

**FINAL DRAFT**  
**2003 Report of the American Medical Association – Medical Student Section**  
**Task Force on Medical Student Debt**

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## **Executive Summary**

Medical student debt at graduation has shown a 20-year trend of increasing at a rate approximately 1% greater than inflation. Over these 20 years, this has led to mean student debt increasing 173%, to an average of \$104,000 as of October 2003. The principal factor behind rising debt is rapidly-rising medical school tuition. Tuition itself is increasing due to several factors, including a loss of federal funds that indirectly supported medical education through faculty clinical revenues and the “Dean’s tax”.

Several peer-reviewed studies indicate that high levels of debt affect specialty choice (driving students away from primary care) and lead to depression, burnout, and feelings of excessive burden among residents. Complementary data indicate that the debt burden falls more heavily on students from underrepresented minority groups. These groups therefore feel a greater burden and are particularly discouraged from entering medicine and from practicing in medically underserved areas.

Medical student debt is at a crisis point. The contraction of the U.S. economy has led to state budget crises nationwide, translating into decreased funding for medical education and particularly for public medical schools. As a response, these schools are raising tuition at record rates. The tuition increase from 2001 to 2002 at public medical schools was 14% over inflation. Some schools have chosen to raise tuition mid-year and make these increases retroactive, despite the fact that students at those schools had already received their loan disbursement for that year. In-state tuition and fees at some public schools exceed the amount that can be borrowed through Stafford loans, forcing students to accept high-rate private debt to continue their education. Presently, loan payments consume between 40 and 50% of the average resident’s after-tax salary. Together, these factors sum to a crushing burden that will worsen unless immediate action is taken.

Action is needed on multiple levels and timescales to resolve the student debt crisis. In the short term and at the federal level, loan repayment must be made easier. The currently ongoing re-authorization of the Higher Education Act of 1965 presents an excellent legislative opportunity. The single most effective point of advocacy is increased access to consolidation loans, which can reduce a borrower’s interest rate by 5%. To this end, Congress should repeal the single-holder rule (which prevents competition in the consolidation market) and continue to let students lock in low fixed rates on consolidation loans. Other amendments to the rules of loan repayment, such as the ability to defer repayment until residency is completed and increases in the tax deductibility of student loan interest, would not reduce debt but would make repayment less burdensome.

In the long term, payment for undergraduate medical education must depend less on loans. Programs such as the National Health Service Corps, the Armed Forces Health Professions Scholarships, and the Medical Scientist Training Programs provide some scholarship dollars, but they are not enough. Favorable tax treatment for scholarships will stretch the dollars further, but the present programs only cover medical students with certain special interests and are not able to fund all the students who are willing to participate. Therefore, scholarship support must be increased by expanding state and national service-based loan repayment programs and by greater scholarship fundraising on the part of medical schools and state societies. Further federal and

state funding must support medical education in general instead of individual students. A source of funding must be located for undergraduate medical education, just as Medicare funds are used to support and subsidize graduate medical education. Increases in resident salaries, while beneficial, would be less effective than directly paying for education since part of the funds would go to paying loan interest rather than actual education costs.

While changes in federal and state law can put money into the system and ease repayment, medical schools must also work to reduce student debt burden. As noted above, schools must aggressively raise and endow scholarship funds. Moreover, existing students must be protected against excessive tuition increases once they matriculate. Tuition caps, either over all four years or within each year, are a necessary part of the solution. Furthermore, revenue must not be surreptitiously increased by shifting costs from tuition to mandatory fees. Schools must recognize the economic value of the clinical work done by students and account for this in setting tuition. Medical schools can also make the process more efficient by cooperating more with undergraduate institutions through collaborative debt counseling and through integrated programs such as existing BS/MD six-year programs.

To achieve this broad a set of changes, new coalitions must be formed beyond our traditional alliances with the AAMC and AMSA. In Washington, the AMA can and should partner with existing higher education groups such as the American Council on Education and the National Association of Graduate-Professional Students in order to leverage the connections those groups have built with members of Congress. In the states and medical schools, the AMA and its MSS can find allies in specialty societies and in student organizations that focus on improving education for underrepresented groups such as women and minorities.

The recommendations given on pages 33-35 of this report are extensive and call for careful policy research and aggressive advocacy by the AMA-MSS and the AMA. All of the recommended actions are necessary to develop a complete and comprehensive solution to the present crisis. Action at only one level will not suffice; only by simultaneously reducing the cost of education, increasing grant-based financial support, and facilitating debt repayment can we reduce the burden on students and residents and ensure the future diversity and well-being of the physician workforce.

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## **I. Background**

### **I.A. Changes in the Cost of Medical Education**

There are two principal factors driving increases in the cost of medical education. The first is an increase in the actual cost of teaching. In a 1997 study, Jones and Korn estimated that total educational costs range from \$72,000 to \$93,000 per student per year. However, this estimate includes the cost of supporting faculty activities in research and patient care. The actual cost of teaching medical students is estimated as \$40,000-\$50,000 per student-year. Recent trends in education include a shift to more costly modalities such as small-group problem-based learning and clinical training in outpatient settings. As accrediting bodies and outside groups encourage schools to make use of these and other innovations, costs are expected to rise further.<sup>1</sup>

The second factor in the rising cost of medical education is the loss of “Dean’s tax” funds that previously subsidized education. The Dean’s tax is a percentage of the revenue from faculty clinical practices that is taken by the administration and used to support the medical school. American medical schools assess an average 10% tax on faculty practice income,<sup>2</sup> and this assessment is estimated to represent 35% of a medical school’s total revenue.<sup>3</sup> Faculty have recently had to devote more time to patient care to generate that revenue, largely due to the emergence of managed care<sup>4</sup> and reduced Medicare payments mandated by the Balanced Budget Act of 1997.<sup>5</sup> These changes in the health care financing system have eliminated what was, in essence, a source of federal support for undergraduate medical education.

### **I.B. The Role of Tuition in Medical Education**

Over half of the allopathic medical schools in the U.S. are public schools. The average percentage of their revenue derived from state and federal sources has fallen from 70% in 1965 to 32% in 1998.<sup>6</sup> As states face mounting budget deficits, state-subsidized medical schools have become increasingly dependent on tuition revenues. The average in-state tuition and fees at public medical schools increased more than 12% between 2001-2002 and 2002-2003, more than twice the average percentage at private schools.<sup>7</sup>

Despite these increases, tuition continues to make up only a small percentage of total revenue at the majority of American medical schools. During the 1997-1998 academic year, tuition accounted for an average of 2.8% and 5.1% of the operating budgets of allopathic public and private medical schools respectively. These percentages have remained relatively constant over the past thirty years.<sup>8</sup> Tuition accounts for a higher percentage of the operating budgets at osteopathic schools, approximately 47%, due to these institutions’ smaller operating budgets.<sup>9</sup> Nevertheless, the majority of all American medical schools’ budgets are derived from non-tuition sources, including federal and state governments, research grants, philanthropic support, and the “Dean’s tax”.

## **I.C. The Student's Pocketbook: Rising Tuition and Debt Trends**

### **I.C.1. Total Student Indebtedness, 2001-2002**

According to the Association of American Medical Colleges (AAMC) 2002 Medical Student Graduation Questionnaire, 81.7% of graduating allopathic medical students carry outstanding loans on their medical school education and 62.8% carry loans on their college/premedical education. The mean per capita *total educational debt*, including both college and medical school loans, for 2002 graduates of allopathic medical schools is \$86,870.<sup>10</sup> Excluding the students who have no loans, the mean per capita debt is \$103,855. For osteopathic medical schools the mean per capita total education debt for 2001 graduates of is \$128,700, according to the American Association of Colleges of Osteopathic Medicine (AACOM)'s Debt, Career Plans and Opinions of Osteopathic Medical Students in 2001 survey.<sup>11</sup> In addition to total education debt, students carry an average of \$7,967 (allopathic) and \$8,300 (osteopathic) of non-educational debt, which includes loans for automobiles, credit cards, and other living expenses.<sup>10, 11</sup>

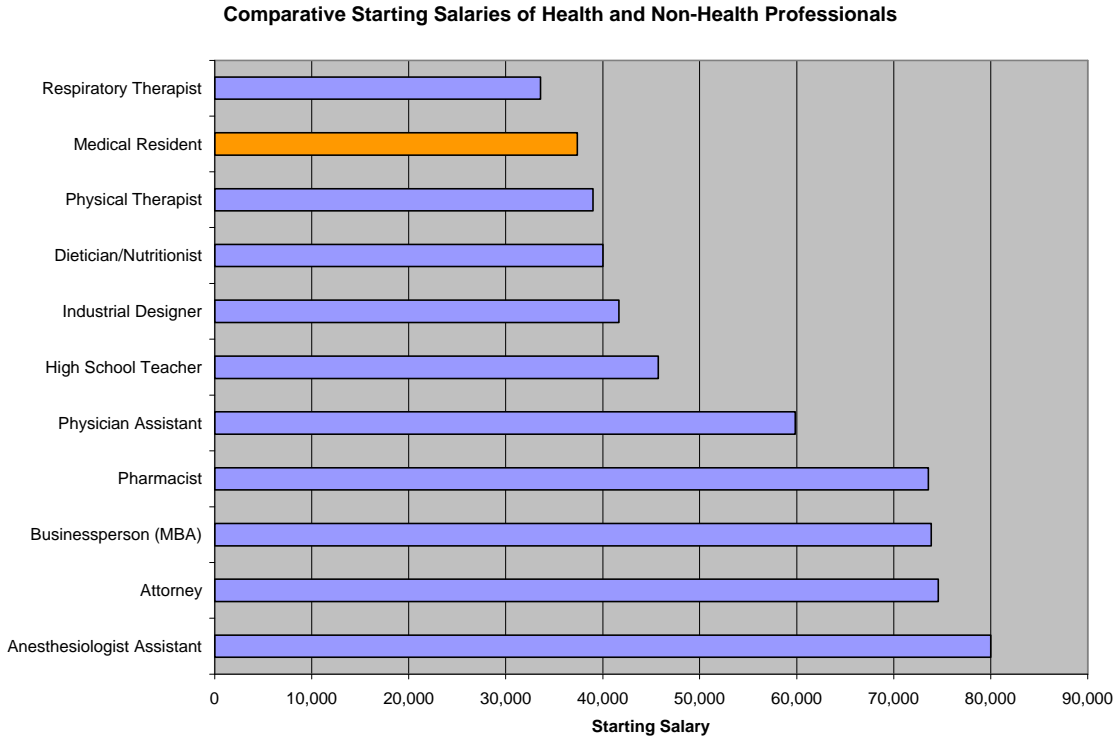
### **I.C.2. Debt: Private vs. Public Institutions**

Significant differences in debt level exist between attendees of private versus public medical schools. Approximately 40% of allopathic students and 76% of osteopathic students attend private medical schools.<sup>10,11</sup> Indebted students who attended private allopathic and osteopathic medical schools had an average of \$123,780 and \$136,700, respectively, while indebted students who attended public allopathic and osteopathic medical schools had an average of \$91,389 and \$103,900, respectively.<sup>11,12</sup> Standard repayment terms range from 10 to 30 years, and total educational cost can be 175% to 300% of the initial loan once interest is factored in.<sup>13</sup> Salaries of resident physicians, which average \$37,383 for the first year, are generally smaller than those of other professionals such as nurses, clinical assistants, and lawyers.<sup>14</sup> Figure 1 illustrates the disadvantage medical students are at compared to other professionals in repaying their loans. Not only does their debt tend to be greater than that of other professionals, but they are also less able to pay off that debt due to their lower salaries.

