SQU Med J, April 2010, Vol. 10, Iss. 1, pp. 6-11, Epub. 17th Apr 10
Submitted 26th Dec 09
Revision Req. 31st Jan 10, Revision Recd. 9th Feb 10
Accepted 16th Feb 10

EDITORIAL

Privatisation of Medical Education

Viewpoints with a global perspective

Syed I Shehnaz

خصخصة التعليم الطبي

وِجْهات نظر مع منظور عالمي

سيد الياس شيهناز

In the past several decades, there has been an incredible increase in the privatisation of medical education with rapid expansion in the number of private medical schools. This trend has had widespread implications globally and influenced medical educational policies all over the world.

Privatisation is the act of reducing the role of government or increasing the role of the private institutions of society in satisfying people's needs; it means relying more on the private sector and less on government.[1] Hence the privatisation of medical education can be defined as "Medical Education being imparted by an organization which is not a part of the government bureaucracy." Private medical schools can be totally autonomous or partially autonomous (controlled at various levels and in various degrees by government). They can be profit-generating institutions (revenues which enrich one individual or a consortium) or non-profit institutions which are more society centered. This article is essentially based on print and electronic data available from the World Directory of Medical Schools published by WHO,[2] the International Medical Education directory maintained by Foundation for Advancement of International Medical Education and Research and medical literature.[3]

Global Nature of the Trend: Examples

There has been a worldwide boom in private medical education. India tops the list with the largest numbers of medical schools within one country (271). Out of these about 137 are privately owned institutions.[4,5,6] Next comes the United States with 62 private institutions out of a total of 131 medical schools.[7] American private universities are heavily supported by government research grants and usually are non-profit institutions.[8] In Asia, there are 79 medical schools in Japan, with 50 governmental and 29 private colleges.[9] Other countries like Malaysia (11 private institutions),[10] Thailand,[3] and the Philippines [3] have also ventured heavily into private medical education. In Europe, the United Kingdom, with a total of 44 medical schools, private medical education is a relatively new entrant with only one private school, the University of Buckingham Medical School.[3,11,12] Similarly, Germany also has only one private school out of a total of 36.[13] Medical education in Greece[14] (seven medical schools) and the Netherlands (eight medical schools) [15] is fully government funded, while Spain has only two private institutions out of a total of 28.[16] In the Oceania region, Australia has 19 medical colleges with only two being private medical universities.[3,17] New Zealand has two schools, both of which are government funded.[18] The Pacific islands have 6 schools, most of which are private.[3,4] Recently there has been a spurt of private medical colleges in the Caribbean region.

Department of Pharmacology, Gulf Medical University, Ajman, United Arab Emirates
Email: shehnazilyas@yahoo.com

Many of these 56 schools are private institutions which have become alternate destinations for aspiring American and Canadian students.[4,19] In South America, Chile has a total of 60 schools, 35 of them private,[20] while in Africa, Nigeria has only 2 private medical colleges out of a total of 34 schools[21] whereas Sudan has eight.[22] In the Gulf Cooperative Council countries (GCC countries), there are a total of 32 medical colleges. Yemen has four private medical colleges, the United Arab Emirates (UAE) has three and Bahrain has two. Saudi Arabia, Qatar and Oman have one private medical college each. Kuwait has no private medical college.[3,23]However, in countries like China,[24] France,[25] South Africa[2,3] and Canada[26] medical training is under the full control of the state.

