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Legislating Healthcare: A Legislative History of Healthcare Equity and Access in the Mid-20th Century United States

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ABSTRACT: Historically, the United States has struggled to provide accessible healthcare to all Americans. Now, due to the COVID-19 pandemic, the country must rebuild its healthcare system to account for the devastating loss of healthcare personnel and the impending physician shortage. This paper discusses four U.S. laws that were intended to increase accessibility and how their history can guide the nation to better healthcare.

KEYWORDS: Healthcare, Manpower, Health Manpower Act, COVID-19, Comprehensive Training Act, National Planning, History

The United States government historically has not provided support for healthcare in the way that other countries, like the United Kingdom with its National Health System, have done. Yet, support for national healthcare took on new importance with the introduction of Medicare and Medicaid during the Johnson administration in the 1960s. Nevertheless, making good healthcare available to all citizens has remained a challenge in the 21st century.

Americans today face the consequences of the COVID-19 pandemic, and the deficits within the healthcare system's protocols on preventative care and delivery revealed themselves as healthcare workers dealt with a shortage of medical personnel and supplies. Death, layoffs, and healthcare professionals' overwhelming responsibilities led to significant levels of burnout, thus, departure from the medical profession. In fact, in October 2021, the survey research company Morning Consult reported that 18 percent of healthcare workers quit their jobs since the start of the pandemic (Gavin 2021). To correct these consequences of the pandemic, it is imperative first to understand what steps the federal government implemented in the past and can still use to help rebuild the healthcare system today. This article discusses four laws first introduced in the late 1960s that attempted to improve the country's healthcare system: the Health Manpower Act of 1968, the Comprehensive Health Manpower Training Act of 1971, the National Health Planning and Resources Development Act of 1974, and the Health Planning and Resources Development Amendments of 1979. Likewise, by exploring this legislation, this article aims to help in understanding the discussions and outcomes of past legislation and how they may benefit us today as we undergo several crises in the medical community.

When President Lyndon Johnson took office in November 1963, he first addressed America's civil rights issues—a major emphasis of John F. Kennedy's presidency and legacy—and then prioritized accessible healthcare. The push to make healthcare available to Americans beyond Medicare and Medicaid and improving the quality of care for the nation's people were significant parts of Johnson's legacy (Starr 2015, 235-258). His mission was personal, having watched his father and mother die relatively young from a heart attack and cancer, respectively, his grandmother suffered from a stroke, and Johnson suffered from a heart attack in 1955 (Dewitt and Berkowitz 2012, 163). However, the goal of the Medicare and Medicaid programs to provide

accessible healthcare to elderly and poor citizens was hindered by a dire shortage of physicians in the 1960s (Crawley and Hooker 2013, e333-e341). The legislation introduced during and after his presidency, which aimed to increase the number of providers and ameliorate the physician shortage, helped make that legacy possible.

The Health Manpower Act of 1968 was a continuation of the Health Professions Educational Assistance Act of 1963 and amended the Public Health Service Act first enacted by the 78th U.S. Congress in 1944, which attempted to streamline existing public health offices under one umbrella (Snyder 1994, 721-722). The Health Professions Educational Assistance Act was the first legislation to provide federal aid to health professions schools, a feature missing from the 1944 Public Health Service Act. Although the Health Professions Educational Assistance Act provided funds for constructing new teaching facilities and loans to students, it only focused on preventing a reduction in enrollment (MacBride 1973, 1). Unlike the 1963 law, the Health Manpower Act focused specifically on increasing enrollment and improving the quality of education by providing funds to build non-teaching research facilities (MacBride, 6).

Overall, legislators used the new law to support the education of health professionals via new buildings to expand the capacity of medical students, institutional and student assistance, and special project grants in the hopes that the number of physicians across all healthcare specialties would increase. Unlike previous legislation, this new act provided greater leniency with federal funding to provide multi-purpose facilities instead of classrooms exclusively (MacBride 1973, 6-7). The Health Manpower Act also revised what constituted institutional grants and further explained the purposes of special project grants. These grants were designed by the Committee on Interstate and Foreign Commerce to encourage more students to enroll in and, ideally, graduate from professional schools. According to a 1973 report titled *An Overview of the Health Professions Educational Assistance Act, 1963-1971*, "Each school with an 'approved application' was to receive \$25,000 [from institutional grants] each year" (MacBride, 6). Additionally, the remaining funds for the year were divided among the schools that increased enrollments and the number of graduates over previous years. To further incentivize schools, the new law doubled the funds for each student over the enrollment goal (MacBride 1973, 7).

