DOCUMENT RESUME

ED 180 325 HE 012 053

TITLE	The Costs of Health Professions Education. Regional Spotlight, Vol. XIII, No. 1, Fall, 1979.
INSTITUTION	Southern Regional Education Board, Atlanta, Ga.
PUB DATE	79
NOTE	13p.
AVAILABLE FROM	Southern Regional Education Board, 130 Sixth Avenue, N.W., Atlanta, GA 30313
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	Budgets; *Costs; *Economic Factors; Federal Aid; Government School Relationship; *Health Occupations Education; Health Services; Higher Education; Manpower Needs; Medical Education; Medical Schools; *Professional Education; Research; Student Teacher Ratio; Teacher Salaries; Trend Analysis; Tuition; Universities
IDENTIFIERS	*Allied Health Occupations Education; *Cost Containment

ABSTRACT

Causes for interest, problems in understanding, cost figures, future problems, and recommendations concerning the cost of health professions education are explored in this excerpt from a presentation on cost issues to the Southern Regional Education Board. Among causes cited for interest in the cost of educating health professionals are concern for the cost of health care in general and the size of the budget (an estimated $7.8 billion in 1976-1977). Difficulty in understanding the costs of health professions education lies, in part, in the complexity of teaching, research, and services covered. Cost figures show that in general the greater the research focus of a school, the higher its cost, that faculty and related support personnel account for at least 70 percent of the total cost figure, and that the lower student/faculty ratio and higher salaries are largely responsible for the greater faculty cost. Five reasons to expect even higher costs in the future, such as a decline in federal research and manpower training funds, are considered. Three recommendations, including removing the mystique from medical education, are offered. Excerpts from the remarks of eight other speakers are also included. (PHR)

REGIONAL SPOTLIGHT

SOUTHERN REGIONAL EDUCATION BOARD

NEWS OF HIGHER EDUCATION IN THE SOUTH

Vol. XIII, No. Fall, 1979

The Costs of Health Professions Education

The Southern Regional Education Board devoted most of its 1979 annual meeting to consideration of cost and manpower issues in health professions education.

This edition of Regional Spotlight features a major excerpt from a presentation on cost issues made by health economist John Craig, vice president of the John Hartford Foundation and former director of the Health Policy Research Group at the Georgetown University School of Medicine. In addition, highlights from the remarks of eight other speakers are also included.

In contrast to the situation ten, or even five, years ago, "cost" is a word figuring prominently in today's discussions of health sector activities. Nationally, the federal government and the health industry are engaged in a continuing debate on how best to contain the growth of health expenditures.

At the state level, Medicaid agencies continue in their struggle to meet the health care needs of the poor without simultaneously bankrupting state treasuries. Most states now are placing curbs on the construction of health care facilities and the purchase of new equipment. A number of states are attempting to reduce the growth in hospital outlays through the activities of hospital rate-setting and cost-control commissions.

Locally, communities are attempting to eliminate excess hospital beds and duplicative services; employers are trying to reduce the cost of employee health benefits; and insurers are experimenting with more cost-effective health insurance plans and reimbursement methods.

In this relatively new "cost-containment" atmosphere, the cost of health professions education is also receiving more attention than it has at any time since the Institute of Medicine produced its landmark study on the subject in 1974. What are the motivations for this renewed interest?

First, concern about health professions educational costs is a part of the general concern about the rising cost of health care in this country. The health sector is commanding a steadily expanding share of the national income, with national health expenditures growing from 5 percent of Gross National Product in 1960 to 7 percent in 1970 and to 9 percent in 1977.

A similar trend is apparent in the federal budget, where health outlays as a percent of the total have risen from 3.5 percent in 1960 to 9 percent in 1970 and 12 percent in 1977. Even with the large increases in federal and private contributions to health care, state and local governments have experienced no fiscal relief in their health care obligations. For example, between 1970 and 1976, total state and local health care outlays rose by an average 13 percent each year.

The many questions that are being raised regarding the costs of health professional school activities are a subset of the larger set of questions being asked about the appropriateness of the costs of operating the health care industry as a whole. Because the links between the health professional schools and the industry are so direct, the costs of operating these schools are often singled out in general cost-containment discussion.

The second cause for heightened interest in health professional school costs is their sheer magnitude and their share of the overall higher education budget. In 1976-77, the various health professional schools — medical, dental, veterinary, pharmacy, allied health, etc. — together spent an estimated $7.8 billion. This total includes about $1 billion for training residents and interns. All told it amounts to about 17 percent of the total higher education budget.

In the Southern states, we estimate health professional school expenditures to have reached almost $2 billion in 1976-77, or 25 percent of the national total.

Table 1

Institutional Operational Support for Health Manpower Education from State Revenues, 1973, 1974, 1975, 1979 (provisional) in 000's

	1973	1974	1975	1979	State Funds for Health Education as a Percent of Operational Appropriations for Higher Education: 1973-75	1979
United States[1]	$662,260	$818,246	$911,467	N.A.	12	—
SREB States	304,211	384,102	—	971,910	13	19
Alabama	15,788	26,301	29,756	63,000[2]	15	17
Arkansas	10,360	13,062	N.A.	22,795[3]	15	16
Florida	43,340	54,683	N.A.	84,000	16	16
Georgia	14,213	17,226	16,063	26,326[4]	8	8
Kentucky	20,056	21,410	21,268	31,400[2]	14	12
Louisiana	16,455	20,788	25,855	53,000[5]	13	19
Maryland	24,214	27,253	36,836	50,000[6]	17	17
Mississippi	11,254	14,317	19,543	27,727[7]	13	13
North Carolina	31,851	40,579	42,131	76,600	14	15
South Carolina	11,617	15,335	18,981	56,000[8]	11	21
Tennessee	10,793	12,963	15,561	35,183[9]	9	13
Texas	69,037	91,648	94,053	350,000[6]	17	25
Virginia	19,488	22,059	26,376	62,769[2]	11	15
West Virginia	5,543	6,458	6,418	33,731[9]	7	23

Source: 1973, 1974 and 1975 data, U.S. Department of HEW, *State Programs Supporting Health Manpower Training: An Inventory*, Volume 1, M.M. Chambers, *The Grapevine*, 1979 health education data from state higher education agencies, SREB states, except where extrapolated from 1973 - 1975. Student aid, except special residency programs, is excluded. Teaching hospitals are included in states which fund these as part of their higher education budget.

