# MEDICAL EDUCATION FUNDING:

## Recommendations from the

## State University System of Florida Presidents' Workgroup

## February, 2009



### Background

In August of 2008, State University System (SUS) of Florida Chancellor Mark Rosenberg asked University of Florida President Bernard Machen to chair a workgroup composed of presidents of the SUS institutions that offer programs leading to the M.D. degree. Besides the University of Florida these include existing medical schools at Florida State University (President T.K. Wetherell) and the University of South Florida (President Judy Genshaft), soon to open medical schools at the University of Central Florida (President John Hitt) and Florida International University (President Modesto Madaique), and a Florida Atlantic University (President Frank Brogan) -University of Miami affiliated program.

The workgroup was charged with focusing on two areas. First, it was to explore the options for creating and funding a staff position associated with medical education in the Board of Governors office at a suitable level. Second,

the workgroup was to explore whether it was possible to establish a more transparent, systemic, and rational approach to medical education funding than the one currently employed.

## Board of Governors Staff Position Devoted to Medical Education

Whatever its merits, the argument for creating a position dedicated to medical education at the Board of Governors office has largely been overtaken by fiscal events of such deep concern that the workgroup can only recommend that the question might be resurfaced at such time as the economic climate improves. The Board's current staff coverage, complemented by the demonstrated collegiality of the Florida Council of Medical School Deans, will need to suffice for the foreseeable future. Since the Board of Governors passed its Medical Education Initiative in 2006, the Council has worked actively with the Board office on several fronts. These include collaborative initiatives to implement statewide efficiency measures and disaster preparation procedures, as well as articulating with the Department of Health to create a Physician Workforce Strategic Plan per statutory requirement. There is every reason to expect that such a collegial environment will continue.

***<u>Recommendation #1:</u> Consideration of a Board of Governors staff position devoted to medical education should be delayed until the economy improves. Current Board of Governors staffing devoted to medical education is important, productive, and should continue at the current level.***

## SUS Medical School Funding

Many of the general observations contained herein stem from an important report, "The Financing of Medical Schools," published by the Association of American Medical Colleges (AAMC) Task Force on Medical School Financing. Although it was written in 1995, this report remains relevant as a foundational document that identifies and characterizes medical school activities, costs, funding sources, and initiatives to adapt to fiscal constraints. Perhaps as importantly, the AAMC report has proven to be prophetic with regard to the vulnerabilities in which medical schools increasingly find themselves in given the perfect storm of changes to healthcare provision in recent years, new curricular costs, more competition for dwindling state support, and an increasingly hostile fiscal climate from local to national levels. The workgroup acknowledges its debt to the AAMC and the authors of that report.

For good reasons it has been said, "If you've seen one medical school, you've seen one medical school." Medical enterprises in the United States, in contradistinction to the general perception that they exist only to produce doctors, have historically been and largely remain diverse in mission, organization, size, and structure. Their diversification is at least as prevalent and perhaps more so in Florida than elsewhere. It manifests in FSU's focus on producing rural and general practitioners, its absence of a teaching hospital, and its less traditional clinical experiences; in UF's and USF's substantial research foci; in FIU's "community-infused" curricular model; and in FAU's student body

size. This diversity of model and operation should be viewed as a strength of Florida's medical education system, just as it is nationally.

***<u>Recommendation #2:</u> Florida's medical education diversity, both public and private, should be valued, supported, and preserved. Funding models current or proposed must be designed so as not to disadvantage institutions because of their diversity.***

There are, however, also some important commonalities among medical schools with regard to funding. Florida's public medical schools, like most public medical schools nationally, have relatively small bases of "hard money" support in the form of state appropriations. Beyond state appropriations, the usual sources of medical school revenues include tuition and fees, faculty practice plans, federal research, and endowments and gifts.

Historically, the financial health, stability, and excellence of medical schools has correlated with the extent to which discretionary and unrestricted funds are available to schools and departments to support core academic objectives. Like their parent universities, medical schools traditionally operate by receiving revenue with varying degrees of restriction. Generally, the more flexible the funding source, the more able are medical school deans to use those funds to reinforce the academic enterprise. Grants, contracts, and federal research dollars accompanied by stipulations for their use provide the clearest examples of highly restricted revenues. Gifts can also be highly restricted.

The revenue with the greatest level of flexibility is associated with faculty practice plans. This revenue source has been chiefly responsible for expansion of

public medical school revenues over time, and faculty practice plans are important not only for their contribution to the growth in absolute dollars, but also because these sources of income could be used to support critical unfunded academic programs. These dollars assist in creating financial health and stability in medical schools because of their discretionary and relatively unrestricted nature, and many medical schools share in common a major dependence on clinical support for academic programs.

***<u>Recommendation #3:</u> Dollars generated from faculty practice plans should be understood as positive assets for the state and central to supporting the teaching, research, and service missions of medical schools. It is critically important that faculty practice plans be understood as augmenting rather than replacing state appropriations in support of medical school missions.***

The growth of managed care, consolidation of providers, and price competition threaten the traditional role that faculty practice plans have had in medical education. If in 1995 faculty practice plans and, therefore, flexible revenues appeared to the AAMC to be eroding, the evidence is even more compelling today. Medical school faculty practices and teaching hospitals are competing with other health care providers on an increasingly uneven, ill-defined, and misunderstood playing field.