The Health Manpower Act designated funds for special project grants with several applications in mind. The grants funded updated curricula and research in educated-related fields. They also focused on training new types of personnel, assisting schools with operating costs or accreditation requirements, and establishing experimental teaching and training facilities (MacBride, 7). Special project grants were provided with the considerations of whether the project would result in increased enrollment, shorter training times, and relief to applying schools with desperate financial aid need (MacBride 1973, 7). The Health Manpower Act's institutional and special project grants provided greater funds to the institutions that recruited the most students and had the highest percentage of graduating students. Ideally, this approach could help decrease the physician/patient ratio—seen as a major part of the healthcare crisis—by increasing the class size of medical schools and thus increasing the output of physicians.

Although the assistance and grants were deemed necessary by the American Medical Association (AMA) and medical schools nationwide, the requirements to claim them proved challenging for institutions. The AMA cautioned about this exact situation during its testimony as part of the bill's debate. In June 1968, two months before the Health Manpower Act was passed by Congress and signed by President Johnson, the House Subcommittee on Public Health and Welfare heard testimony from physicians and medical educators about the proposed law. Dr. William A. Sodeman, a member of the AMA executive committee of medical education, and Dr. C.H. William Ryhe, the director of the Division of Medical Education, spoke before the committee on the legislation as representatives. Sodeman began his statement by reminding the committee of the AMA's testimony in August 1963, in which the organization advised Congress to prioritize the increase and improvement of physical facilities for medical education and expressed the need for assistance in construction (Health Manpower Act of 1968 Hearings 1968, 95). He also delivered a joint statement provided by the AMA and the Association of American Medical Colleges (AAMC) on March 5, 1968, which affirmed that “to meet national expectations for health services, the enrollment of our nation's medical schools must be substantially increased” (95). The statements reveal that the AMA and AAMC, both prominent organizations for medical education, agreed the best approach to obtain this goal was to provide financial support for the construction of additional facilities. The two organizations generally

supported the bill but also suggested a few refinements to improve the legislation's impact on medical education. The organizations recommended that “federal matching funds be available as the plans of individual schools are developed and the local matching funds are obtained” to prevent any delay and complications (96). For institutional and special project grants, the AMA recommended that “there should be a greatly increased allotment of federal funds for the operational expenses of medical schools, to be matched by those schools through private or local government sources, with every effort made to keep the federal contribution on a supplemental basis” (96). Apart from the recommendations and revisions, the AMA expressed its concern over requiring that schools expand or grow their enrollments in return for operational support. Although the AMA representatives assured Congress that they understood the urgency of the incentive, they wanted to emphasize the importance of the provision that authorized the Health, Education, and Welfare (HEW) secretary to waive the requirement for certain schools based on their financial crisis. The AMA appeared worried that this bill could make matters worse if leniency was not given to medical schools. Furthermore, the AMA was concerned that the government might apply strict guidelines that could cause a decline in enrollment because the costs incurred by the schools to build new facilities would ultimately be covered by tuition and fees, putting an additional burden on the students.

When Congress passed the Health Manpower Act of 1968, the United States was in desperate need of physicians in all areas of healthcare. To resolve the shortage, Congress decided to focus its attention on medical schools. The institutional and special project programs can be recognized as the most influential additions to the Health Manpower Act as these programs contributed to the promising increase of medical students in the United States. The AAMC tracked medical school enrollments and the number of graduates starting in 1965. During that academic year, 32,835 students were enrolled, and the number of graduates was 7,574. By the 1970-71 academic year, enrollment increased by more than 7,600 students, totaling 40,487 students, and the number of graduates increased to 8,974. Most telling of the impact the Health Manpower Act had on physician numbers, however, is the jump in graduate numbers seen during the academic year of 1975-76, in which 13,634 graduated (AAMC, 2016). Although medical school is typically a four-year program, the number of graduates in the 1975-76 academic year shows the impact of the

1968 law on enrollments and graduate rates. In fact, the increase in graduates between the 1971-72 statistics and the 1975-76 statistics demonstrate the largest increase between 1965 and 2016, when the AAMC last reported data. When comparing the increase of students between the academic years of 1965-66, and the 1970-71 graduation rates between 1971-76, there is a clear indicator that the program effectively targeted the needs of medical schools and allowed for growth in the student body. The Health Manpower Act extended and broadened authorizations for educational assistance programs until its expiration on June 30, 1971 (Kline 1971, 10). In addition to this legislation, the Nixon administration—still fearful of a workforce shortage—created the Office of New Careers under the Department of Health, Education, and Welfare to develop training programs for military medical corpsmen returning from Vietnam (Schmeck 1969, 1).

