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Financing Undergraduate Medical Education

JOHN E. CROWDER, MD, MS Educ, *Orange, California*

THE FINANCING of undergraduate medical education is an increasingly complex task. With such complexity come problems which do not respond to yesterday's solutions. This paper will review selected current problems in the financing of undergraduate medical education, and will analyze some innovative remedies being proposed to meet these financial difficulties.

Historical Perspective

Several developments occurring in recent years illustrate the growth of medical education in the United States. The medical schools' educational responsibility has increased from 65,000 (medical student equivalents) in 1961 to 110,000 in 1972. In 1961 undergraduate medical students accounted for approximately half of a student population of 65,000. This contrasts with 1972 when only 40 percent of medical students were medical undergraduates, the remainder being interns, residents, predoctoral and postdoctoral students in the basic and clinical sciences and some students in related health professions.[1]

Another indicator of change in medical education is the fact that university medical centers and affiliates accounted in 1970 for 20 percent of all the health care provided by the nation's hospitals compared with less than 14 percent in 1965.[1]

Expenditures for medical school operating programs grew from $200 million in 1961 to $780 million in 1971. At the same time, money spent for specifically sponsored research programs increased from $220 million to $930 million.[1]

Believing that the nation's medical schools contribute generally to the well-being of society, the federal government has gradually increased its support from less than $10 million in 1950 to more than $400 million in 1972.[1]

In 1972, a total of 45 state governments paid $332.6 million to partially support 105 public and private medical schools. One year later (1973) the amount of state government support increased to $400.7 million.[2] During the past 10 years available figures indicate that the states' proportional contribution to the operating expenditures of publicly-owned medical schools has remained constant at 55 percent.[3]

Whereas tuition and fees paid for 13 percent of the schools' total operating programs expenditures in the fiscal year 1960-1961, by 1971-1972 tuition and fees paid for only 8.9 percent of expenses. On the other hand professional fee income support increased from 6.0 percent in 1960-1961 to 16.3 percent in 1971-1972. Endowments and gifts accounted for 12.0 percent in 1960-1961 but had dropped to 8.1 percent by 1971-1972.[3]

The Problems

Emerging from the above statistics is a clear picture of increasing federal government financing of medical education in the face of static support from the state governments and declining

Dr. Crowder is Chief, Adult Inpatient and Emergency Psychiatric Service, Orange County Medical Center; and Assistant Adjunct Professor of Psychiatry and Human Behavior, University of California, Irvine, California College of Medicine.

Reprint requests to: J. E. Crowder, MD, Department of Psychiatry and Human Behavior, Orange County Medical Center, 101 City Drive South, Bldg. 2, Orange, CA 92668.

contributions proportionally from the private sector.

It is precisely this shift from private and local financing toward federal government support which is at the heart of the current problems. While it is expected that those giving financial support should receive a detailed accounting of how such funds are expended, the federal government is attaching more and more strings to its share of the funds. No longer is it willing to be merely a passive contributor; now it actively seeks to shape both educational and fiscal policies in the nation's medical schools. Where the government's goals coincide with the objectives of the medical schools, there is no conflict. But this is not always the case.

Compare the schools' reluctance to increase enrollment (fearing to overburden educational resources and anticipating a sacrifice in quality) with the desire by the federal government to link subsidies to enrollment boosts. The House Committee on Interstate and Foreign Commerce reviewed the nation's medical manpower needs and heard testimony offered by representatives of medical schools. The committee reported that it had "weighed carefully the proposal of the Administration, the Association of American Medical Colleges, and others testifying before the subcommittee not to include an expansion of enrollment requirement as a condition for receipt of capitation grants. Although the proposal might have merit if only small amounts of federal assistance were involved, the committee feels strongly that if schools are to receive assistance of the magnitude proposed in this bill there should be results—there should be increased manpower. The capitation grants will give the schools hundreds of thousands of dollars and in some cases millions of flexible funds to be used at their own discretion to meet their educational needs."[3]

The president of the Association of American Medical Colleges (AAMC), John A. D. Cooper, MD, recognizes that medical schools are in a precarious position and has cautioned the federal government against trying to find hasty, inadequate solutions: "The medical schools and their teaching hospitals which have become increasingly dependent on federal funds as their other fiscal resources become less adequate to carry out their socially vital missions, are being used as a convenient handle to advance the federal government's solutions to perceived shortcomings on the national health scene."[4]

According to the AAMC the annual cost per medical student of the educational program leading to the MD degree is estimated to range from $16,000 to $26,000 in 1972 dollars.[1]

Possible Solutions

Where will the money come from tomorrow?