[1] 32 states.

[2] Based on specific health-related line items only.

[3] Some allied health programs not included.

[4] Instructional costs only.

[5] Health science centers only.

[6] Projected, assuming continuation of 1973 - 75 level of health education support as a percent of total higher education support.

[7] Junior colleges not included.

[8] Allied health not included.

[9] Reflects newly established medical school at Marshall University and West Virginia School of Osteopathic Medicine.

Not all of these funds were spent on education; substantial portions went to research and service programs operated by schools. But these totals tell us something about the relative size of the health professions education programs.

The growth of these budgets has become a particular source of concern to the states — who own most of the schools and finance about one-quarter of their total costs. In 1975, the SREB states expended $442 million on health professional training; in 1979, the expenditures will be $1 billion (see Table 1). The bulk of this dollar, 58 percent, goes to medical training, but the states have also established substantial commitments to allied health, dental, and nursing training (see Figure 1). In most SREB states, health manpower appropriations account for around 15 percent of the total state higher education appropriation.

Expenditure levels of this magnitude are bound to attract attention, but even more attention is being accorded them because of their recognized potential for further growth. The nation today has 114 fully operating medical and 59 fully operating dental schools. That is 26 and 12 more, respectively, than it had in 1965. An additional dental and nine medical schools are in various stages of development. Five of the developing schools are in the SREB region. Yet, the established schools plan modest expansion in their enrollments through the mid-Eighties.

Add to this the facts that per-student educational costs in the health professional schools tend to rise more rapidly than do other higher education costs and that the rest of the higher education establishment is gearing down to lower enrollment growth rates. It is clear that health professional school costs, left untended, are likely to assume an even greater role in the total higher education budget than they do now. Absolute dollars aside, concern about the possible imbalance in the higher education structure is naturally provoked by this growth potential.

Third, renewed concern about costs is the product

of ongoing major shifts in the burden of financing health professional education. Expectedly, most of the concern is being expressed by the parties to whom the burden is being shifted (the students and the states) not by the party *from* whom it is being shifted (the federal government).

The topic of education costs is not a very hot one in Washington. It is, however, an increasingly topical one with state legislatures, boards of trustees, and student organizations. In sum, educational costs become an issue primarily at points when the financing burden is being shifted from one party to another. And then, it is a subject of great interest mainly to those who are being assigned the burden.

Major features of the shifting pattern of finances of health professions can be identified by considering data for medical schools (see Figure 2). The federal contribution to the undergraduate medical education budget has been falling — from 54 percent in 1965-66 to 39 percent in 1976-77. The portion borne by the states and students (via tuition) has been rising — 20 percent in 1965-66 to 43 percent in 1976-77.

These shares would have risen even faster had not the medical schools been able to tap revenues generated by their teaching hospitals and their faculty physicians engaged in the practice of medicine. The substantial growth — 6 percent in 1965-66, 45 percent in 1976-77 — in these service revenues (from teaching hospitals and professional fees) has been the safety valve as the federal government has gradually reduced its role as a major financer of medical education. That safety valve is now threatened as hospitals attempt to cut costs and retain revenues in the face of cost-containment activities.

There are other important details regarding the shifting burden of health professional school costs. One detail is that, just as the federal share has declined, so has it shifted away from focus on institutional and programmatic support toward student support to which service obligations are attached. Thus, the rising tuition share only partly reflects the rising cost burden on students. Another important detail is that while the public and private schools differ markedly in their patterns of finance, they are, in fact, becoming more similar as the private schools have increasingly had to turn to states for support in recent years.

Another factor is the burden of the cost of graduate medical education, and many nursing and allied health programs. Traditionally, the costs of these programs have been paid primarily by teaching hospitals from public and private service revenues, i.e., funds from Medicaid, Medicare, and private insurers, and secondarily by the states and/or students. This pattern of finance, too, is changing in response to two forces.

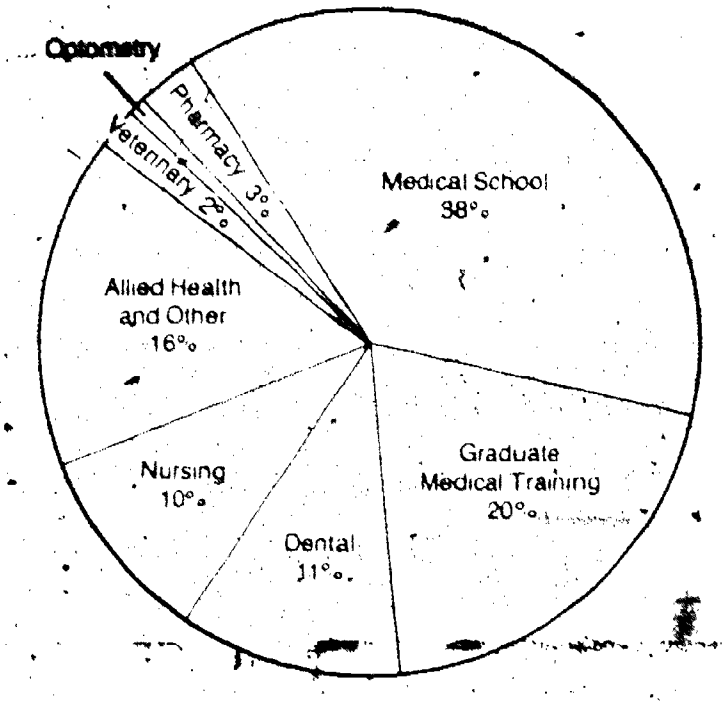
On the one hand, increasingly large numbers of graduates are entering family practice and other primary care residencies which are much more dependent on state revenues than the traditional (for example, internal medicine) residency programs. On the other hand, under the pressure of the general cost-containment drive, community hospitals and the public and private insurers are attempting to reduce their financial commitments to the support of residency, nursing, and allied health training. To the extent that these efforts succeed, greater burdens will have to be assumed either by states or by students or by both.