While progress was made under the Health Manpower Act, to keep the program going, Congress needed to pass new legislation with additional modifications. In 1971, Congress enacted the Comprehensive Health Manpower Training Act of 1971. Its major provisions focused on and emphasized the previous programs and methods of assistance that were seen in the Health Manpower Act of 1968; Congress also made modifications to increase staffing further. Specifically, the Comprehensive Health Manpower Training Act restructured the institutional grants and special project grants from the previous law.

The updated institutional grants distributed \$3,500 per full-time student instead of the previous \$25,000 flat grant. In other words, the new bill incentivized institutions that increased the number of full-time students enrolled, creating the opportunity for institutions with more students to surpass the original \$25,000. While the new law encouraged growth, it made qualifying for a grant in the first place more challenging. For a school to qualify, it had to show a student-body growth of at least 5 percent per year (Kline 1971, 31-32).¹ These conditions set by the Comprehensive Health Manpower Training Act, though challenging, led to a significant increase in student populations in medical schools. Compared to the 1970-71 academic year, which saw 40,487 enrolled students, the 1975-76 academic year showed an additional 15,000 enrolled, increasing the number of enrolled students to 55,818 (AAMC, 2016).

Regarding special project grants, the new bill broadened its purposes and specified that half of the grants' funds could be used to aid institutions in financial distress. Additionally, the Comprehensive Health Manpower Training Act amended the Health Manpower Act of 1968 by "authorizing that combinations of schools of medicine, public health, pharmacy, optometry, and podiatry applying for grants to construct facilities were eligible applicants" (Kline 1971, 28). This revision potentially acted as a turning point as leniency in construction grant eligibility could have been a factor in the resulting increase in students, which led to an increase in health professionals across all areas of expertise. Moreover, these revisions made it possible for "any nonprofit private schools eligible for the construction grant program may be eligible for the loan guarantee and interest subsidy" (28). Similar to the amended eligibility clause, this revision towards private establishments provided more support under the possibility of an increased turnout of graduates and health professionals overall. It seems apparent that while developing these revisions, Congress members recognized that to expand access to healthcare, access to medical education needed prioritization. Therefore, educational programs at these post-secondary institutions had to evolve to attain the desired growth.

In the years following the passage of the Health Manpower Act and the Comprehensive Health Manpower Training Act, officials recognized that the issue of healthcare accessibility for the nation's population had shifted. Even though more people were graduating from medical programs, the more significant problem of distribution in rural areas remained. That is when the goal shifted from increasing the overall workforce to increasing primary care doctors in specific geographical areas. As opposed to the previous laws in which renovating medical schools were the subject of interest, Congress now focused on how medical services were delivered. Senator Edward Kennedy proposed the 1974 National Health Planning and Resources Development Act to help expand healthcare services and place providers in underserved parts of the country. In order to correct the national imbalance, legislators of the act prioritized "primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas" (Public Law 93-641 1975, 2227). In an effort to develop better and more robust health services, the law divided the

¹ Kline, pp. 31-32. Schools with 100 students or less needed to increase enrollments by at least 10%. Schools with more than 100 students needed to increase enrollments by 5% or 10 people, whichever was greater.

nation into sections and had officials living in those areas determine medical needs and plan according to each area's population and demographics. Newly defined health service areas and health system agencies were created to accomplish this goal. Health system agencies were local and regional health planning organizations that were situated within health service areas. For instance, the law defined a health agency as a non-profit private corporation, such as a hospital, in which the majority of the health service area population resided (2232). For a region to qualify as a health service area, it had to meet a list of requirements, such as including at least one center that could provide highly specialized health services and a population requirement of 500,000 to 3 million unless an exception was approved by the HEW secretary (2230). The health service agencies were responsible for improving the health of the residents by "increasing accessibility, acceptability, continuity, and quality of health services" while keeping costs low (2235). Additionally, health service agencies were responsible for preventing unnecessary duplication of health resources (2235). To ensure the success of the act, The HEW secretary tasked the health system agencies with analyzing collected data from their respective areas, including statistics on residents' health, the status of health care delivery, and the details of area resources and how they were utilized (2236). Once national guidelines for health planning policy and data had been reviewed by the HEW secretary, respective health systems then set their annual implementation plans into motion.

