Rationing medical education.

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Abstract

The purpose of this paper is to discuss the role of rationing in medical education.

Medical education is expensive and there is a limit to that which governments, funders or individuals can spend on it. Rationing involves the allocation of resources that are limited.

This paper discussed the pros and cons of the application of rationing to medical education and the different forms of rationing that could be applied.

Even though some stakeholders in medical education might be taken aback at the prospect of rationing, the truth is that rationing has always occurred in one form or another in medical education and in healthcare more broadly. Different types of rationing exist in healthcare professional education. For example rationing may be implicit or explicit or may be based on macro-allocation or micro-allocation decisions. Funding can be distributed equally among learners, or according to the needs of individual learners, or to ensure that overall usefulness is maximised. One final option is to allow the market to operate freely and to decide in that way. These principles of rationing can apply to individual learners or to institutions or departments or learning modes.

Rationing is occurring in medical education, even though it might be implicit. It is worth giving consideration to methods of rationing and to make thinking about rationing more explicit.

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Introduction

Medical education is expensive.[1] It costs hundreds of thousands of pounds to provide undergraduate and postgraduate medical education and thus to bring an individual school leaver to the level of a consultant specialist.[2] New advances in medical education have likely added to the cost even though there is no question but that these new advances are welcome.[3] However there is a limit to that which governments, funders or individuals will spend on medical education. Even though spending on medical education is worthwhile, there is no doubt that eventually a ceiling of spending will be reached.

When that ceiling is reached, it is inevitable that providers of medical education will start to ask questions about what funding should actually be spent on. What will be the answers to these questions? And how will providers decide? The answers to these questions are not all that simple and the method by which they might be answered inevitably leads to the subject of rationing.

Rationing involves the allocation of resources that are limited.[4] Even though some stakeholders in medical education might be taken aback at the prospect of rationing, the truth is that rationing has always occurred in one form or another in medical education and in healthcare more broadly.[5,6] If we lived in a perfect world, then everyone who wanted to become a medical student could become one and all students would have state-of-the-art resources, technology and tutors constantly at their fingertips. Unfortunately we don't live in a perfect world. Even though such resources would likely benefit learners, economic constraints mean that they cannot be made available to all. And this in its essence is rationing.

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Economic constraints might be relatively loose or extremely tight. Currently the UK spends five billion on healthcare professional education every year far more than what it has done in the past. But this five billion has to compete with other demands. For example the government must pay for healthcare and education more generally out of the same common budget. Even though budgets for healthcare professional education might be ring-fenced and protected, they will never be limitless.

Different types of rationing exist in healthcare professional education. For example rationing may be implicit or explicit. A medical school that runs small group simulation sessions may realise that the ideal tutor learner ratio is 1: 5. However it may need to save costs and will therefore set the ratio at 1: 7. This is less than ideal for the learners, but it will save the school the salary of one tutor. This rationing is explicit.[7] By contrast, many rationing decisions are implicit rather than explicit. For example a tutor might realise that a certain group are doing well and that they need less tutor time. This group will receive less education as a result. This action might be reasonable; but the tutor is unlikely to articulate his decision or his reasons for it. Thus this type of rationing is implicit.

Rationing may also be based on macro-allocation or micro-allocation decisions. For example a health service may decide that it needs more nurses as a result it may allocate a larger proportion of funding for the education or nurses. As a direct result, there will be less funding for the education of doctors. This will be a macro-allocation rationing decision. Alternatively cuts to budgets may mean that individual tutors make individual small decisions to cut resources on an *ad hoc* basis. These will be micro-allocation rationing decisions.

So if rationing already occurs, is it worth thinking about the forms of rationing that would be fairest for stakeholders involved from learners to institutions to funders? It is almost certainly worth thinking about this, and there are a number of different options. Funding could be distributed equally among learners, or could be distributed according to the needs of individual learners, or could be distributed to ensure that overall usefulness is maximised.[8] One final option is to allow the market to operate freely and to decide in that way. These principles of rationing can apply to individual learners as above but could equally apply to institutions or departments or modes of learning. None of these approaches are best or worst, however it is worth giving some consideration to the operationalisation of each one and the advantages and disadvantages associated with it.

Distributing funding equally among learners is the most straight forward. It is easily understood and seems naturally fair. It is also fairly simple to put into practice. Its disadvantages are that some learners have greater needs than others and so sharing resources equally will by nature not be education according to needs. This approach may also result in insufficient attention being paid to the greater good. Lastly it seems counterintuitive at a time when medical education and education more broadly is increasingly trying to target individuall earners' defined needs.[9] Distribution according to the needs of individual learners overcomes some of the shortcomings of the previous approach. Different learners have different needs, so targeting resources to needs makes sense. However some will feel this is unfair. A talented learner who is advanced in their competency level may feel that it is unfair that they get fewer resources than someone who is struggling. At a time when the consumerist and individualist perspective is affecting all walks of life including medical education, voices such as these may become louder.[10,11]

There is also the more fundamental question – whose needs should be catered for? Is it the needs of individual learners or the needs of patients and populations who need a particular casemix of healthcare professionals or the needs of institutions that might need different levels of funding to remain viable? There is also the question as to how exactly to assess needs and what needs to focus on. Should it be knowledge needs which are probably easiest to measure but possibly least important or behavioural needs of which one could say the opposite – they are the most difficult to measure and yet most important.

Distribution of funding so that overall usefulness is maximised is another option that will appeal to many. However once again there are difficult questions to be answered as to how to define overall usefulness and then how exactly to achieve this by means of rationing. To look at the first dilemma first, overall usefulness at a macro level might be the rationing of funding so

that monies spent on healthcare professional education achieve the correct balance of competent healthcare professionals that the population needs.[12] So in certain countries it might mean more frontline healthcare workers and primary care nurses and fewer doctors. So rationing in this context might mean rationing of undergraduate or postgraduate education of medical students and doctors and that would be a reasonable course of action in this setting.

One final option is to allow the market to operate freely and to decide in that way. However there is every reason to believe that his would not be a wise course of action in the context of medical education. A freely operating market would mean that each stakeholder within the market would act only according to their desires. So a medical student would take out a big loan to pay for tuition gees and then would then seek a high paying job to pay back the loan. The cost of healthcare would likely rise as a result as much of healthcare budgets are paid on salaries. The needs of patients and populations are almost tangential to this system of medical education and healthcare. Allowing medical education providers to operate according to free market principles would enable them to increase tuition fees and thus their income to a stage when only the rich could afford a medical education. Courses would get longer as institutions sought to justify their inflated fees. Once again the needs of patients and populations would be sidelined. Defenders of such systems would say that market forces would eventually correct faults in the system that might arise. This is probably correct but it would only occur after a generation of healthcare professionals was lost. It takes fifteen years to educate a healthcare professional – short term thinking can take a very long time to correct.

So if rationing of medical education is inevitable, what form of rationing is most likely to be best? There is no clear answer other than to state that a free market is probably the worst choice. Most would also accept that the best way to choose between the other alternatives is to make decisions under the principles of transparency; to ensure that decision makers have few or no conflicts of interest and that any conflicts are declared; and to have mechanisms in place whereby certain decisions can be reviewed and sometimes reversed.[13,14] Rationing medical education may seem parsimonious – but the truth is that it has always happened and will always continue. As educators we must do our best to ensure that rationing is as fair and reasonable as possible.[15,16]

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