The Southern states are already committed to supporting an average of 161 family practice residencies each, and the number is growing. States with particularly large family practice commitments are Florida, Georgia, North Carolina, South Carolina, Texas, and Virginia. States with particularly large allied health commitments are Arkansas, North Carolina, Tennessee, and West Virginia. For each of the latter states, more than 24 percent of the state health manpower appropriation goes to allied health programs.

In sum, the consequence of major changes in the finance of health professional education is that tuitions are rising rapidly, increasing numbers of students are graduating with service obligations, and state health professional appropriations are escalating. This shift in the cost burden to students and states (in which the Southern region fully shares) is provoking concern about the legitimacy of the costs these parties are being asked to bear.

Figure 1

How the State Health Professional Training Dollar is Spent in the SREB States

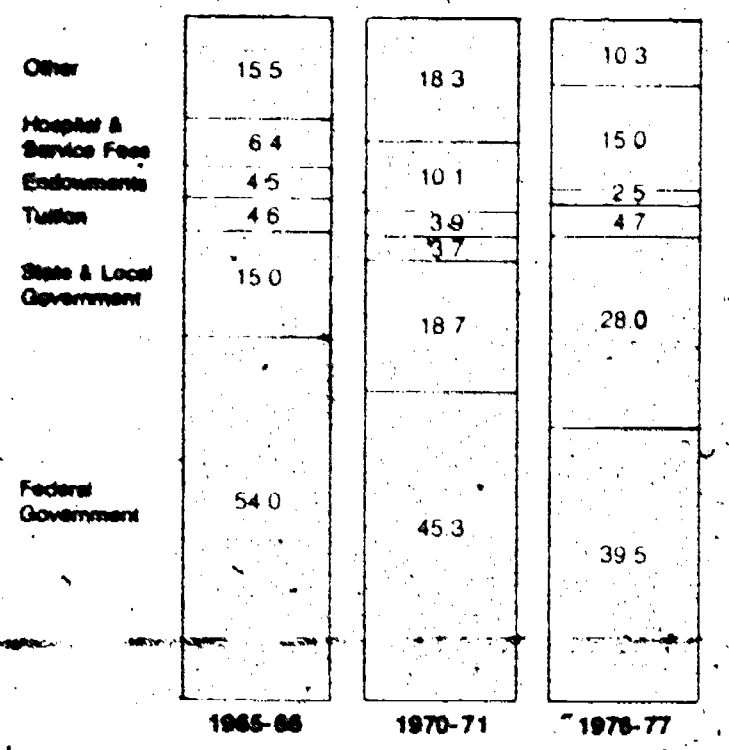


Total SREB State Training Funds: $442 Million in 1975 and $1 Billion in 1979

Figure 2

Source of Medical School Revenues, 1965-77

(Percent of Total)



A fourth major motivating factor behind the new attention to costs derives directly from the shift in burden to the student (see Figure 3). As tuitions rise and as free scholarships and low interest loans become increasingly scarce, considerable concern is being expressed that the health professional schools once again will become populated largely by students from wealthy backgrounds.

One of the by-products of the expansion and heavy subsidization of the health professional schools which occurred in the late Sixties and early Seventies was that the doors of these schools were opened to lower income and minority students to an extent never before achieved. Thus, by 1977, 9 percent of medical students were minority students, and 10 percent were from low-income families; 7 percent of dental students were minority students. Some see efforts to hold down costs as one major feature of a strategy for preserving the gains made in a broader social representation in the health professions.

A fifth factor contributing to the renewed interest in health professions educational costs is that substantial differences in costs are observable among different types of schools — medical, dental, veterinary medicine, etc. — and the differentials among individual schools of any type are hardly less great. Thus, in 1973, the annual educational costs, per student, of medical schools ranged from $7,000 to $19,000.

A number of states have inaugurated only recently health-professional education programs; many of these were modeled after lower cost programs. The tendency, though, is for program costs to escalate over time. Some of these states and schools are now asking penetrating questions about costs in the hopes of avoiding going down the high-cost path in which other states and schools have been trapped.

A final reason for the renewed interest in cost is simply the fact that we know so little about the factors which contribute to higher costs or the relationship between education products and educational costs. This lack of understanding regarding health professional school costs is leaving many state officials and boards of trustees frustrated in their attempts to balance budgets equitably in the new cost-containment, fiscal restraint environment. Which activities and associated costs are legitimate, and which are surplus? The current focus on costs, then, reflects frustration that we have so few tools for assessing the legitimacy of burdens being placed on states and students, and the hope that by asking penetrating and relevant questions, we can develop the required management tools.

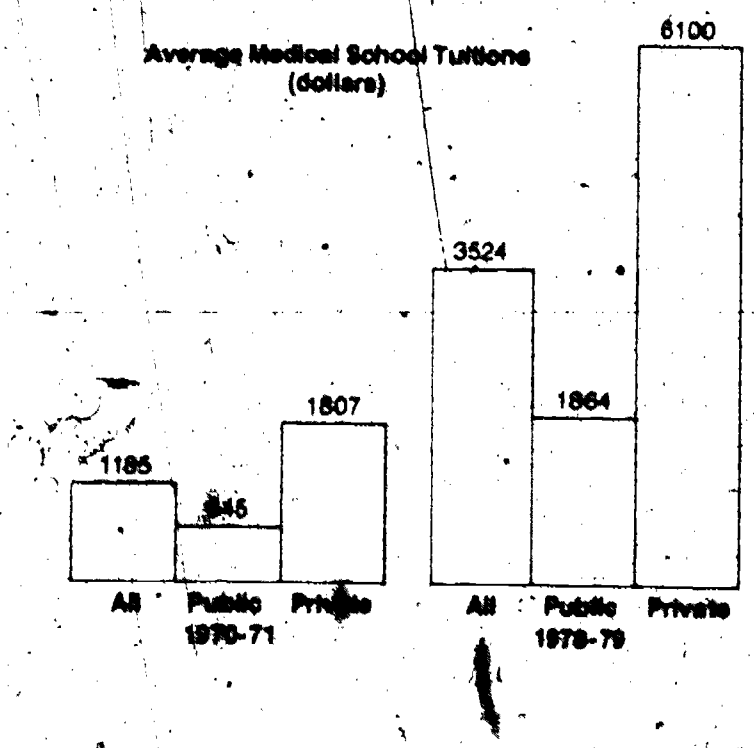
Fundamentals for Understanding the Cost Problem

