

Medical Education: Return On Investment

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Medical education is expensive. The high cost of medical education means that there is increasing pressure on funders, providers and learners to ensure that medical education delivers return on investment.⁽¹⁾ There are a plethora of methods to achieve this aim; however they all work on the premise that costs must be controlled and/or returns increased. At a micro level there are arguments for doing a range of small things differently: for example more of the curriculum could be delivered in low cost environments or by means of online learning.^(2,3) Or perhaps medical students could get involved in quality improvement initiatives during their attachments so that they start to deliver returns whilst they still learn.⁽⁴⁾

While all these initiatives are worthy and useful, they are unlikely to make a massive difference to overall education and workforce budgets. However at a macro level, if you spend hundreds of thousands of pounds educating a medical student and they leave the country where they received their education, then a great deal of loss is incurred.

In this regard the recent report by the GMC into the state of medical education and practice in the UK makes for sobering reading.⁽⁵⁾ In the UK in 2013, 12,231 doctors stopped practising. 77% of doctors gave a reason as to why they stopped. The most common reasons were moving abroad and retiring. Unsurprisingly age had a significant effect. According to the report “81% of doctors aged 50 years and under were moving overseas and less than 1% were retiring”. A proportion of these were doctors who qualified abroad and who thus were leaving the UK to go back home. Less than 4% of doctors cited revalidation as a reason for relinquishing their license to practice. Less than 3% of doctors left for maternity or paternity reasons. When doctors plan to leave the UK to work in medicine abroad, they need a certificate of good standing from the GMC. The number of UK graduates issued such a certificate has increased in recent years. Most requests for certificates of good standing were for doctors aged from 25 to 27. This is worrying because such doctors will recently have completed their undergraduate education and yet already wish to go abroad. As a caveat however it should be remembered that not all those who request such a certificate actually do go abroad.

So what does all this data mean for the economics of medical education and workforce development? At a macro level it means quite a lot. UK graduates who leave the UK in

their mid 20s will have received a medical education worth hundreds of thousands of pounds and will have not have delivered much in return. They are likely to have practiced for only about two years and then under close supervision and whilst continuing to receive a substantial amount of postgraduate education.⁽⁶⁾ The economics are stark – a great deal of input and little or no output. The amounts of funding involved dwarf any calculations with regard to small changes in curriculum delivery that might save costs. To make matters worse when graduates emigrate, the government loses the ability to pursue them for repayment of their student loans – a further loss to the exchequer.

And so if this means quite a lot, it is surely worth asking the question as to what if anything can be done about it? Some would suggest a coercive approach. Graduates could be compelled to pay for the cost of their education if they emigrate. But this wouldn't work – as there would be no effective way of following them up. Some would suggest that they should only be given a letter of good standing from UK authorities when they have worked in the UK for a set amount of time – maybe five years - but European Union laws regarding free movement of workers would render this unworkable. Alternatively graduates could have provisional registration for a longer period – thus forcing them to stay in the UK for longer – but the GMC is talking about moving the point of registration to exit from medical school – in exactly the opposite direction. In any case such a move would have deleterious effects on the international recognition of UK medical education.

If coercion will not work, the only alternative is to try to make the UK a more attractive place to work as a doctor. This will mean better training programmes, improved terms and conditions, better job prospects, and portfolio careers which might involve a blend of education, research and clinical practice.⁽⁷⁾ State of the art facilities in medical education that satisfy learner and institutional needs can be cost effective.⁽⁸⁾ More academic training programmes that lead to graduates who can then work in academe and clinical practice are also likely to be a good long term investment.

Some of this would cost money, but the return on investment

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would be a more contented and stable workforce that wants to stay in the UK. The alternative is continuing to pour funding into a bucket with a hole at the bottom. Cost and value in medical education can at times be a complex concept to grasp – involving models and ideas like cost utility formulae and sensitivity analyses. But sometimes it can be simplicity itself – involving the spending of funds in the reasonable expectation of returns. Retaining doctors might be a good way to start.

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