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Introduction

In response to a recommendation from the AAMC Organization of Student Representatives (OSR) Administrative Board, and in follow-up to the AAMC staff report, *Medical School Tuition and Young Physician Indebtedness* (www.aamc.org/publications), prepared by Paul Jolly, Ph.D., the AAMC Executive Committee requested that AAMC President Jordan J. Cohen, M.D., appoint a working group on student educational costs and debt. Working group members were appointed by Dr. Cohen in April 2004. Deborah E. Powell, M.D., Dean and Assistant Vice President for Clinical Sciences, University of Minnesota Medical School, chaired the working group. A full roster of working group members is provided in Appendix A.

Preamble

At this time, repaying the current levels of educational indebtedness does not represent an insurmountable burden for the average physician beginning clinical practice, and a medical education continues to be a sound investment for the future physician. However, if educational debt continues to rise at current rates and physicians' incomes continue to barely keep pace with inflation, there is realistic concern for the future affordability of medical education. This report contains recommendations to medical schools for preventive measures necessary to counter recent trends so that the combination of rapidly increasing levels of educational debt and relatively flat physician incomes does not, in the long term, pose problems for students, residents, practicing physicians, the medical profession, and the well-being of society.

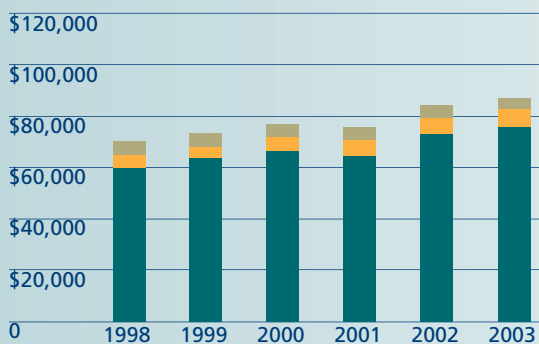
It should be noted that the challenges associated with rapidly rising educational costs and debt affect health professions other than medicine, and indeed all of higher education. Comprehensive solutions to these problems will, therefore, require a joint effort with other educational and health professions organizations. Failure to adequately address these challenges could have serious implications for the health of the nation if they impede the supply of physicians or diversity within the medical profession.

In examining the issue of medical student debt, a number of findings from the *Medical School Tuition and Young Physician Indebtedness* report are particularly instructive:

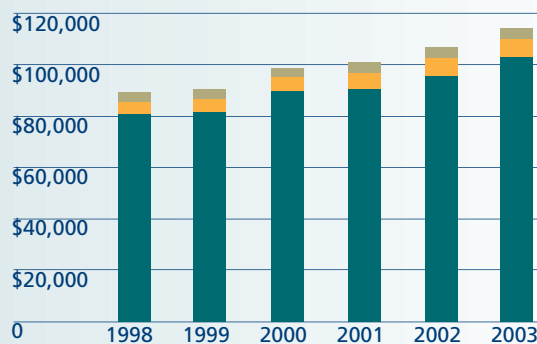
- More students are completing college with higher undergraduate educational debt burdens than in the past, even before they begin to accumulate additional educational debt from graduate and professional school education (Figure 1).*

Components of Debt: Mean Debt Components of All Graduates

Public Medical Schools



Private Medical Schools

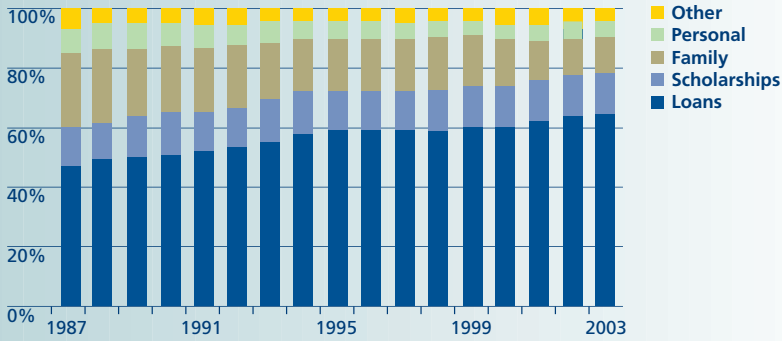


Source: AAMC Graduation Questionnaire

Figure 1

* Some of the data in this report appear in P. Jolly, "Medical School Tuition and Young Physician Indebtedness," *Health Affairs* 24 (2005).

How Students Pay for Medical Education

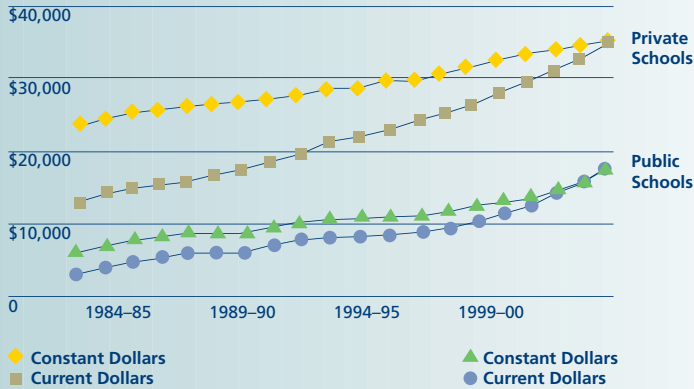


Source: AAMC Matriculating Student Questionnaire

Figure 2

- Medical students fund a large proportion of the cost of their medical education with educational loans (Figure 2).
- Medical school tuition and fees have increased at rates far in excess of inflation, while, in the same time period, physician income has not kept pace with inflation (Figures 3 and 4).

