*Clinical Medicine* 2013, Vol 13, No 6: 573–5

# Funding of medical education: the need for transparency

Jane Dacre and Kieran Walsh

**ABSTRACT – Medical education is vital to the future of healthcare provision. It is also expensive. We should ensure that the funding spent on medical education is spent in the most cost-effective way possible and delivers the best possible returns on our investment. Budgets that have been allocated to medical education should be spent on this and not on research or clinical care. Educational budgets should be transparent – so that their use and misuse are clear. We should develop a culture of lifelong learning and continually make explicit that future healthcare professionals need investment in their education to maintain the quality and safety of healthcare delivery.**

**KEY WORDS: Medical education, cost, transparency**

*Medical education is a form of technical education in the efficiency of which the public, if they only realized it, are interested as much if not more than in many others to which public money is given, inadequately it is true, but without hesitation.*

James Kingston Fowler[1]

## Introduction

Many of us believe that education and training are vital to the future of the medical profession. For many years both have been integral to our pattern of service delivery in the UK and internationally. As the nature of clinical practice changes, providers of care have become ever more conscious of their local cost improvement targets. This results in an inevitable attrition of the funding for education. This paper outlines the currently changing situation in the funding of medical education and training in the UK, some recent developments and some proposed principles for the future funding of medical education in undergraduate and postgraduate settings. Funding mechanisms for medical education are complex and become more complex as education progresses into postgraduate training and continuing professional development. For this reason the authors have largely concentrated on undergraduate medical education. Even though many of the examples given are based in the UK, the authors feel that this is an international issue and one that many medical educators in many countries will recognise.

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## Training and education

The primary focus of the early years in our medical schools is on educating potential doctors. The standards for this education are clearly articulated in the UK General Medical Council's (GMC's) document *Tomorrow's doctors*.[2] British medical schools have been audited against these standards by the Quality Assurance of Medical Education (QABME) process. In 2012, this process was redesigned by the GMC to form regional risk-based visits, covering both undergraduate and postgraduate medical education. As medical careers progress from undergraduate to postgraduate training, the focus moves from an emphasis on education towards an emphasis on training. Education is cerebral, training is practical, and our doctors need both to support the development of the appropriate knowledge, skills and attitudes for medical practice.

Currently, students begin their careers in medical schools. There are 34 medical schools in the UK, from which around 7,000 doctors graduate each year. The education provided is quality assured by the GMC. After graduation, trainees enter a foundation programme, which is 2 years long (FY1 and FY2). They gain full registration with the GMC at the end of FY1. They then move through core and specialty training, delivered wholly in the NHS, taking a number of postgraduate assessments along the way, and finally achieve a Certificate of Completion of Training (CCT) and are entered on to the specialist register. For those trainees who have not followed the traditional path, their entry on to the specialist register is certified with a Certificate of Eligibility for Specialist Registration (CESR). Trainees pay to receive these certificates.

At the moment, postgraduate training is delivered in the NHS and organised and managed through the postgraduate deaneries. As the planned NHS reforms in England come into play, and Health Education England takes over all of the NHS education portfolio, postgraduate deaneries will be replaced by local education and training boards (LETBs).[3]

## Education and training funding

The funding streams for medical education and training have always been generous, but neither are transparent nor ring fenced. This has allowed both the university sector and the NHS to reallocate education money to more pressing priorities. In the universities, this is research; in the NHS, it is patient care. Recent developments in medical education have put more pressure on the finite amounts ultimately allocated to medical education. For example, the costs of small group teaching and one-to-one workplace-based assessments are more expensive than the old methods of learning by apprenticeship or in large numbers in a lecture theatre. This has created an increasing level of conflict across education, research and clinical service delivery.

Medical education funding currently comes from a variety of sources. Universities receive an amount for a block contract from the Higher Education Funding Council (HEFCE), known as HEFCEt. Following the review by Lord Brown, this has been reduced and the reduction replaced by tuition fees that students pay themselves.[4] The current average fee is £9,000 per student per year in British medical schools (although this amount is still much less than that charged in the USA). It is, however, a substantial amount of money over a 4- to 6-year course, and there are concerns that it is likely to deter more socially disadvantaged individuals from embarking on a career as a doctor

NHS hospitals that take undergraduate medical students also received funding from the Service Increment for Teaching (SIFT) until April 2013. SIFT monies were of variable amounts, with the majority going to trusts for the additional facilities needed for clinical training. In large teaching trusts, this was a large amount of money, sometimes several million pounds. It was often far more than the amounts actually required for training purposes. It was regarded by the trusts as an essential income stream not directly related to educational needs. It was seen as a 'complexity payment', reflecting the complex case mix of patients in our teaching hospitals.

Another funding source is the medical and dental training levy (MADEL). This was meant to cover postgraduate training. There was also the non-medical education and training (NMET) budget, which covers non-medical clinical education (ie education for nurses and allied health professionals).

