



# CHANGING FINANCIAL BASE FOR DENTAL EDUCATION

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## ABSTRACT

In recent years, there have been material changes in the manner in which U.S. dental schools are funded. This fact has had profound ramifications for the practices, operations, and culture of the schools. The kinds of programs supported, patients treated, and students admitted all are affected by the sources of available revenue as schools can only do that which does not jeopardize their economic viability.

Changes in revenue sources was one of the major themes of the monograph on the economics of dental education recently published by the American Dental Association.<sup>1</sup> Of particular interest is Chapter 4 of that work by Dr. James Hardigan of Virginia Commonwealth University School of Dentistry.<sup>2</sup> In the table of his contribution, Hardigan showed, using data from the ADA's annual publication *Surveys of Predoctoral Dental Education*, that for the period fiscal year 1991 to fiscal year 2001, there had been a material drop in support from both the federal and state governments for both public and private institutions. In response, schools have had to make up the resulting deficits by raising tuition, seeking more donations from alumni and other friends, and increasing clinic revenues by raising fees and changing the demographics of patients treated. A summary of the table is presented, along with an update using fiscal year 2002 information from the ADA survey (Table 1).

As the data demonstrates, while federal, state, and local governmental support for U.S. dental schools continues to drop, there has been an accompanying rise in tuition charged to students.

As noted in the article, there has been an especially pronounced rise in the tuition of public institutions. Although the tuition of all dental schools is reported as having raised an inflation adjusted

60.1 percent during the period fiscal year 1991 to fiscal year 2001, when broken down between public and private institutions, the inflation adjusted increase is 74.9 percent and 53.0 percent, respectively. Additionally, for the most recent year reported by the ADA, fiscal year 2002, total reported tuition revenue for public schools increased from \$163.24 million to \$179.31 million, or 9.8 percent; and for private schools, from \$297.12 million to \$315.71 million, or a more modest 6.3 percent. Anecdotally, UCSF has seen dental student enrollment fees more than double from \$9,964 in fiscal year 2001 to \$21,778 in fiscal year 2005, an increase of 119 percent. It should be noted there has been no increase in the number of students, and that since 1991, the UCSF School of Dentistry's state budget allocation has been cut more than 25 percent. In fiscal year 2005, the state portion of UCSF's total campus budget is about 10 percent. In order to adapt to these changes, the UCSF School of Dentistry has had to close its clinic on the grounds of San Francisco General Hospital, which it had opened in 1979, and also eliminate its AEGD and baccalaureate dental hygiene program. At



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**Table 1****Changing Financial Base of Dental Education**

All U.S. dental school revenue sources (thousands)

	FY 1991		FY 2001		FY 91- FY 01		FY 2002		FY 01- FY 02
		% of total		% of total	% of change	Adjusted for inflation		% of total	% of change
Tuition and fees	\$221,177	24.8%	\$460,363	30.9%	108.1%	60.1%	\$495,027	31.2%	7.5%
State and local govt.	\$426,086	47.8%	\$489,394	32.8%	14.9%	-11.7%	\$486,065	30.6%	-0.7%
Federal govt.	\$10,924	1.2%	\$11,387	0.8%	4.2%	-19.8%	\$10,947	0.7%	3.9%
Patient care	\$153,211	17.2%	\$329,578	22.1%	115.1%	65.4%	\$368,337	23.2%	11.8%
Gifts and endowments	\$28,876	3.2%	\$87,858	5.9%	204.3%	134.0%	\$112,259	7.1%	7.8%
Recovery of indirects	\$24,842	2.8%	\$42,429	2.8%	70.8%	31.4%	\$50,168	3.2%	18.2%
Other	\$25,815	2.9%	\$70,412	4.7%	172.8%	109.8%	\$65,021	4.1%	-7.7%
Total	\$890,931	100.0%	\$1,491,421	100.0%	67.4%	28.7%	\$1,587,824	100.0%	6.5%

Hardigan JE, The Financing of Dental Education's Future. In: Brown LJ, Meskin LH, editors. *The Economics of Dental Education*. Chicago: American Dental Association, Health Policy Resources Center; 2004. © 2004 American Dental Association. Reprinted by permission.

this time, the regents are considering raising fees an additional \$2,000-plus for fiscal year 2006. It should also be noted that the school's administration fully supports this increase as these funds are necessary to counteract the effect of state budget cuts and unfunded increases in operating costs.

As shown by the ADA data, in response to materially reduced government support, the schools have done what they could to increase patient care revenues. This has been accomplished despite material federal and state cuts to Medicaid (Medi-Cal/Denti-Cal in California) and Medicare reimbursements. Medicare supplied significant monies to dental schools via the graduate medical education program, which provided resident and faculty salary support to postgraduate education programs in clinical specialties such as orthodontics and periodontics. Shortly after it was decided that the Medicare trust fund would be the source of funding for the \$400 million to \$600 million in new prescription drug benefits, and

that there would be no new Medicare taxes levied, a change of regulations was promulgated by the federal government, resulting in the disqualification of about half the graduate dental programs in the United States from any further graduate medical education support.

