INTRODUCTION

Rapidly rising expenses of medical education, concomitant cutbacks in federal support of financial aid for undergraduate medical students, and consequent increases in levels of student indebtedness, will result in long term adverse effects on the availability and delivery of health care in the United States. The following statement addresses this critical problem for undergraduate medical education. However, this is only part of the much larger problem of how to ensure a viable system of medical education that produces appropriate numbers of well trained physicians to meet the nation's medical care and research needs. Equally important parts of this broader problem involve maintaining sufficient residency training opportunities, generating adequate numbers of well prepared faculty and research professionals and financing graduate medical education. Many of these issues have been addressed by the College in a detailed response to the Final Report of the Graduate Medical Education National Advisory Committee (GMENAC) (1). The entire medical education system is a national resource that should be supported and cultivated, not only to maintain and improve the nation's health, but also to enhance our scientific and research capability.

SUMMARY OF POSITIONS

1. Financial aid programs must be designed to ensure equal opportunity for undergraduate medical students from every socio-economic stratum.

2. Physicians who borrow to support their education must fulfill their loan repayment obligations. To do otherwise is inexcusable.

3. Federal financial aid in the form of scholarships with provision for repayment through obligated service should be maintained. Priority in the awarding of such scholarships should be given to students from underrepresented minorities, women, the financially disadvantaged, and others from populations or areas that are medically underserved.

4. The College recommends that a national commission, advisory to the federal government and to the nation as a whole, be established from the public and private sectors for the purpose of analyzing the social implications of national policies concerning the financing of undergraduate medical student education. The commission's purview
should include delineating the ramifications that relate to responsibility for paying for medical education, determining any obligations for national service incurred by medical students, and clarifying the relative roles of federal and state governments, private institutions, and individuals who pursue medical careers. The report of this commission should be the basis for development of national policy on the relationship of medical education and the public welfare.

POSITION

1. Financial aid programs must be designed to ensure equal opportunity for undergraduate medical students from every socio-economic stratum.

RATIONALE

The average cost of attending the first-year class at a private U.S. medical school in 1982-83 was $18,256; costs at public medical schools averaged $9,639 for state residents and $12,876 for non-residents (2) (Table 1). Approximately 86% of all medical students graduating in 1983 were financially in debt and the average indebtedness was $23,647 (3) (Table 2). Projections indicate that students graduating from some private medical schools in 1984 will have accumulated debts of $50,000 to $60,000, and that by 1985 debts of $40,000 will be typical for all students graduating from both public and private schools (4,5,6).

The high costs of medical education (Figure A) and consequent increases in student indebtedness necessitate continued availability of programs providing financial support. It is recognized that investments of time and money in medical education can be expected to yield high financial rewards. College graduates entering medical school in 1983, however, will not begin practice until 7-9 years later. While they forego the earnings opportunities of their fellow graduates, they will incur substantial expenses and accumulate high debts for which repayments will reduce their future disposable income. Even physicians who ultimately enter less lucrative specialties will be able to repay relatively large loans and still realize disposable incomes exceeding those of most college graduates (7). Nevertheless, those who lack access to the initial investment for such potential earnings, have no choice and will be excluded from the ranks of the profession.

The College believes that cutbacks in federal programs of financial assistance will most affect lower and middle income students, underrepresented minorities, women, and the financially disadvantaged. Representation of these groups in medical schools improved during the 1970's largely due to such federal programs as the Health Professions Student Loan program, the Guaranteed Student Loan program, the Exceptional Financial Need Scholarship program, the Health Education Assistance Loan program, the National Health Service Corps Scholarship program and other federal initiatives. Cutbacks in these programs can consequently be expected to deter such students from seeking medical careers, resulting in less progress toward
achieving more representational medical school classes or toward attaining a physician population that is most reflective of the nation's population.

In the view of the College, it is retrogressive and counterproductive for the federal government to cut back at this time on the availability of funds for scholarships and low interest loans. Although it is widely expected that there will be an overall surplus of physicians by 1990, the need for federally supported undergraduate medical education assistance will continue. Federal financial assistance will be needed to ensure that opportunities for medical careers are not restricted based on family financial resources, that opportunities are increased for underrepresented minority and financially disadvantaged students, and that medical students' career and specialty decisions are not dictated by financial considerations.

