2	17%
Somerset	13	29.3	35%	24	3	13%
Waldo	7	25.9	31%	16	3	19%
Washington	10	29.3	35%	18	5	28%
York	51	41.6	50%	51	12	24%
TOTAL	475			418	188	

V.

SUMMARY COMMENTS BY TURNER BLEDSOE, M.D., CHAIRMAN,
HEALTH MANPOWER SUBCOMMITTEE, ADVISORY COMMITTEE ON MEDICAL
EDUCATION TO APPROPRIATIONS COMMITTEE

SUMMARY OF THE PHYSICIAN HEALTH MANPOWER ISSUES RELATED TO THE
MAINE POSTGRADUATE HEALTH PROFESSIONAL EDUCATION PROGRAM

I. PHYSICIAN SURPLUS

THE GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE (GMENAC) REPORT PREDICTS A SURPLUS OF PHYSICIANS BY 1990.

A. THE REPORT IS BASED ON PROJECTED NATIONAL TOTAL NUMBER PHYSICIANS/ TOTAL POPULATION.

1. THE DATA ARE NOT PROJECTED RELATIVE TO INDIVIDUAL STATES.

a. MAINE IS NOT GUARANTEED A SURPLUS.

B. THE REPORT PROVIDES SOPHISTICATED NEW METHODOLOGY, GUIDELINES OF MANPOWER ADEQUACY, AND DESCRIBES SERIOUS GEOGRAPHIC MALDISTRIBUTION PROBLEMS.

1. USING SIMILAR GUIDELINES AND METHODS, AND TAKING MALDISTRIBUTION INTO ACCOUNT, MAINE HAS A DEFICIT OF APPROXIMATELY 212 PRIMARY CARE PHYSICIANS (AS OF 1978 DATA).

2. FURTHER DEFICIENCIES OF OTHER SPECIALTIES ARE LIKELY TO BE REVEALED BY ONGOING ANALYSIS.

II. TRENDS IN MAINE'S PHYSICIAN MANPOWER GROWTH

A. BETWEEN 1976 AND 1978 MAINE'S DEFICIT IN PRIMARY CARE PHYSICIANS DROPPED FROM APPROXIMATELY 418 TO 212. THIS CHANGE WAS ACCOMPANIED BY A 16% OVERALL GROWTH IN TOTAL PHYSICIANS IN THE STATE. THE IMPROVEMENT IN PHYSICIAN SUPPLY FAVORED THE BEST SUPPLIED COMMUNITIES AND LEFT SERIOUS RESIDUAL DISTRIBUTION PROBLEMS IN SMALL COMMUNITIES.

B. DESPITE THIS GROWTH IN PHYSICIAN SUPPLY, IN 1978 25% OF MAINE'S POPULATION LIVED IN COMMUNITIES BELOW THE MINIMUM FEDERAL GUIDELINE OF ADEQUACY AND 55% OF THE POPULATION LIVE IN COMMUNITIES THAT SHOULD HAVE AT LEAST A 15% INCREASE IN PRIMARY CARE PHYSICIANS TO MEET THE GMENAC CRITERIA OF SUFFICIENT SUPPLY.

C. BETWEEN 1978 AND 1980 THE GROWTH OF TOTAL PHYSICIAN SUPPLY HAS SLOWED SIGNIFICANTLY (APPROXIMATELY 68 PHYSICIANS AS OPPOSED TO THE PRIOR 207). THE IMPACT OF THIS SLOWED GROWTH ON PRIMARY CARE PHYSICIAN SUPPLY AND DISTRIBUTION IS NOT KNOWN BUT IS UNDERGOING ANALYSIS NOW. RESIDUAL DISTRIBUTION PROBLEMS ARE A CERTAINTY.

D. PROJECTED CUTBACKS IN THE FEDERALLY FUNDED NATIONAL HEATLH SERVICE CORPS ARE LIKELY TO WORSEN OUR PHYSICIAN SUPPLY IN SMALL COMMUNITIES.

