Commissioning medical education: principles for best practice

We need to ensure that we get value for money for our investments in medical education. Commissioning is one method of ensuring that we get value. However, like any other tool, it needs to be used properly.

A strategic model of funding medical education is that of commissioning. As with clinical commissioning, education commissioning is based on a purchaser–provider split within medical education – whereby the purchaser buys medical education services from a number of different competing providers. This article outlines a number of key principles that should underlie the commissioning of medical education and that should ensure that commissioning is an effective tool to drive quality in medical education and at the same time control costs. The principles are that:

1. Commissioning should be based on learners' needs and ultimately on public health and population needs
2. There needs to be a genuine choice given to the institutional purchaser
3. Purchasers must be able to ensure that providers are accountable to them, and that they can use the levers of commissioning to purchase not just provision of medical education but also potentially education outcomes
4. The process of commissioning should be efficient, reasonably quick and non-bureaucratic
5. The quality of education services should be the keystone of education commissioning
6. Purchasers must be allowed to develop as organizations, to achieve stability, and to become learning organizations themselves.

Commissioning

Medical education is expensive (Brown et al, 2002). Its expense has led to increasing interest in different models of funding medical education – models that will ensure better returns on any investment. One strategic model of funding medical education is that of commissioning. As with clinical commissioning, education commissioning is based on a purchaser–provider split within medical education, whereby the purchaser buys medical education services from a number of different competing providers (Department of Health, 2004; Petsoulas et al, 2014). The purchaser is typically a health authority within a region and the providers are typically institutions where education takes place (they might be in primary or secondary care). Commissioning of medical education has become an accepted strategy in a number of different territories in the UK. In England local education and training boards are commissioners of medical education. The providers of education are hospitals or primary care clinics where training takes place.

This system has been in place in England for approximately 3 years. It is thus still too early to know the long-term effects of the commissioning framework on medical education. So far an early success of the new system has been the commissioning of more interprofessional health-care professional education. However, the system has also been criticized for adding bureaucracy where it is not needed. Commissioning was introduced at the same time as other changes (such as budgetary constraints) and so it is difficult to say for certain which changes produced which outcomes.

Principles for commissioning medical education

Despite the increasing adoption of commissioning there is remarkably little literature on how to commission education and how to ensure good returns on investment. This article suggests a number of principles that should underlie the commissioning of medical education and that should ensure that commissioning is an effective tool to drive quality in medical education and at the same time control costs.

Commissioning should be based on learners' needs

The first principle underlying commissioning is that commissioning should be based on learners' needs and ultimately on public health and population needs. In this regard commissioning should be no different from any other model of medical education provision (Prideaux, 2003). This principle might seem self-apparent, yet it is surprising how often purchasing decisions in medical education are driven by the need to spend budget or are based on the limitations of what is available in local medical education services. Sometimes purchasing decisions are driven by what learners say that they want rather than what a comprehensive learning needs analysis might show. To

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give an example, if a local needs analysis demonstrates that a region needs GPs then primary care education is the form of education that should be commissioned.

The purchaser needs a genuine choice

A second principle underlying commissioning is that, for it to be effective, there needs to be a genuine choice given to the institutional purchaser (Department of Health, 2003; Smith et al, 2005). For example if a local education board decides that it needs to educate more geriatricians, then for commissioning to work there must more than just a single provider of health-care professional education in elderly care. If there is just one local hospital where geriatricians can be trained, then in effect there is no choice to the purchasing board and no incentive to use commissioning levers to drive up quality or control costs among providers.

Commissioning must be based on regulated competition among providers and if there is only one potential provider then this simply will not work. However, such competition must still be regulated. Regulation may be as heavy or as light touch as the context demands. For example in this case all providers might be required to be accredited providers of high quality clinical care or might be required to be certified as safe providers of education by the national medical council. Generally in markets with a deep public–private intersection, regulation can be a driver of costs and so can be detrimental to efficiency. Careful consideration must be given to the intensity of regulation.