Forces bringing about the Trend

The reasons for the sudden increase in private medical schools are manifold. On the one hand, in many developing countries, due to the population explosion, the demand for places at medical schools is greater than the available supply. In addition, governments are unable to meet the medical needs of society due to both economic constraints and limited infrastructure.[27] On the other hand, the booming private sector economy means more aspirants from the expanding middle class are entering the medical field. This increase of wealth amongst a subset of society has led to a differential growth of private medical schools in the richer and healthier states/countries.[6] In the developed countries, the emergence of new private schools has been driven by workforce shortages. The demands of the population for increased use of recent technological advances in medicine as well as higher average life spans has increased the requirement for medical services in these countries.[28]

Globalisation has resulted in an increased demand for medical professionals from foreign countries (outsourcing). This lure of increased income has led to more entrants into health professions. This enhanced need for medical schools is fulfilled by private medical schools. Indian physicians form the bulk of foreign trained physician in all the major five developed countries (UK, US, Canada, Australia and New Zealand) [29] and this correlates with the fact that India has the greatest number of private medical institutions in the world.[4, 6]

India has also become the leading country promoting 'medical tourism'. A similar situation can also be found in countries like Malaysia and Thailand which advertise cheaper medical care to foreign patients. This lucrative demand for "exported" medical services may be instrumental in the mushrooming of private medical colleges in India and Malaysia.

Changes in government policies in many countries have resulted in the climate being more conducive to privatisation. In India, relaxed regulations resulted in a growth spurt in private medical colleges in the mid-1980s. Political leaders and businessmen found new avenues to make large earnings from private medical schools in the form of high tuition fees. Many regional governments want to appease their electorate from different caste and ethnic groups. Hence they also support the opening of private medical schools by specific minority and ethnic groups.[27]

Total or partial lack of medical education facilities in some countries (Eritrea, Somalia, Namibia, Botswana) [4,30] or stringent admission criteria (USA, Canada)[4,19,31] may have resulted in the residents of these countries going to other countries for their medical education.

Advantages of Privatisation

More medical schools, whether private or public, can meet the need of an ever expanding population and have the potential of enhancing access to health care for all sections of society. There is a strong relationship between the number of medical schools and physician density;[4] hence, more medical schools in low density areas will certainly increase the physician density. The dependency of the local population on expatriate doctors can also be reduced and the health care needs of the local population can be adequately catered for.[30,32]

More medical schools (public or private) will also create more job opportunities for everyone. There will be a healthy competition between the private and public medical institutions benefiting the prospective job candidate.[30] Chances of improvements in the government-run colleges will be greater so as to 'keep up' with the private sector. The monopoly in medical education by government-

run institutions will be substantially reduced, as alternatives become available for students, faculty and the community.

A further advantage is that, with privatisation, medical education will not be dependent on policies driven by political scenarios and could eventually become the sole responsibility of various private medical institutions. In some private medical colleges, with sound financial backing, up to date facilities and technology can reach the students faster than in government colleges. There will be no "red tape" involved as far as infrastructure and facilities are concerned.

Disadvantages of Privatisation

Usually, the primary intention of the trusts/agencies running the profit generating medical colleges is to earn money through a business venture. This is typically the yardstick against which all decisions regarding the institution are made. The common factor in all the private medical colleges around the globe is that they are more expensive than the public medical schools. Medical education has become costlier over time and the burden of debt on medical school graduates increases due to the high tuition fees in private medical schools.[5,33,34,]

The quality of students entering programmes in private institutions is more often dependent on their paying capacity rather than their merit. Some institutions do insist on minimum standards of admissions, but these standards are definitely below those required by state-owned schools. Hence the quality of the doctors coming out of these institutions is likely to be compromised.[35]

The quality of training provided in private medical colleges is also questionable.[35,36] Major problems facing the private medical colleges are poor staffing, poor quality of training and high student /teacher ratios. The staff frequently lack proper training in medical education.[36] Many of the faculty work in these colleges on a part-time basis, or are appointed only for the purpose of accreditation (short term appointments). In some countries, the increased demand for teaching faculty is met by faculty with dual appointments.[36,37] Deficiencies in physical infrastructure with a shortage of equipment, laboratories, cadavers or prosected specimens and chemicals are also rampant.[34]