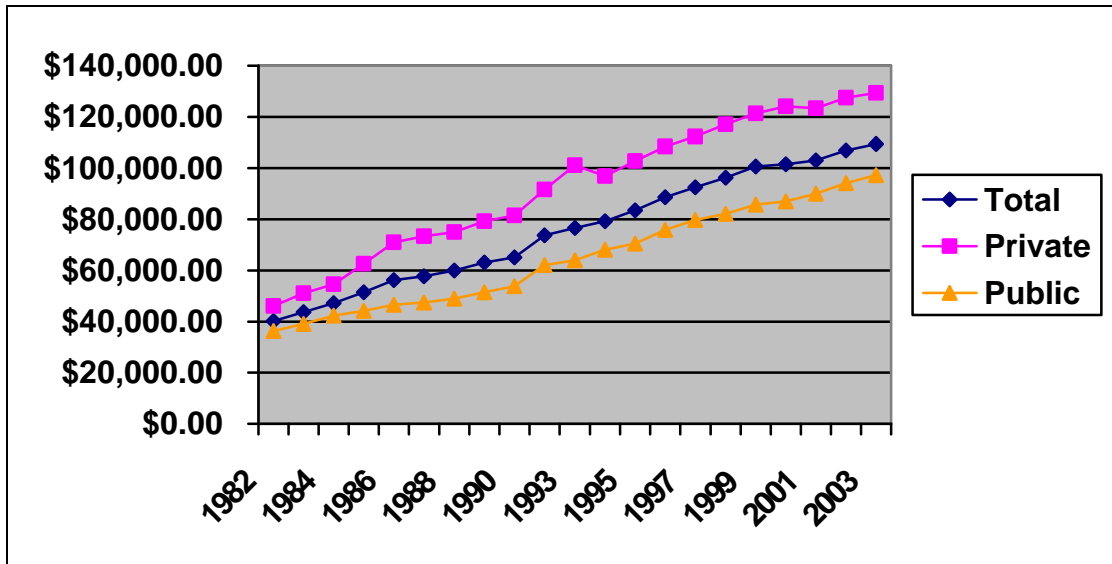
### **I.C.3. Trends in Indebtedness**

#### **I.C.3.a. A Long-Term Trend of Increasing Debt**

Medical student debt has steadily and swiftly increased over the past two decades without deceleration. The continual growth of debt is charted in Figure 2. In constant (inflation-adjusted) dollars, mean debt for indebted allopathic medical students has increased 173% since 1982 and 48% since 1992.<sup>12,15</sup> Mean student debt has increased faster over the past 20 years for graduates of private medical schools (180% increase for private schools versus a 168% increase for public schools). However, more recent trends show mean student debt increasing faster for graduates of public institutions: Since 1992, student debt has increased 57% versus 41% for graduates of public versus private medical schools, respectively.<sup>12,15</sup>



**Figure 1:** Comparison of average medical resident salary to salary of other professionals inside and outside the health-care system. These professionals often have lower debt due to shorter training periods, but all receive higher salaries and are thus even less burdened by educational debt. Sources: American Medical Association,<sup>16</sup> Graduate Management Admissions Council,<sup>17</sup> Salary.com.<sup>18</sup>

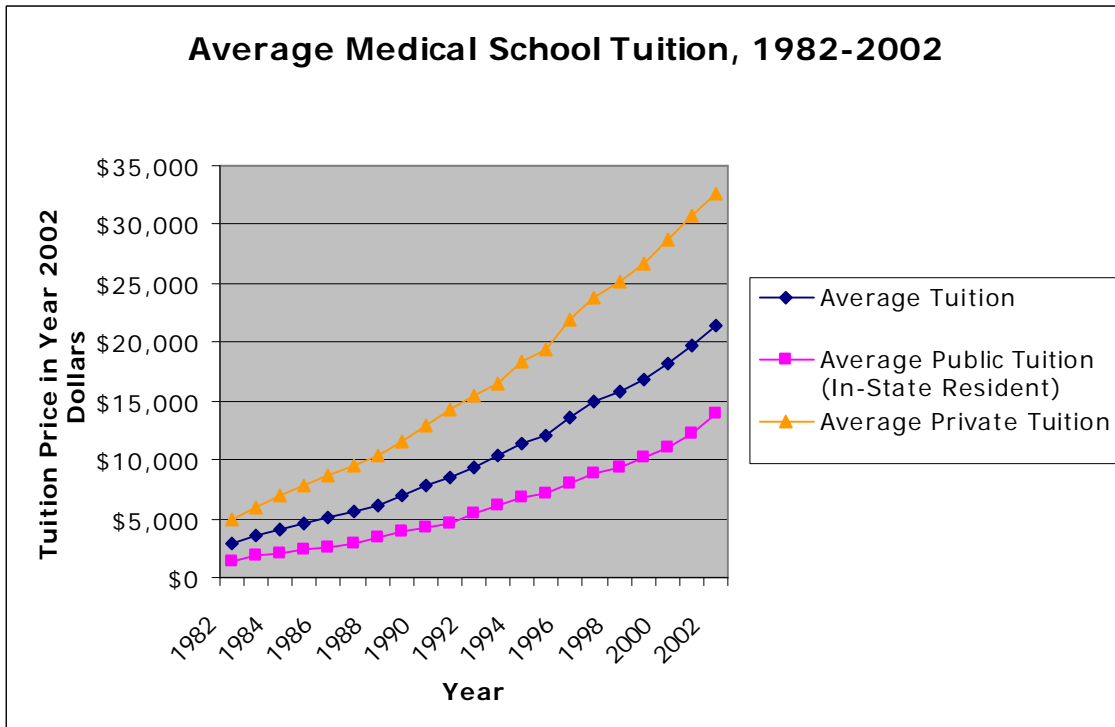


**Figure 2:** Medical student debt in 2003 dollars over the past 20 years. Student debt has continued to outpace inflation at slightly over 1% per year, with the trend showing no sign of leveling off.



**I.C.3.b. Causes of Increasing Debt Burden**

Increases in student debt have tracked increases in tuition, fees and other costs of attendance. The mean annual tuition and fees for private allopathic medical schools is \$30,960 and \$32,601 for residents and nonresidents, respectively. The mean annual tuition and fees for public allopathic medical schools is \$14,577 and \$30,924 for residents and nonresidents, respectively.<sup>19</sup> In constant dollars, tuition and fees for private medical schools have increased 435% since 1960 and 69% since 1982. Tuition and fees for public medical schools have increased 387% and 543% since 1960 and 143% and 173% since 1982 for residents and nonresidents, respectively.<sup>12</sup> Figure 3 illustrates the accelerating growth of tuition over the past 20 years.



**Figure 3:** Average tuition at public and private medical schools, adjusted to 2002 dollars. Medical school tuition continues to rise faster than inflation, and public schools are now rising faster than private schools. Data courtesy of Association of American Medical Colleges.<sup>20</sup>

States that face major budget shortfalls may respond by retroactively increasing tuition during the school year. The State University of New York (SUNY) system implemented such an increase beginning during the 2001-2002 school year. In 2000-2001, the tuition for SUNY students was at \$10,840. For the 2001-2002 academic year, medical students in the SUNY system received a tuition increase of \$2000 after the close of the fall semester. The tuition increase was reported to be in response to declining state aid and the desire to hire additional faculty members. Additional increases at the SUNY schools have followed and are scheduled to continue through 2004-2005. These increases have placed extreme and unreasonable burdens on students already carrying heavy debt loads. It seems likely that, were these tuition increases known before the school year started, some SUNY matriculants would have selected another medical school or altered their annual budget to compensate. This scenario of mid-year and/or

retroactive increases has played out at a number of other medical schools in the US, including but not limited to the five medical schools in the University of California system.

While tuition and fee increases are the primary factor in student debt, there are other contributors to the problem. The average premedical debt of indebted allopathic medical students has increased 274% since 1982 (from \$7,489 to \$20,494 in constant dollars).<sup>10,21</sup> The percentage of graduates carrying premedical debt has increased from 39.8% in 1992 to 62.8% in 2002.<sup>10,15</sup> Factors such as a higher cost of books, supplies and living expenses may also play a role in increased student debt. According to 1985-1995 data, total aggregate costs, rather than tuition and fees only, are the main determinants of student borrowing. As limits on borrowing from federal loans have been raised, matriculants have indicated an increasing role of loans and a decreasing role of personal or family income and savings in financing their medical education.<sup>19</sup>

1995 data indicate that other factors, such as longer time to graduation, greater numbers of female students, greater racial/ethnic diversity, admission of older students, and changes in parental income have had only small effects on medical student debt.<sup>19</sup>

#### **I.D. Summary of Current AMA Student Debt Policy**

The AMA has developed extensive policy regarding student debt, loan repayment, and methods of financing undergraduate and graduate medical education. A complete listing of specific policies is given in Appendix I. Key aspects of AMA policy are:

- Placement of medical student debt as a top legislative priority.
- Support for favorable tax treatment of medical education expenses, including deduction of interest payments and tax exemptions for scholarship income.
- Deferment of loan payments until after residency and fellowship.
- Strengthening of existing scholarship and loan repayment programs.
- Development of new funding sources for graduate medical education and a move away from tuition as a funding source for undergraduate medical education.

AMA action based on these policies has led to legislative successes, the most recent being passage of the Affordable Education Act of 2001. The Act increased the deductibility of loan interest and placed service-based scholarships such as the National Health Service Corps (NHSC) program on the same tax footing as other scholarships. These new benefits sunset in the year 2010 along with many other tax changes proposed by the second Bush administration, but it seems likely that they will be made permanent before that deadline.

#### **I.E. Service Obligation Programs for Loan Repayment**

Some students choose to manage their debt by entering into service contracts with various public agencies. We present here a summary of these programs.

*Military.* The Health Professions Scholarship Program (HPSP) offered by the Army, Navy, and Air force requires one year of military service for each year of assistance provided while in

school. The grants cover all educational expenses and provide a stipend (US Army Health Professions Scholarship Program - Army Regulation 601a-141). The Health Professions Loan Repayment Program (HPLR) provides up to \$50,000 in loan repayment with an eight-year service commitment. The Specialized Training Assistance Program (STRAP) provides residents in selected specialties a stipend of \$11,130; enrollees must join the army reserves for two years.

*National Health Service Corps.* The United States Health Resources and Services Administration provides tuition, educational expenses, and a stipend to select awardees of the NHSC scholarship; recipients must commit to four years of service in primary care in an underserved area or immediately repay all disbursements plus interest. The NHSC also provides up to \$50,000 in loan forgiveness plus 39 percent tax assistance for two years of service. States and the Indian Health Service have their own loan forgiveness programs both in addition to, and in cooperation with, the NHSC and may be able to offer further loan assistance beyond two years.

*National Institutes of Health Extramural Loan Repayment.* The NIH offers up to \$35,000 a year in loan repayment and tax reimbursement for each year of committed service. For each year of loan assistance, the recipient will owe one year of dedicated research time. One year renewal contracts are available. All MDs and DOs are eligible, but must be recipients of F32 (postdoctoral) or T32 (institutional research) training grants and must have debt in excess of twenty percent of their income on their date of qualification, among other qualifications (for a full set of rules, see NIH notice NOT-OD-01-064. There are dedicated programs for residents/fellows from disadvantaged backgrounds, or for students doing research in health disparities, contraception and infertility, pediatrics, or clinical research.

*NIH Intramural Loan Repayment.* The NIH also offers loan repayment programs for researchers, residents and fellows with appointments at the NIH, paying up to \$35,000 annually.