Although the National Health Planning and Resources Development Act's purpose was to improve access to adequate health care across all parts of the nation, members of the AMA argued that the new law's inherent flaws opposed its purpose. They argued that the law did not directly address issues of access to medical care and that it prioritized the opinions of non-medical personnel, both of which undermined its potential success. In March 1974, AMA representatives Dr. Russell B. Roth and Dr. James H. Sammons appeared before the Senate Labor and Public Welfare Committee to voice their concerns and disapproval of the legislation. Roth, president of the AMA, believed that the legislation did not directly address the issue of maldistribution and lack of medical access (Senate Committee on Labor and Public Welfare 1974, 416-417). He stated, "This [issue of physician distribution] is extraordinarily difficult, and we do not feel that it is possible to legislate the answers. These are motivational problems" (417). Roth then directed the committee's attention to the divisions of health areas,

explaining that after adapting four different health areas in the past, Congress was once again redefining these health areas "with no real assurance that the areas would pay attention to patterns of medical service and patterns of referral" (420). His statement addressed the root of the systemic problem with the new bill—that adding a bureaucratic layer to monitor the quality of and access to healthcare did not solve the scarcity problem of healthcare providers in underrepresented areas. By acknowledging the existence of multiple health areas that failed to yield significant results, it becomes apparent that the committee's continuous adjustments to the legislation were generally ineffective.

Roth expressed further concerns over the planning agencies' governing boards, noting that the legislation intended to divide representation into thirds, with one-third being healthcare providers. However, the definition of health provider presented in the legislation included "not only physicians but institutions, hospital people, those who pay for the services, [and] the insurers of care." This definition revealed personnel uninvolved in the actual care of patients. Those working in managerial roles and insurance companies were included in that "health provider" definition, further diluting the voices of experts that the law specifically identified as a key component to the law's potential success. This disproportion is what Dr. Roth claimed to be an "aggravation of the problem which beset comprehensive health planning from the very beginning." After making this statement, Roth proposed that the majority representation should be providers and supported this statement with public opinion polls records that favored providers in charge of health care plans as opposed to other groups (420-1). Judging from the arguments put forth by Roth, it is clear that the AMA believed effective solutions to the distribution issue would be accomplished by greater involvement of the medical community due to their knowledge and experience.

Sammons also criticized the authority given to the HEW secretary under the new legislation. He asserted that the secretary of HEW, Casper Weinberger (later Secretary of Defense under President Ronald Reagan), was not a trained healthcare professional. However, Weinberger would still have the power to dictate "the movement of physicians and other health care personnel over a period of years by defining areas which cannot be used in terms of services rendered" (490). Throughout the hearing, it is clear that the AMA not only desired a greater role in this discussion but also believed that the issue stemmed

from the education and self-interests of the healthcare providers. Roth and Sammons emphasized to the committee the importance of actual medical providers being involved in the policymaking that affected them and their patients. It was this disconnect between federal policy and the organization of officials that could arguably explain the failure of the National Health Planning and Resources Development Act.

