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ABSTRACT

Problems facing health professions schools and academic health centers that can damage health were identified by the Southern Regional Education Board, along with recommendations for action within the states. Nine problems for these schools and centers concern: declining applications and enrollments for dental schools and many schools of pharmacy, nursing, and allied health programs; declining enrollment of minority and disadvantaged students as a result of rising tuitions and loan reductions; certain professions are pressing for higher academic levels of education; young practitioners continue to choose the more lucrative specialties in medicine; teaching hospitals are losing both paying patients and staffs to more competitive community hospitals; teaching hospitals are expected to provide more indigent care; teaching hospitals may lose a portion of their teaching cost revenues from Medicare and from patients whose hospital bills are paid by business/industry; health professions curricula are oriented to younger patients rather than the elderly; and curricula emphasize illness rather than prevention. To respond to these problems, 23 recommendations are offered to state officials, boards of higher education, licensure boards, health planners and program managers, and leaders in academic health centers and professional schools. (SW)

Recommendations Health Professions Education

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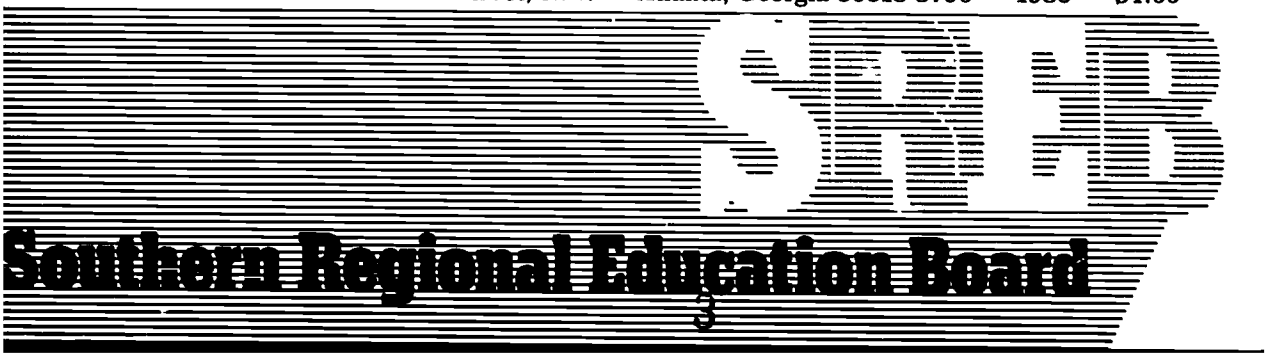

BACKGROUND

High quality health care at an affordable cost is clearly a priority with American citizens. Meeting this priority depends on the health professions schools and the academic health centers that educate physicians, dentists, nurses, pharmacists, and allied health professionals, and merits the attention of educational leaders and elected officials.

Because of major changes occurring in the health care system, these schools and academic health centers may not be able much longer to meet their responsibilities. Those changes include competition among providers of health care, cost containment pressures by business and government, the take-over of health care by for-profit health and hospital corporations, and increased liability problems.

Assuming that the problems of health care and the health professions will be resolved through normal economic market forces simply will not do as public policy. Too many factors distort the economic market forces--indigent medical care and the high costs of health professions education are two major ones.

Funding for the specialty training of physicians and the clinical education of nurses and allied health professionals in the teaching hospitals has been coming from patient care fees charged through Medicare and other third-party payers. University teaching hospitals have higher costs, not only as a result of the added teaching costs, but also because they serve more indigent patients and persons with expensive specialized needs, such as burn care, premature newborn care, and open heart surgery.

Now, the federal government through its Medicare program and business and industry through a variety of health payment programs are reducing the amounts they pay for teaching costs on the hospital bills of their patients. In addition, the competition is forcing more indigent patients to be treated at the state

teaching hospitals. This is because community hospitals cannot afford the losses in their efforts to survive the competition for patients and pay the dramatically increasing costs of liability insurance.

Moreover, much of the illness and disability of the general population today is the consequence of life style problems (overeating, smoking, drinking) rather than of infectious diseases and purely biological conditions as in the past. Thus, practitioners are now being expected to counsel patients and families regarding nutrition and preventive health practices so that individuals will be motivated to change their life styles--not just to diagnose and treat their pathological conditions.

An added consideration for policymakers in the South is that the region's population is showing dramatic increases in the number of elderly patients who need greater amounts of medical/health care. The region needs more health professionals trained to work with older persons as well as a better coordinated and financed system of services for the elderly to replace the jumble of services that now exists.