POSITION

2. Physicians who borrow to support their education must fulfill their loan repayment obligations. To do otherwise is inexcusable.

RATIONALE

The American College of Physicians believes that all physicians who borrow to finance their medical education should fulfill their financial obligations. The College considers it reprehensible for physicians to be in default.

Data reported by the Health Services Administration indicated that as of 30 June 1981 more than 28% of borrowers under the combined Health Professions and Nursing Student Loan programs were delinquent in loan payments by 90 days or more. More than $34 million was overdue on loans totaling $77 million (8). Subsequent collection efforts by the federal government and by educational institutions resulted in substantial reductions in delinquency rates. Between 30 June 1982 and 30 June 1983, the overall HPSL delinquency rate decreased by 26% (9). Nevertheless, of 92,966 loans issued to graduates of allopathic medical schools, 5,367 or 8.1% were overdue by 90 days or more. As of 30 June 1983, the HPSL program had loaned a total of $290 million, of which $10 million (3.4%) was then overdue.

Proposed changes in the Health Professions Student Loan (HPSL) program, requiring each medical school to reduce student loan delinquency rates to no more than 5%, could restrict severely the number of schools eligible to participate in the program. Because the HPSL program is financed through a revolving fund, unpaid loans result in fewer funds being available for current borrowers. Any proposal to further restrict the availability of HPSL loans in schools with a record of graduates with high delinquency rates would further penalize current students because of the actions of their predecessors. Means of debt collection that do not penalize current and future borrowers must be devised.
Alternatives to be applied to delinquent borrowers might include state licensure suspension, garnishment or disallowance of Medicare and Medicaid payments, and denial of government employment, grants, and contracts.

Although the HEAL program and Parent Loans for Undergraduate Students (PLUS) have been offered as alternative means of financing, these loans entail fluctuating rates of interest and require that interest payments be paid or compounded while the student is still in training. Unlike the subsidized loan programs, which permitted the deferral of repayment until completion of medical education and training, the high repayment obligations of HEAL and PLUS may discourage students from pursuing medical careers. The College favors a continued federal role in ensuring financial access to the medical education system through the provision of low-interest loans. The federal government should continue to serve as a guarantor of financial access to medical education.

POSITION

3. Federal financial aid in the form of scholarships with provision for repayment through obligated service should be maintained. Priority in the awarding of such scholarships should be given to students from underrepresented minorities, women, the financially disadvantaged, and others from populations or areas that are medically underserved.

RATIONALE

The continuing expansion of the supply of physicians, coupled with increasing competition within the profession, has resulted in improvements during the past decade in the geographic and specialty distribution of physicians (10,11,12). Despite these improvements, which are expected to continue, areas remain in which the numbers of physicians are insufficient to meet the medical care needs of the population. Such areas include city ghettos, barrios, small rural towns, unincorporated communities, prisons, and Indian reservations (13,14,15). Competitive forces alone will not overcome the obstacles that discourage physicians from locating or practicing in areas they perceive as either undesirable or economically inadequate to support a medical practice.

The College believes it is essential to continue federal efforts to assure the provision of medical services in underserved areas. Scholarship programs such as those of the National Health Service Corps and the Armed Forces Health Professions, which entail obligated service in return for scholarship assistance, serve a dual purpose of maintaining opportunities for medical education and assuring that medical manpower is available for national needs. Such programs offer an acceptable alternative path for entering the medical profession to students who might otherwise be deterred by the high cost of medical education and the prospect of substantial long-term financial indebtedness.

In addition to assuring a steady stream of qualified medical personnel to serve the needs of underserved areas, obligated service programs have the
potential for inducing physicians to establish permanent practices in such areas. They offer an opportunity to obtain a sustained practice experience in an underserved area on a trial basis while minimizing additional personal financial risks. Furthermore, they expose some physicians to such an experience who might not otherwise have considered practice in a remote or underserved area.

Because of the desirability of preserving a representative diversity within the medical profession, the granting of obligated service scholarships should be based on financial need with preference for students from underserved areas, particularly for underrepresented minorities, women, and the financially disadvantaged. By encouraging the training and placement of physicians with ethnic, social, and cultural backgrounds that are in common with those who are most medically underserved, it is hoped that the needs of these populations will be better met and that physician practices will be established and maintained in underserved areas.

