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Public-Private Partnerships to Maintain Primary Care Workforce Pipelines

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Becoming a physician in the United States requires a staggering financial investment. The typical medical school graduate leaves with over $200,000 in student debt. [1] High costs are driven in part by fixed program expenses that do not scale down with class size—things like simulation labs and specialized equipment. For students in graduate and professional health care programs, the recent tightening of federal student lending limits threatens to worsen access and could contribute to workforce shortages.

The end of the Grad PLUS lending era and the beginning of new borrowing limits for graduate and professional students are predicted to hit high-cost, high-social-value fields—like medicine and health care—the hardest. In the void left by reduced access to federal loans, there is an opportunity to build a more sustainable higher education finance ecosystem. One strategy for doing so is targeted collaboration between the public and private sectors to avoid workforce shortages in essential fields like primary health care.

The Problem

Fixed costs in health care training programs create inefficiencies that are passed on to students.

Tuition for medical and health care training programs is shaped in part by fixed costs that remain stable regardless of class size. These costs can come from things like physical classrooms and labs, specialized utilities like medical gas lines and refrigeration, and expensive hands-on equipment and simulators. [2] Personnel costs for instructors, technicians, and support staff are also factors. Because these investments do not scale down with fewer students, they create a baseline cost that tuition must cover, making it hard for institutions of higher education to lower student charges quickly or substantially.

Primary care fields are experiencing urgent shortages.

Primary care fields like family medicine and pediatrics are experiencing the most dire shortages in the US health system. The Health Resources and Services Administration projects a shortage of over 70,000 physicians in 2038. [3] Americans living furthest from metropolitan areas will be hit hardest by this shortage. The nursing workforce that supports primary care services is also projected to suffer shortages that hit rural regions the hardest.

States need strategies for deploying new federal funds to improve rural access to health care.

States have a real-time opportunity through the newly authorized Rural Health Transformation (RHT) program to expand health care access in rural regions. [4] The RHT program provides $50 billion over five years for states to improve rural health care outcomes. These programs can serve as a short-term revenue source for states or localities to test new models for training tied to documented or projected workforce shortages. Research shows that people trained in rural areas are more likely to stay and work there, making this a particularly promising lever. States are already receiving federal funding to bolster access. A review of publicly available grant applications reveals room for strategic private sector involvement. Without swift action to tap private partners responsibly, the sustainable success of the program could be at risk.

The Solution

Training programs may find it beneficial to partner with the private sector to minimize the impact of high fixed costs on student access to health professions, particularly as access to federal student loans evolves. Public-private partnerships (PPPs) are arrangements between public and private sector organizations, corporations, or other establishments. In higher education, they are typically used for infrastructure projects like student housing and campus services like dining halls and bookstores. In the health care training context, carefully designed PPPs can help resolve the tension created by borrowing limits, fixed costs, and the need to maintain essential professional pipelines. To be effective, PPPs must be anchored from the outset to specific, documented workforce shortages.

The golden rule for designing effective public-private partnerships is to first identify the specific market failure or workforce shortage in mind, then identify potential partners. Otherwise, policymakers risk creating solutions in search of a problem and partnerships with third parties that may themselves only be in search of a revenue stream. [5] For example, a nursing shortage driven by a lack of clinical placement slots requires a different solution than a shortage caused by unaffordable tuition prices. Both could be addressed by a PPP, but each would be drastically different in composition and structure. The former could be addressed through partnerships between learning providers and hospitals, and the latter with employer-tuition sponsorship, service-related debt relief, or other financial tools and incentives that facilitate enrollment. Further, adding more medical professionals without targeting specific shortages, like those found in the primary care arena, risks flooding the specialist market with doctors and nurses that are not in demand and may struggle to find work.

An additional caution is warranted for protecting the public side of a PPP. Training partnerships should be kept structurally separate from arrangements where for-profit hospitals or private medical companies (and their investors) effectively control physicians and nurses. Vertical integration of the health care industry is already proving costly for patients, and it is important to preserve the independent, clinical voice of health care professionals and those under their guidance. [6] PPPs for training should therefore include strong guardrails to prevent capture of the education mission by private partners with financial interests that may be at odds with public health needs.

Examples of Cross-Sector Partnerships in Support of Health Care Training

Even before changes to student lending were on the horizon, hospitals and other medical providers found ways to partner with training programs to maintain their workforce pipelines, many of which could be further applied to the graduate medical education context.

Springfield, Illinois: Partnerships for a Health Care Workforce Hub

For nearly a decade,Springfield's Memorial Health and Hospital Sisters Health System (HSHS) St. John's Hospital, the two anchor institutions of the now-regional health care hub, have offered incentives to attract and retain health care talent. Memorial Health's Horizon Program offers up to $5,250 in tuition assistance each calendar year, bi-weekly stipends ranging from $1,000 to $1,550, and signing bonuses for qualified candidates pursuing degrees in health care workforce shortage areas. [7] The program is available to students enrolled at the University of Illinois Chicago's Springfield Nursing Campus to encourage ties to the region. Beyond those education pathways, Memorial Health also offers reimbursement of up to $1,000 per professional certification to support the hospital's workforce needs.

