

OPINION

Cost and value in healthcare professionals' education: should we consider a monopsony model?

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The education of healthcare professionals is expensive [1]. The world spends approximately 100 billion dollars annually on the education of its healthcare professionals [2]. In recent years there has been growing interest in researching ways in which more value could be gleaned from this spend on healthcare professionals' education. This might mean saving costs or achieving more and better output for a given cost. Research will be needed to work out how to do this-however in the meantime education providers must make pragmatic decisions on where to spend their budgets and maximize their outcomes. Such providers may be as large as Ministries of Health or Education or as small as a single medical school. One way in which they could maximize their buying power is to consider the monopsony model.

Monopsony is the market power exerted by buyers [3]. If there is a single large buyer and lots of small sellers, then a large buyer should be able to leverage its size to negotiate a better deal. The same phenomenon happens when buyers group together to form a consortium. In effect they form a single large buyer. So what might happen if medical schools formed consortia and decided to exert their resulting monopsony? If they were to do so, then it is likely that they could use their collective power to ensure a better deal when purchasing a range of products such as e-learning resources, simulation equipment, assessment instruments, or problem-based learning scenarios. They could also ensure a better deal when accessing services such as faculty development programs or mentoring support tools. Many education providers have the potential to form monopsonies; however, there is limited evidence that they do

so, some evidence in fact points to the contrary.

E-learning is one case in point. In the United Kingdom, a recent government paper cited the amount of duplication of e-learning resources [4]. The paper recommended that a register of all e-learning resources be set up. The paper suggested that local providers "do not purchase or develop content where suitable material already exists" and that "sharing should be actively encouraged" [4]. Savings could thus be achieved if education institutions behaved like a monopsony. Similar arguments could be made about purchase of simulation equipment. A national consortium of medical schools could use their collective bargaining power to enable themselves to bulk-buy simulation equipment at a lower cost per item. Simulation companies would win bigger contracts and also their cost of achieving the sale would be lower as they would not need individual sales people to contact individual schools.

In the field of assessment instruments, some progress has been made in exploiting the potential of a monopsony. A number of universities have formed consortia to share their assessment material or to bulk-purchase such material [5]. This material might include multiple choice questions or objective structured clinical examination questions or any other type of assessment instrument. Institutions can share and co-purchase not just assessment questions, but the software that might host the questions, analyses them and even administer the test. The same principles could be applied to the purchase of problem-based learning scenarios; however, little progress has been made in this regard perhaps because such scenarios may constitute a large part of the curricula of new schools, and new schools may wish for their curricula to remain unique.

A monopsony could also ensure a better deal when accessing services – such as faculty development programs. Currently there are 76 master's degrees in health professionals' education available worldwide [6]. A review of such programs found that

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they have much in common in terms of “focus, content, and educational requirements” and that their “variations are mostly in organization and structure.” This certainly suggests that schools might consider purchasing access to an existing program for their faculty—rather than inventing their own—depending on the online availability of the course or perhaps its geographic proximity to the school in question. If this is the current state of play with regard to using the power of a monopsony then clearly there is considerable progress to be made; however, perhaps the reasons for slow progress could be explored first. There are some clear barriers to this approach in healthcare professional education. In some territories there is competition among educational institutions and this competition may make co-operation impossible. Also some institutions may correctly feel that their institution is unique and that they cannot co-purchase with other institutions. These are reasonable objections; however, they are not insurmountable.

University consortia could buy content in bulk and then allow individual schools to localize it—thus getting the best of both worlds. There are undoubtedly downsides to the monopsony approach but perhaps we should make reasonable effort in this approach first before dismissing it.

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CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

SUPPLEMENTARY MATERIAL

Audio recording of the text.

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