Before turning to look at some specific cost data and anticipated trends in costs, there are four important underlying issues which need to be explored briefly.

First, let me expand on why we seem to know so little about the costs of health professions education. Two factors are the key to the existing state of near ignorance. On the one hand, health professional schools are unique in the extent to which they combine teaching, research and service activities. They are also unique, at least among professional schools, in the variety of different types of programs and degrees they offer students.

Figure 3

Shifts in Financial Burdens to Students and States



The umbrella of the academic health center is a broad one, and its revenue sources and products are a substantial multiple of those of the other professional or graduate schools. The faculty member who is involved solely in teaching is rare. Few other professional or graduate schools use part time or partly-compensated faculty to the extent common in the medical and dental schools. The consequences of this diversity in activities and revenue sources are substantial conceptual problems in netting out real educational costs.

Health professions educational costs cannot be understood apart from the cost issue in the health sector as a whole. The 500 teaching hospitals account for 29 percent of all hospital expenditures. Over 50 percent of all physicians are engaged in some sort of teaching or other medical school activity. Faculty salaries in the medical schools are geared to compensation rates for practicing physicians.

Just as the health sector has operated on the basis of retrospective reimbursement for services delivered, so have its professional schools. Besides major advances in quality and access to health care, the well-known by-product of the public and private health insurance system has been escalating service costs; consumers have few incentives to be cost-conscious in using health care services, and providers profit little from worrying about the cost of the products they deliver. As a result, the health sector has consumed an increasingly large share of Gross National Product, and has developed a life-style which in many ways is luxurious even by national standards.

Hospitals have replaced churches and civic centers as the most richly appointed community facilities. The industry has seen little need to develop information on costs and quality because there have been so few pressures, internal or external, for it to do so. Thus, only now are we beginning to develop rudimentary information on why one hospital costs $180 per day and a sister institution costs $250 per day, and on the extent to which mortality in the intensive care unit of one hospital differs from that in another. And this sort of information is being assimilated and put to use only in those few states — Maryland being the foremost example — which are getting serious about cost-containment.

This situation carries over to the health professional schools. These schools, like the health sector, have enjoyed access to public (or quasi-public, in the case of the private insurance dollar) treasuries well beyond that achieved by any other group of schools. Their life-styles mirror those of the health sector as a whole. They have grown accustomed to growth rates well above the national average, to compensation

Health Care and Health are Improving

"... we have markedly improved our medical care affairs during the last decade ..."

—DAVID E. ROGERS, M.D., President, The Robert Wood Johnson Foundation

"Basically, my message is that sometimes when things change, they actually get better.

"This is the case in the American scorecard on the adequate numbers of health professionals we are turning out, on improving abilities of people to find a doctor when they need one, and on national statistics which suggest that Americans are healthier today than they were a decade ago.

"Let me make it clear that the cost problem remains — indeed grows steadily worse — and we simply must find ways of containing or moderating those costs. Further, certain groups of people still have striking, sometimes tragic, problems getting the health and medical care they need, and we must find ways to bring them into the system or the system to them.

"But the evidence in the aggregate shows that we have markedly improved our medical care affairs during the last decade . . . . The data suggests that our American system, composed of many independent institutions and people going at problems in their own way, does work, and perhaps better than we are sometimes wont to recognize . . . .

The Supply of Health Professionals

"Despite the large increases in medical school graduates and the opportunity for pursuing generalist training which has taken place since the mid-Sixties, many have continued to believe that the nation will remain short of physicians delivering basic one-on-one generalist or primary care through the Eighties.

"But, missing from all these projections has been solid information on just what role our large cadre of physician specialists plays in rendering such continuing personal care. While some have long suspected that we have a hidden system of general medical care delivered by specialists, its extent has not been known or considered in manpower projections heretofore.

"Here the results reported in the June 14, 1979, issue of the *New England Journal of Medicine* are of particular importance. They show that, at present, one out of five Americans receives continuing general medical care from a physician who calls himself a specialist. Surprising numbers of cardiologists, obstetricians, even dermatologists, offer continuing primary care services to very significant numbers of the patients they see.

"Further, careful projections suggest that although a shortage of general physician services still exists today, continuing specialist participation in such care will mean that this nation will have adequate numbers of physicians providing general medical services by the mid-Eighties without further regulation, or federal intervention in the educational or training system . . . ."

levels approximating those of their practicing counterparts, and to reimbursement for costs with few questions asked.

Anyone who would attempt to understand or do something about the cost of health professional education must first come to grips with the environment in which these schools function: it is expansionist; it places a low premium on cost-consciousness; and it produces little information useful in judging the legitimacy of reported costs. Many problems associated with controlling professional school costs to date derive from the fact that the corresponding cost-control efforts impacting the sector as a whole have been comparatively mild.

A third factor important to an understanding of health professional school costs involves the "chicken and egg" relationship between costs and revenues. As in every other education area, wealthier schools tend to have higher costs than less wealthy ones. Some marginal improvement in product can always be made by an additional expenditure of dollars. The health professional schools have been in a unique position for spending additional available dollars because of the potential for the use of costly new technologies in their research, service, and even teaching activities.