At the same time, changes in the nature of the curriculum are increasing costs. These increases are due to pedagogical best practices such as the use of small teaching groups, the use of technology in the classroom and for clinical experiences, and the migration of clinical education to community sites, which increases administrative and infrastructural costs. The result of this dynamic is

to see that the need for flexible funding to assist in addressing teaching, service, and research costs is escalating at the very time when the availability of these funds is being negatively impacted by an intensely price-sensitive, complicated, and competitive healthcare marketplace while, also at the same time, they are viewed by some as capable of replacing rather than supplementing state dollars.

***<u>Recommendation #4:</u> Despite any historical growth in funding, either in the aggregate or by particular funding sources, the overall financial well-being and stability of SUS medical schools, and especially the level of their state support, should be considered an area of increased rather than diminished concern since the Board of Governors 2006 Medical Education Initiative was approved.***

Increased attention by Florida's medical schools to reducing costs and doing business differently has been an important step in facing the current fiscal crisis. These efforts are ongoing and result in the sorts of change that characterize complex businesses in the process of transforming their institutional culture, structure, and operation. Depending on the institution, efficiency initiatives may include changes in faculty and departmental management, use of non-tenure faculty appointments, freezing or reducing faculty salaries, defining and limiting the financial guarantees of tenure, reducing staffing, and consolidating departments.

In addition, new sources of support and increased support from traditional sources, are being sought to compensate for the past or potential reductions in clinical revenues. All SUS schools are seeking to enhance support from private foundations and industry. The UCF medical school's success in

receiving full scholarship support for its entering class is but one example that, with perseverance, such support is available. These forms of revenue, however, are likely to have minimal flexibility and impact.

***<u>Recommendation #5:</u> State University System medical schools should be expected to actively seek new sources of revenue as well as institutional and inter-institutional efficiencies and cost reductions. Results should be reported regularly to the Board of Governors.***

It is of critical importance to expect that the financial stability of its medical schools is a legitimate concern and partial responsibility of state government. If Florida expects its medical schools to continue world-class biomedical research on the one hand while providing quality healthcare to low income and indigent citizens on the other, then it must do its part in maintaining and preserving the crucial functions, goods, and services that characterize high quality medical education. Beyond the provision of services and educational opportunities, certain of the SUS medical schools are at the heart of huge academic health center complexes that serve as major employers for the region and confer significant economic and heathcare benefits to the people of the region and state. At the University of Central Florida the economic development potential of the Lake Nona "Medical City" is exciting and apparent. Elsewhere, SUS schools are importantly integrated into the fabric of communities, as in the case of Florida International University's curricular framework.

***<u>Recommendation #6:</u> It is overwhelmingly to Florida's interest to be proactive in ensuring that its public and private medical schools are healthy and stable because their provision of services, their knowledge-creating capabilities, and***

***their economic development potential as well their educational mission of producingnew doctors.***

Given the several external forces that are creating instability in medical schools—from remarkable changes in healthcare provision to worldwide fiscal climates—it is imperative that forces internal to Florida do not exacerbate the instability. Accordingly, Florida needs to agree on a reliable, rational, and transparent level of state support based on a standard cost of instruction per medical school student benchmarked against national indicators, irrespective of institutional mission, incoming non-State funding sources, program diversity (except insofar as it can be accommodated in a cost of instruction calculation), or tuition differentials.

***<u>Recommendation #7:</u> To be successful, medical schools must compete for external (e.g., federal and clinical) dollars while the state contributes support that is appropriate and dependable. The State University System should not be resistant to funding Florida's medical schools at the same rate per student irrespective of institution so long as that rate is rationally derived, and reliable; and so long as other revenues, especially those derived from clinical practices, do not enter into the calculation to supplant the State's portion of its responsibility to medical education.***

Florida's current method of funding medical education appears to be the product of disconnected individual requests over time. Virtually all of the schools are advantaged or disadvantaged, as the case may be, according to the particulars of legislative budget requests based on growth, facility expansion, site expansion, equity funding, or wholesale requests for new schools altogether. While the SUS schools worked to put together a ten-year funding request, it

continues to be unclear that there is a single coin of the realm that substantiates the requests individually, while at the same time pulling them together into a coherent, systemic approach to medical education funding for the State.

Recognizing that, clearly, there may be some startup costs attendant to new medical schools, a single cost of instruction per student could serve as the foundation for future requests, with these provisions: first, it would have to arrive at an appropriate level. Here, national comparisons might assist as a determinant. In 1995 the AAMC found that schools were operating within a fairly narrow range of direct instructional costs per medical student: $40,000--$50,000. The average, $45,000, would equate to $64,905 in 2008 dollars according to the U.S. Department of Labor, Bureau of Labor Statistics. Where should Florida be with regard to that figure? It may be that the State can not or should not be expected to support full instructional costs; however, no one would be enthused at a cost of instruction that resulted in a mediocre commitment by the State toward its medical schools.

Secondly, an instructional cost per student would need to (and could) take into account mission differentiation to the extent that undergraduate biomedical students, Ph.D. students, physician assistant students, and others, as appropriate, could be valued at lesser portions of the cost of instruction per M.D. student.

And finally, state funding that resulted from an instructional cost per medical student would have to be predictable. Devising a formula that does not

result in commensurate appropriations will drive institutions back to old and predictable habits.

Florida has an opportunity to become a national leader in medical education with its two older, traditional schools, its one recently implemented school, its two new schools that will open their doors in Fall 2009, and its program affiliated with an independent institution. Advocating for adequate, comparable funding for all, derived from a sound methodology will be the first prerequisite, if the Board of Governors is to assist in realizing this potential.