POSITION

4. The College recommends that a national commission, advisory to the federal government and to the nation as a whole, be established from the public and private sectors for the purpose of analyzing the social implications of national policies concerning the financing of undergraduate medical student education. The commission’s purview should include delineating the ramifications that relate to responsibility for paying for medical education, determining any obligations for national service incurred by medical students, and clarifying the relative roles of federal and state governments, private institutions, and individuals who pursue medical careers. The report of this commission should be the basis for development of national policy on the relationship of medical education and the public welfare.

RATIONALE

National policies encouraging the growth of medical schools have evolved without significant discourse concerning underlying issues of social philosophy. These policies, new to the political history of the United States, had their origins just after World War II, but they have been more fully elucidated only during the last two decades. They have sought to 1) encourage medical schools to increase the supply of physicians, 2) assure equal opportunity of education for financially disadvantaged and underrepresented minority students, and 3) promote further scientific advances through biomedical research.

If the nation were to accept the principle that access to adequate health care is a right of all citizens and if physicians are to play a key role in determining the use of the nation's health care system, to what extent should national needs influence physician career decisions? Do physicians who receive their education with support of federal and state tax dollars and policies have any repayment obligations, either financial or in terms of public service, beyond those resulting directly from student loans?
Does governmental responsibility for addressing inequitable distributions of health care services to rural, inner-city, low income, minority, or other underserved groups justify any governmental role in determining the specialties and locales in which physicians will practice? Can or should receipt of public financial support for undergraduate medical education be linked to student agreements to practice in specialties or in geographic areas where there are the greatest unmet medical needs? Is it in the continued public interest to seek to achieve equal opportunities for careers in medicine for underrepresented minority and financially disadvantaged students? At what levels should the public provide financial support for the costly and lengthy educational process required to obtain the knowledge and training necessary to become a physician?

These and related questions deserve thorough and thoughtful responses. They pose dilemmas that arise from conflicts among fundamental American beliefs regarding individual freedom, equality of opportunity, and equitable assurance of protection for all citizens. Health manpower policies that have evolved segmentally must be considered with a degree of coherence that has been lacking. Some significant groundwork has been set forth at different times and in separate reports from, among others, the Institute of Medicine, the Association of American Medical Colleges, the Council of Medical Specialty Societies, and the federal government. The American College of Physicians believes that the time now has come for these and other groups to deliberate in concert on the ramifications of these policies with respect to sources and modes of payment for universities and hospitals concerning education and research in medicine. In addition, attention should be given to the obligations that devolve upon physicians when the society they serve pays for all or part of their professional preparation. A national commission is needed to fully examine these and other issues related to national policy concerning the financing of undergraduate medical student education. Such a commission should be representative of our society and should entail sufficient expertise and resources for such an important undertaking.
NOTES


5. Henikoff LM. Medical school grads are bright, eager, and in debt. American Medical News. 25 December 1981.


9. Alice Swift, Division of Student Assistance, Bureau of Health Professions, HSA, DHHS; (301) 443-4540. Personal communication.


### TABLE 1

U.S. Medical Schools

Tuition, Student Fees, and All Other Expenses, First Year Class
1982-83

<table>
<thead>
<tr>
<th></th>
<th>Range</th>
<th>Median</th>
<th>Average</th>
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<tr>
<td><strong>Private Medical Schools</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Tuition*</td>
<td>$3,500-19,000</td>
<td>$10,350</td>
<td>$10,701</td>
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<tr>
<td>Student Fees</td>
<td>0-1,530</td>
<td>244</td>
<td>281</td>
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<tr>
<td>All Other Expenses¹</td>
<td>4,035-9,685</td>
<td>7,506</td>
<td>7,274</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
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<td>$18,256</td>
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<tr>
<td><strong>Public Medical Schools</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Tuition Residents</td>
<td>0-6,681</td>
<td>2,675</td>
<td>2,686</td>
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<tr>
<td>Nonresidents</td>
<td>900-26,337</td>
<td>6,156</td>
<td>5,923</td>
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<tr>
<td>Student Fees</td>
<td>0-3,695</td>
<td>169</td>
<td>412</td>
</tr>
<tr>
<td>All Other Expenses</td>
<td>3,900-12,200</td>
<td>6,475</td>
<td>6,541</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>9,639</td>
</tr>
<tr>
<td><strong>Residents</strong></td>
<td></td>
<td></td>
<td>12,876</td>
</tr>
<tr>
<td><strong>Nonresidents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Eight private medical schools report lower tuition for residents of their states; this table uses the higher tuition amounts.

