

COMMENTARY

Medical education, cost and policy: what are the drivers for change?

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Medical education is expensive. Its expense has led many stakeholders to speculate on how costs could be reduced. In an ideal world such decisions would be made on sound evidence; however this is impossible in the absence of evidence. Sometimes practice will be informed by policy, but policy will not always be evidence based. So how is policy in the field of cost and value in medical education actually developed? The foremost influence on policy in cost and value should be evidence-based knowledge. Unfortunately policy is sometimes influenced by what might at best be termed tradition and at worst inertia. Another influence on policy will be people – but some individuals may have more influence than others. A further influence on policy in this field is events, and mainly events that have gone wrong. One final influence on emerging policy in medical education cost analysis is that of the media.

Key words

- cost
- medical education
- policy

Medical education is expensive [1-3]. Worldwide spending on medical education is likely to exceed 100 billion dollars annually [4]. Its expense has led many stakeholders to speculate on how costs could be reduced or how return on investment increased. In an ideal world such decisions would be made on sound evidence; however this is impossible in the absence of evidence. Even when evidence exists, practice in medical education is not always informed by it. Practice in medical education is as likely to be informed by history or tradition. Sometimes it will be informed by policy, but policy will not always be evidence based. So how is policy in the field of cost and value in medical education actually developed? The answer is that a range of drivers influence policy development: this short article outlines what some of these drivers are. Through developing a better understanding of the drivers, medical educators should be able to have a greater influence on policy.

The first and foremost influence on policy in cost and value in medical education should be evidence-based knowledge. For example research evidence might demonstrate that online learning is a high value and low cost form of learning [5]. A policy of further investment in online learning would therefore be sound and justifiable. In this paradigm of evidence-based policy making, policy would not be built upon a single piece of evidence – rather it would be built on a number of research studies or ideally a systematic review or meta-analysis. Since policy is rarely made by domain experts, evidence based knowledge must be presented to the

policy-makers by the experts in terms that they will understand and that they can then action. Experts may differ or may have ideological biases of their own and this may influence the advice that they give. Leaders and their team of policy makers must have sound judgement to synthesise the knowledge that they are given and to develop sound policy from it. Ultimately choices must be evidence-based; choices must be explained in a comprehensible way for those who take decisions; and decision makers must be surrounded by staff who understand the evidence. Decision makers must also understand that different types of evidence might guide the policies in different circumstances (for example quantitative and qualitative evidence) and that consideration must be given to the problem of transferability of the evidence to different contexts.

Another influence on policy is what might at best be termed tradition and at worst inertia. For example the scientific evidence may suggest that educating healthcare professionals in primary care is both more effective and cost effective than educating them in tertiary care. However policy-makers may not direct a mass movement of learners from tertiary care to primary care by tomorrow. This is irrational in a purely evidence-based sense; however there may be many practical reasons why policy must lag somewhat behind the evidence. A tertiary care institution may have multiple functions – including clinical care, research and medical education. These functions are often inextricably interlinked – the academics at such

institutions will often care for patients, teach students and carry out research. To withdraw funding for medical education and reallocate it elsewhere could destabilise the entire institution and put its clinical and research activities at risk. Some of the research activities might actually be income-generating for the institution – another financial reason not to endanger them. In the real world policy must move slowly and must sometimes be limited.

A third influence on policy in cost and value in medical education will be people. However some individuals and groups may have more influence than others. Who has most sway will be strongly influenced by the prevailing policy culture of the time. Let's look at a practical example. A series of research studies might demonstrate that a medical education assessment could be performed in a lower cost way without having any influence on the overall result. However all the stakeholders involved may not want to change. A small group of politically astute and clinically credible examiners might trump an army of educationalists, medical educationalists and medical educational economists. Examinees might have an even more limited say. All will be listened to but the culture of policy making at the institution will decide who is listened to most.

A fourth influence on policy in this field is events, and mainly events that have gone wrong. Unfortunately there are all too many examples of this within healthcare and workforce education and development. One example might be the Medical Training Application Service (MTAS) scandal in 2007 in the UK [6]. MTAS was a new method to enable selection into specialty training – but it was beset by technology, confidentiality and educational challenges. Considerable time, effort and cost were expended in the process. Eventually it was closed and an enquiry ensued. The enquiry report and subsequent reports since still bear the mark of the problems that occurred in 2007 [7]. What went wrong has had far reaching consequences in issues as broad as competency based training and flexibility in medical education programmes. It is questionable whether the scandal should have had such a long reaching influence but, regardless of the rights or wrongs of this

phenomenon, there is no doubt but that it has.

A fifth and final influence on emerging policy in medical education cost analysis is that of the media. One example is the introduction of revalidation in the UK. Revalidation is the system whereby doctors maintain their registration with the General Medical Council [8]. The process of revalidation is five yearly and relies on five successful annual appraisals which in turn rely on successful engagement with continuing professional development, quality improvement, 360 appraisals and patient surveys (amongst other less onerous requirements). Various debates have taken place as to the utility of revalidation but few would disagree with the fact that revalidation is associated with significant costs. The purpose of revalidation is predominantly to help maintain standards but the mass media has portrayed revalidation in a different manner. It has reported on a number of major medical scandals involving medical murder, fraud, and doctors having inappropriate relationships with patients [9]. Revalidation has not been designed to prevent these occurrences and will not prevent them. However they have been used by elements of the media to justify its introduction. This is not to say that revalidation is not important or should not be introduced. There is little doubt but that it should have been introduced; however attempts should probably not be made to justify its expense in terms of outcomes that it will not prevent. But the media can develop a powerful narrative, with seemingly simple problems and seemingly simple cures. And the media can place considerable pressure on policy makers. Some people working in the media may have a personal agenda and this agenda may not necessarily coincide with the general public's interests.

In summary policy does not happen in a vacuum in any sphere of life. There is little question but that in a sphere that incurs a cost of 100 billion dollars annually there will be many influences on policy. As medical educators, we ignore these influences at our peril. It would be far wiser to leverage these factors to drive policy in the right direction.

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