In recommendations recently offered by the AAMC Committee on the Financing of Medical Education there is an emphasis on the search for multiple sources of support. The members recommended that the federal government should provide one third of the net cost of undergraduate medical education programs and should continue to offer grants and interest-subsidized loans to worthy students. State governments should continue their present level of support (about 55 percent) of public medical schools and should not overlook support for private schools either, to the extent that private schools contribute to the well-being of society. Only one short paragraph is devoted to general suggestions regarding a school's role in financing through solicitations of gifts and through fee-for-service income.[3]

The AAMC committee has not suggested anything new; rather, it has surveyed the national financial scene in medical education and has recommended continuation of the present direction. This is not adequate.

While its president bemoans the controls tied to federal subsidies, the AAMC through its Committee on the Financing of Medical Education has not found any viable alternatives.

Others have. Part of the solution lies in a largely untapped resource: the recipients of medical education—the physicians themselves.

Although physicians enjoy a generous lifestyle, high social standing and stable income, they do not at present pay for a major share of their education. It is true, of course, that physicians' income is subject to progressive federal and state income taxes to provide general revenues which in turn subsidize the medical schools. But does their obligation regarding the cost of their education stop here?

It has been estimated that the average physician will earn at least $1,500,000 in his productive lifetime. Yet, he currently is asked to pay a total of only $4,000 to $14,000 for his four years of medical education.[5]

In 1971-1972 the average student attending a private medical school in the United States paid tuition and fees accounting for 13.7 percent of the

costs of his education (down from 18.5 percent in 1960-1961). His counterpart at a public medical school paid tuition and fees accounting for only 4.7 percent of his medical education in 1971-1972 (down from 7.6 percent in 1960-1961).[3]

Perhaps medical students cannot afford to pay more than current tuition levels, but physicians certainly can.

Tuition and fees could be doubled or trebled without significantly affecting the applicant pool, *provided* that long-term loans are made available as described below.

Without loans, government subsidized or otherwise, only the children of very rich parents could pay the proposed $10,000 to $15,000 per year for a total of $40,000 to $60,000 in tuition and fees. Some may be frightened by the thought of incurring so large a debt. Yet the same young graduate thinks little about paying the same amount for a home encumbered with a 30 year mortgage. A young ophthalmologist who begins in solo practice may well have to borrow an equal amount to buy equipment and establish an office, to be repaid over 10 to 12 years.

Most of the currently available loans are scheduled to be repaid in full within 7 to 10 years after completion of postgraduate medical education. What is needed is the legal mechanism to be able to stretch out the repayment of larger loans over a longer period of time, such as 20 to 30 years.

This is by no means an original proposal. Daniel R. Challoner of the Institute of Medicine, Washington, D.C., proposed in January 1974 that income-contingent loans be established. Under his plan organizations such as medical schools or a government agency would lend the necessary funds to the student who would pledge to pay back a percentage of his gross income (based on the borrower's future income tax) for a period of years. Instead of simply paying off a fixed amount of principal plus interest, the borrower would continue to pay as long as he is working or until some predetermined maximum limit is achieved (such as 150 percent of the loan plus standard interest).[5]

Under Dr. Challoner's plan larger loans for higher tuition could be made allowing physicians from all income levels to pay for a greater share of their education. Such a proposal should have certain safeguards providing for limited or no liability if the borrower dies, is disabled or does not complete medical school.

A similar proposal was made regarding the support of physicians in graduate medical education by Herbert E. Kaufman of the University of Florida College of Medicine at Gainesville.[6]

"Mortgaging" one's self presents significant legal questions. What would be the security for repayment of the proposed loans? How could a prosperous physician be kept from avoiding repayment through bankruptcy proceedings? Would it be possible or desirable to link relicensure and continuing membership in medical societies with loan repayments? While these questions as well as other personal and ethical issues need to be resolved, the educational mortgage represents a viable alternative to increasing government aid with associated increasing control in medical education. It is a concept which deserves the support of the medical community and merits being the basis for a pilot research study. It is an idea whose time may have come.

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