PROBLEMS FOR HEALTH PROFESSIONS SCHOOLS AND ACADEMIC HEALTH CENTERS

Here are some of the problems currently facing health professions schools and academic health centers that can seriously affect health care.

1. Applications and enrollments are falling. Virtually all health professions schools have marked declines in applications, for example, dental school applications have fallen from more than three applicants per entering student to just over one. Many pharmacy and nursing schools and allied health programs are experiencing reduced enrollments.

2. Declines in enrollments of minority students and students from disadvantaged backgrounds have occurred as a result of rising tuition and cuts in loan funds. The proportions of minority students have never reached more than about half the ratio of minorities in the population. Students from poor families feel now that they have almost no chance of supporting themselves and paying the high costs for years of education in the major health professions.

3. Professionals and faculty members of several health professional schools continue to press to establish higher academic degrees for entry into the professions. There have been some remarkable increases in technology which require advanced levels of education for those professionals who plan to work in highly specialized programs, but whether this requires advanced levels of education for all entry-level workers is debatable. Advanced degree programs are costly and their graduates expect higher compensation.

4. Young practitioners continue to choose the more lucrative highly technical specialties (surgery, radiology, ophthalmology, orthodontia), which already have more than enough specialists rather than family practice, pediatrics, and general medicine and dentistry where they are most needed.

5. Teaching hospitals are losing both paying patients and staffs to more competitive community hospitals. The higher costs of teaching hospitals put them at a competitive disadvantage, especially if their buildings are old and unattractive.

6. Teaching hospitals are being expected to provide more indigent care as the more competitive community hospitals avoid poor patients and seriously ill patients whose illnesses may result in excessive costs and uncollectible debts.

7. Teaching hospitals stand to lose a portion of their "teaching cost" revenues from Medicare and from patients whose hospital bills are paid by business and industry.

8. The curricula of health professions schools are oriented to younger patients and are already full so that adding courses about the elderly is very difficult. Also the teaching hospitals are geared more to teaching about the treatment of acutely ill persons than the long-term care of the aged.

9. The health professions schools, with their full curricula and emphasis on illness, do not teach the skills of prevention--particularly the skills for helping people change their health practices rather than just giving patients advice about what they should do. In addition, health payment programs pay drastically lower fees for counseling of patients than for the technical diagnosis and treatment of illness. Thus, the financial and prestige incentives all favor technological treatment procedures at the expense of preventive care. This needs to be turned around.

RECOMMENDATIONS FOR ACTION BY STATE GOVERNMENTS

In response to these problems facing the health professions schools and academic health centers, state governments should consider alternative courses of action. By "state government" we mean the range of state officials--governors, legislators, higher education agency boards and their staffs, licensure boards and their staffs, health planners, health program administrators, and leaders in the academic health centers and professional schools.

1. When applications and enrollments are falling in the health professions schools,

   State governments must be concerned about the quality of the applicants and insist that essential standards be maintained in both quality of enrollees and the critical mass of students.

   Many educational programs should be reduced in size and/or consolidated for greater efficiency. Because of certain fixed costs, cost reductions will not equal the reductions in enrollments.

   State governments should consider interstate contract arrangements for sharing educational programs that are no longer needed in every state. This step will result in cost savings and stronger academic programs.

2. If certain professions are pressing for higher academic levels of education,

   State governments must assure that employing agencies and the public really require such advanced levels of education. While advancing technology calls for additional knowledge for some practitioners, higher degrees may not be needed for all entry-level practitioners.

State officials must be prepared to resist "degree creep" by professions and educators when it is unwarranted. Appropriate professional oversight and approval of educational programs are necessary, but legislators should refrain from requiring that licensed practitioners must be graduates of educational programs that are accredited by specific professional bodies, which can then mandate degree levels.

3. To combat declines in enrollments of minority students and students from disadvantaged backgrounds,

   State governments should adopt programs to selectively recruit and counsel promising students from these groups. Kentucky, North Carolina, and other states have such programs.

   State governments should provide special preparation programs and financial support to help promising candidates qualify for admission and do quality work in professional schools. North Carolina, Tennessee, and several other states offer special courses and financing.

   State governments should provide counsel and financial assistance to persons who will locate practices in areas of need. The Medical Fairs of Georgia and Tennessee and the Community Placement programs in North Carolina and Oklahoma are examples.

