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COMMENTARY
Funding medical education: should we follow a different model to general higher education?

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Abstract

Issue. There has been much recent discussion on the funding of medical education. There has also been much discussion about the funding of higher education more generally.

Evidence. The topics of discussion have included the rising costs of education; who should pay; the various potential models of funding; and how best to ensure maximum returns from investment.

Implications. Medical education has largely followed the emerging models of funding for higher education. However there are important reasons why the funding models for higher education may not suit medical education. These reasons include the fact that medical education is as important to the public as it is to the learner; the range of funding sources available to medical schools; the strict regulation of medical education; and the fact that the privatisation and commercialisation of higher education may not been in keeping with the social goals of medical schools and the agenda of diversification within the medical student population.

Key words

- medical education
- cost
- economics

There has been much recent discussion on the funding of medical education [1-3]. There has also been much discussion about the funding of higher education more generally. The topics of discussion have included the rising costs of education; who should pay; the various potential models of funding; and how best to ensure maximum returns from investment. As medical education is a form of higher education, it has largely followed the emerging models of funding for higher education. However there has not been much debate as to whether it should do so. Is medical education sufficiently different from general higher education that it merits a different funding model? Can we make the case for special pleading for medical education? In this short article I make this very case. I outline various developments in the provision and funding of higher education and consider how relevant or not these might be to medical education. In this context, when I discuss medical education, I mean the undergraduate provision of medical education at medical schools or universities.

Firstly there is the subject of the importance of higher education and the question of who it is important to. There is no question but that higher education is important to the public and to governments. Higher education is important mainly because of the social, political and economic returns that it delivers. However higher education is also important to the individual who receives it. Indeed some would say that higher education confers more benefit on the individual than it does on society as a whole [4]. Certainly higher education opens doors to the individual to the pursuit of higher salaries, to more career choices and to the world of academic endeavour. As most undergraduates will also admit, going to college is fun – so it opens doors to the joy of pursuit at the same time. However it begs the question as to whether the balance of benefit to individuals and to society is the same for those pursuing a degree in medicine and those pursuing a degree in say accounting. Both sets of graduates will have an enriching career ahead of them – but the accountant will usually be working in private enterprise whereas the physician will be more likely working in public service. This argument is not specific to the profession of medicine – the same is true of the professions of nursing and teaching. Despite these differences medical education has followed the movement in higher education more generally in that the individual must pay for some or all of the cost of their education – notwithstanding the fact that the

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public will accrue as much benefit as the learner will from the outcome.

Secondly there is the fact that today many more people go to university today than did in the past. In the UK more than 40% of the population go to university [5]. This has risen from less than 10% of the population in the 1960s. This is an enormous rise in absolute and relative terms. This has inevitably led to a change in the funding model of higher education. It is enormously expensive for such large numbers to attend university. There has been a rise in the UK population of medical students over the same time period but the increase has not been equivalent in absolute or relative terms. The UK produces 7000 graduate doctors annually – three to four thousand more graduate doctors than it did in the 1960s. This is an increase but its scale is not unaffordable in the same way that the rise in higher education attendance more generally seems unaffordable. However once again it is a case of the higher education dog wagging the medical education tail.

A third driver of change in higher education is the fact that sources of funding have changed from what they were in the past. In the past the small numbers attending higher education has meant that government alone has been able to afford the cost and has been able to do this alone. However in the past twenty years universities have been encouraged to seek funding from different sources [6]. These sources might be tuition fees, but also might be fundraising activities or commercial spin offs or research grants. These different sources suit certain departments more than others. Fundraising for business schools can come from wealthy business foundations – however these foundations are less likely to give to medical schools. Commercial spin offs might come from engineering or information technology departments but are less likely to emerge from medical schools. Certainly medical schools might attract research grants – but their purpose is to fund research and not to subsidise teaching. Similarly medical schools might decide to recruit more international students – knowing that these students will pay higher fees – however these students will not ultimately fulfil what should be the core aim of the school, which is to supply adequate numbers of doctors for the population's needs. In the extended family of diversified funding sources, medical schools become the poor relation.

A fourth tendency is the diversification of forms of higher education. There are numerous types of higher education institutions – from community colleges to traditional universities. This allows institutions to develop and test different service and cost models in higher education. However medical schools do not have this degree of freedom: a medical school is a medical school, and the provision of this form of both vocational and professional education cannot be deregulated [7]. This is largely because of the overarching importance of patient safety. Medicine and medical education must be closely regulated to ensure the safety of patients and the public and so new and different and innovative forms of medical education are limited in what they can do and in the funding model that they can follow. Once again medical education suffers for following a development that simply does not suit its context and philosophy.

A fifth and final trend is growing privatisation. There are many more private higher education institutions than there were thirty years ago. Some of these are for profit institutions. Funding these institutions from a government perspective is straightforward – the learner or their learner's family must pay. Private medical school provision has grown in certain countries – however once again this phenomenon introduces issues for medical education [8]. The main issue is that graduates doctors will only come from wealthy sections of society. This will not be a meritocracy – where the brightest and best become doctors – rather the richest will become doctors. Another issue is learners paying for their own education in a market driven higher education economy. It is understandable that an information technology student would pay a large amount for a high quality higher education – so that they will subsequently get a high paying job in a growing industry that might contribute to the economy – perhaps by means of export. Financial forces ensure that everything happens in a chain of events as it should do, and that all stakeholders are ultimately rewarded. However the same pure market forces are rarely fully unleashed in medical education and in medicine. Payers for healthcare (be they individuals, insurers or governments) have one thing in common – they all want to save costs [9]. One way to save costs is to control physician salaries. Why then should medical students pay significant quantities for their education?

In conclusion funding of medical education has largely followed changes in the funding of higher education more generally. However it is questionable whether this has helped students, institutions, or patients. We should increasingly argue that medical education is different and that this difference warrants a novel approach. There have been a number of tactical attempts to deliver better value from medical education – however these have inevitably been limited in scope and achievement [10, 11]. Now is likely to be a good time to develop a more strategic approach and to rethink the fundamental financial models that underpin medical education.

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