III. EFFECT OF COMPACT ON PHYSICIAN MANPOWER SUPPLY AND DISTRIBUTION.

A. NO FIRM CONCLUSION IS YET POSSIBLE BECAUSE THE GRADUATES OF THE NEW PROGRAM (WITH PAYBACK FORGIVENESS PROVISIONS) ARE JUST STARTING THEIR RESIDENCY TRAINING.

B. INFERENTIAL EVIDENCE SUGGESTS THAT A SIGNIFICANT IMPACT IS LIKELY.

1. FROM THE EXPERIENCE WITH THE PRIOR CONTRACT PROGRAM WITH THE UNIVERSITY OF VERMONT - 44% OF GRADUATES RETURNED TO MAINE WITHOUT A PAYBACK REQUIREMENT OR FORGIVENESS CLAUSE.

2. STUDIES IN THE LITERATURE AND OUR OWN PAST VERMONT EXPERIENCE SUGGEST THAT STUDENTS FROM SMALL COMMUNITIES ARE MORE LIKELY TO PRACTICE IN SMALL COMMUNITIES (40% TO 50% OF THE COMPACT STUDENTS ARE FROM TOWNS OF LESS THAN 10,000 POPULATION).

3. WITH THE NEW COMPACT GRADUATES THERE HAS BEEN AN INCREASE IN THE NUMBER APPLYING TO MAINE RESIDENCY PROGRAMS (71% FROM CLASS OF 1981 AT TUFTS AND UNIVERSITY OF VERMONT).

D. MAINE'S POSTGRADUATE RESIDENCY TRAINING PROGRAMS ARE ENHANCED BY AFFILIATION WITH COMPACT SCHOOLS.

1. EASTERN MAINE MEDICAL CENTER AFFILIATES WITH TUFTS DEPARTMENT OF FAMILY MEDICINE AND IS REIMBURSED FOR PROVIDING PEDIATRIC CLERKSHIPS FOR THIRD YEAR MEDICAL STUDENTS.

2. THE MAINE-DARTMOUTH FAMILY MEDICINE RESIDENCY PROGRAM IS PRODUCTIVELY ALLIED WITH DARTMOUTH AND RECEIVES FACULTY SUPPORT FROM THE SCHOOL OF MEDICINE.

3. THE CENTRAL MAINE MEDICAL CENTER FAMILY PRACTICE RESIDENCY IS AFFILIATED WITH BOSTON UNIVERSITY.

4. THE MAINE MEDICAL CENTER IS CLOSELY AFFILIATED WITH THE UNIVERSITY OF VERMONT AND IS REIMBURSED BY THE UNIVERSITY FOR TEACHING THIRD YEAR MEDICAL STUDENTS IN ALL OF THE BASIC DISCIPLINES OF MEDICINE.

5. LONGTERM TRENDS IN RESIDENCY ACCREDITATION SUGGEST THAT THESE AFFILIATIONS MAY BE CRUCIAL TO THE SURVIVAL OF THESE RESIDENCY PROGRAMS.

VI.

SUMMARY OF TESTIMONY OF
DR. FRANKLIN P. ROBERTS
CHAIRMAN, ADVISORY COMMITTEE ON MEDICAL EDUCATION

We submit for your consideration statements prepared by members of the Advisory Committee on Medical Education covering the areas of dentistry, optometry, veterinary, osteopathic, and allopathic medicine.

At a meeting on February 20, 1981, the Advisory Committee voted unanimously to recommend funding to provide capitation for the 149 students who would be continuing in the pipeline as of September 1981, and to provide capitation again for those continuing for the second year of the biennium. At present capitation rates the cost of doing so would be $1,800,000. Secondly, we recommend a continuation of the present compact with funding for 62 entering seats (versus 64 currently) for September 1981-82. These spaces would be divided as follows:

40 - Allopathic
10 - Osteopathic
6 - Dental
4 - Veterinary
2 - Optometry

Projected cost for 62 seats is 2.3 million dollars making a total cost of 4.1 million dollars for the biennium.