Add this potential to the relatively advantaged position of the health professional schools in tapping federal and state treasuries and their unique ability to tap public and private health insurance funds, and it is clear that part of the high cost of health professions education must be due to the fact that these professions have been richly supplied in resources. It is also likely that some of the substantial cost differentials among different types of schools - medical and veterinary, for example - must be due to the relative ability of the different schools to tap the general flow of funds into the health sector.

Two important ramifications arise from the "chicken and egg" relationship between costs and revenues. On the one hand, current costs reflect the past availability of revenues. Troubles arise — as they are arising now — when funding responsibilities shift from one party to another, and the new responsible party is less willing or unable to maintain the flow of resources and life-styles which had become common under the preceding regime.

On the other hand, the issues of costs and quality are so complicated by the interrelationship between costs and revenues that it is difficult to judge the legitimacy of the cries of panic and distress which arise when a new funding piper begins to play a different tune.

The fourth general issue which needs to be addressed before we move on to a more specific discussion of costs is whether the cost of health professions education is really something which merits a great deal of attention. It is obviously, from all that has

The Changing Federal Role

". . . during the next several years, medical schools will be forced to seek additional sources of revenue . . . or they will have to cut back in a variety of ways."

—RUTH S. HANFT, Acting Deputy Assistant Secretary for Health Research, Statistics, and Technology, Department of Health, Education, and Welfare

"The general consensus at the federal level, based on all but a pure needs model, is that the gross supply of physicians is adequate, and that further expansion is not only unnecessary but the consequences of expanded supply are very serious in terms of escalating health care expenditures and costs. Economists estimate that every additional physician produces demand for services in the range of $250,000 to $350,000 per year.

"Rather than providing generalized support for health professions education, the federal government is proposing to target its support to solve the problems of specialty and geographic distribution. HEW proposes to support undergraduate and graduate training in primary care through project grants to support departments of family medicine and primary care residencies . . . .

"In addition, HEW proposes expansion of the National Health Service Corps scholarships which require payback provisions as a way to ameliorate geographic distribution problems . . . . Furthermore, it will continue to support the training of physician's assistants and nurse practitioners. In many sparsely settled areas, clinics run by nurse practitioners and physician's assistants are providing quality primary care services . . . .

"The schools are now faced with cutoff of capitation, decline in real dollars for biomedical research, and potential decline in patient care revenues. There is no question that, during the next several years, medical schools will be forced to seek additional sources of revenue, either from the states or from increased tuition, or they will have to cut back in a variety of ways . . . .

"I think some greater productivity could be achieved in the clinical practice areas, combined with schoolwide rather than departmental practice plans . . . .

"Tuitions could be raised, particularly in the state schools where they rarely cover a quarter of the costs. However, some offsets would be needed in increased scholarships and subsidized loans to provide support to low and middle income students, otherwise the health professions will be closed except for the wealthy.

"The expansive years are gone. Federal support is shrinking, both in direct and indirect support . . . . The federal government, however, will necessarily have to recognize that a reduced financial commitment will mean a reduced role in the development of national health professions manpower policy. It will also mean a return to more state and local autonomy and influence on medical education."

been said to this point, a thorny issue. But is it an important one? Or is it important to anyone besides those who are being asked to pay the bill? I would argue that it is an important issue, and in doing so I will again draw a parallel between the health professional school cost problem and the general health care cost problem.

A few experts have argued that all the hoopla over rising national health expenditures is really much ado about nothing, that we need worry no more about what percent of Gross National Product is devoted to health care than we worry about the percentage devoted to, say, the consumption of alcoholic beverages or theater tickets.

This sort of argument ignores several fundamentals about the way health care is financed and produced in this country. Forty percent of it is financed directly out of tax revenues, all of it is heavily subsidized by tax allowances, and the health care insurance industry is essentially a quasi-public operation. Severe limitations on price competition and advertising, and substantial professional control of the number of health care providers and their organization, place the health care industry squarely in the public sector.

For all of these reasons we can no more leave the determination of the total health care bill to the industry alone than we leave the determination of the total defense bill to the military and defense contractors alone, or, for that matter, the determination of the total education bill to the educators alone.

Some experts have argued that the cost of health professions education is not an important issue. These arguments ignore the central place of the health professional schools in the health care system and that, by tradition, politics and economics are closely intertwined in these schools. These schools have participated in the same heavily subsidized, open-ended financing arrangements as have the hospitals and physicians. In consequence, the cost of their products is an important public concern.

Southern Governors Comment On Quality and Costs

Governor Lamar Alexander, Tennessee

"In our discussions of cost-containment, changing faculty ratios, and implied suggestions that research may not be as important as it has been, I think we ought to be careful. I don't know enough about medical care to be certain, but I would suspect that quality could slide quickly . . . . I hope that those of us who hold government offices and people with long experience in medical education can make decisions that will not sacrifice a level of care and leadership in medical research that is extremely important. We have to recognize, of course, that not every medical school can be a Johns Hopkins, but we need to make sure we have Johns Hopkins left after we get through containing the costs."

Governor Harry Hughes, Maryland

"The containment of hospital costs is one thing that we are rather proud of in Maryland. It hasn't been easy. In fact, it has been very difficult, but the hospital cost review commission has been composed of good people, firm people (which is absolutely necessary), and the result has been in the last few years that the commission has been able to hold down the increase in hospital costs in Maryland significantly below the national increase. It has been the result of making some very hard decisions, and giving the commission some 'sticks.' I think its biggest stick is something called a 'letter of comfort.' If a hospital wants to expand by issuing bonds, then the hospital cost review commission can give the hospital a 'letter of comfort' approving rates for the hospital that are sufficient to pay off the bond. If a hospital doesn't get that letter, it is very difficult to sell the bond."

The Legitimacy of Current Education Cost Levels

We have already considered total budgets of the health professional schools. These budgets cover the operating costs of research and service delivery activities as well as teaching activities. What are the purely educational costs of these schools? In 1974, the Institute of Medicine grappled with this question and developed a set of figures detailing the annual per student educational cost for different types of health professional schools.