*State Loan Repayment Programs.* California and Colorado, among other states, have programs that provide up to \$150,000 in loan repayment for five years of service in an underserved area. Neither program requires that this service be in primary care.

*Practice based programs.* Some practices will provide loan repayment as a part of an incentive package for recruiting physicians.

## **II. Significance of Increasing Student Debt**

There are several conflicting studies on the impact of student debt on the American health care system, especially with regard to specialty choice. At debt levels between \$25,000 and \$75,000, a 1998 JAMA study by Marci et al. found a linear correlation between rising debt and influence on specialty selection.<sup>22</sup> Beyond \$75,000, the relationship flattened out. Other studies found that debt began significantly influencing specialty decision above \$75,000.<sup>23,24</sup> While the precise level of debt that produces influence remains unclear, it is indisputable that students who have not yet crossed that threshold will do so if current trends continue, and it is well-proven that there is a genuine influence of debt on specialty choice.<sup>25</sup>

## II.A. How Much Debt Is Too Much?

At the time of this writing, average debt at graduation is approximately \$104,000. In addition, nearly 21% of medical school graduates now carry an educational debt load more than \$150,000, an amount which most published studies agree affects specialty decisions.<sup>25,26</sup> Regardless of actual debt amount, perceived burden from educational loans is correlated with the percentage of monthly income that is required for loan payments.

Borrowers whose debt payments comprise less than 7% of their gross monthly income generally do not experience difficulty in paying off their loans.<sup>27</sup> As debt burden increases above 10% of gross income, perception of difficulty also increases with 76% of borrowers feeling extremely or very burdened, and 53% feeling more burdened than they had expected.<sup>27</sup> When considering graduates who entered the low-paying jobs in a generally high-paying sector (such as physicians who practice primary care in underserved areas), 86% felt extremely burdened and 65% experienced more hardship than anticipated.

An overview of how borrowers' total debt burden consumes their monthly income is shown in Table 1. A few key facts illustrate the problem faced by the average resident with a debt of \$104,000 and a salary of \$38,000 per year:

- Monthly payments of \$1,168 on this debt represent 50% of monthly take-home pay after 27% federal income tax.
- In order to remain under the 7%-of-monthly-income level and avoid repayment difficulties, total debt for this resident could not exceed \$20,000. This is less than the cost of *one year* of tuition, fees, and expenses at many medical schools.
- If this resident defers payment (with interest still accumulating) until the end of a three-year residency and makes an average primary care starting salary of \$120,000 per year, the monthly payment will still be 21% of pay after federal taxes (and even higher depending on state and local taxes).

Starting Balance	Mean Monthly Payment		Total Interest Paid		Mean Monthly Resident Income Remaining	
	10yrs	30yrs	10yrs	30yrs	10 yrs	30 yrs
\$50,000	\$536	\$276	\$14,375	\$49,398	\$2,105	\$2,365
\$109,500	\$1,175	\$605	\$31,481	\$108,180	\$1,466	\$2,036
\$125,000	\$1,341	\$690	\$35,937	\$123,490	\$1,300	\$1,951
\$150,000	\$1,609	\$828	\$43,125	\$148,188	\$1,032	\$1,813
\$200,000	\$2,145	\$1,104	\$57,500	\$197,587	\$1,022	\$1,537

**Table 1:** Monthly loan payments and residual income for various debt burdens with a salary of \$38,000 per year and a *low* fixed interest rate of 5.25% No late payments or defaults are assumed. Values are given for standard 10-year repayment and for the optional extended 30-year repayment.

## **II.B. Effect of Physician Debt on Patient Care**

### **II.B.1. Decreased Diversity of the Physician Workforce**

A 1998 AAMC study found that premedical students are dissuaded from medical careers because of financial concerns, discouragement from practicing physicians, and the ability of another field to satisfy their interest in science. These financial barriers may make minority and financially disadvantaged students particularly unlikely to choose medicine.

Increasing tuition may disproportionately affect underrepresented minority students, whose families are often less able to contribute financially to their educations. Underrepresented minority students are more likely to rely on unsubsidized loans to fund their educations.<sup>28</sup> Furthermore, underrepresented minority students graduate with higher debt burdens than their Caucasian counterparts, despite being more likely to receive a scholarship or grant. This may be due to differences in the general socioeconomic status of these students; the AAMC reports that underrepresented minority medical graduates are more than 25% more likely than their peers to have non-education debt.<sup>29</sup>

To reduce health disparities, the Department of Health and Human Services has made increasing the number of health professionals from underrepresented racial groups a priority of its Healthy People 2010 campaign. According to the Healthy People 2010 Companion Document on Workforce Development, minority physicians are more likely than their Caucasian counterparts to serve in communities where there is a shortage of physicians, to treat minority patients, and to research those diseases that disproportionately affect minorities.<sup>30</sup> As noted above, the present debt crisis particularly affects minority students, exacerbating the shortage of minority physicians and delaying improvements in care for minority populations.

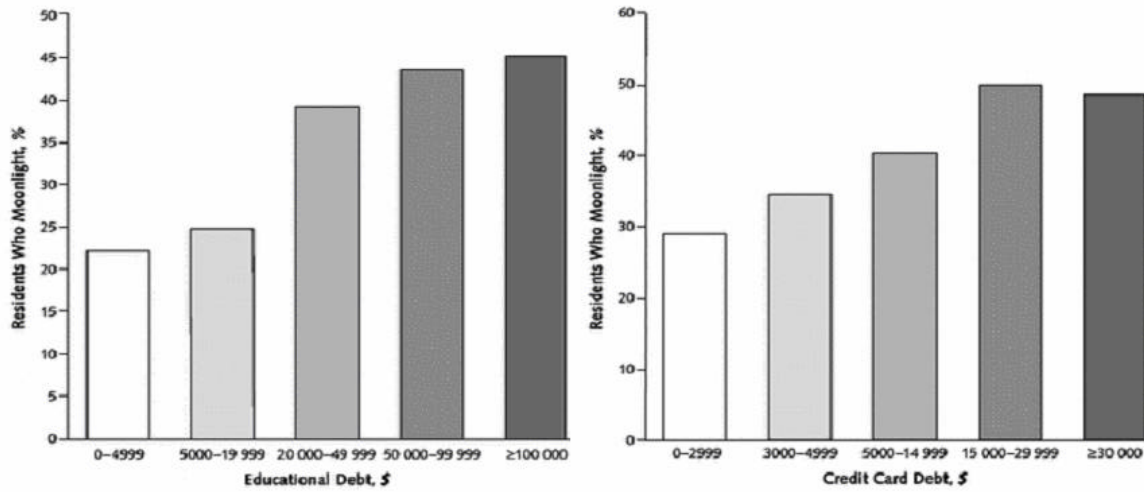
African Americans, Hispanics, and Native Americans remain underrepresented in medicine. Although these groups comprised nearly one quarter of the US population in 1997, less than one eighth of that year's allopathic medical students were members of underrepresented minority groups. The Census Bureau estimates minorities will make up almost a third of the US population by the year 2010 and nearly half by the year 2050.<sup>28</sup> Thus, in order to achieve proportional representation in the medical profession, considerable increases in the number of minority medical students will be necessary.

Beyond implications for access to health care, ethnic and racial diversity among medical students may provide an educational benefit for all students. In a recent study published in *Academic Medicine*, more than 75% of medical students surveyed at Harvard and UCSF believed a diverse student body improved their ability to work with those from different backgrounds. The student debt crisis therefore has dire implications for the cultural competence of the future health care workforce.<sup>31</sup>

### **II.B.2. Increasing Physician Burnout**

In a study of 4,128 internal medicine residents, a substantial number had financial and emotional distress that could have interfered with training.<sup>32</sup> Forty-three percent of the respondents had monthly disposable income less than \$100, 16% could not afford safe housing, and 52% were

unable to purchase necessary books or equipment. Thirty-three percent of residents surveyed worked as moonlighters. Moreover, as debt increased, so did hours spent moonlighting; see Figure 4 for details. Moonlighters on average had less disposable income, suggesting that additional income is necessary to meet their fixed financial costs.

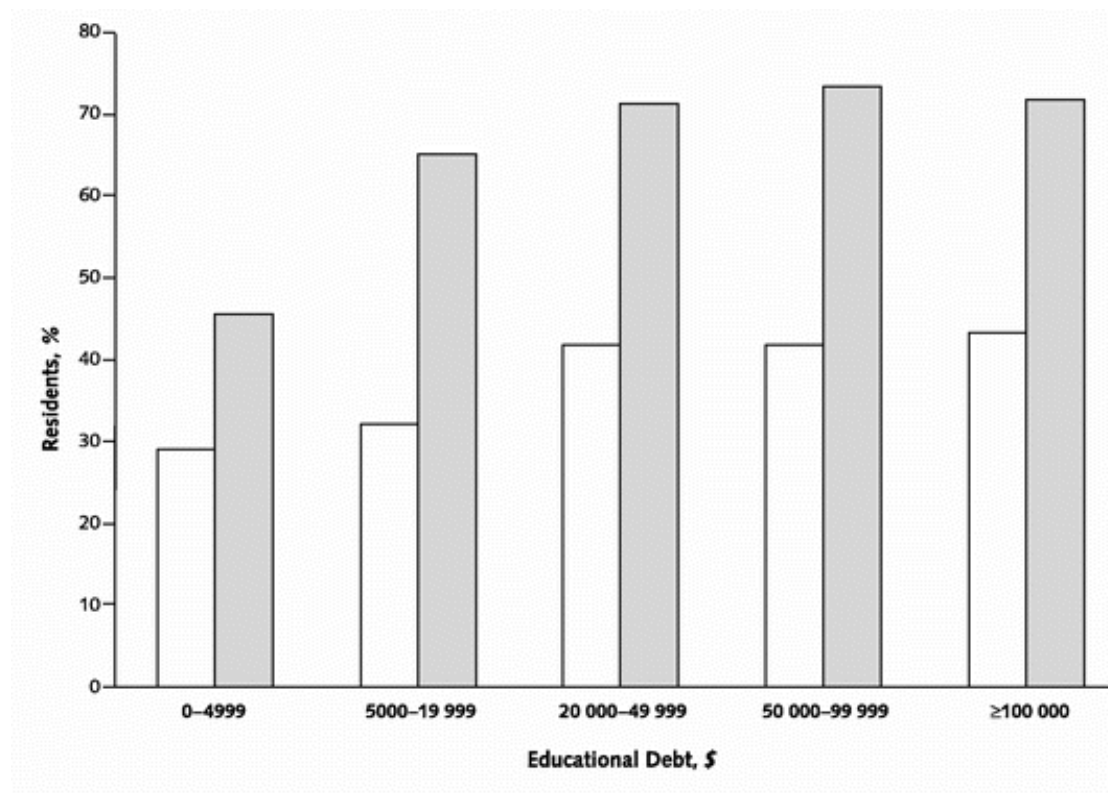


**Figure 4:** As resident educational and personal debt increases, increasing numbers of residents turn to moonlighting. In addition to decreasing resident quality of life and thereby potentially increasing burnout, excessive moonlighting places a resident in danger of violating the recent ACGME duty hour guidelines.

It is not difficult to extrapolate the reduced level of caring a resident financially obligated to work an additional 40 hours would demonstrate. This extra work will increase fatigue and possibly contribute to medical errors while adversely affecting the resident’s mental health. Indeed, 23% percent of residents in the study reported becoming less humanistic, and 61% reported becoming more cynical. Increasing debt predicted depressive symptoms and increasing cynicism on self-report; see Figure 5. Increasing cynicism was also noted in medical students and may be related to anger during residency. Finally, moonlighting to pay education debts places residents in danger of violating the recently-introduced Accreditation Council for Graduate Medical Education (ACGME) duty hour guidelines.

