Financing of Primary Care Graduate Medical Education—
the Need for Evidence

TO THE EDITOR:
Voorhees et al put forward a fascinating and innovative proposal for the structuring and financing of graduate medical education in primary care.1 However, the aim to drive forward the agenda of primary care education is not a new one. Here for example is Alfred Hardwicke in 1844: “The general practitioner must not entrust his interests to the hands of others; he must not allow any other grade to interfere in his education, or acknowledge any power to control his practice that does not emanate from members of his own rank.”2

If aspirations for primary care education resulted in a slow pace of change over the following 170 years, then it is certainly worth considering why this is the case. Even though Voorhees et al are to be congratulated for bringing up the much neglected issue of cost in medical education, the glaring omission from their paper is any mention of cost effectiveness in graduate medical education or cost benefit or cost utility ratios.

In the absence of such mention, some critics will inevitably see a fixed floor funding at $100,000 per resident per year as an attempt to fix a problem by throwing money at it. And why should it be $100,000? Why not $200,000 or even $300,000? Most funders of most medical education programs will be happy to invest, provided that they know that their money is being spent in the most cost-effective way. However, an evidence base on how to get maximum returns from investment in medical education is strikingly absent from Voorhees et al’s article and from medical education generally. It would be great if we could say that weekly small-group teaching sessions with four primary care trainees and one facilitator per group resulted in competent professionals and that running more frequent groups or smaller groups was wasteful and less frequent or larger groups less effective. It would be great if we could say that one session in a high fidelity but low technology simulator once per week resulted in competent professionals and was worth it for the amount of funding spent. However, we cannot say anything like either of these two statements because of the missing evidence base on what constitutes cost effective education for primary care professionals. If educational research with hard economic endpoints in mind were to start now, then we would be less likely to be in the same position in another 170 years.

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References