The figures, updated for inflation and matched with comparable data for other professional schools, provide a convenient kickoff for a specific look at current costs and cost trends. For 1979, the average cost for a year in medical school is $19,170; for dental school, $13,240; for veterinary medical education, $10,970; for baccalaureate training in nursing, $3,660; for law, $4,250; and for engineering, $6,500. And medical schools, for example, vary from about $10,000 to $28,000.

Some of this variation is systematic. Major differences are associated with public or private ownership; private medical schools tend to be more costly than public ones. The reverse holds for dental schools. More important is the diversity of a school's program, particularly its focus on research activities.

In general, the greater the research focus of a school, the higher its educational costs. This seems to account for much of the difference in costs between medical and, say, veterinary or law schools. Among medical schools, the extent of research is likewise an important factor explaining cost differentials.

Policy Options Available to States in Meeting Health Manpower Needs

"Universities, like most people and most organizations, make more meaningful, effective and lasting changes when they see it in their own interest to do so."

– GORDON H. DE FRIESE, Director, Health Services Research Center, University of North Carolina at Chapel Hill

"Not only is the context for policy formulation regarding health manpower highly politicized, but much of what takes place under the rubric of 'health manpower policy' is basically a set of considerations of the role of the university and other higher educational institutions in the production of additional manpower.

"This is an extremely narrow perspective on the larger problem of providing adequate numbers of health practitioners to meet the public need. A focus that is exclusively on the production or training of new personnel will usually ignore altogether what is known about the determinants of health manpower distribution and the way in which the distribution of manpower can affect the general need for additional health practitioners. The more important weakness of the policy focus on manpower production is the neglect of prevailing patterns of professional practice, the organization of health care services, and the mechanisms for financing health care services as important influences on health manpower needs.

"What is called for is a perspective that gives emphasis to the health services delivery system, not the individual provider. Such a 'system' perspective would make it more likely that policy with respect to health manpower development would recognize the important influence on health manpower needs and demands of certain organizational and institutional structures within this complex industry that delivers health care.

"I am referring here to the way in which hospitals, nursing homes, public health departments, comprehensive primary care programs, and other organized approaches to health care tend to create their own demand for certain categories of health personnel irrespective of the need for health services in the general population.

"To some extent, state legislatures have dealt with this phenomenon in recent years through the passage of state 'certificate-of-need' laws that have been used to retard the rate of unnecessary and cost-ineffective capitalization and technology development in the health field. It has rarely been (but should have been) a major component of the argument in favor of certificate-of-need legislation that such laws act to prevent the unnecessary expansion of the health manpower sector through the staffing of unneeded health facilities . . . .

"Universities, like most people and most organizations, make more meaningful, effective and lasting changes when they see it in their interest to do so . . . . As I look at the experience acquired in my own state and elsewhere in the establishment of new programs designed to deal with health manpower issues and problems in recent years, I am impressed by the degree of success that comes from clearly stating the problem to be addressed, from involving universities and practitioners in the professions, early and throughout the policy formulation process, and from the arrangement for frequent — and more informal — feedback to persons on key legislative committees who are responsible for policy in these problem areas. In my own view, there is little to be gained, and much to be possibly lost, from an effort at this stage to formally identify organizational units charged with the responsibility for program monitoring and control."

In many of the health professional schools, faculty and related support personnel costs account for at least 70 percent of the total cost figure, and often the personnel cost share is higher. This fact tells us that any serious attempt to deal with the professional school cost problem must come to terms with the issue of staffing patterns and compensation levels. The problem in the professional schools does not lie primarily in the rising cost of, say, building maintenance or fuel consumption. These costs are rising too, but they make a comparatively minor addition to the total budget.

In sum, those who would seriously do something about health professions educational costs must be willing to take on seriously four key questions respecting the faculty of these schools: 1) faculty staffing ratios; 2) faculty compensation levels; 3) how faculty spend their time; and 4) the revenue generating potential of different faculty members.

For example, we know that much of the higher cost of a medical education can be explained by these schools' lower student faculty ratios (1.3:1 compared to 2.4:1 in law schools), faculty compensation levels ($44,000 annually for clinical faculty) which approach those of practicing physicians ($63,712), and substantial support of persons whose research or service activities are not always covered by matching revenues. The law schools are comparatively cheap precisely because of their higher student faculty ratios, their continued tradition of faculty compensation well below that of comparable practicing lawyers ($32,000 for faculty, $47,000 for practicing lawyers), and continued focus of faculty on teaching as opposed to compensated or uncompensated research and teaching activities.

Problems Ahead

Are health professional school education costs too high? Is it possible to hold the line on budgets without requiring major sacrifices in quality? Again, we have little hard information to answer these questions, but most management experts would tell us that very likely costs are, in fact, well above what they need to be.

There are five good reasons to argue that if health professional school costs are already out of line, they may well become more so in the face of existing trends and expected developments.

First, there is the future course of federal research and manpower training funds. We have every reason to expect continued declines in federal manpower training outlays, and federal expenditures for research will probably do no more than keep up with inflation if that.

Commitments have been made by schools and states on somewhat different assumptions regarding the federal contribution to the health professional schools. The schools and the states will be under considerable pressure to honor these commitments themselves. With reduction in sponsored program revenues, there will be considerable pressures to shift costs currently being borne on the research and service budgets back on to the education budget. This can only mean still higher educational costs and upward pressures on the share of these costs borne by students and the states.

The second major trouble spot derives from health sector cost-containment activities. We have seen the increasing dependence of health professional schools on hospital and physician practice revenues. Cost-containment is already a reality and these revenues are being affected, depending on the cost-containment activities of different states. The effect will be a reduced flow of revenues to the schools with no certainty of compensating reductions in costs.

The third area of concern is a direct offshoot of cost-containment activities, namely a tendency to shift graduate, undergraduate clinical, nursing, and some allied health training costs off the health service budget and on to the health education budget. We have seen that most of the costs of graduate education are now borne by hospitals and are paid for out of service revenues. In the face of attempts to retard the growth rate in these revenues, efforts to pass training costs back to the schools or the state budgets are occurring already. We can expect such efforts to intensify.