### II.C. Student Debt Has Reached a Crisis Point

Medical school tuition is increasing across the country at an alarming rate. The high cost of tuition may put a medical education out of the reach of disadvantaged students and students with other financial responsibilities (i.e. those with children). Public medical schools have traditionally offered affordable tuition rates to in-state residents, thus enabling students with limited personal financial resources to attain their dreams of becoming physicians without accruing massive amounts of debt. However, as shown in Figure 3, many states have considerably increased their in-state tuition in recent years. Only three states currently offer annual medical school tuitions of less than \$10,000, down from twenty-two states six years ago.



**Figure 5:** Increasing cynicism and depression with increasing debt burden. White bars represent residents with more than four symptoms of major depressive disorder, grey bars residents who report increased cynicism.

In New York, tuition at State University of New York (SUNY) schools has increased more rapidly than have financial aid resources, leaving some groups of students in financial crises. After three consecutive tuition hikes of \$2,000 each, an in-state medical student at SUNY-Stony Brook would have to borrow nearly \$40,000 to entirely cover tuition, fees, and living expenses.<sup>33</sup> Because this amount is more than the current limit of \$38,500 per year on Stafford loan borrowing, students have had to seek out private loans as well. Disadvantaged students and those with poor credit ratings face difficulty obtaining such loans. Moreover, students who are married and/or have children generally must borrow in excess of the estimated student budget, leaving them with sizeable private loans that are not subject to consolidation following graduation. Continuing the Stony Brook example, a student heading a family of 4 would have annual living expenses of approximately \$50,000. If this entire amount must be taken out in private loans, the student would accumulate \$46,472 in private debt. This is a crushing debt burden given the high interest rates associated with private borrowing.

As medical student debt escalates, so does the debt burden of residents and young physicians. As shown in Section II.B.2., higher debt among residents leads to burnout and dissatisfaction. Similarly, high debt burden leads to doubts about career choice among young physicians in primary care.<sup>34,35</sup> Young physicians are the least likely of all physician groups to participate in the development of their profession through organized medicine. There has been a continual decline in the number of physician-researchers since 1980, including a decrease in the number of new investigators applying for NIH R-01 grants; physician-scientists fell from four percent of the

physician workforce to approximately one percent in 2000.<sup>36,37</sup> Additionally, the pressures of paying off a mortgage-sized educational debt may affect young physician decision making regarding patient care, although this possibility has not yet been rigorously studied.

### **III. Advocacy Goals for Reducing Student Debt**

#### **III.A. Federal Legislative Options**

Key targets for action on medical student debt in the 108<sup>th</sup> Congress are:

- 1) Securing adequate funding for Title VII health professions programs in the FY 2005 Labor-Health and Human Services, Education and Related Agencies appropriations bill;
- 2) Reauthorization of the Higher Education Act;
- 3) Expanding and protecting the National Health Service Corps (NHSC) Loan Repayment Program; and
- 4) Broadening the tax-exempt status of medical scholarships.

##### **III.A.1. Title VII Programs**

Title VII of the Higher Education Act includes all federal funding for post-baccalaureate study. Title VII programs with direct impact on medical student debt include the Faculty Loan Repayment Program and the Scholarships for Disadvantaged Students Program. These programs address the twin goals of increasing access to medical education and promoting diversity. Decreasing their funding directly increases the overall debt load specifically for minority and disadvantaged medical students. As was explained in Section II.B., the U.S. already faces a shortage of students and physicians from disadvantaged and minority backgrounds. We can ill afford to lose further support for those students.

The Faculty Loan Repayment Program provides for the repayment of educational loans of individuals from disadvantaged backgrounds who are health professions students or graduates, and who have agreed to serve for not less than two years as a faculty member of an eligible health professions school. The Scholarships for Disadvantaged Students program provides scholarships to financially needy full-time students from disadvantaged backgrounds, enrolled in health professions and nursing programs. On July 10, 2003, while allocating more than the Administration's request, the House of Representatives cut Title VII funding by \$30 million.<sup>38</sup> The House of Representatives provided \$42.3 million for scholarships for disadvantaged students, lower than the FY2003 funding level of \$47.8 million and \$32.5 million above the Administration's budget request. The House also provided \$1.1 million for the Faculty Loan Repayment Program, \$150,000 less than FY2003, even though the Administration requested zero funding for this program. Regardless of the outcome of the FY2004 Appropriations process in the Senate, further advocacy is needed to restore and increase funding for these programs.



### **III.A.2. Reauthorization of the Higher Education Act**

The reauthorization of the Higher Education Act of 1965 (HEA) during the 108<sup>th</sup> Congress presents an opportunity to:

- III.A.2.a. Broaden the definition of “economic hardship” for determining eligibility for student loan deferment
- III.A.2.b. Extend the deferment period to the entire residency/fellowship period
- III.A.2.c. Continue student loan forbearance
- III.A.2.d. Sustain the current federal student loan consolidation program with fixed interest rates
- III.A.2.e. Eliminate the “single holder rule”
- III.A.2.f. Preserve the in-school interest subsidy
- III.A.2.g. Increase the tax deduction amount and income thresholds for student loan interest
- III.A.2.h. Expand current loan programs including Medicine specific programs
- III.A.2.i. Include dependent care costs in the “cost of attendance” definition.

The Department of Education called for comments and proposed changes in early 2003, and the House Education and Workforce Committee held hearings through summer and fall of 2003 regarding the reauthorization of the HEA. The Senate is not expected to take action on HEA reauthorization until 2004.

#### **III.A.2.a. Broadening the Definition of Hardship for Loan Deferment**

The 1992 reauthorization of the HEA established a three-year student loan deferment period for resident physicians who qualified as having an “economic hardship.” Hardship is determined by the borrower’s income and his/her debt-to-income ratio. A borrower is considered to have an economic hardship if:

1. He/she is working full-time,
2. He/she has a federal education debt burden that equals or exceeds 20% of the borrower’s adjusted gross income (AGI), and
3. The difference between the AGI minus such burden is less than 220% of the greater of: (a) the annual earnings of an individual earning the minimum wage or (b) the income official poverty line applicable to a family of two.

Many medical borrowers do not qualify for loan deferment under the current definition of economic hardship. Elimination of the 220% rule would allow for more resident physicians to qualify for loan deferment. Alternatively, if elimination of the 220% rule is not possible, increasing the 220% threshold would benefit more borrowers with large federal education debt burden in lower-paying specialties such as primary care.

### **III.A.2.b. Extending the Hardship Deferment Period**

Residents who qualify for student loan deferment may only defer loan repayment for up to three years – the minimum duration of residency training. Extension of loan deferment throughout the entire residency and fellowship periods would decrease financial stresses on those residents whose training lasts beyond three years. During the deferment period, residents with subsidized student loans would not be charged interest; however, interest would have to be paid on unsubsidized loans or be capitalized into the principal. There are presently 61,902 residents in programs that last beyond three years, or 63% of the total number of residents working in the United States.<sup>39</sup>

### **III.A.2.c. Maintaining Forbearance as an Alternative to Deferment**

Eligible resident physicians who have exceeded the three-year deferment period or who do not qualify for deferment may seek to put their student loans into forbearance for the remaining duration of their training, loan or other applicable period, as specified by law or contract. Forbearance differs from deferment in that loan payments are not eliminated entirely, but are reduced temporarily to some more manageable level, with larger payments expected later during the term of the loan. It is granted at the discretion of the loan servicer/holder, either public or private. Absent extension of the deferment period, continuation of student loan forbearance could provide certain short-term benefits in managing the financial burdens of medical education.

### **III.A.2.d. Retaining Fixed-Interest Rate Consolidation Loans**

Consolidation is perhaps the most critical issue during this reauthorization. The ability to consolidate student loan debt allows new physicians to cut their payments in half through lowered interest rates and income-sensitive repayment terms. The consolidation program as presently authorized also gives borrowers a fixed interest rate for the life of the loan, protecting students against escalating interest rates.

Under the current consolidation program, students who have received multiple loans may consolidate them exactly once, expanding their term of payment and locking in a fixed interest rate that is often lower than the rate of the original loans. Representative David Wu (D-OR) has authored a bill (**H. R. 2711**) that would allow refinancing of a consolidated loan and would cap interest rates on consolidated loans at 6.8%. Representative Rosa DeLauro (D-CT) has also introduced legislation (**H. R. 2505**) that would let borrowers refinance consolidated loans. However, lenders maintain that allowing borrowers the ability to refinance consolidated loans at lower interest rates will shift taxpayer subsidies from students in school to borrowers in repayment and would constitute a retroactive change imposed by the federal government on contract terms.

From a student perspective, the ability to reconsolidate and refinance loans and obtain a fixed interest rate is particularly important now, when interest rates are at historic lows. With the

ability to refinance consolidated loans, certain borrowers could take advantage of up to 5-percentage-point decreases in their current interest rate. As shown in Table 2, a drop of five points in interest rate will allow a resident to keep 10% more of his/her already small after-tax salary. Using the average resident salary of \$38,000 quoted above, consolidation loans could save a resident as much as \$3,600 per year.

Interest Rate	Mean Monthly Payment	Percentage of Take-Home Pay
1%	\$959	36%
2%	\$1,008	38%
3%	\$1,057	40%
4%	\$1,108	42%
5%	\$1,161	44%
6%	\$1,216	46%
7%	\$1,271	48%
8%	\$1,329	50%
9%	\$1,387	53%
10%	\$1,447	55%

**Table 2:** Monthly loan payments on a \$109,500 loan (average medical student debt) paid over 10 years as percentage of post-tax (based on single IRS tax brackets) income on a salary of \$38,000 (average PGY-1 salary) given various interest rates. No late payments or defaults are assumed.

### III.A.2.e. Eliminating the “Single Holder” Rule

The “single holder rule” requires student loan borrowers who wish to consolidate educational loans to refinance through their current lender when all their existing loans are held by that lender. This prevents students from taking advantage of more favorable terms offered by competing lenders. Representative Ralph Regula (R-OH) has introduced a bill, the **Consolidation Student Loan Flexibility Act of 2003 (H. R. 942)**, for elimination of the rule.

Repeal of the single holder rule has been unachievable in the past. Lenders have strongly supported the rule because increased consolidations at low rates decrease their profits. Also, some members of Congress believe that scarce federal monies should be used for assisting current and future students, rather than former ones. (This is a misconceived argument; see below.) The reauthorization of the HEA is an opportunity to revisit the issue. The current rule limits consumer choice in refinancing student loans. Furthermore, more than one third of all federal student loans are held by one particular private loan holder, Sallie Mae, which means the likelihood of a borrower falling under the single holder rule is relatively high.<sup>40</sup> Lobbying efforts on this rule should emphasize the importance of consumer choice and the ability to obtain the best possible loan terms for student borrowers carrying large educational debt loads.

It is critical to understand that consolidation does not actually divert funds from students presently in school. In fact, due to the service fees that lenders must pay to the federal government, the Federal Family Education Loan consolidation program generated **\$1.4 billion** in federal revenue over 1995-2002 and is projected to generate another **\$1 billion** in 2003-2004.<sup>41</sup>

While consolidation loans originating in the past few years may have a net cost over the lifetime of the loan due to presently low interest rates, changes in the program cannot affect those costs in any way because the loans have already been made. The only thing that can be affected is the cost of loans originated in federal fiscal years 2005-2010, the years between now and the next reauthorization. Between now and the next reauthorization, loans originated after FY2004 will generate \$850 million in cash flow if interest rates follow Congressional Budget Office estimates.<sup>41</sup> When discounted to net present value for credit scoring purposes, this represents a federal budget savings of **\$1.9 billion**. In short, as long as the present fee structure remains in place, consolidation lending under existing fixed-rate terms benefits both students and the government.

