Teaching Hospitals in Trouble: Finding Solutions

LAST WEEK’S RESIDENT PHYSICIAN Forum column explained some of the financial challenges facing teaching hospitals and the threat that reduced funding poses to graduate medical education (GME). To address these challenges, legislators and medical educators have proposed several ways to strengthen GME funding.

Sen Daniel Patrick Moynihan (D, NY) has introduced a bill to revamp the financing of GME in the United States. His plan calls for freezing the GME subsidy at its current level and not permitting further annual reductions. Another suggestion has been to pay teaching hospitals directly for treating low-income patients and training nurses, rather than continuing to pay Medicare managed care plans for those services.

The National Bipartisan Commission on the future of Medicare and the Medicare Payment Advisory Commission have spent a great deal of time analyzing Medicare and its role in funding GME. Both groups recommended reducing the number of GME positions, providing transitional support for institutions that choose to downsize their GME programs, and providing stable support for teaching hospitals. They suggest that Medicare’s direct medical education funding, which pays for the direct operating costs of a residency program, including resident and attending salaries and benefits, either be funded through a separate entitlement program or through a multiyear discretionary appropriations. They believe this would separate the needs of teaching hospitals from the prevalence of political machinations.

Some, including the American Medical Association, have suggested establishing a separate medical education trust fund that would be financed by a fee levied on private health insurance premiums, as well as contributions from Medicare and Medicaid. Maryland, for example, has an all-payer statute, which requires contributions to GME funding by all insurers. This proposal has the advantage of broadening the burden of paying for medical education.

All stakeholders must come to regard the financial well-being of teaching institutions as vital to America’s health care system. The ultimate standard for these institutions must be not only superior training and the dissemination of specialized knowledge, but also the ability to deliver the best medical care available anywhere. We must shore up this key part of the nation’s biomedical infrastructure. All changes should aim to preserve the cost-containment measures included in the 1997 law. Simply plugging holes in the current funding patchwork will not ensure stability for the future.

If we want to continue at the cutting edge of research and provide the highest quality patient care, we must revamp the archaic system of financing medical education in the United States. For physicians to have any say in this critical debate, GME financing and infrastructure must become part of the undergraduate, graduate, and CME curriculum. If we do not make our voices heard, others will make these crucial decisions for us—decisions that will have ramifications for many generations to come.

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Poetry related to medicine has burgeoned over the past decade, becoming a recognizable genre in its own right. As health and medicine encompass ever more of our public and private concerns, the rising poetic response from those whose lives brush against illness seems a vibrant sign.