HSHS St. John's REACH Program provides the same IRS maximum-allowed benefit of $5,250 across three pathways. [8] The REACH Partnership offers aid to students enrolled at either Springfield's St. John's College of Nursing or Southern Illinois University Edwardsville who are studying in a clinically

focused field. The REACH Prepaid program offers the benefit to students across 1,000 programs who are pursuing technical roles such as medical assistants, lab techs, and pharmacy techs. The third path, REACH Reimbursement, is designed for students pursuing education in areas that support the hospital's operations. These Springfield area initiatives support students pursuing training at any credential level, including in graduate and professional programs. [9]

Fredericksburg, Virginia: A Public University and a Private Hospital Partner to Create a New Medical School

The commonwealth of Virginia included $1.7 million in its 2026 budget to form a public-private partnership between the University of Mary Washington and Mary Washington Hospital to open a new medical school. [10] The funds will be used to develop a "cost-efficient medical education model that… reduces student cost and leverages existing public and private assets." [11] The project is meant to address physician shortages in the region and improve patient access to care. The two entities will share the cost of building and running training programs that will be focused on developing community physicians, setting them apart from typical medical schools housed at research-intensive institutions that are highly specialized. Supporters hope the focus on the community physician pipeline will keep more doctors in the Fredericksburg region. [12]

New Orleans, Louisiana: A Health Insurance Company to Fund Incoming Medical Students

Xavier University of Louisiana, a historically Black Catholic university in New Orleans, joined forces with a regional health system, Ochsner Health, to establish a new medical school, Xavier Ochsner College of Medicine, which will admit its inaugural class in 2027. Health insurance company Humana is also joining the partnership to provide $3 million in scholarship funds for qualified students who commit to practicing in Louisiana. [13] The Xavier example is notable for its focus on increasing the supply of primary care professionals, but it also warrants caution because it blurs the line between payer, provider, and training institution, which exemplifies the kind of vertical integration that could compromise clinical independence if a PPP is implemented without strong guardrails.

Critiques and Responses

Federal and state governments already support graduate medical education.

True—federal and state governments already make payments to teaching hospitals and institutions to support graduate medical education, though support has been static since the late 1990s. [14] The National Health Services Corps also provides scholarships and loan repayment in return for working in medically underserved areas after graduation. [15] Medicare is the largest source, which contributed $21 billion in 2023. [16] However, the number of students supported by Medicare graduate medical education funds was capped in 1997, and any expansion of support for trainees and institutions will require the participation of other sectors. [17]

Public-private partnerships cede too much control over education to private companies and could erode the quality of the training.

This is a legitimate concern. When private partners gain influence over curricula, admission criteria, or clinical rotation priorities, the educational mission can drift toward investors' and owners' bottom lines and away from public health needs. Quality erosion could manifest as reduced time for foundational sciences, overemphasis on narrow skills, or pressure to pass students who are not yet fully competent. To guard against this, any PPP should include explicit contractual provisions that reserve all academic decision making to the educational institution alone. Regular, independent audits of educational outcomes should also be conducted and the results made publicly available. Accreditation bodies could be tapped here to ensure PPP arrangements do not compromise educational standards.

Public-private partnerships have inherently misaligned incentives.

This is a core tension. Private partners, especially investor-owned health systems or corporations, operate with a fiduciary duty to maximize profit. Education, by contrast, is a social good with returns that accrue over decades and that can also be non-financial. This mismatch could lead private partners to push for training models that prioritize profitable specialties over primary care—even though there are widespread needs for more primary care practitioners. Mitigating this requires alignment on non-negotiable social outcomes. To find this alignment, contracts could tie private partner compensation to verifiable public goods like placement in shortage areas or patient access improvements. Public partners should also have options to terminate agreements if there are signs of mission drift.

Incentives should also be aligned with outcomes to create a balanced partnership. An example of this in action is Wisconsin's "Grow Our Own" graduate medical education grants, which require hospitals to match public funds to spread the risk evenly. PPPs should also be anchored to a specific workforce need, starting with a documented or projected shortage rather than a vague pitch. The private partner must shoulder its share of the risk, while institutions should calculate social value and require the partner to factor that value into its commitments.

Public-private partnerships risk leaving the public partner stranded if the private partner disinvests or fails.

This could be a serious risk. Private partners may disinvest when returns are slow, leadership changes, or if priorities shift. Worse, if a private partner goes bankrupt or simply ceases operations, the public partner—in this case, a university, state, or teaching hospital—could be left with unfinished or inaccessible facilities and operational costs that were previously shared and are now their sole burden. Taxpayers could then face a de facto bailout to keep training programs open. PPP agreements should include continuity-of-services clauses that account for each of these worst-case scenarios. States could also consider requiring private partners to post letters of credit or insurance policies that cover losses specific to the PPP.

Mismatched time horizons are a further risk if PPPs are not carefully designed. Investors looking for shorter term financial returns may clash with the longer timeline required for social returns. This could push partners to prioritize profitable specialties to the detriment of high-needs fields. Plus, applying PPP models—long used for campus infrastructure and increasingly within academic programs—introduces risks of mission drift and conflict of interest.

To mitigate these risks, specific safeguards must be built into any PPP. Transparency is non-negotiable, as evidenced by student polling on the need for clarity. [18] Partnerships must also maintain an arm's length relationship in governance; just as a university cannot dictate a corporation's board, the private partner must abstain from institutional decision-making. Firewalls between governance structures are essential to protect the public's interest in the partnership.

Conclusion

Overall, PPPs are a useful but narrow tool. They should be employed only when tied to a real shortage, designed explicitly to reduce financial barriers for students, and built with strong

guardrails to preserve clinical independence. They are not a blank check for training expansion, as success requires each partner to have an inherent stake in the outcome. This is classic interest convergence at work: shared goal, shared risks, and shared rewards. If those conditions are met, however, PPPs can transform graduate and professional medical education from a driver of student debt into an engine of opportunity.

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