**III.A.2.f. Preserving an In-School Interest Subsidy**

Under the in-school interest subsidy as defined in 20 USC 1078, the government pays interest on subsidized Stafford and Perkins loans while students are in school. This subsidy prevents capitalized interest from compounding upon the principal borrowed once the student enters repayment. Without the subsidy, interest would accrue on student loans beginning at disbursement (when the student enters school), rather than after graduation. Elimination of this subsidy has previously been rejected by Congress. Nonetheless, attention to this issue is critical to ensure that the subsidy remains intact during the reauthorization process. Table 3 illustrates that the use of subsidized loans can save thousands of dollars in interest over the standard 10-year repayment. Although the decrease in monthly payment is only \$100, that small amount represents a significant difference when working within a resident’s limited budget. However, this table does also indicate that the present subsidized Stafford borrowing limit of \$8,500 is fairly low, and that greater impact could be achieved by raising that limit to \$10,000 or higher.

<b>With In-School Interest Subsidy</b>				
<b>Interest Rate</b>	<b>Interest Accrued</b>	<b>Debt at Graduation</b>	<b>Total Repaid</b>	<b>Monthly Payment</b>
3.42%	\$6,627.00	\$134,627.00	\$159,147.81	\$1,326.23
5%	\$10,340.00	\$138,340.00	\$176,077.25	\$1,467.31
7%	\$15,040.00	\$143,040.00	\$199,297.65	\$1,660.82
8.25%	\$17,977.50	\$145,977.50	\$214,854.44	\$1,790.45
<b>Without In-School Interest Subsidy</b>				
<b>Interest Rate</b>	<b>Interest Accrued</b>	<b>Debt at Graduation</b>	<b>Total Repaid</b>	<b>Monthly Payment</b>
3.42%	\$9,024.00	\$137,024.00	\$161,981.47	\$1,349.84
5%	\$14,080.00	\$142,080.00	\$180,837.42	\$1,506.98
7%	\$20,480.00	\$148,480.00	\$206,877.37	\$1,723.98
8.25%	\$24,480.00	\$152,480.00	\$224,424.69	\$1,870.21

**Table 3:** Effect of the in-school interest subsidy. Calculations assume the 2002-2003 average private tuition of approximately \$32,000 per year, capitalization of interest upon graduation, a 10-year repayment period, and an \$8,500 limit on subsidized Stafford borrowing.

### **III.A.2.g. Improving the Tax Deductibility of Student Loan Interest**

Graduates of higher education are able to deduct up to \$2,500 in student loan interest each year. This deduction amount has not kept pace with the increase in the cost of higher education.<sup>42</sup> The deduction is available only for interest payments made during the first 60 months in which interest payments are required on the loan; this is far shorter than the time required to pay off student loans, and is still shorter than some residencies. The deduction became available to filers in 1998. At that time, the deduction was \$1,000 and was set to rise to \$2,500 for 2001 and beyond. A recently enacted increase in thresholds (adjusted to inflation) allows single filers with annual adjusted gross income (AGI) up to \$65,000 and joint filers with AGI up to \$130,000 to deduct student loan interest on their federal taxes. Increasing these income thresholds would allow more borrowers, especially those with high debt loads, to qualify for the benefit. In October 2003, Representative Phil English (R-PA) introduced the **Higher Education Affordability and Equity Act**, which would further raise the thresholds to \$115,000 for single and \$230,000 for joint filers and would remove entirely the cap on the size of the deduction.

### **III.A.2.h. Expanding Current Loan Programs**

The current Stafford and Perkins loan programs are designed for traditional students who will earn a full income upon graduation. Law students or engineers will join a firm or start their own business. New physicians, however, enter into residency, in which their income is limited to the salary granted by their residency. Salaries of residents are often not adequate to cover both loans and basic necessities. A separate loan program, the extension of Pell grant eligibility to cover professional school students, or a modified “health professions Stafford” could lessen the burden on young physicians.

Elements of a successful new or modified loan program would include comparable rates to those offered to Perkins or Stafford loan recipients and the possibility of deferral of loan payments through residency (with a continuance of federal interest subsidies during deferment). Physicians could then begin to pay their loans when their training is truly complete – after residency. Likewise, expanding the Pell grant program or creating a medicine specific equivalent would target the economically disadvantaged students who are borrowing at the highest rates.

### **III.A.2.i. Including Dependent Care in the “Cost of Attendance”**

Medical students are not allowed to include dependent care, dependent health insurance, or dependent living expenses as part of their “cost of attendance” when their financial aid packages are being considered. With more non-traditional students and students with families, inclusion of dependent care costs in the “cost of attendance” definition is important for many borrowers. Although this would increase their borrowing limits, such a change would still reduce final debt. If dependent care expenses were taken into account, non-traditional students would receive more generous financial aid and would more easily qualify as having financial hardship.

### **III.A.3. National Health Service Corps Loan Repayment Program Reforms**

Senator Maria Cantwell (D-WA) and Representative George Nethercutt (R-WA) have introduced bills in the Senate (S. 529) and House of Representatives (H.R. 1522), respectively, to exclude loan repayment payments received under the NHSC Loan Repayment Program from gross income for federal taxation purposes. This would provide aid to health professionals seeking loan repayment and serve as an incentive for joining the NHSC, thereby increasing the number of providers in underserved areas. Currently, there are approximately 2,000 applicants for 350 NHSC positions. At the same time, approximately 20% of Americans are living in designated health professional shortage areas.<sup>43</sup> It will be necessary to significantly expand the NHSC and similar incentives to reach the federal target of one primary care physician per 3,000 patients in each geographic area.

### **III.A.4. Tax Exemptions for Medical Scholarships**

Students in the NHSC and Armed Forces Health Professions Scholarship programs receive not only tuition reimbursement, but also a stipend to cover their living expenses. Under existing federal law, the tuition reimbursement is exempted from federal income tax as “qualified educational expenses”, but the stipend is not. The same is true for students in most M.D./Ph.D. programs and students covered by various private and school-sponsored scholarships. In addition to making loan repayment easier, it is possible to reduce aggregate student debt by increasing the number of scholarships available under these various programs. One option to stretch each scholarship dollar further is to extend the existing exemption to cover stipends as well. Over the long run, this will allow more students to be supported on the available scholarship funds. The Higher Education Affordability and Equity Act mentioned above also includes this provision.

## **III.B. State Legislative Options**

There are three areas of potential action to alleviate medical student debt at the state level:

### **III.B.1. Tuition Caps**

Medical students in New York State have created a SUNY Task Force to end tuition hikes, particularly mid-year increases. This initiative is supported by the Medical State Society of New York (MSSNY) and the AMA. The ultimate goal of the SUNY Task Force is to pass state legislation that would institute four-year tuition caps on medical school tuition at state medical schools. This would allow students to make informed decisions about what medical school they plan on attending, as well as allow for better financial planning. For a more detailed analysis of the need for tuition caps, either legislatively or voluntarily imposed, see Section III.B., Medical School Policies.

### **III.B.2. State Tax Deductions for Loan Interest**

In February 2003, New York Assemblyman Lafayette proposed A4331, an amendment to tax laws that would provide a state income tax deduction for the interest accrued on student loans. A4331 has currently been referred to the Ways and Means Committee, and is unlikely to emerge from committee without significant grassroots activity from students and physicians. Similar legislation could be introduced elsewhere with the assistance of medical societies in other states.

### **III.B.3. State Service Loan Repayment Programs**

#### **III.B.3.a. Proposed Changes to Existing Programs**

According to the AAMC, 45 states, the District of Columbia, and Puerto Rico all have state based loan repayment programs, although the number of positions available and source of funding varies by state.<sup>44</sup> The National Health Service Corps fills an average of 350 spots from a pool of 2,000 applicants each year, and applicants may be assigned to positions far from their home region. State based Loan Repayment Programs (LRPs) more closely fit the natural desire of students to stay in the state or region where they trained, increasing the likelihood they will remain in practice in the underserved area after their service obligation is filled.

To increase their effectiveness, LRPs should allow medical students and residents to apply as late as possible in their training in order to accommodate changes in career plans and student priorities. While programs can be targeted towards primary care, it makes sense to allow other specialties to apply as well (indeed, certain specialists are in shorter supply in rural areas than are primary care physicians) to best serve the changing needs of the communities.

The impact that any state LRP will have in addressing both the issues of access to care and student debt will depend on that state's commitment to increasing program funding. The limiting factors are likely to be the number of spots available in the program and the total loan repayment. In our era of expanding state budget deficits, locating funds for an LRP can be difficult. Looking to other options, such as state medical boards and foundations, and even creating federal matching funds, may be necessary. Since funding is unlikely to ever be sufficient to meet the needs of interested students and underserved populations, loan repayment programs by themselves are not the final solution. They may, however, be able to mitigate the worst effects of climbing debt loads on access to care for underserved populations.

#### **III.B.3.b. Case Study of a New Program: The California Physician Corps**

The California Physician Corps (CPC) was established on January 1, 2003.<sup>45</sup> Modeled after the National Health Service Corps, CPC will repay up to \$105,000 in student loans after three years of service (\$25,000 for one year, \$60,000 for two years) to physicians who choose to practice in underserved rural and urban areas of the state. CPC mainly targets primary care physicians (internal medicine, pediatrics, family practice, and OB/GYN), but up to 15% of participants each year can be specialists. Resident physicians can apply for this program in their final year of residency or any time afterwards. Specific to the needs of the California population, the program also includes language fluency stipulations. The program is currently run by the state of

California in conjunction with the California Medical Board (CMB), and more information can be found on the CMB website: <http://www.medbd.ca.gov/mdloan.htm>.

The CPC was created in response to the growing physician shortage crisis in California (highlighted by the results of the 2000 census) and pressure from a variety of different advocacy groups. In many parts of the state, patient to physician ratios had climbed into the thousands, and legislators had introduced bills to allow unlicensed Mexican physicians to staff clinics in underserved areas in order to alleviate the clinician shortage. The California Medical Association Medical Student Section proposed a loan repayment program modeled after the National Health Service Corps as an alternative solution. According to their surveys, 51% percent of students felt that a loan repayment program would increase their likelihood of practicing in an underserved area. That percentage jumped to 62% if they were allowed to make the choice during residency.

Initial funding for the CPC was accomplished through reallocation of State Medical Board funds. Alternative sources of funding, such as the California Foundation, are being explored for future years.

### **III.C. Reform of Individual Medical Schools' Financial Policies**

Medical school is a serious financial commitment. While in school, students face major spending on tuition, fees, and living expenses. After graduation, the student's income increases, but it is now directed toward loan payments. Medical schools and their associated universities are able to reform their policies to reduce the burden both before and after graduation.

#### **III.C.1. Changes in Policies Regarding Tuition**

Tuition comprises the bulk of school-induced student debt. Any prudent education borrower will incorporate expected tuition increases into their budget well in advance of committing to a program of study. In the past, students could anticipate most schools setting tuition prior to beginning the academic year and raising it annually. Traditionally, tuition increases were unwelcome and burdensome, but were at least predictable and stable. Recently, that trend has been replaced by mid-year tuition hikes, retroactive increases, and exponential growth in percentage tuition increases. Upon entry to medical school, students can no longer assume or even extrapolate how much tuition they will be required to pay throughout their four years of education. Strategies aimed at assisting or managing debt repayment are likely to be ineffective at reducing aggregate debt unless the creation of new debt can also be slowed. The ultimate solution therefore must involve some form of tuition cap, either over all four years or within each year. We recommend that tuition not be permitted to increase above \$50,000 per year at a private school or \$30,000 per year at a public school, with future adjustments for inflation.