The present program was initiated as a cost-saving measure under legislation in 1976 and 1978, but based on the original compact legislation of 1958. It is clear from the wording of these statutes that there was an expectation that the compact would be continued indefinitely. For example, no provision was made for service payback for any period short of the four years; that is, a student is obligated to practice in Maine for four years to offset, even without any provision for capitation support. This is a consequence of wording "that an amount equal to 1/4 of the indebtedness...shall be forgiven for each year which the state contract student practices his profession within the State" without provision for support for periods less than full term.

Also, attention has been given to a loan program for the compact. We would emphasize, however, that without access a loan program is meaningless. In fact, most of our compact schools have used substantial portions of the capitation for scholarships for Maine residents, including $7,000 at New England College of Osteopathic Medicine, $4500 at New England College of Optometry, $3,000 at the University of Vermont, $2700-$3900 at Tufts Dental School. Thus, indeed, the access money is providing substantial financial support for our residents. The University of Vermont has indicated that acceptance in the future would drop to one or two Maine residents per year without the compact, as indeed was the case prior to 1959. Tufts would likewise return to pre-compact policies, which generally meant acceptance of one to two students per year.

We wish to emphasize that the Maine contract students are highly qualified, despite our high ranking in applicant/acceptance ratios and are, in fact, performing at a considerably higher level than the average. At Vermont, where 12% of the students are selected for membership in Alpha Omega Alpha, the national medical honor society, 30% of the Maine contract students are included; and 50% of the Maine residents are in the upper one-third of their class. Furthermore, over many years

Maine residents have performed significantly higher than national average on Medical College Application and Testing scores. Maine's high acceptance ratio reflects partly the lack of opportunities in other health related careers for the unsuccessful Maine applicants. Faculty advisors must give early attention to screening out those who might be uncompetitive for acceptance, since training for other health-related careers is severely limited. By contrast during the writer's tenure as health professions advisor at North Carolina State University, he found it relatively easy to steer non-competitive health professions applicants into one of dozens of training programs at Raleigh, Chapel Hill and Duke. Schools such as New York University have about 100 such career programs leading to certification of one kind or another, most of which are acceptable alternatives to medical school for the unsuccessful applicant. In Maine those who fail to gain admission are left with few choices other than switching to unrelated majors or moving out of state, and in so doing adding one or more years to their undergraduate degree program. Our pre-health professional students become aware of this situation early and tend to screen themselves as they assess their chances for realizing their career aspirations. The Governor's recommendation makes no allowance for current juniors and seniors who have worked long and hard with the expectation that they would have a reasonable chance of gaining admission to a health professional school. The situation would be comparable to eliminating the forestry program without provision to continue those students presently enrolled. To take such action it seems to us would be morally, if not legally, indefensible. It is true that occasionally students would still gain admission without the compact, and we estimate that with the present applicant pool the acceptance rate overall would become about 10%. Given such odds one could not in good conscience advise any student who is a Maine resident to pursue these goals. The situation is a result of strong regional preferences in admissions policies, and few schools accept from a national pool. Only one Maine resident is currently enrolled in a non-compact public medical school, i.e., the University of Cincinnati.

Hundreds of Maine families and students aspire to these careers and those who are able to do so would undoubtedly leave the state to establish residence elsewhere. Unfortunately, most of these students come from families with modest means and some from families at the poverty level who would find it most difficult to move.

It is well-documented that a relationship exists between the quality of health care delivery and proximity to medical centers with training programs. The extensive training program at the Maine Medical Center, as well as family practice residencies throughout the state have come into existence in conjunction with the compact. Without it they would be in jeopardy. Related benefits to the state are arrangements for consultation services from these schools. The State of Maine would be taking a giant step backward in all of these areas by failing to continue the compact. We strongly recommend continuation of this program.