For a number of years now, the NHS and the Department of Health have recognised the need to review and clarify the use of these large educational budgets. The amounts of money involved are so large, however, that their removal or reduction could threaten the financial viability of some of the country's flagship teaching NHS trusts. So any proposed review has been pushed back until now.[5] The total multiprofessional education and training (MPET) budget for 2011–12 in England was £4,879 million.[6] In April this year (2013), implementation of this long-awaited review was started. A tariff has been agreed nationally, which will be adjusted for the local market forces factor. This will result in a significant loss of SIFT from our larger teaching hospital trusts and an eventual gain to smaller education providers, when enough money becomes available. To mitigate the large losses to the university teaching hospitals, there is a cap on the annual amount lost (£2 million per year), but eventually all training funds will comply with the tariff. Even though the MPET budget is still large and the tariff will make education monies follow the students more explicitly, the question remains as to how much of it will actually be spent on medical education and how much will continue to be diverted to other trust businesses. For this reason it is difficult to say exactly what proportion of medical education monies will reach the frontline. (Most of the funding that is earmarked for postgraduate education pays for the salaries of trainees.) It will be interesting to know if LETBs and trusts will top-slice from the new education budgets; however, data like this is simply not available yet, but may become so in the new tariff environment.

In the universities, the promotion prospects of academics are directly related to their research output, not to their activities in medical education. With incentives traditionally encouraging academics to get involved in research rather than education, it is unsurprising that sometimes teaching duties are given secondary priority. Thus, funding that should be spent on medical education in the university sector is often spent on research. This will increase as all universities prepare for the next Research Excellence Framework in 2014, where educational expertise and performance are not included.

## Value in medical education

There is undoubtedly a need for greater transparency and ring-fencing of funding of medical education budgets at undergraduate and postgraduate levels. This is especially the case at the level of the LETBs and trusts: the LETBs should be able to hold the trusts to account to ensure that budgets allocated for medical education are spent on this and that processes for this spend are explicit and transparent.

However, for funding that is ultimately spent on education, there is also a need to ensure value for money.[7] Just as we expect clinical care to be cost-effective, we should also expect medical education to be cost-effective or to deliver tangible returns on our investment. Although there is growing evidence as to 'what works' in medical education, there is little evidence on cost and value in this field. Research is needed, but in the immediate absence of such research we will need to return to first principles in making decisions about what to invest in. For example, even though simulation is undoubtedly an effective technique in medical education, it is expensive – and much of the cost can relate to the degree of technology used in the delivery of simulation. How high tech (and therefore expensive) does simulation need to be? The answer is only as high tech and expensive as is needed to achieve intended learning outcomes. So, a communications skills simulation does not need to happen in a state-of-the-art simulation centre – a low-tech and low-cost simulation will often be just as effective.[8] Certainly, educators in developing countries have been able to show what can be achieved with simple homemade simulation equipment.[9] Ker *et al* have also shown that more thought needs to be given to the alignment of cost, fidelity, technology and effectiveness in simulation.[10] This is important, especially considering the importance of simulation in delivering education in an environment that is safe for both patients and learners. Regardless of the form of medical education, we must ensure that we offer maximum value for funding invested.

## Risks

The risks of reducing funding for education and training are significant. Funding cuts would probably result in a reduction in the standard of clinical practice and might contribute to an increase in referrals to the GMC about impaired fitness to practise, especially as the culture of revalidation becomes embedded for doctors and their employers. There is a growing body of evidence, for example, that

improved communication skills result in higher patient satisfaction and fewer complaints[11,12] and that communication skills are improved by effective training programmes – so these programmes need to be funded. The focus on financial targets may undermine the quality of clinical care delivery, as evidenced by the Francis report.[13] There are other possible outcomes to funding cuts: fewer people might be trained to the same standard or learners might pay part of the cost of training themselves. However, these outcomes would not be favourable either. Fewer trained specialists would result in lower access to care and, at a time when trainees' salaries are rising below the rate of inflation, it is unlikely that they would be willing to pay for their training.

Trainees have enjoyed much better support from trainers over the past few years, and would be likely to miss this closer relationship that has developed. Lack of adequate supervision of practical procedures is likely to result in an increase in medical accidents, a reduction in the quality of care and a subsequent increased risk to the safety of our patients. As trainees are so heavily involved in clinical service, a reduction in training posts would also be likely to leave some less popular specialties and geographical regions with too few doctors to run safe emergency rotas that are compliant with the European Working Time Directive. There could be a redistribution away from those regions or specialties that have more doctors now to other regions or specialties. However, this could result in shortages in those areas that are currently filled. All of this is likely to result in increased litigation, which may in the end be more expensive to the health service than the original investment in education.

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