### **III.C.1.a. Four -Year Tuition Caps**

In 2001-2002, only 7 of the 125 US medical schools had a tuition cap policy whereby tuition is set for the four years at matriculation. By setting the tuition in advance, these seven schools guarantee that their students will not receive any unexpected increases. While it is impossible to control all of the potential pitfalls of financing medical school, these schools allow their students to control a substantial component.

There is a potential danger to students at private schools, as the burden of any increases in the cost of medical education will fall entirely upon entering students. However, Washington University, a private school, caps tuition upon matriculation. In 2002, Washington University students who financed their education through loans averaged \$91,324 in debt, much less than the national average for private school students at \$123,780 and slightly less than the national average for public schools at \$91,389.

### **III.C.1.b. Annual Tuition Caps**

While the four-year tuition cap is the ideal practice, it is difficult for medical schools to fix tuition for four years unless they are guaranteed steady sources of funding. Most other medical schools set their tuition on a yearly basis due to the lack of reasonable foreknowledge of the availability of outside sources of funding, e.g. funds from state government, alumni benefactors, and other private donors. This is particularly true for public medical schools, which rely heavily on state budgets for funding. In difficult financial times, medical schools may not have sufficient government funds to maintain their operations. Therefore, schools, their parent universities, or state governments may impose large and unanticipated tuition increases to generate the needed income. While yearly tuition increases merely complicate one's long-term financial planning, mid-year increases can wreak havoc.

As long as schools cannot fix tuition on a four-year basis because of external factors, they should endeavor to provide their students with a reasonable estimate of the cost of attending the school over four years. While this is an imperfect solution it does allow students to have some idea of their total education cost, thus allowing them to make more informed financial decisions. At the very least, schools must not raise tuition mid-year or in a retroactive manner.

### **III.C.2. Changes in Policies Regarding Fees**

In addition to their tuition, medical students also pay a variety of fees (defined as money required from students for some specific reason). These include fees for computers, activities, gyms, and others resources medical students may use. Other fees mandated by the school or university for their medical students include disability insurance fees, health insurance fees, and malpractice insurance fees. Some universities levy fees on medical students simply for being medical students (e.g., the "professional students fee" at the University of California for students enrolled in professional but not academic graduate programs.)

Raising tuition has some checks and balances in most situations. It affects all students, is undesigned funding that will be fought over by intramural constituencies, and in some situations it may have to be approved by the legislature. Fees, however, are not governed by the same principles and can often be raised more easily. Close attention must be paid in order to prevent fees from outstripping tuition as the principal source of excessive debt.

### **III.D. Innovative Strategies for Reducing Student Loan Needs**

#### **III.D.1. Increasing Grants and Scholarships**

The ultimate problem caused by high tuition and fees are the loans that need to be absorbed in order to cover those costs. Grants and scholarships reduce medical student reliance on loans. A shining example is the Mayo medical school, which provides 50% of students with tuition scholarships, made possible by benefactor dollars.<sup>46</sup> State medical societies could assist in this process by organizing physician scholarship drives. The AMA could further support schools in such an endeavor by providing “best practices” examples and/or convening conferences (most likely in conjunction with the AAMC). Schools that have used students as callers and have placed all funds raised directly into a scholarship pool have had substantial increases in giving for undergraduate medical education.<sup>47</sup> While it is not known if this strategy would be successful for medical schools or state societies, it would be foolhardy to ignore it.

#### **III.D.2. Collaborative Graduate-Undergraduate Debt Counseling**

Schools are able to provide financial aid expertise and debt counseling. These services help medical students reduce the impact of the almost-inevitable loans. Since debt accumulation begins during undergraduate study, medical schools can help future medical students by coordinating debt counseling with undergraduate financial aid offices. Schools without attached undergraduate campuses could achieve this by partnering with nearby colleges.

#### **III.D.3. Collective Buying to Reduce Student Expenses**

Schools can take action to reduce accessory costs of education. These include, for example, the cost of parking at and eating at hospitals during the clinical years and the cost of purchasing stethoscopes, tuning forks, and other medical supplies. Schools could coordinate large purchases of these products and reduce the cost to the end users through economies of scale. A non-mandatory fee charged by the school could cover these purchases.

## **IV. Long-Term Remedies for Controlling Medical Student Debt**

Throughout this report, we have outlined the critical issues relating to the current medical student debt crisis. We have discussed the root causes of increasing tuition, the effects that it has on medical students, physicians, patients, and the health care system in general, and a number of

short term options for alleviating or mitigating the worst consequences of the rapid rise in medical student debt. Though we are many years away from a long term, sustainable solution to the financing of medical education in this country, in this section we will discuss a number of possible starting points for tackling this issue in the coming decades.

#### **IV.A. Increasing Existing Scholarship Funding**

Most debt reduction efforts have focused on assisting students in loan repayment. While this may be an efficient way to encourage young physicians to work in primary care, underserved areas, the military, or in research, those career tracks do not cover the majority of new medical graduates. As costs to the medical schools for educating medical students are significant (see Section I.A. and below), and as state and federal support for education wanes, schools often see no option besides increasing tuition or sacrificing quality if they are to remain solvent. Scholarship funds at most medical schools are limited, and often are focused on students from disadvantaged backgrounds, minority students, those students who are interested in pursuing research, or the top ranked students in the class.<sup>47</sup>

“Medical education, originally the core mission of the medical school, has been moved to the periphery because the evolution of AMCs occurred as a response to outside forces, without due consideration of education.”<sup>48</sup> Academic Medical Centers (AMCs) are increasingly focusing resources towards research and patient care, and are making demands on faculty that detract from the academic mission. AMC fundraising is similarly focused on building infrastructure for research and clinical services, not on scholarships or funding general education.<sup>49</sup>

Increasing the pool of scholarship funds is the least costly way to reduce the effects of debt on medical student decision-making and reduce the debt burden on residents and young physicians. As shown in Table 1, students who pay interest rates of 5.25% over thirty years will pay back twice the amount they borrowed over the life of the loan. Scholarship funds cost little to administer and often generate goodwill with students; despite this, endowments and gifts for scholarships are a small percentage of medical school finances – 3.8% in 1998-1999.<sup>47</sup>

There are several possible strategies for increasing scholarship funds. National, state, county, and school-based funds exist and all could be targets for expansion or revision. However, there is no single national entity that could raise sufficient dollars to fund every medical student. Federal government funding is considered below. The AMA Foundation distributed \$723,762.09 to 179 schools in 2003;<sup>50</sup> this is far short of the hundreds of millions of dollars that medical students spend on tuition each year. While the Foundation may be able to alter its mission to include a general scholarship fund for medical students, it is not certain that it would be more efficient than medical schools or other local bodies. The Foundation could establish itself as a central body for the distribution of medical school scholarships from other national bodies, or could serve as a central repository for information on other national scholarship funds.

State medical societies do collect and distribute scholarship funds, either through the society or through the medical schools themselves. The willingness of more state societies to take on this task is unknown. The Kansas State Medical Society has formally expressed a willingness to

increase its fundraising efforts in order to help reduce student debt,<sup>51</sup> and other state organizations have informally expressed interest. Enlisting the assistance of state medical societies should be explored.

Medical schools themselves may be the most logical source of scholarship fundraising. Schools already have significant fundraising infrastructure and mechanisms to allocate and distribute funds to all students. Funds currently being raised for infrastructure could also be raised for assisting with the costs of medical training itself, although students often lack control over the school's fundraising priorities. Medical school alumni donation rates are generally significantly lower than undergraduate or other alumni donation rates. Raising money from medical school alumni for a general scholarship fund (or smaller, named funds) has helped Mayo and Georgetown University Medical Schools keep tuition inflation rates lower than the national average and to fund a large proportion of their students.<sup>46</sup> Enlisting medical schools to raise funds specifically for the purposes of tuition reduction or scholarship funds, from alumni or from philanthropic sources, should be explored.

While the efforts at each level may not be able to stem the raising tide of debt alone, concerted effort at the local, state, and national level may at least bring stability to student costs. Loan repayment programs may be more effective in bringing young physicians to underserved areas than scholarships, but reduced debt in the general physician population may also reverse or mitigate the trend away from academic medicine, primary care, and underserved areas.

#### **IV.B. Earmarking Federal Funding for Undergraduate Medical Education**

While the concept of direct federal funding of undergraduate medical education (UME) might seem foreign to many on this side of the Atlantic Ocean, there is strong precedent for federal involvement in funding medical education in the United States. Since 1965, the federal government has funded graduate medical education (GME), primarily through Medicare but also through other government programs such as Medicaid, the Veterans' Administration, and the Department of Defense. In its original report to Congress on the creation of the Medicare Program, the House Ways and Means Committee made clear not only the value of medical education, but also the importance of supporting it at the federal level: "...educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education cost in some other way, that a part of the net cost of such activities should be borne to an appropriate extent by the hospital insurance program..."<sup>52</sup>

Currently, Medicare supports teaching hospitals with \$7.8 billion per year for Direct Medical Education funding (resident and faculty salaries) as well as Indirect Medical Education funding (the less tangible costs associated with running an academic hospital). Additionally, certain states provide funding to GME via the federal Medicaid program to the tune of \$2.4 billion dollars a year. The Department of Veterans' Affairs funds roughly 10% of all resident positions in the US and the Department of Defense covers an additional 3%. Finally, the new Children's Hospital Teaching Fund provides \$235 million per year in support of GME.<sup>53</sup> All told, the federal government pays nearly two-thirds of the estimated \$18 billion per year it costs to train America's 100,000 residents.<sup>54</sup> If we accept that undergraduate medical education costs about

\$40,000 to \$50,000 per year per medical student, then the total cost of UME for our country's 80,000 osteopathic and allopathic medical students would be \$3.2 to \$4.0 billion per year, a fraction of what the federal government already pays for graduate medical education each year.

If GME is seen as a public good, worthy of support by the federal government, then UME should be treated the same way. It is true that residents are directly providing for the public good by caring for patients, while medical students might not seem to be. However, medical students do spend a significant amount of their time providing care to patients, both inside the hospital through their required and elective medical rotations and outside the academic system through their volunteer work in free clinics. Additionally, undergraduate medical education provides an indirect public good by training the future physician workforce of America.

The simplest route of federal funding for UME would be a dedicated fund administered by a body such as the Department of Health and Human Services. However, there is little precedent for dedicated federal funds towards medical education, making this route less politically feasible. More likely would be earmarking funds for UME from some larger source of funding already going into Academic Medical Centers (AMCs). Medicare is the most obvious example, as funding for GME already flows into AMCs from this source. Increasing the funding Medicare puts into medical education by 10% and earmarking it for undergraduate medical education would give AMCs across the country an additional \$780 million dollars a year to spend on educating the future physicians of America. If used honestly by AMCs to mitigate the impact of rising debt on this future physician workforce (and stipulations could be put in place requiring them to do so), tuition at public and private institutions could be reduced by nearly \$10,000 a year. Increasing Medicare funding towards medical education by 22% would completely pay for medical student tuition and fees at all public and private medical schools in the country (based on average cost of public and private allopathic medical school tuition and fees).<sup>55</sup> This latter goal is neither realistic nor strictly necessary, but it highlights the long term impact that relatively small increases in federal funding towards medical education could have on medical student tuition and fees, and, as a result, medical student debt.