Further, due to budget cuts to the Medicaid program, many states, like California, have reduced the number of procedures covered and the reimbursement rates for those procedures. Some states, like Massachusetts, have even eliminated Medicaid adult dental services altogether. As most U.S. dental schools' student clinics serve as safety net providers, this has had the effect of forcing schools to consider changing their patient base away from persons on public assistance and toward those who have dental insurance or can afford to pay fees. Because of low reimbursement rates and elimination of procedures covered, some schools have felt compelled to put a limit on the number of Medicaid patients they schedule for appointments.

It should be noted that a main driver

for the decision of governments at all levels to cut back on educational funding is decreased revenues caused by tax cuts. As there is presently no meaningful discussion on the need to restore these cuts at either the federal or state levels, it can be presumed that decreased government support for education and patient care will be a reality for U.S. dental schools for at least the foreseeable future.

The success that schools can show in increasing their patient care revenues has come about by being diligent about raising fees, improved marketing to increase patient flow, scheduling more faculty and student clinic hours, improving collection efforts, and reducing the number of indigent patients. It is worth mentioning that given the increasing administrative burdens associated with insurance billings, many schools, like many private practitioners, have begun to require patients to pay their own bills and take personal responsibility for seeking reimbursement from their insurance companies. As an example, at UCSF over the past five years, it has seen its cash receipts portion of

**Table 2****Changing Financial Base of Dental Education**

Changes in average student-debt burden

Type of school	FY 1992		FY 2002		Total increase		Percent increase	
	Nominal	Real	Nominal	Real	Nominal	Real	Nominal	Real
All	\$55,550	\$71,229	\$107,503	\$107,503	\$51,953	\$36,274	93.5%	50.9%
Public	\$42,700	\$54,752	\$85,840	\$85,840	\$43,140	\$31,088	101.0%	56.8%
Private	\$75,166	\$96,382	\$136,060	\$136,060	\$60,894	\$39,678	81.0%	41.2%

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annual clinical revenue go from \$3 million of \$13 million to more than \$5 million.

In response to reduced funding, U.S. dental schools have also materially increased their efforts to solicit donations from alumni, grateful patients, and persons friendly to the cause of dental education. As shown by the ADA figures, in general, schools have been very successful in increasing this source of revenue and are suitably grateful to the many donors who have stepped forward to assist in this time of need. It should be mentioned, however, that soliciting donations is an ongoing, labor-intensive activity that requires appreciable time and effort by a school's senior administrators and staff. Further, many gifts come with well-defined donor restrictions that reduces the flexibility with which the money can be used.

The category "Recovery of Indirects" describes the administrative portion of contracts and grants for research paid to the university doing the work. As the data shows, U.S. dental schools have increased somewhat the research activity of their faculty and have benefited thereby.

The "Other" category relates to miscellaneous school revenues generated by such activities as offering continuing education classes for licensed practitioners and rental of facilities for national and state board exams. As the data

shows, although only a small part of total revenues, there has been some strong growth in this sector.

With materially increased tuition comes, of course, increased student debt loads. The best source for gauging the extent of this phenomenon is the annual survey of graduating dental students conducted by the American Dental Education Association.<sup>3,4</sup> This source was relied upon by Hardigan in his Chapter 4 of the ADA monograph previously cited to prepare his Table 4.3 which is reproduced but relabeled as Table 2.

As the data shows, not surprisingly, student debt is rising as fast as tuition. Also, as with tuition, debt levels are rising faster at public as opposed to private schools. The ramifications of rising student debt levels have, of course, been a matter of great concern for some years now. There are obvious implications for access to a professional school education for people of low-income backgrounds, the ability of our graduates to accept lower-paying positions in the public health or nonprofit sector upon graduation, and the ability of graduates to finance the purchase of practices from retiring practitioners.

### Conclusion

Barring some drastic change in public policy, which will result in raising taxes to generate revenues and

which governments can then use to better fund higher education and patient care for the underserved, dental schools will have to continue to raise student tuition and develop entrepreneurial initiatives to raise revenues. Public schools especially will have to accept de facto privatization in order to survive economically and also accept the fact that there will be certain populations that can no longer afford to attend these institutions nor seek care there.

Also, schools will have to examine their academic programs and support those which can either attract outside funding or generate their own sources of revenue. Those that can do neither will have to be eliminated in order to maintain the economic viability of the school. CDA

**References** / 1. Brown LJ, Meskin LH, editors, *The Economics of Dental Education* Chicago: American Dental Association, Health Policy Resources Center; 2004.

2. Hardigan J, *The Financing of Dental Education's Future*, 2004.

3. Weaver RG, Haden NK, Valachovic RW, Annual ADEA survey of dental school seniors: 2002 graduating class. *J Dent Educ* 66(12):1388-1405, 2002.

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