Competing Incentives: For-Profit Hospitals Add Complexity to Graduate Medical Education

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Graduate medical education (GME) is an enterprise that has high-stakes obligations to multiple stakeholders, including the public, patients, hospitals, and residents and fellows themselves. How GME is implemented not only affects the current state of health care but also has profound influence on the future clinician workforce. Since the creation of Medicare in 1965, the US Government has financially supported the salaries and other costs inherent in training physicians. This is accomplished almost entirely via payments to teaching hospitals, through direct and indirect payments (in the form of a multiplier on payments for care delivered to Medicare beneficiaries). This type of funding structure for the training of professionals is a unique and unusual relationship that does not exist in other professions, including others with overtly public-serving missions (eg, social work, public defenders, public servants). As such, GME can be considered a public good, and the tax-paying public has a right to expect that the system will act in the service of the larger community and its priorities.

To a large extent, the GME system—the government funding of teaching hospitals that facilitate the postgraduate clinical education of physicians—has functioned for the greater good. It provides for sustained staffing of a system of care for patients in many hospitals, including safety net hospitals that otherwise might be understaffed. Through the National Resident Matching Program it ensures a steady pipeline of well-trained physicians across the spectrum of medical specialties. The Accreditation Council for Graduate Medical Education (ACGME) oversees this process and, through its evolving program requirements, helps maintain a minimal standard of education and supervision. Government funding of GME is dependent on programs and institutions maintaining accreditation.

Although the multiple stakeholders participating in GME (government, training hospitals, the ACGME, and residents and fellows) have responsibilities to the public and to each other, the training system relies mainly on hospitals to act as appropriate stewards of the funding and workforce. Teaching hospitals are asked to dedicate appropriate resources to education and to not use those resources for non-educational purposes (eg, leveraging debt, expansion, or balancing the budget). Unfortunately, the hospitals' incentives do not always align with those of the other GME stakeholders.

As a complex and multilayered system, GME is constantly grappling with competing interests. Hospitals have a need to ensure their workforce is well-trained, yet not overworked to the point of making them error prone. Hospitals need to ensure appropriate supervision and training for residents, but also a desire and need to provide care at the lowest cost. Past abuses of this system that led to highly publicized bad outcomes have led to greater regulation of work hours and supervision—but the tensions between education and what is euphemistically called "service" (meaning working excessive hours at low pay) persist.

Into the mix has come a growing involvement in education by for-profit hospitals. Hospitals that, by definition, focus more on the bottom line and profits for shareholders, have come to appreciate the value in training residents. This has only added to the tensions between education and service. It remains unclear whether the ACGME's oversight systems are up to the task of ensuring that these sites do not place profit above education. With the not entirely overlapping missions of educational institutions and for-profit health care institutions, it is appropriate to evaluate whether the participation of the for-profit sector in education is truly serving the public good.

In this issue, Lassner et al attempt to untangle some of these tensions by investigating GME provided by institutions with varying priorities.[1] They report that there is a rapidly increasing number of residency programs (in general surgery, internal medicine, and pediatrics) affiliated with for-profit hospitals. This greater participation is likely, in part, related to the added value an educational program may have in attracting consumers. However, one cannot help but wonder the extent to which GME participation is used as a means to provide more care at lower cost to the institution, by replacing costly on-site physicians and advanced practice clinicians with lower paid residents

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and fellows. The authors go on to explore whether this shift may have educational repercussions. Their finding that board pass rates (after adjusting for covariates) have no association with the for-profit status of hospitals for internal medicine and general surgery is reassuring. But we have ongoing concerns that for-profit status might affect training in ways large and small other than board pass rates.

One need look no further than the example of Hahnemann University Hospital (HUH) to see some of the challenges that arise as for-profit companies become more involved in the lucrative and hospital-centered business of training physicians.[2] After HUH, a historic safety-net institution that had a long history of providing GME, was purchased by a private investor, residents and fellows were used as pawns in a game to shore up the finances of a hospital in financial trouble. In 2019, the city of Philadelphia was rocked by HUH's abrupt closure. Program directors scrambled to find alternative hospitals where 583 soon-to-be unemployed residents and fellows could continue their training.[3] Meanwhile, the bankrupt owners of HUH attempted to auction off their Centers of Medicare & Medicaid Services (CMS) funded GME slots in a desperate effort to raise money. The auction was challenged in court by CMS, but the winners of the auction (a conglomerate of 6 local hospitals) withdrew their bid of $55 million before there was a judicial decision regarding the legality of such an auction.[4] Thus, such a gambit could be tried again. One can easily imagine a cash-strapped safety-net hospital selling GME slots that were predominantly providing primary care, to a geographically distant for-profit hospital which might use the funding for the training of more profitable specialties. Such an action, like the actions taken by HUH leading up to its closure, contradicts multiple priorities and responsibilities of GME to the public and the residents and fellows themselves. At this point, there are inadequate safeguards in place to prevent this from happening.

We have concerns about the misaligned priorities outlined above. It is tempting to postulate that for-profit institutions exacerbate this misalignment, yet there is a dearth of evidence that this is the case. We applaud Lassner et al for taking an important step toward rigorously studying this possibility. Continued investigations of educational outcomes, workforce distribution, and appropriate use of funding are imperative given the changing landscape of hospitals participating in GME.

References

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