Due to increasing Medicare budget constraints, the \$7.8 billion presently spent on graduate medical education should not be taken for granted. Even small increases in this figure would be difficult to attain. Furthermore, tying medical education funding, whether graduate or undergraduate, to the federal Medicare program lacks long term sustainability since the Medicare program itself is slated to run out of funds within the next 30 years. However, this also presents a perfect opportunity to address medical education financing. As various Medicare reforms are debated and implemented in the coming decades, we will have the opportunity to argue for incorporating long term, sustainable funding of medical education into those reforms.

An alternative to Medicare funding is the National Institutes of Health (NIH), another organ through which significant amounts of money flow into AMCs. The National Institutes of Health pours \$9.65 billion dollars a year into 125 U.S. medical schools, though the actual NIH award per medical school varies widely from \$100,000 to \$382,000,000.<sup>56</sup> If even 8% of these funds were earmarked for undergraduate medical education, it would be enough to reduce tuition by \$9,650 a year for every medical student in the country. However, the amount of funding actually available to each medical student would vary by institution depending on their yearly NIH

award, from about \$63,700 per medical student per year at Johns Hopkins University to about \$28 per medical student per year at Southern Illinois University. This would not be an equitable solution; one way around this would be to earmark the funds at the national level as a percentage of total NIH grants per year, and then devise a mechanism for distribution to public and private medical schools. Schools can be required to use the money solely to fund UME, with the intention of reducing tuition. Though this avenue for funding undergraduate medical education remains logistically complex, it benefits from the fact that the NIH itself is not suffering from budget crunches to the same degree as Medicare, Medicaid, and other government programs. Additionally, there are precedents for NIH funding of education. NIH presently pays tuition, fees, and a stipend for medical students participating in the Medical Scientist Training Program and for Ph.D. candidates in certain scientific programs. However, this option will likely face opposition from AMCs and especially research scientists as it would cut further into the percentage of their grant award that they are actually able to spend.

#### **IV.C. Expanding Loan Repayment Programs**

As detailed in Section I.E., there are a number of federal, state, and foundation based Loan Repayment Programs (LRPs) currently operating. Two of the largest, the National Health Service Corps and the Indian Health Service, tie loan repayment to service for a specified amount of time in a particular type of underserved area. In October 2002, President Bush signed the "Health Care Safety Net Amendments" legislation (S.1533), which both reauthorized and strengthened the National Health Service Corps (NHSC), increasing funding for it and creating a demonstration project to include additional types of health care professionals, such as chiropractors and pharmacists.<sup>57</sup> Furthermore, the President's FY 2003 budget proposal called for \$191.5 million for the NHSC, an increase of \$44 million (29.8 percent).<sup>58</sup> These actions by Congress and the President, coupled with the creation and expansion of state LRPs by states such as California, signal the willingness of federal and state government to put more money into LRPs that directly improve access to health care for underserved citizens. One possible solution to the issue of medical student debt would be capitalizing on this willingness by expanding federal and state LRPs to cover as many medical students as would be willing to participate.

The NHSC estimates that roughly 50 million Americans currently live in Health Professional Shortage Areas across the United States. They also estimate that 27,000 primary care professionals are needed to adequately serve all the people living in HPSAs, but current funding allows for only 2,700 active NHSC clinicians who care for about 4 million people.<sup>59</sup> Clearly, the number of spaces for participating clinicians could be expanded 10 fold without filling up the need for health professionals in underserved areas. Other LRPs such as the Indian Health Service could also be expanded as necessary to meet the need of their target populations.

There are a number of qualities that make LRPs an attractive solution to the growing crisis in medical student education costs, the most important of which is that they address two critical issues simultaneously: medical student debt and access to health care. By tying increased access to care to the issue of medical student debt reduction, the latter becomes more politically viable. Advocating for LRPs allows organized medicine to join a wide range of coalition partners, from patient advocates to inner city and rural municipalities to other allied health professional

organizations, in pushing for a program that serves all. By recruiting medical students and physicians interested in providing care to the underserved, these programs also function to remind both the medical profession and the public of the important and ancient role of service that remains fundamental to the practice of medicine.

There are at least two major drawbacks to LRPs as a long-term solution to the problem of medical student debt. First, it is unclear at what point increasing opportunities for medical students to participate in LRPs will saturate demand for the program. In past years, the NHSC has received about 2,000 applications. Increased advertising (and increasing levels of debt in the coming years) may convince more students to apply to the program. However, LRPs like the NHSC are unlikely to be a viable option for a significant percentage of indebted medical students in this country for a variety of reasons, whether due to choice of specialty or family restrictions that prevent movement to an underserved area. Even more important, however, is the fact that LRPs function to shift federal funds into the hands of already wealthy banks by covering not only the cost of medical education (reflected by the principal loan amount) but also the interest on that principal that the student owes to their lender. Paying for medical education up front would be a far more efficient way of addressing medical student debt.

#### **IV.D. Decreasing Total Duration of Pre-Residency Education**

The U.S. system of medical education is the only system where the majority of medical students complete an undergraduate degree before entering Undergraduate Medical Education. In the entering class in 2001-2002, only 1% of students entering US medical schools had no bachelor's degree.<sup>60</sup> This unique system is alleged to produce more well rounded medical students with a better grounding in the humanities and the non-medical sciences than European or Asian programs, where UME is a six year program of study following secondary school.<sup>61</sup> According to the AAMC, there are 28 BS/MD programs currently in the United States.<sup>62</sup> Most require that the students complete a four-year course of study before beginning medical school; a few allow entrance into the MD program following the third year of study on a competitive basis. In other words, many BS/MD programs shorten medical training by only one year, and that only in the best case.

International medical graduates (IMGs) who attend six-year programs have similar attrition and transfer rates as US medical graduates and have consistently outperformed US Medical Graduates on in-training examinations in Internal Medicine.<sup>63,64</sup> This academic advantage may be an artifact due to the high standards of certification imposed by the Education Committee for Foreign Medical Graduates, as fewer than 25% of all IMGs applying for certification ultimately gain entry into a US residency program. However, it does demonstrate that graduates of six year medical programs are capable of competing with US medical graduates who spend an additional two years in "undergraduate" training.

While the traditional pathway established in the last century is unlikely to change, the establishment of six year medical schools that incorporate all the traditional undergraduate training into the medical school curriculum may be desirable in order to reduce the costs of education to both society and to the student. Transition to a six year program would also enable

the medical system to respond more quickly to shortages in medical personnel, attract able candidates who are unable to pay for eight years of education, and reduce the cost of the application process.

#### **IV.E. Including Clinical Work Performed in Tuition Calculations**

There have been numerous cost analysis of medical education in the preclinical and the clinical years. Various cost sharing methods for faculty time, resident time, facilities used, have been developed and deployed, including the AAMC's "mission based" budgeting.<sup>47</sup> However, none of these cost calculating methods includes the work that students do in gathering data, moving patients, writing staff notes and orders, and performing other "scut" work that has little direct bearing on the education of the student. Traditionally, this work was viewed as a part of the trade service that students made for attending physicians' and residents' teaching time and to the hospital for their use of facilities. It has additionally been seen as teaching the value of hard work and dedication to patient care.

However, as the number of clinical faculty who can afford to donate teaching time has declined, and as universities have begun "costing" teaching time and facilities use to students, the work that students do should not be ignored in the calculations. Patients are often stunned to hear that medical students are not paid for their work in the clinical years, and are even more surprised that we pay for the privilege of caring for patients. Paying students for work time in hospital (as they are in Denmark) or including that time in calculating costs of education is necessary to arrive at an accurate assessment.

#### **IV.F. Increasing Resident Salaries**

Increased resident salaries would mitigate some of the difficulties that residents face in paying off their large debts. The sources for such funding are unlikely to be federal GME funding, as such funding is currently strained and may be cut or eliminated. A requirement that all health care payers pay an "education tax" towards the training of health professionals has been proposed by many, including the AMA, AAMC, and Congress, but has never been realized.

#### **IV.G. Summary of Long Term Solutions**

To address the underlying causes of medical student debt in the long run, it will be necessary to garner public support for medical education as a public good, and to reinforce the value the physician community places on medical education. The current cost-driven model of education has not left a place for the value of education in the system, and does not value the contributions of medical students when calculating costs. Federal, state, and local monetary support will be necessary to keep tuition affordable. It may be beneficial in the long run to shorten the length of "undergraduate" training in medicine from eight to six years.



## **V. Potential Allies and Coalition-Building Strategies**

### **V.A. Rationale**

Like most issues in Washington, advocacy for educational financing occurs in a larger community. In this case, the principal players deal with complex funding and regulatory rules and involve major financial institutional powers, as well as the leading colleges, universities and other academic centers across America. Given the breadth of AMA's interests, our involvement with these individual entities and the coalitions they form is more limited than with other physician legislative and regulatory issues. Historically, however, our AMA has worked individually and in productive coalitions on issues of mutual concern in the reauthorization of the Higher Education Act and issues ranging from student loan consolidation, and interest deductibility to NHSC concerns.

### **V.B. Traditional Allies**

In considering legislative action based on this report, any list of potential collaborators must include our traditional allies in the medical profession. These include:

**Association of American Medical Colleges (AAMC)** – AAMC is a part of major education coalitions such as ACE (see below) and has extensive experience lobbying lawmakers on education issues. Because AAMC has a history with education groups and is considered the voice of American medical education, these groups may look to AAMC to judge proposals advanced by the AMA.

**American Medical Student Association (AMSA)** – Although AMSA disagrees with the AMA on various points of policy, there has historically been good cooperation on student debt between AMSA and the AMA-MSS, as evidenced by joint efforts to combat the Clinical Skills Assessment Exam. AMSA also has a full-time student lobbyist based in Washington.

**Minority-Group Medical Societies** – Groups such as the **American Medical Women's Association (AMWA)** and **Student National Medical Association (SNMA)** represent constituencies that particularly stand to lose from continued increases in medical student debt. As noted in Section II.B., groups that are presently underrepresented in medicine are disproportionately burdened by rising debt. These societies therefore have a strong incentive to serve their members by partnering with the AMA.

**Medical Specialty Societies** – Several societies, such as the ACP and the AAFP are regular partners with the AMA and, like us, place a high priority on addressing the concerns of medical student members. Societies in primary care specialties are particularly valuable allies, as they credibly argue that high medical student debt drives students away from primary care, an argument that resonates well with Congress and the public.

## **V.C. Potential New Partners**

As noted above, in order to maximize our effectiveness, the AMA must tap into the knowledge, personal connections, and logistical support of existing higher education and financial aid advocates. Key groups that are likely to ally with us include:

### **V.C.1. National Association of Graduate-Professional Students (NAGPS)**

NAGPS is a small organization composed of and funded by graduate students. However, they consider professional students to be members through their universities' graduate student associations. NAGPS has previously adopted AMA policies as part of their legislative platform. Their current legislative focus is a broadening of the tax-exempt status of graduate and professional scholarships; this initiative is supported by AMA policy and would benefit a significant fraction of medical students. Furthermore, NAGPS legislative actions are essentially determined by one Legislative Concerns chair. Therefore, NAGPS could serve as a bridge to introduce AMA education priorities to the larger education community.

### **V.C.2. American Council on Education (ACE)**

ACE is an umbrella organization representing literally hundreds of groups involved in education from preschool through adult education. Membership includes university organizations, student groups, professional societies, and financial aid associations. Health professions members include the American Osteopathic Association, Association of Professors of Medicine, and American Dental Association. ACE regularly comments to Congress and the Department of Education on a wide variety of education financing and regulation proposals, and their letters are viewed as representing the consensus of the full education community.