The fourth problem derives from the enlarged flow of graduating health professionals and the resulting possibility of physician and other health professional surpluses by the mid-Eighties. Surpluses are already being sighted in a number of areas. Whenever an overproduction in a given professional

Assuring that Health Manpower Policy is Directed to State Health Needs

"Equitable distribution of a basic set of health services cannot be brought about solely by market forces."

—WILLIAM H. STEWART, M.D., Acting Head, Department of Preventive Medicine and Public Health, Louisiana State University School of Medicine in New Orleans

"Increasing the number of health professionals as the only means to resolve distributional problems which effect access to health services does not work. For example, it does little good to push up the output of dental schools to meet the well documented dental needs of the people if the coverage of dental services by health insurance carriers or governmental programs is limited. Dental services are not high priority expenditure items by the general public if cash payment is the only means of paying for these services. Yet, need is there and deferred need has a human price . . . .

"The number of health personnel graduating from the health professional and technical schools of a state obviously bears on meeting state health needs. However, there is no way a given number can be accepted as adequate unless it can be connected to a clear idea of what level and kinds of health services are basic to meet the health needs of all people of the state . . . .

"The number of graduates from the health professional and technical schools in a state has been viewed as an end in itself. To assure that state health manpower policy is directed to basic state health needs, the number of graduates must be viewed as a means toward that end . . . .

"The lessons of the past decade teach that the demand for health services will always exceed the supply of manpower to provide those services in the absence of limits on purchasing power. Moreover, the stimulation of demand for health services by the presence of health professionals themselves has become quite clear.

"There is emerging a recognition that access to health services cannot be open-ended. But if there are to be any limits, there must be some rationale for the distribution and use of the health services considered to be basic to meet the health needs of the people. The rationale is required if there is to be some degree of equity of access to these health services across the state . . . .

"Equitable distribution of a basic set of health services cannot be brought about solely by market forces . . . . The implications of adopting the objective of equal access to basic personal health services to give direction to the health manpower policies of the state are far-reaching. It will require considerable planning and decision-making by the state.

"One of the major implications is recognition of the essentiality of an interlock between the health service system of the state and its manpower policy. Without this interlock, the present situation will continue with growing uncertainty about the propriety of the increasing investment in health manpower production by the states. This is particularly true when that investment is viewed in the context of the total investment in higher education.

"If the state does adopt equal access to a basic set of health services as the objective to guide state health manpower policy, the state will need integrated planning which links health manpower policy to state health needs. This will require data-gathering systems for the state and its subdivisions which permit analysis in sufficient detail to illustrate state health needs at the personal health services level area by area."

manpower area occurs, there is always a tendency to deal with the surpluses by retaining more professionals in the professional schools and by extending the period of training. Individuals encounter more difficulties in establishing themselves in practice and increasingly seek out marginal employment or extended training in their parent universities.

Those of us who work in academic health centers know that this phenomenon is not uncommon. Some of us attribute part of the "over-specialization" problem to this phenomenon. Again, the effect is to push the cost of professional education above what it needs to be. Even if the marginally employed professionals manage to finance their direct costs, they still generate administrative burdens whose costs the educational budget must bear. Thus, the likely surpluses in health professionals are an additional factor pushing educational costs above legitimate levels.

The fifth troublesome area involves the tendency of developing schools and programs, most of which were originated with a specific primary care, lower cost focus, to follow the standard academic health center model with the full complement of specialty training and auxiliary health professional education programs. This tendency is well recognized and I will not elaborate on its effects here.

It is impossible to calculate the net effect of these forces on educational costs, tuitions, and state appropriations. The unknowns at this point are simply too numerous. The direction in which state outlays are headed, however, should be clear from the trend data.

Recommendations

Most discussions of health professional school costs conclude with agreement that the problem is a complicated one and with a sense of frustration among the paying parties concerning their ability to ever judge the legitimacy of the costs they are being asked to bear, or even to forecast with any accuracy what those costs are likely to be. I will close with three recommendations which I hope will be at least a start toward a remedy of this situation.

First, I think it is time that we remove some of the mystique from medical education -- that we establish some norms for the mix of faculty teaching, research, and service hours, per health professional student, which are essential to producing an acceptable educational product, and that we hold the schools to agreements to produce so many graduates at a given cost. The trend in the hospital sector is to get away from cost-plus reimbursement, toward fixed contracts for delivery of specific volumes of service, and toward the generation of the types of information which make the new, cost-effective reimbursement methods feasible.

Just as health care consumers are no longer willing to leave unquestioned cost differentials between hospitals of $100 per day, so can we no longer leave unquestioned interschool annual cost differentials per medical student of $10,000. If the states and students wish to avoid being assigned possibly unfair cost burdens, they must exert pressures toward the same type of accountability that is being established in the hospital sector. This accountability requires the development of substantially more information on costs and revenues than the schools have been asked to produce before. And, it requires setting firm limits on the state and student contributions. Here as elsewhere, revenue caps seem to be an essential part of the remedy.

How do we go about producing this information?

The Legislature and Health Manpower Policy

"Our biggest problem is that the academic community finds it very difficult to respond to questions in a limited time period . . . ."

—DELEGATE MARILYN GOLDWATER, MARYLAND

"It has been my experience over the past few years that more and more decisions impacting on health manpower policy and the health care delivery system are being made in the political arena, often by legislators who have no background in the health delivery system and are just beginning to learn what it is all about. They are reacting to perceived needs brought to them by their constituents.

"Legislators and legislatures are also rather understaffed when it comes to research personnel, at least most of us are. To correct the situation, I felt that we ought to be drawing upon the resources of the academic community. I chaired a committee in Maryland that set up such a mechanism between the legislature and the academic community. And it is working; we are learning more about the academic community; they are learning more about the legislature.