4. When young practitioners continue to specialize in the oversupplied technical specialties rather than in primary care where they are most needed,

   State governments should take steps to provide incentives for students to choose the more needed specialties. This may involve loan forgiveness programs and special stipends for training in primary care. Several SREB states have programs that could be strengthened and expanded.

State governments should implement programs of special recruitment, enriched educational opportunities, and special placement to encourage and assist more graduates to go into primary care and the specialties where they are needed. Area Health Education Centers in Arkansas, North Carolina, and Kentucky provide firsthand experience for physicians, nurses, and allied health workers to learn primary care in smaller communities. Placement of students with rural practitioners may also be used by some schools.

To discourage training programs in specialties that are already oversupplied, state legislatures should limit support unless there is clear evidence for demand for services.

5. When teaching hospitals are losing paying patients and revenues,

State governments must encourage and assist the teaching hospitals to restructure so that they can command a broader segment of paying patients and families by adding outpatient services, nursing homes, and service for families' total health needs, not just hospital care. This will provide a broader teaching base, but it will also require a considerable change in structure.

State governments must be prepared to provide the renovations and specialized equipment where needed so that teaching hospitals can compete for paying patients. If this is not done, the states must be prepared to provide funds so that these hospitals can survive without private paying patients.

States should consider divesting state-owned teaching hospitals into private entities or turning their management over to for-profit hospital corporations so that the hospitals have greater operating flexibility and access to private capital for renovations and expensive equipment. State officials must consider the long-range implications on the states' teaching and service obligations.

State legislatures must find ways to limit the costs of liability claims and insurance for the hospitals.

6. If teaching hospitals are being burdened with heavier loads of indigent patients,

   State legislatures must consider raising funds to support indigent hospital care. The support could come from taxes on all hospital admissions, taxes on health insurance premiums, or general tax revenues. Local governments, which may need taxing authority, should also be required to pay a share of the costs for care of their indigent citizens.

   To reduce the load on teaching hospitals, state legislatures should consider requiring that <u>all</u> hospitals provide a certain amount of indigent care.

   States should consider plans to reduce the number of medically indigent persons through extending Medicaid coverage or requiring that more employers provide health benefits for their employees.

7. If teaching hospitals are about to lose a good part of the "teaching cost" monies from Medicare and patients supported by business and industry,

   State governments must find other ways--general appropriations, higher tuitions, or special taxes--to support the clinical teaching in these hospitals. Higher tuitions should be accompanied by scholarships or loan-forgiveness programs for disadvantaged students.

   Health professionals must also consider approaches to reducing the costs of clinical teaching, for example, through increased use of volunteer faculty and shortened periods of instruction.

8. To provide health professionals with knowledge about working with the elderly,

   State leaders should make clear that they expect this information to be included in health professions education. Support should be provided for staff to concentrate on introducing this knowledge throughout the curricula.

   State governments and institutions should develop cooperative arrangements for sharing faculty expertise in gerontology and health in the elderly. Consortia of institutions should be encouraged and supported.

   State governments should encourage and support specialized geriatric evaluation centers to prepare more faculty and to conduct training programs for community practitioners who have already graduated.

9. So that professional schools introduce prevention practices into their curricula,

   State leaders should let it be known that they expect clinical prevention to be included in the curricula. Support should be given to faculty to add these competencies to the curricula of the schools.

   State governments should modify the health payment systems so that practitioners (and faculty) are paid as much or more for prevention counseling as for technological diagnosis and treatment.

   State legislatures should indicate their concern by establishing laws regarding use of seat belts, driving under the influence of alcohol and drugs, immu.izations, etc.

CONCLUSION

As a result of both federal and state initiatives, education in the health professions expanded dramatically during the 1960s and 1970s when there was little concern about the costs of health care or of health professions education.

All of that has changed. The federal government has already withdrawn most of its support and is taking steps to make further cuts in the funding for specialty education and research. The states had a 35 percent increase in the costs of medical schools between 1980 and 1984.

Meanwhile, the pressures of competition and cost containment are putting ever-growing financial pressures on the teaching hospitals that provide the clinical education for health professionals. Some teaching hospitals have already been "divested" into private entities; more must do something to increase their revenues or they will go out of business.

State leaders must be aware that the pressures on the health professions schools and the academic health centers are such that they cannot long survive following patterns of the past.

There are many possible alternatives to address these changes. States can no longer afford to ignore taking action. To do so will only increase the pressures until crises occur.