Dear Editor:

In the UK and in many other countries throughout the world, medical students are paying for their medical education\(^1\). They might be paying the entire fee or a sizable proportion of it - but many of them are increasingly making a contribution. As students make more of a contribution, inevitably they will start to see themselves not just as passive recipients of a medical education but rather as purchasers, and purchasers with rights. Some providers of medical education might see this as a threat but it may also be an opportunity. In other industries and even within healthcare itself, purchasers thoughts and feelings are actively sought out by providers – to see what they might need and want, and what they might pay for. Willingness to pay studies have thus become more common in healthcare and other works of life\(^2\).

What role might willingness to pay studies play in medical education? Willingness to pay is a measure of the value that purchasers or consumers place upon a commodity\(^3\). They can work in conventional market situations where purchasers pay directly for products with their own money; they can work in non-conventional situations where users might not directly pay for a service but where they might be asked how much they might need and want, and what they might pay for. Willingness to pay studies have thus become more common in healthcare and other works of life\(^3\).

Willingness to pay studies are inevitably quantitative in nature – as they focus around a monetary sum or a series of possible monetary sums; however, learners thoughts and feelings can also be analysed from a qualitative perspective. Qualitative data from willingness to pay studies can reveal deep insights into the needs and desires of learners\(^4\).

So how might willingness to pay studies actually work in practice within the discipline of medical education research? At their simplest, willingness to pay studies could be used to help medical schools decide what value to set their tuition fees at, or to help providers of continuing professional development to decide how to cost their services. In some ways, willingness to pay studies are being implicitly conducted all the time: if schools set their fees too high, then application rates will fall, a similar scenario will play out for providers of CPD. However the weakness of these activities is their very implicitness and the fact that they are not published in the mainstream literature. Medical educationalists can thus draw limited conclusions from this area.

Another way that willingness to pay studies might work in medical education is that providers of medical education might make explicit the cost associated with a certain aspect of medical education and assess learners real or hypothetical willingness to pay. For example, a medical school might cost its provision of simulation and work out the cost of this provision for an individual student. The student could then be asked...
whether they feel that the service at this cost offers value for money or perhaps more tellingly whether they would be willing to pay this amount if they were actually paying for it themselves. The same could happen with provision of e-learning or ambulatory care learning or a variety of other aspects of medical education.

What would providers of medical education then do with the results (such as the figures) that would emerge from studies of this kind? If education providers are to be learner-centric then certainly the learners view should be taken into account when providing education. If learners are not willing to pay or feel that too much of their tuition fee is being spent on something that they don’t value, then schools should certainly listen and consider cutting back on this aspect of the curriculum. However this will not always be the case—sometimes clearly they should not. Learners might not like exams and might not like the fact that a proportion of their tuition fees are spent on exams—however they are still essential. Willingness to pay studies might suggest other actions to providers. They might suggest that there is a mismatch between the perceptions of learners and teachers. For example teachers might feel that the professionalism component of the course is extremely important and worth investing in. By contrast the learners might be surprised by the amount spent on it and feel that their tuition fees should be spent elsewhere. In this scenario it may be that the curriculum needs to make clearer to learners why professionalism is important—to borrow a phrase from the commercial world—it will effectively need to “sell” professionalism to them.

Medical education is expensive. Despite its cost, until recently little thought has been given to cost effectiveness or costs benefit or cost utility ratios in medical education [5]. When these concepts have been examined, it has been typically from the perspective of the provider who must make educational and economic decisions. The learner has remained a silent player (and payer) in this field. However, it is time to look at this issue again—this time from a new perspective—that of the learner. We might find that they have interesting things to say—and not just about cost but about medical education itself.

Yours Sincerely,
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