"Our biggest problem is that the academic community finds it very difficult to respond to questions in a limited time period, such as our 90-day session, when all the answers are needed yesterday instead of tomorrow. But, we do have a nine-month interim period during which the academic community has time to respond to questions and give us some background for the next session. This works extremely well . . . .

"In Maryland, our Health Systems Agency has a written agreement with various groups within the state that are concerned with developing health manpower policies. The agreement exists between the statewide Health Coordinating Council, the Maryland Health Planning and Development Agency, the Vo-Tech division of the State Department of Education, and the State Board for Higher Education. How that agreement is working depends upon which person you talk to and from which agency. I think that the agreement has formed a basis for a good working relationship but now it is up to the executive branch and the legislature to exercise their oversight functions to make sure that, in fact, the agreement doesn't exist just on paper."

Again, parallels with what is going on in the hospital sector, particularly in the state of Maryland, are apt. There, selected hospitals, including highly respected ones, are undergoing close scrutiny regarding their admission rates, diagnostic case mix, lengths of stay, use of X-rays, etc., and their patients' outcomes, i.e., mortality rates for specific types of services. Out of this work, norms are being developed for service and reimbursement levels, and hospitals are agreeing essentially to serve their clienteles from a predetermined, not an open-ended, budget.

I think that a similar effort is required in the health professional schools. I would recommend that states who want to place some limits on their growth in costs must enlist the support of a few selected schools who will agree to a detailed analysis of their activities and to experiment with the development of educational norms and fixed-price support from their revenue sources. Out of this cost-justification exercise will emerge the groundwork for movement from the existing cost-plus method of paying for health professional education toward fixed price contracts for specific types of products.

My second recommendation is that states and boards of trustees who genuinely want to do something about their health professional school costs must be prepared to "bite the bullet" on program cutbacks and enrollment reductions. If health sector cost-containment becomes a reality, there is increasing evidence that the nation's need for additional health manpower will likely be below current anticipated production levels. Federal education dollars are already being withdrawn from educational activities as part of the fallout from cost-containment. Are the states and students to pick up the tab for educational commitments which no longer appear valid?

Finally, let me recommend that many states have another "bullet to bite," namely tuition levels. With public school tuition levels now averaging less than $2,000 and starting physician incomes averaging over $50,000, a public school medical education must be one of the very best bargains available in any

During SREB's 1979 annual meeting, Dr. Harold L. McPheeters, director of SREB's Commission on Mental Health and Human Services, outlined a plan for a Health Manpower Policy Analysis Center at SREB. Here are excerpts of his remarks.

"Ever since the Southern Regional Education Board began, 31 years ago, health professions education has been one of the major concerns of its studies, plans, and projects. Because health professional schools are expensive and difficult to staff, regional perspectives and regional sharing seem especially desirable. Many SREB studies and reports have had significant manpower policy implications — especially policies related to the development of new schools to train more professionals.

"Recently, however, it is clear that many of the region's health manpower problems are not simply matters of supply. In the health occupations, the supply is nearly adequate, but the states still have problems of poor distribution, especially to rural areas and to certain specialty areas, poor utilization of manpower, low productivity in some situations, and conflicting requirements for licensure and certification. As these problems have become more apparent, SREB has received increasing numbers of requests for information that might help the states address them . . . .

"The SREB Center will differ from the typical health policy or health services research centers in the universities in that it will be primarily a kind of 'switching center' between health policymakers in the states and the major university research programs. The Center will, however, do some policy analysis itself. Here's how it will work:

- A small Health Manpower Policy Analysis Advisory Committee of policy persons from the state legislatures, health planning agencies, higher education agencies, and academic health science centers will advise on significant health manpower policy issues, how they manifest themselves in the states, and the constraints within which they must be answered.
- If the issue is one for which considerable research and analysis have been done already and if time constraints are short, SREB will have the staff capacity to gather the existing research, consolidate it into a concise analysis, and report it to policymakers.
- If it is a policy issue that has not been substantially researched, SREB will contact some appropriate research program, most likely in one of the region's universities, and help that program obtain the funding to carry out the research and analysis.
- SREB will then have the staff capacity to prepare the policy research findings for publications, workshops, or consultation activities for the states' policymakers.
- The reports of the Center will contain analysis of policy issues and alternatives. They will make recommendations and point to desirable directions, but they will not formulate any over-arching policies for the South or any of its states. The Center will state its findings but will not advocate any particular policy.
- The Center will address health manpower policies of interest to state governments of the South, particularly those of concern to all or several states, rather than policies of primary concern to national or federal health policymakers."

market. While this pricing pattern handles several political and educational opportunity issues, it exacerbates the cost problem by encouraging excessively large numbers of students to clamber for admission to medical schools, and by shifting the cost burden from a highly visible spot (the individual) to a position of comparatively low visibility (the state tax dollar). There is little general concern about professional education costs because so little of the cost is paid from any individual's pocket. Constituencies for doing something about the cost problem are not going to be easily developed as long as the cost burden is as widely distributed through the tax dollar as it is now. Educational opportunity concerns can be managed through mechanisms other than a low tuition policy. For both strategic and equity reasons, states that wish to tackle the health professions education cost policy ought to consider a serious review of their current tuition policies.

Conclusion

Much of what I have said will be viewed as highly critical of the nation's health professional schools. Let me hasten to add, then, that I join others in viewing our health care delivery and health professions educational systems as among the premier accomplishments of the American system. Among the high goals which the nation set for itself in the 1960s, none has been met more clearly than that of universal access to quality health care. The health professional schools contributed mightily to the achievement of this goal; in large part, the problems to which I have pointed are the product of this success. Their correction will not be easy. But corrective actions need not be punitive, and financial crises need not be inevitable, if problems are identified and addressed with sufficient lead time for their orderly management. It is in this spirit that my somewhat iconoclastic remarks are offered.

REGIONAL SPOTLIGHT

NEWS OF HIGHER EDUCATION IN THE SOUTH

Published by the

SOUTHERN REGIONAL EDUCATION BOARD
130 Sixth Street, N.W.
Atlanta, Georgia 30313

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