There is also a reduced availability of patients for clinical teaching in private medical schools. This is because the number of in-patients in the private hospitals of richer countries tends to be less due to their reduced length of stay, sicker patients avoid examinations by students, and an admission of increasing number of elderly patients who are in no condition to give a history due to cognitive impairment.[38] Scarcity of "clinical material" in private medical colleges in the poorer developing countries is due to the lack of patient paying capacity as the private hospitals are much costlier than the government-run hospitals.[6,36]

It has been observed that government support has always helped to improve the quality of education, in particular by covering the increases in costs as laboratory science has evolved. This means that "When government support declines, so too do intellectual standards."[39]

Many newly formed private colleges are not accredited by the national accreditation body. Accreditation is a quality control measure for maintaining high standards of medical education and of health care for the nation. It also instills public confidence in medical schools and ensures that graduates' competencies comply with national standards.[40] The absence of accreditation for some of these private medical colleges will result in a questionable future for their graduates as their qualifications may not be nationally and internationally recognised.

A further disadvantage of privatisation is that there is a lack of social and racial diversity in private institutions. Their medical students usually come from privileged backgrounds.[34,39,41] Also with an increase in tuition fees there will be a further rise in the socioeconomic status of these students.[42,43] As a result of the high tuition fees, under-represented minority groups will have restricted access to medical education. Racial diversity among health professionals results in better communication and improved health care delivery for ethnic minority patients; formation of a culturally competent health care workforce; maintenance of high quality of medical education and increased medical and public health research.[44,45] This lack of racial and socio-economic diversity in private medical colleges will, in the long run, affect patient care.

Most of the private institutions are set up in richer and healthier states or regions with a higher

ratio of medical school admissions to population.[5,6,27] Medical students from rural areas are more likely to practice in rural areas than those from urban upbringings.[46,47] Hence these factors will result in a misdistribution of doctors and resources and favour urban over rural areas.

More medical colleges will result in an anticipated oversupply and misdistribution with too many new doctors entering the medical profession. This will result in a future lack of job opportunities for fresh graduates. Already in Malaysia, there has been a ban on opening any more private medical colleges due to the projected excess of doctors.[10]

Some private medical schools isolate medical education from the health care system, as they are exclusively an educational industry. All the immigrant medical students in these schools are obligated to go to their home country after education. In fact, the whole purpose of many of the newly opened medical schools (in the Caribbean Islands, for example) is to produce doctors for the USA or Canada.[4,19,31]

Guidelines for Privatisation of Medical Education

The deficiencies found in private medical colleges can be removed if there is stringent monitoring and enforcing of international standards by government and health agencies. Fees should be standardised and more stringent entry criteria should be imposed for candidates so that the quality of the graduates does not suffer.

To ensure availability of patients for clinical teaching, medical schools with no training hospitals or inadequate clinical materials should be required to sign memoranda of understanding with teaching hospitals, general practice clinics, and private hospitals. Private universities can become community-based medical schools, with the majority of students' exposure to patients in the community rather than in hospitals.[17] Multidisciplinary clinical skills laboratories can help the students learn basic clinical skills in simulated environments using models and simulators, simulated patients, and standardised patients.[38]

Mandatory accreditation should be introduced and non-compliant institutions should be placed on probation with their student enrollment suspended or accreditation withdrawn. In fact, with the mobility of the health professional workforce, international accreditation seems to be the way of the future. Regulating accreditation boards should ensure that the curricula in all private medical schools are clearly defined and tailored to meet the needs of the society. The curriculum should be scrutinised carefully and the colleges kept up to date with the recent advances in science, medical education and health. Continuous curriculum evaluations done by the medical colleges themselves should become a norm. Current teaching and learning methods promoting student-centered, competency-based learning and problem-solving abilities should be emphasised. The 'ideal' overall teacher-student ratio should be maintained. Faculty development programmes should be made mandatory.

The number of private medical schools should be limited and a reduction in student intake enforced. Quality, rather than quantity, should be the priority. A regulatory cap should be imposed on regions with very large numbers of medical colleges and measures should be taken to ensure more medical colleges are set up in rural areas. The access to medical education for students from ethnic and social minorities should be increased. This can be done by affirmative action, as in US schools, or by a reservation system as in India.