**Excludes Uniformed Services University of the Health Sciences which does not charge tuition or student fees.

¹Includes room and board, books and supplies, transportation, etc.

Source: AAMC. Memorandum No. 82-43 to Council of Deans, 12 August 1982.


**TABLE 2**  
**AAMC 1983 MEDICAL STUDENT GRADUATION QUESTIONNAIRE**

Total Number of all students who responded to Questionnaire 10,481  
Percentage of All Final Year Students Who Responded 65.6%

### RESPONDENT'S DEBT

<table>
<thead>
<tr>
<th>Debt Level</th>
<th>Pre-medical</th>
<th>Medical</th>
<th>Total</th>
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<tr>
<td>No debt</td>
<td>70.5</td>
<td>15.6</td>
<td>13.0</td>
</tr>
<tr>
<td>$1 to $4,999</td>
<td>20.2</td>
<td>3.0</td>
<td>3.5</td>
</tr>
<tr>
<td>$5,000 to $9,999</td>
<td>7.0</td>
<td>6.3</td>
<td>6.4</td>
</tr>
<tr>
<td>$10,000 to $14,999</td>
<td>1.3</td>
<td>9.9</td>
<td>9.5</td>
</tr>
<tr>
<td>$15,000 to $19,999</td>
<td>0.5</td>
<td>15.8</td>
<td>15.2</td>
</tr>
<tr>
<td>$20,000 to $24,999</td>
<td>0.3</td>
<td>17.4</td>
<td>16.6</td>
</tr>
<tr>
<td>$25,000 to $29,999</td>
<td>0.1</td>
<td>9.8</td>
<td>10.2</td>
</tr>
<tr>
<td>$30,000 to $49,999</td>
<td>0.1</td>
<td>18.4</td>
<td>20.0</td>
</tr>
<tr>
<td>$50,000 or more</td>
<td>0.0</td>
<td>3.9</td>
<td>4.7</td>
</tr>
</tbody>
</table>

**Total responding to question**: 10,288  
**No response**: 193  
**Mean debt of respondents**: $1,229  
**Mean debt of indebted respondents**: $4,167

### SPOUSE'S DEBT

<table>
<thead>
<tr>
<th>Debt Level</th>
<th>Undergraduate</th>
<th>Graduate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No debt</td>
<td>76.9</td>
<td>76.5</td>
<td>61.4</td>
</tr>
<tr>
<td>$1 to $4,999</td>
<td>14.7</td>
<td>3.3</td>
<td>12.7</td>
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<tr>
<td>$5,000 to $9,999</td>
<td>6.6</td>
<td>4.9</td>
<td>8.6</td>
</tr>
<tr>
<td>$10,000 to $14,999</td>
<td>1.2</td>
<td>4.1</td>
<td>5.2</td>
</tr>
<tr>
<td>$15,000 to $19,999</td>
<td>0.2</td>
<td>3.2</td>
<td>3.4</td>
</tr>
<tr>
<td>$20,000 to $24,999</td>
<td>0.2</td>
<td>3.2</td>
<td>3.3</td>
</tr>
<tr>
<td>$25,000 to $29,999</td>
<td>0.1</td>
<td>1.1</td>
<td>1.7</td>
</tr>
<tr>
<td>$30,000 to $49,999</td>
<td>0.1</td>
<td>2.9</td>
<td>3.1</td>
</tr>
<tr>
<td>$50,000 or more</td>
<td>0.0</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

**Total responding to question**: 4,914  
**No response**: 149  
**Mean debt of spouses**: $959  
**Mean debt of indebted spouses**: $4,150

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*Respondents are excluded from the computation of percent for any category in which they did not indicate a debt level.

FIGURE A

U.S. MEDICAL SCHOOL MEDIAN TUITION AND FEES FOR FIRST-YEAR MEDICAL STUDENTS
1960-61 THROUGH 1982-83

Dollars
12,000
10,000
8,000
6,000
4,000
2,000
0
60-61 65-66 70-71 75-76 80-81 82-83

Source: AAMC. Medical Education: Institutions, Characteristics and Programs, October 1983.