Dear Editor:

Medical education is associated with significant costs\(^1\). Those who are responsible for the delivery of medical education must continually make decisions that have financial consequences\(^2\). Sometimes decisions are to invest in a new product or service, sometimes to disinvest. Sometimes decisions involve the educator realising that they should switch from one provider of medical education to another, or from one product to another. Consciously or unconsciously these decisions are inevitably made on value—educators want to maximise the outcomes from medical education or to minimise costs\(^3,4\). But decisions to change inevitably involve cost in themselves—these are called switching costs (or sometimes switching barriers). Switching costs are not unique to medical education—they occur in all walks of life\(^5\). If switching costs are too high, they can cancel out any savings made as a result of going with a lower cost purchase. There are various types of switching costs—understanding the types and understanding methods of preventing or overcoming switching costs will enable medical educators to make better purchasing decisions.

Switching costs come in a variety of forms. They include costs related to exit, search, learning, equipment, and installation. Some authorities would include non-financial costs in switching costs. These might include the psychological worry of changing from a tried and trusted provider to a new one. However for the purpose of this article, switching costs mean financial costs only. This is not to dismiss non-financial costs but rather to define terms at the start. Let’s take the various types of financial switching costs one by one.

Exit costs are the costs of giving up an existing product or service. They might include breach of contract payments. For example a medical educator may wish to change from one online learning provider to another. However the educator may have agreed terms and conditions with the existing provider that last for three years and may have to pay a penalty to exit the contract early. The way to prevent having to pay exit fees is simply to read the fine print in contracts in the first place and establish early potential break points in the contract. If exit fees are in place however and the provider insists that they are paid then the medical educator has no legal recourse but to pay. However some providers may wish to remain on good terms with purchasers and so may be willing to negotiate down from the full fee. Exit costs may not necessarily be contractual. For example an educator who wishes to change simulation equipment or move from one simulation provider to another will have to de-install and dispose of existing simulation equipment and account for all the costs associated with this.

Learning costs are fairly straightforward. For example a medical education unit may purchase a new online assessment service. All staff and learners who will use this new assessment service will have to learn how to do so. The learning costs here are directly related to staff time—but educators should be aware of the wide range of staff who may have to use this service including faculty, administrators, psychometricians, and invigilators (this list is not exhaustive). There is no way to completely prevent learning costs—other than by continually asking how easy or hard staff will find using a new service. Sometimes providers will provide free training for staff along with the new service.

Search costs are an important component of switching costs\(^6\). If an educator is dissatisfied with a current provider of medical education, then they must search
for an alternative. The time that they spent searching is the search cost. Sometimes the search cost will exceed the cost savings of a new product or service, rendering switching irrational. Search costs have fallen as a result of far easier and wider searching made possible by the internet—however they have not disappeared altogether. There is no ideal way to minimise search costs. It is probably wisest to be continually on the lookout for new innovations—even when the medical education unit might not need any. Then when the time to change comes, everyone will know exactly where to look.

Then there are equipment costs. For example an existing online learning portfolio may be compatible with the software at a medical school. A new, better and lower cost portfolio may not be, and so the educator who wishes to change will have to install new software. The costs associated with this may be more than the savings achieved as a result of the lower cost portfolio. There is little that can be done to prevent this. Ideally portfolios should work on a range of equipment, but the pace of change of technology renders this very difficult.

Finally the newly purchased medical education product or equipment will need to be installed. Installation costs once again are reasonably straightforward to understand. A medical educator might buy new simulation equipment but then must think about how best to install it and sometimes about its compatibility with existing simulation equipment. Some providers of simulation equipment or indeed other medical education products may include installation in the costs—it is always worth checking.

Switching costs should always be considered when thinking about the cost and value of medical education. Increasingly medical education is provided in a complex integrated and joined-up world—where seemingly simple changes can have far-reaching consequences and far-reaching costs. Switching costs shouldn’t necessarily stop you switching, but they should encourage you to look before you leap.

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The author reported no conflict of interests.

References