

The shifting economics of academic medicine

Academic medicine—in many ways the crown jewel of the U.S. healthcare system—was built on a delicate bargain: hospitals generated the margin, medical schools advanced education and research, and faculty practice plans delivered care while anchoring the academic mission. For decades, this tripartite structure held together through a sense of shared purpose and a series of implicit understandings.

That equilibrium is under strain. Hospital margins are slim and at risk; federal funds for research and teaching are under threat; and there is an increasing demand for capital and new technology investments. There are rising physician employment costs, intensifying internal competition for clinical support and growing investments in education and training. Clinical workforce shortages are more pressing than ever. All of these factors have stressed the traditional model, so that what once looked like a sustainable financial arrangement today resembles structural imbalance.

Data from Vizient’s 2025 Funds Flow Benchmarking Study suggest this is a significant issue. This benchmarking study, produced by [Vizient Member Networks](#) in collaboration with [Kaufman Hall](#), a Vizient company, collected data from 61 U.S. academic medical centers, comprising more than half of all AMCs in the United States.

This makes it one of the nation’s most comprehensive resources on how funds are deployed across clinical operations, graduate medical education (GME), leadership and mission support.

The survey showed that median funds flow equaled 12.8% of academic hospital net patient revenue and faculty devoted 72% of their time to clinical work. However, **no direct correlation was found between spending and better quality outcomes, nor was any found between spending and stronger hospital margins.** Instead, it found that governance, alignment and accountability emerged as the true differentiators of sustainable funds flow models.

In this time of financial scarcity, transparency among all parties is needed regarding both funding and accountability of funds to ensure they are aligned in advancing the academic

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tripartite mission. The alternative is an untenable disconnect between mission and margin, which threatens academic medicine’s long-term sustainability.

Trends influencing the shift

For much of modern academic medicine, faculty compensation reflected a tradeoff. Physicians accepted lower pay than they could have earned elsewhere in exchange for stability and the opportunity to teach and/or conduct research. This so-called **academic discount** was widely understood and accepted.



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But market dynamics have changed. In some markets, the academic discount has lost some of its intrinsic appeal. Faculty physicians compete with their non-academic peers and at least in some instances have come to expect comparable compensation. The cost of supporting faculty physicians has risen sharply, mirroring [national trends](#) in employed physician economics. Increasing shortages in many specialties has added tension to compensation pressures.

As the discount disappears, the financial burden shifts. Hospitals and faculty practice plans must absorb higher compensation costs while still supporting teaching and research missions that rarely cover their costs. What was once a set of minor financial obligations has become a series of material growing line items, requiring tighter governance and accountability.

Governance structures can exacerbate the problem. In many academic health systems, hospitals, schools of medicine and faculty practice plans operate as separate legal entities with overlapping authority but limited shared accountability. In integrated structures, a single governing board and senior leadership can make coordinated decisions across the enterprise, but many systems operate under fragmented models in which each entity protects its own interests to the potential detriment of the whole. In those cases, systemwide finances can deteriorate, resulting in a scenario in which the flow of funds are determined by historical precedent rather than by strategic intent.

The result: hospitals often are expected to backstop academic losses, and academic leaders assume growing support. Neither side has full visibility into the tradeoffs being made nor to the risks being taken.

GME adds another layer of complexity. Many academic medical centers fund residency positions beyond their federal caps. The benchmarking study found the median level of support at 1.5 times their federally funded residency cap, a move typically justified as investments in workforce development or mission fulfillment. Yet few organizations rigorously track whether those investments pay off for their constituents. Retention rates for over-cap residents are frequently unknown, so there is usually no clear evidence that graduates stay, fill priority specialties or reduce *locum tenens* staffing costs. In those cases, the strategic intent of GME expansion may not be fully realized in measurable workforce outcomes, especially in regions that are starting to see a decline in resident applications.

The implication: academic health systems are funding GME costs with limited line of sight to value in building the future workforce.

Clinical leadership is a vital part of how academic medicine leads advancements in medicine, how the clinical care team provides care to patients and how peer top performance in quality is achieved.

Funding for faculty leadership roles has reached 5% of total funds flow, with no quantifiable link to system enterprise results in quality, growth, workforce or margin. Leadership compensation is often treated as a supplemental payment or recognition for administrative duties, not as a role with defined expectations and accountability for enterprise performance.

The challenge: to align leadership responsibilities with accountability for results.

Labor economics complicate matters further. Rising physician workforce shortages including caps on resident hours have placed significant pressure on the cost of labor. As salaries for advanced practice providers (APPs) rise, additional medical residents might appear to be a less expensive alternative. However, APPs and residents are not the same and often do not possess the same skillset; and many practices make [inefficient use of their APPs](#). The practice also raises an uncomfortable question: is workforce strategy driving GME decisions, or are staffing pressures forcing difficult tradeoffs in balancing educational mission, service and financial sustainability?

The bottom line: without clear ROI metrics, over-cap GME, rising compensation costs and increasing leadership investments can become one of the largest and least scrutinized components of funds flow.

Restoring alignment and accountability

Academic medicine faces a financial challenge: insufficient discipline around how enterprise strategy is aligned, how the mission is funded and how the organization is led and governed. Four levers matter most:

- 1. Strategic alignment.** With the varied and complex structures of the academic enterprise, the board and senior leadership must create alignment to strengthen the link between mission and margin, clarifying funding tradeoffs and making strategic decisions on funding priorities.
- 2. Financial transparency.** Systems need a clear, shared understanding of how dollars move among hospitals, schools and faculty practices. This includes visibility into faculty time allocation across clinical, teaching, research and administrative roles. Basic questions about headcount and effort should not be hard to answer.
- 3. Shared governance.** Decision rights and accountability should be aligned across the tripartite enterprise. This does not mean blowing up a board structure, because oftentimes formal board unification is not feasible. Yet even in those cases, well-defined agreements and governance processes can help balance mission priorities with

Why ratios matter more than raw dollars

One of the most important insights from Vizient's funds flow survey is methodological: systems may not be using the right metric when judging the totality of the funds flow. It turns out that looking at **total dollars** might obscure more than it reveals; a \$100 million transfer means different things depending on the size of the institution. Instead, by analyzing funds flow as a **percentage of net patient revenue**, the data provide a clearer picture of scale and sustainability.

Ratio-based comparisons reveal patterns. Institutions that appear similar in absolute spending can diverge sharply when viewed relative to revenue. Smaller systems may be devoting a far larger share of their clinical earnings to academic support than their larger peers, or vice versa.

This shift in perspective reframes the conversation. A smart funds flow analysis asks whether the level of investment is proportionate, intentional and aligned with strategic priorities, not whether an organization can afford a subsidy in absolute terms.

financial realities. Without them, fragmentation tends to persist by default rather than design.

- 4. Accountability.** Investments in faculty, leadership roles and GME should be tied to measurable outcomes and accountability. That does not mean reducing academic investments to favor short-term margin, but it does mean asking hard questions about productivity, retention and impact. Stewardship of the mission requires more than good intentions.

Academic medicine needs smarter, more strategic stewardship. The institutions that confront uncomfortable truths about how their models actually work, not how they

were designed to work decades ago, are more likely to adapt and thrive. The academic mission is essential, but its sustainability requires it be grounded in economic reality.

Editor's Note: The aggregate findings from Vizient's 2025 Funds Flow Benchmarking Study provide a national view of how funds are deployed across clinical operations, graduate medical education (GME), leadership and mission support. Vizient Member Networks members received deeper, peer-specific insight through full benchmarking results and facilitated dialogue that place their own funds flow patterns in comparative context.

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