The Cost of Residency Education

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When doctors and hospital leaders are asked why health care is so expensive, we usually cite a familiar list of excuses. People are living longer. Technology is capital intensive. There is cost shifting to cover the uninsured. The cost of training America’s health workforce is an important underlying reason for health care inflation, but educational costs often seem to fly under the radar screen during the larger health reform debate. It is difficult to explain the high cost of health care. It is even harder to justify the increasing cost of medical education given the pervasive influence of rising tuition on who attends medical school and what medical school graduates do with their careers.

When it comes to the cost of graduate medical education (GME), we are at a loss to explain much of anything. Although family medicine residencies have been around for more than 40 years, we understand too little about how much they cost and how this expense is changing. Program directors complain that teaching hospitals are making money at their programs’ expense. Hospital administrators insist they lose money by sponsoring residency programs. From the outside of this debate, we look silly. Given the enormous pressure to constrain health care costs, particularly in the Medicare program, this puts us in a dangerous position at a dangerous time.

Thus, it is timely that Lesko and colleagues have studied the cost of residency programs in the University of Washington (UW) Family Medicine Residency Network over the past 10 years. In this issue of Family Medicine, they report that the 12 residencies in their study annually cost their sponsors an average of $27,260 per resident more than the program’s revenues, but the variability among the programs is striking. Why is there so much difference from one program to the next? Faculty and resident salaries are relatively standardized, so the cost differences among programs lie primarily in the financial performance of family medicine teaching clinics. Unfortunately, we do not have a standard financial model for such clinics. Some are hospital sponsored, some are Federally Qualified Health Centers (FQHCs), and some are provider-based clinics. This makes it difficult to compare one teaching clinic to another financially. The clinics in this study had an average collection rate of only 44% of charges, a direct result of caring for a mostly poor and underserved patient population. Of course a low collection rate can also result from poor billing and collections performance, a common problem in teaching practices. The percent of patients without health insurance ranged from 1% to 51% (mean 12%), so the clinics are performing important service roles beyond their teaching missions. Thus, the cost of each residency includes more than just educational costs. We have known about this service mission for a long time, but still the financial differences among the programs are impressive even though they are all in the same regional network.

Lesko’s paper raises important policy questions. Why is there so much variability in Medicare support for these programs? Medicare GME payment varied from $52,778 to $197,118 per resident annually. This variation is well known to those who study GME funding but nearly impossible to justify to anyone else. What should be done about the Medicare cap on residency positions? The programs in this study averaged 5.4 positions above the cap.
in 2010. If our nation really needs family physicians, is it reasonable to expect local hospitals to assume all of the cost of these additional residents? How can we best support programs that care for large numbers of uninsured patients in addition to their teaching missions? Two of the three programs that had revenues exceeding expenses had converted their teaching clinics into FQHCs, thereby garnering additional revenue for Medicare and Medicaid visits to compensate for uninsured care. Should more programs consider this option?

What should family medicine’s academic leaders do about this? The business interests that today control much of American medicine do not want to hear that we don’t know why things cost so much. Unexplained cost variations are being scrutinized as never before. Our discipline urgently needs a standardized model to track and compare the financial performance of residency teaching clinics. We have standards from the Medical Group Management Association to compare private practices; we need similar benchmarks for teaching clinic performance. We have national and regional comparators for faculty and resident salaries; we need benchmarks for the cost of clinic space, staff, and equipment. If our residencies are asked to care for uninsured or under-insured patients, we should know the impact of such decisions on the financial performance of the programs. Caring for the underserved, while important to our communities, generates costs that are not educational. The sooner we sort this out, the better we can demonstrate that our programs do far more than produce family physicians. In the eyes of our faculty, family medicine residencies are a bargain. It is up to us to prove it. In the current economy, every dollar counts.

References