### **V.C.3. Committee for Education Funding (CEF)**

CEF is somewhat smaller than ACE, and is more tightly focused on funding issues where ACE comments on all education-related legislation. CEF's major focus is on appropriations legislation, where they regularly and successfully lobby for increases in education funding at all levels. CEF would be of particular benefit as a partner in lobbying for increased spending on programs that support undergraduate medical education, such as federally subsidized loans, scholarship programs, and possibly even funding derived from patient care revenues.

### **V.C.4. Association of American Universities (AAU), National Association of State Universities and Land-Grant Colleges (NASULGC), National Association of Independent Colleges and Universities (NAICU)**

Together, these three groups represent the universities to which medical schools are attached. NAICU represents private schools, NASULGC public schools, and AAU overlaps NASULGC and NAICU as a special-interest organization for universities heavily invested in research and graduate/professional education. Essentially all universities retain in-house lobbyists, and these organizations are the gathering point for those lobbyists. Involving NAICU, NASULGC, and AAU (possibly through ACE or NAGPS) would allow the AMA and its student members to draw on the full resources of their universities. AAMC, by contrast, generally only works with lobbyists directly affiliated with medical schools.

## **VI. Recommendations**

The current debt crisis has been decades in the making and cannot be fixed overnight. The AMA and other stakeholders in the health care delivery system must develop a new and sustainable infrastructure for funding undergraduate medical education through careful study. However, there are actions that can and should be taken immediately to prevent the crisis from deepening while a long-term solution is found.

### **VI.A. Actions To Be Taken Immediately**

#### **VI.A.1. National Advocacy by the AMA and AMA-MSS**

- Our AMA must continue to actively participate in the reauthorization of the Higher Education Act. Specific lobbying targets include:
  - Elimination of the “single-holder” rule
  - Continuation of the consolidation loan program and a consolidator’s ability to lock in a fixed interest rate
  - Expansion of the deferment period for loan repayment to cover the entire duration of residency and fellowship
  - Broadening of the definition of economic hardship as used to determine eligibility for student loan deferment
  - Retention of the option of loan forbearance for residents who are ineligible for student loan deferment
  - Inclusion of dependent care expenses in the definition of “cost of attendance”
- Our AMA should support the “Higher Education Affordability and Equity Act”, which would raise income thresholds and deduction limits for the student loan interest tax deduction and which would broaden the tax-exempt status of medical scholarships such as the NHSC and Armed Services Health Professions programs. This legislation essentially implements current AMA policy.
- To support AMA staff in taking the above advocacy action, our AMA-MSS should urge its DC Fellow to make medical student debt his/her principal issue for legislative monitoring and lobbying efforts.

#### **VI.A.2. Local Advocacy by State Medical Societies**

- Our state medical societies should actively lobby for further expansion of state loan repayment programs, and in particular expansion of those programs to cover physicians in non-primary-care specialties. The AMA should support its member societies in this action by coordinating efforts and centralizing information and resources.
- Our state medical societies should actively solicit funds (either directly or through their Foundations) for the establishment and expansion of medical student scholarships. Again, our AMA should develop a set of guidelines and suggestions to assist states in carrying out such initiatives.

- Our state medical societies should advocate for an annual tuition cap of \$50,000 at private medical schools and \$30,000 at public medical schools (adjusted for inflation from 2003 dollars) within their states.

### **VI.A.3. Coalition Building**

- The AMA should investigate any advantages to be gained in becoming a member of the American Council on Education and/or the Committee for Education Financing, in order to strengthen our ties to the higher education community. Existing work done through the Coalition for Student Loan Fairness should be more aggressively publicized.
- Our AMA-MSS form a new coalition, to include at a minimum the members of the present Coalition of Medical Student Organizations, the medical student sections of specialty societies, and the National Association of Graduate-Professional Students, for the purpose of sharing information and coordinating lobbying activity on student debt.
- To support that new coalition and further develop its connections in Washington, our AMA-MSS should join the National Association of Graduate-Professional Students as an Affiliate Member.

## **VI.B. Long-Term Actions**

### **VI.B.1. Studies to Develop New Education Financing Schemes**

As can be seen above, there is no clear path to sustainable medical education financing. More data are needed on what options would be most acceptable to policymakers, medical schools, the public, and other stakeholders. We recommend that our AMA conduct the following studies in order to better understand its long-term options. We have recommended specific councils that we feel are appropriate, but it is far more important that the studies be done.

- Potential new sources of Graduate Medical Education funding and ways to increase resident salaries (Council on Medical Education).
- The feasibility of and strategies for creating new and/or expanded loan programs specifically for the health professions (Council on Legislation/Council on Medical Education).
- The feasibility of earmarking federal funds to undergraduate medical education for the purpose of reducing medical school tuition at public and private universities (Council on Legislation/Council on Medical Education).
- The need for non-primary-care physicians in underserved areas, focusing on how the National Health Service Corps and similar loan repayment programs could feasibly be expanded to cover specialties beyond primary care (Council on Medical Service).

- Appropriate methods for calculating the value of the clinical work performed by medical students and taking such calculations into account when determining the cost of educating a medical student (Council on Medical Service).

### **VI.B.2. Reform of Medical School Policies**

Although these changes must be undertaken by individual schools, and therefore will take time, our AMA should actively press schools to implement them as soon as possible.

- Medical schools should use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies.
- Medical schools and their associated universities must not charge broad and ill-defined student fees. Multiple voluntary fees that are earmarked for specific and well-defined purposes are more likely to genuinely benefit students and are harder to use to cover losses in other revenue sources.
- Medical schools to cooperate with undergraduate institutions to establish collaborative debt counseling for entering first-year medical students.
- Universities, especially those seeking to open new medical schools, should create more BS/MD integrated programs. However, such programs should not eliminate or replace existing traditional medical school positions.

**Appendix I: Current AMA Policy on Medical Student Debt**

<b>Tax Deductibility</b>	
<b>H-305.955</b>	<b>Cost of Medical School and Educational Loan Interest</b> Supports tax deductibility of student loan interest.
<b>H-305.963</b>	<b>Tax Deductibility of Interest on Educational Loans</b> Supports action to restore tax deductibility of interest on educational loans.
<b>H-305.970</b>	<b>Interest on Education Related Debt</b> Supports tax deductibility of loan interest
<b>H-305.978</b>	<b>Tax Deduction Status of Educational Loans</b> Supports tax deductibility of loan interest
<b>H-305.997</b>	<b>Income Tax Exemption for Medical Student Loans and Scholarships</b> Supports income tax exemption on amounts received under medical scholarship or loan programs.
<b>Deferment</b>	
<b>H-305.961</b>	<b>Student Loan Deferment</b> Supports legislation that will defer loans until completion of residency
<b>H-305.965</b>	<b>Student Loans</b> Supports deferral of loans until completion of residency
<b>H-305.972</b>	<b>Postgraduate Deferrals for Guaranteed Student Loans</b> Supports deferral of loans until completion of residency and supports simplification of deferral process.
<b>Tax Deductability for NHSC and Related Programs</b>	
<b>H-305.937</b>	<b>Taxation of Student Loan Repayment Programs</b> Supports tax exemption for funding received through loan repayment programs
<b>H-305.940</b>	<b>Tax Exemption for Federal Medical Profession Scholarships</b> Supports the AMA working with the AAMC to achieve tax exemption for federally funded health profession scholarships
<b>NHSC and Physician Distribution</b>	
<b>H-165.900</b>	<b>Support for the Health Care Infrastructure</b> Supports funding for programs that enhance the recruitment and retention of physicians for practice in underserved areas as part of health reform
<b>H-200.959</b>	<b>Support for the Funding of the National Health Service Corps</b> Supports funding of NHSC at least at the 1995 level.
<b>H-200.982</b>	<b>Significant Problem of Access to Health Care in...Underserved Areas</b> Supports development of incentives to make practice in underserved areas more attractive for primary care physicians.
<b>H-200.983</b>	<b>Health Manpower</b> Supports reauthorization of Title VII programs, supports NHSC and primary care training, opposes Medicare cuts for GME.
<b>H-200.984</b>	<b>National Health Service Corps Reauthorization</b> Supports reauthorization and adequate funding for NHSC
<b>H-200.985</b>	<b>Increasing Support for Service in America's Inner Cities Through the NHSC</b>

	Supports earmarking a certain percentage of repayment opportunities for the NHSC loans and scholarships for underserved inner-city facilities
<b>H-200.989</b>	<b>National Health Service Corps</b> Opposes diverting NHSC physicians to other countries
<b>H-305.952</b>	<b>Title VII Financial Assistance for Medical Students and Practice Choice Limitations</b> Opposes restricting Title VII aid based on specialty choice.
<b>Graduate Medical Education Funding</b>	
<b>H-305.945</b>	<b>Funding of Graduate Medical Education</b> Addresses various GME funding issues – see policy
<b>H-305.959</b>	<b>Reduction in the Cost of Medical School Education</b> Supports AMA study of how medical education costs can be reduced
<b>H-305.966</b>	<b>Medical School Disclosure of Available Financial Aid Resources</b> Encourages medical schools to provide information about financial aid resources to prospective students, and reaffirms/calls to action previous AMA policy – see policy
<b>H-305.988</b>	<b>Cost and Financing of Medical Education and Availability of First-Year Residency Positions</b> Addresses various medical education financing issues – see policy
<b>H-305.995</b>	<b>Funding for Medical Students</b> Addresses various medical education financing issues – see policy
<b>Loan Repayment</b>	
<b>H-305.948</b>	<b>Direct Loan Consolidation Program</b> Supports the existing consolidation loan program.
<b>H-305.950</b>	<b>Fairness in Publication of Names of Loan Defaulters</b> Opposes publication of names of defaulters on federally funded student loans.
<b>H-305.982</b>	<b>Student Loan Repayment Defaults</b> Supports withholding reimbursement/payment to loan defaulters
<b>H-305.989</b>	<b>Financial Assistance for Medical Students</b> Urges physicians to repay their loans, opposes denial of medical education on the basis of lack of funds.
<b>H-305.991</b>	<b>Repayment of Educational Loans</b> Opposes non-repayment of loans, supports collection of overdue debts, supports debt education of students prior to graduation
<b>Other/General</b>	
<b>H-305.934</b>	<b>Medical School Tuition Increases</b> Opposes mid-year and retroactive tuition increases
<b>H-305.938</b>	<b>Use of Social Security Numbers in Student Loan Accounts</b> Opposes use of social security numbers for student loan account numbers
<b>H-305.941</b>	<b>Recognizing Dependent Care Expenses in Determining Medical Education Financial Aid</b> Supports a “cost of attendance” definition that includes dependent expenses
<b>H-305.946</b>	<b>The Ecology of Medical Education: Financing Undergraduate Medical Education</b> Supports development of a stable medical education funding source

	(similar to CPT codes) and supports medical schools more closely linking revenues and teaching expenditures
<b>H-305.954</b>	<b>Repayment of Medical School Loans</b> Supports working with HRSA to increase financial aid opportunities, supports low interest/extended payment program for young AMA physicians
<b>H-305.973</b>	<b>Financing Undergraduate Education</b> Supports various existing funding sources, opposes undue reliance on tuition and fees as funding source
<b>H-305.992</b>	<b>Student Loans</b> Supports efforts to secure funds at reasonable interest rates for student loans
<b>H-305.999</b>	<b>Financial Aid to Medical Students</b> Urges all physicians to contribute to the Foundation to raise funds for medical scholarships and loans.
<b>H-310.934</b>	<b>Medical Student Debt</b> Supports elevation of medical education debt to our AMA's top several legislative priorities



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