Providers must be accountable to purchasers

A third fundamental principle is that purchasers must be able to ensure that providers are accountable to them, and that they can use the levers of commissioning to purchase not just provision of medical education but also potentially education outcomes. For example a purchaser might decide to buy e-learning resources from a provider, but it might be wise to ensure that the purchaser–provider contract stipulates that a certain minimum level of usage must be achieved by learners before the provider is paid in full. In this way the purchaser will be more likely to have made a cost-effective investment in learning and the provider will be incentivized to deliver usage and thus value (Sandars, 2010). This principle will work in the context of e-learning purchase and provision, and also in the context of simulation in medical education or even the provision of space for medical education (Walsh et al, 2007). Sometimes it is worthwhile developing 'key performance indicators' in consultation with learners, regulators, providers and commissioners and incorporating these into binding contracts as a tool for ensuring that commissioned education drives up standards.

Commissioning should be efficient

A fourth principle is that the process of commissioning should be efficient, reasonably quick and non-bureaucratic. This will be in the interests of purchasers, providers, learners and the public. Unfortunately this principle is not always followed; commissioning arrangements can be so complicated that they put off perfectly capable providers; the processes of tendering, bidding, judging, awarding and contracting can be slow and expensive and can eat into any savings made by the appointment of a lower cost provider; a flawed commissioning process might be open to legal challenge with further resultant delays and expense. In this regard, education commissioners could learn from clinical commissioners who have often learned through experience the best means of ensuring that the process of commissioning is sufficiently robust to protect the reasonable interests of all parties, but not so byzantine that stakeholders emerge with poor education or financial outcomes.

Quality is key

A fifth principle is that quality of education services should be the keystone of education commissioning (Genn, 2001). Commissioning certainly might save costs; it might drive up the number of health-care professionals who achieve competence; it might even generate innovation among providers. But if the quality of medical education falls as a result of commissioning then the process should be deemed a failure as a whole. Commissioning inevitably brings the culture of commerce to the medical education domain; however, this culture must not become the predominant one. By contrast a culture of excellence in medical education must remain and commissioning should be seen as simply a means to achieve this ends and not other ends (and certainly not an end in itself).

Purchasers must become learning organizations

A sixth and final principle is that purchasers must be allowed to develop as organizations, to achieve stability, and to become learning organizations themselves. Constant organizational redevelopment – of either purchasers or providers – will not allow the development of expertise in commissioning or delivery. Purchasers need time to decide on strategy, to commission in light of the strategy, to follow up with providers and find out what worked well and what they could have done better (Health Service Journal, 2005). Providers need time to align their strategy with that of commissioners, to learn from tendering processes (whether they succeed or fail), and then to learn from the process of delivery. This learning will take years to develop – however, it is vital if this system is to succeed. Commissioning needs to be long term and strategic, not short term and opportunistic.

Conclusions

Commissioning of medical education is still relatively in its infancy. Much more work needs to be done to develop defined regulations that will ensure that commissioning will deliver the medical education that learners need. However, as such rules and regulations are developed, these underlying principles should be kept in mind and used to steer the direction of travel. The commissioning cycle of planning, delivery, evaluation and learning is no different

KEY POINTS

- Quality of education services should be the keystone of education commissioning.
- The process of commissioning should be efficient, reasonably quick and non-bureaucratic.
- Commissioning should be based on learners' needs and ultimately on public health and population needs.
- Commissioners must be able to ensure that providers are accountable to them.

to evaluation cycles in any model of medical education: thus there is a sound foundation on which commissioning can be built (Goldie, 2006).

Attention must also be paid to the potential downsides of commissioning. These include the bureaucracy involved in commissioning (which can add to overall costs), the potential lack of integration that might result when a number of different providers are commissioned to provide services and the potential to change the culture within organizations to one where competition acts as a barrier to fruitful cooperation. It is an interesting question as to whether any system that introduces another layer of management and competition in a complex system such as medical education can actually deliver cost improvements. Data in this regard may emerge over the next few years. **BJHM**

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