Three years after the implementation of the National Health Planning and Resources Development Act, the U.S. Government Accountability Office (GAO) published a status report on how the law was progressing, citing multiple issues regarding HEW's administration of the health planning programs, and discrepancies between state and local levels. A major downfall of the law was the organization of the programs and offices. The Bureau of Health Planning and Resources Development demonstrates an example of this organizational issue, which was composed of employees who had previously worked in the Comprehensive Health Planning, Regional Medical, and Hill-Burton hospital construction programs but were merged into one by legislators of the new law (U.S. Government Accountability Office 1978, 17). Poor communication and a lack of specified, approved job descriptions led to "delays in developing and publishing regulations and guidelines needed by HSAs [Health Systems Agencies] and SHPDAs [State Health Planning and Development Agencies] to implement the act" (GAO 1978, 17). This disorganization eventually resulted in the delay of national guidelines that were finally distributed by legislators in March 1978, nearly four years after the original law was passed (GAO 1978, ii). In addition to this issue, HSAs, which were intended by lawmakers to improve accessibility and lower medical costs, were struggling to develop efficient health systems plans due to inaccurate, outdated data, or even lack thereof. Some issues noted by one HSA included how the physician manpower data was incomplete and unreliable, environmental and occupational health information were not collected by health agencies, and admission and discharge data from hospitals were unavailable. Furthermore, it appeared that data issues were exacerbated in HSAs that had no prior health-planning experience, and several HSAs admitted that implementing the law proved difficult because they had to develop their own data (25-27). Although data and organization appear to be a majority of the act's complications, HEW's failure to follow through on its responsibilities as laid out by the law seems to have had the greatest impact. For instance, HEW was responsible

for creating regulations and guidelines for health planning programs. However, it experienced significant delays due to litigation and new procedures finalizing regulations. Consequently, HEW regional offices "had to make policy decisions and augment bureau guidance" thus creating inconsistencies throughout the country (15). To rectify these problems, Congress implemented the Health Planning and Resources Development Amendments of 1979, which clarified the guidelines and responsibilities of health system agencies and the HEW secretary. National guidelines that the HEW secretary previously reviewed required an annual review as set forth by the new law (Public Law 96-79 1979, 593). Additionally, how the secretary approached health data was changed to include the unique circumstances of underserved populations in rural communities (593). The Health Planning and Resources Development Amendments also drew attention to the assistance needed by health system agencies and required that HSAs must have an identifiable program that can support members in activities such as training and continuing education (606). Moreover, the new legislation attempted to correct the communication problems by amending health plan requirements through "consultation and coordination (in accordance with regulations of the secretary) between the state agency, the statewide coordinating council, the state mental health authority, and other agencies of the state government designated by the governor" (607).

Since the 1970s, the U.S. government has continued to search for solutions to fix the ongoing problems with healthcare in America. President Bill Clinton pushed for—but never accomplished—universal healthcare. President Barack Obama oversaw the passage of the Affordable Care Act, which provided access to medical insurance to those who had long gone without it. These efforts have attempted to address the continued stress and vulnerability of the healthcare system. As a result of the COVID-19 pandemic, the healthcare system, its doctors and nurses, and the basic infrastructure have been completely undermined and needs rebuilding (Wolfe 2022). While fighting on the front lines, nearly half a million healthcare workers were lost to overwhelming conditions, burnout, layoffs, and death (Yong 2021). Since the pandemic, 1 in 5 healthcare professionals have quit their jobs (Galvin 2021), and in a February 2022 poll, 1 in 4 admitted that they would likely leave the healthcare field soon (Page and Stanton 2022). The loss of healthcare workers is not only concerning for the current system but also for the future of medicine. When asked if given a chance to choose their career again, one-third

of participants were unsure whether they would choose healthcare (Page and Stanton 2021). Although these survey results are troubling, the AAMC has revealed that medical school applicants increased by 18% for the 2021 academic year, potentially fueled by students' desire to effect change after seeing the prevailing efforts of health personnel during the pandemic (Weiner 2020). This trend shows promise for potentially increasing the workforce in the healthcare field. However, the AAMC also estimated that the physician shortage could be up to 139,000 physicians by 2033 (Weiner 2020). To prevent and amend this shortage, health professional schools will need to expand their infrastructure and enrollments, as we saw under the Health Manpower Act and the Comprehensive Health Manpower Training Act. They must also implement the lessons learned about healthcare distribution across the nation from the National Health Planning and Resources Development Act and the Health Planning and Resources Development Amendments to ensure all Americans have equal access to healthcare. The four laws discussed in this paper aid in understanding where and how to implement change. Legislators must prioritize the development of health professional schools and communication at local and federal levels to increase the number of physicians and other health personnel. Furthermore, by utilizing the experience gained from past legislative history and its effects, we can work efficiently toward correcting this nationwide imbalance seen in all fields of the healthcare system. The pandemic was a tragedy, but it has also served as an opportunity to better our healthcare delivery for patients and personnel alike.

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