Conclusion

In light of the limitations of the available information, concrete conclusions on the merits and demerits of privatisation cannot be formulated. Nevertheless, privatisation is definitely a useful tool for addressing some of the problems faced today in the field of medical education and it also serves to enlarge the health manpower resources. However, as with any other powerful tool, if used indiscriminately, it can cause more harm than good.

The way forward is more stringent monitoring of private institutions by governments and other authorities. Private institutions should be goal directed and outcome focused. They should assume responsibility for their products, be they medical graduates, research results, or models of health service delivery. They should accept the kudos as well as the brickbats for the outcomes. Privatising medical education should not mean that governments lose the ability to direct medical

education. The unplanned growth of substandard medical colleges should be curtailed and quality should be emphasised over quantity. As advocated so long ago by Flexner, the numbers of sub-standard medical schools should be drastically reduced by closing those not meeting the stipulated standards, while encouraging the growth of those, public or private, which have the potential to contribute to the health of the nation.

ACKNOWLEDGMENT

The author is grateful to Professor RC Bandaranayake for his guidance and encouragement.

References

1. Savas E.S. Privatization and Public-Private Partnerships. New York: Chatham House Publishers/ Seven Bridges Press, 2000.
2. World Health Organization. World Directory of Medical Schools. From http://www.who.int/hrh/wdms/en/index.html. Accessed Oct 2009.
3. Foundation for Advancement of International Medical Education and Research. International Medical Education Directory. From https://imed.faimer.org. Accessed Oct 2009.
4. Boulet J, Bede C, Mckinley D, Norcini J. An overview of the world's medical schools. Med Teach 2007; 29:20–6.
5. Supe A, Burdick WP. Challenges and issues in medical education in India. Acad Med 2006; 81:1076–80.
6. Sood R. Medical education in India. Med Teach 2008; 30:585–91.
7. Association of American Medical Colleges. Medical schools. From http://www.aamc.org/medicalschools.htm. Accessed Oct 2009.
8. Bloche MG. Should government intervene to protect nonprofits? Health Aff (Millwood) 1998; 17:7–25.
9. Kozu T. Medical education in Japan. Acad Med 2006; 81:1069–75.
10. Lim VK. Medical education in Malaysia. Med Teach 2008; 30:119–23.
11. Nellis H, Sikora K. Independent medical school is long overdue. BMJ 2005; 330:537
12. Cohen D, Fišter K. Rejecting political correctness. BMJ 2005; 330:62.
13. Chenot JF. Undergraduate medical education in Germany. Ger Med Sci 2009; 7:Doc02.
14. Georgantopoulou C. Medical education in Greece. Med Teach 2009; 31:13–7.
15. Cate OT. Medical education in the Netherlands. Med Teach 2007; 29:752–7.
16. Palés J, Gual A. Medical education in Spain: current status and new challenges. Med Teach. 2008; 30:365-9.
17. Lawson KA, Chew M, Van Der Weyden MB. The new Australian medical schools: daring to be different. MJA 2004; 181:662–6.
18. Fitzjohn J, Wilkinson T, Gill D, Mulder R. The demographic characteristics of New Zealand medical students: the New Zealand Wellbeing, Intentions, Debt and Experiences (WIDE) Survey of Medical Students 2001 study. N Z Med J 2003; 116:U626.
19. Van Zanten M, Boulet JR. Medical education in the Caribbean: variability in educational commission for foreign medical graduate certification rates and United States medical licensing examination attempts. Acad Med 2009; 84:S13–6.
20. Cruz-Coke R. The evolution of Chilean universities from 1981 to 2004. Rev Med Chil 2004; 132:1543–9.
21. Ibrahim M. Medical education in Nigeria. Med Teach 2007; 29:901–5.
22. Fahal AH. Medical education in the Sudan: its strengths and weaknesses. Med Teach 2007; 29:910–4
23. Abdulrahman KAB. The current status of medical education in the Gulf Cooperation Council countries. Ann Saudi Med 2008; 28:83–8.
24. Lam TP, Wan XH, Ip MSM. Current perspectives on medical education in China. Med Educ 2006; 40:940–9.
25. Doan BD, Lévy D, Pavot J. Demographic forecasts of medical workforce supply in France (2000-2050). [What numerus clausus for what future?] Cah Sociol Demogr Med 2004; 44:101–48.
26. Gray JD, Ruedy J. Undergraduate and postgraduate medical education in Canada CMAJ 1998; 158:1047–50.
27. Mahal AS, Mohanan M. Growth of private medical education in India. Med Educ 2006; 40:1009–11.
28. Brooks PM, Lapsley HM, David B Butt. Medical workforce issues in Australia: "tomorrow's doctors — too few, too far". Med J Aust 2003; 179:206–8.
29. Mullan F. Doctors for the world: Indian physician emigration. Health Affairs (Millwood) 2006; 25:380–93.
30. Muula AS. Every country or state needs two medical schools. Croat Med J 2006; 47:669–72.
31. McAvinue MB, Boulet JR, Kelly WC, Seeling SS, Opalek A. U.S. citizens who graduated from medical schools outside the United States and Canada and received certification from the Educational Commission for Foreign Medical Graduates, 1983-2002. Acad Med 2005; 80:473–8.
32. Broadhead RL, Muula AS. Creating a medical school for Malawi: problems and achievements. BBMJ 2002 325:384–7.

33. Elam CL, Scott KL, Gilbert LA, Hartmann BA. A comparison of applicant and matriculant trends, and rising costs of medical education in United States medical schools and at the University of Kentucky College of Medicine. J Ky Med Assoc 2003; 101:201–7.

34. Bhatt VR. Medical education: at what cost? Student BMJ 2006; 14:265–308.

35. Mahal AS, Shah N. Implications of the Growth of Dental Education in India. J Dent Educ 2006; 70:884–91.

36. Kumar S. Report highlights shortcomings in private medical schools in India. BMJ 2004; 328:70.

37. Ananthakrishnan N. Acute shortage of teachers in medical colleges; existing problems and possible solutions. Nat Med J India 2007; 20:25–9.

38. Crotty BJ. More students and less patients: the squeeze on medical teaching resources. Med J Aust 2005; 183:444–5.

39. Duffin J. Occasional essay: What goes around, comes around: a history of medical tuition. CMAJ 2001; 164:50–6.

40. Azila NM, Tan CP. Accreditation of medical schools: the question of purpose and outcomes. Med J Malaysia 2005; 60 Suppl D:35–40.

41. McManus IC. The social class of medical students. Med Educ 1982; 16:72–5.

42. Kassebaum DG, Szenas PL, Schuchert MK. On rising medical student debt: in for a penny, in for a pound. Acad Med 1996; 71:1124–34.

43. Kwong JC, Dhalla IA, Streiner DL Baddour RE, Waddell AE, Johnson IL. Effects of rising tuition fees on medical school class composition and financial outlook. CMAJ 2002; 166:1023–8.

44. Cohen JJ, Gabriel BA,Terrell C. The case for diversity in the health care workforce. Health Aff (Millwood) 2002; 21:90–102.

45. Magnus SA, Mick SS. Medical schools, affirmative action, and the neglected role of social class. Am J Public Health 2000; 90:1197–201.

46. Kassebaum DG, Szenas PL. Rural sources of medical students, and graduates' choice of rural practice. Acad Med 1993; 68:232–6.

47. Easterbrook M, Godwin M, Wilson R, Hodgetts G, Brown G, Pong R, et al. Rural background and clinical rural rotations during medical training: effect on practice location. CMAJ 1999; 160:1159–63.