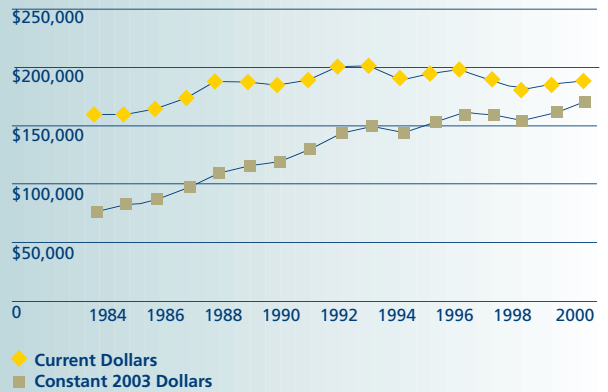
Tuition—Current Dollars and Constant 2004 Dollars



Source: AAMC Data Book

Figure 3

Physician Income



Source: AMA

Figure 4

- For the past two decades, over 60 percent of medical students are from families with incomes in the top quintile of all American families, while only 20 percent of medical students are from families with incomes in the lowest three quintiles (Figure 5).
- The median indebtedness of medical school graduates has increased dramatically over the past 20 years (Figure 6).

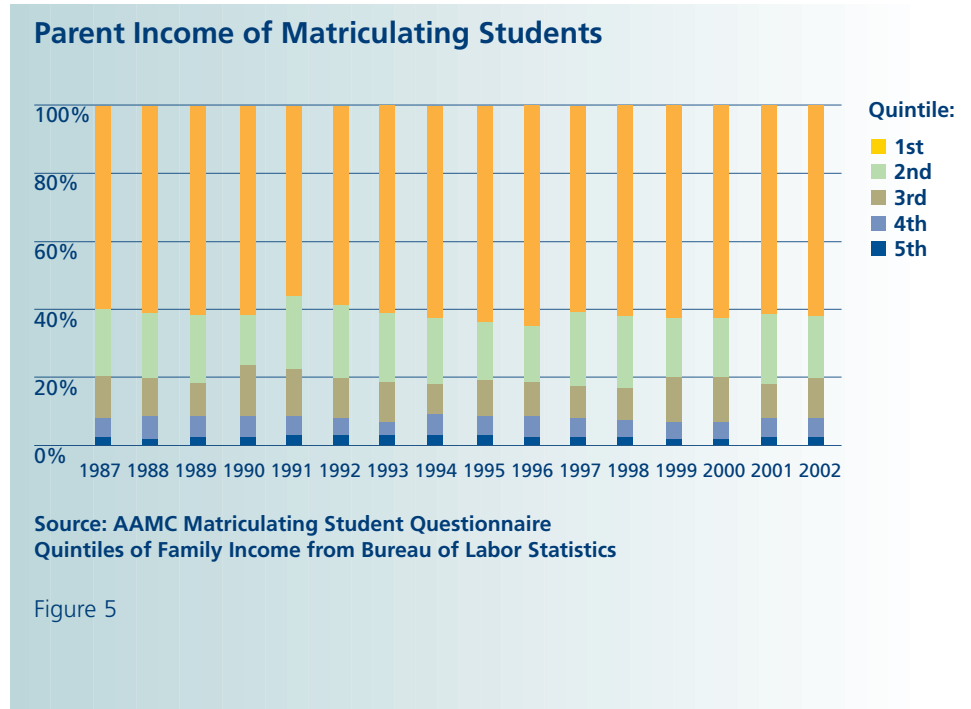


Figure 5

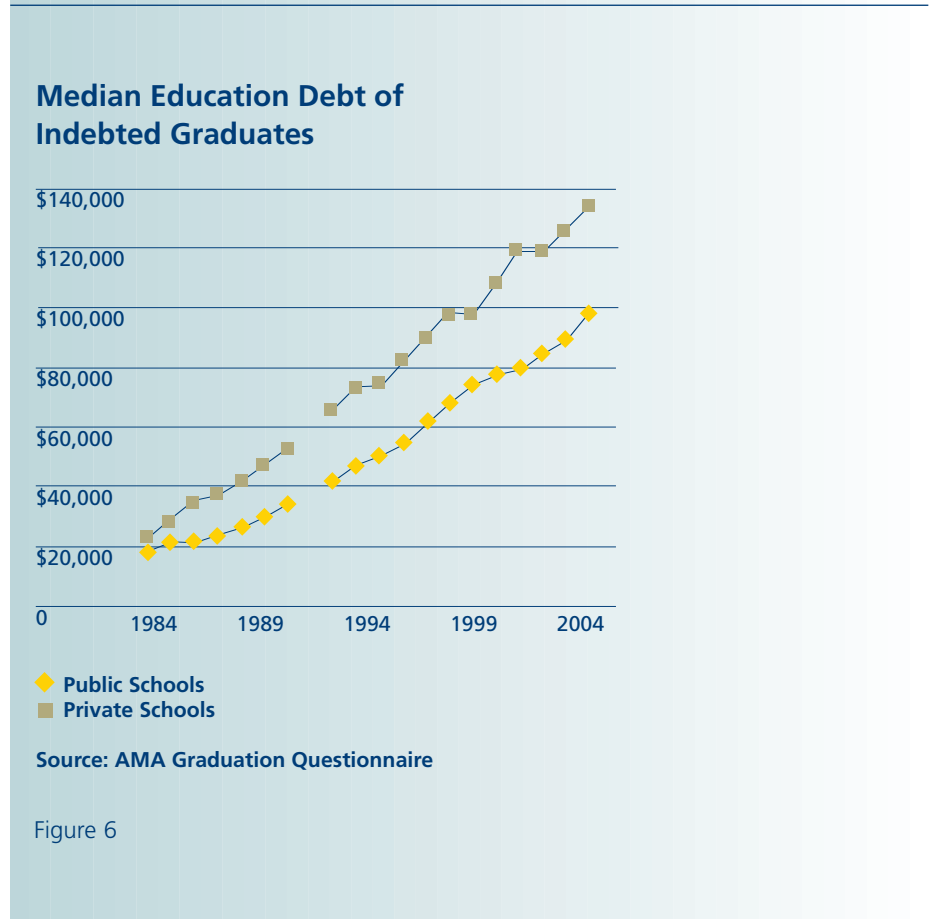
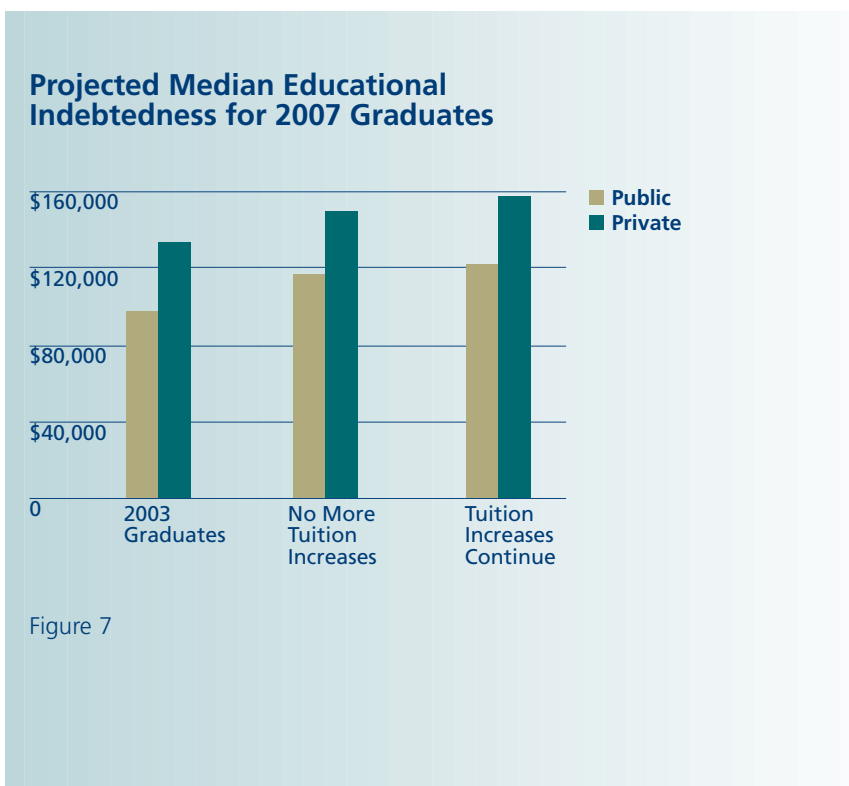


Figure 6

This increased indebtedness reflects several current factors in medical education:

- Medical education is an expensive undertaking for both medical schools and medical students. A few of the intrinsic contributing factors include: building, equipping, and maintaining state-of-the-art educational, laboratory, and clinical facilities; faculty and staff members' salaries; supporting ongoing innovations in educational methods and patient care activities that reflect concurrent changes in modern medical care; and the close faculty supervision and assessment of students required in the clinical environment. In addition, various external factors, including, in some instances, declining state support for higher education, contribute to the demands and uncertainty of managing a medical school's finances.
- The demographics of the medical student population have changed significantly over the past several decades. Fifty years ago, medical students were typically white, unmarried, male, and recent college graduates. Today's medical students are almost equally male and female, and many students are married and have families. Today's students represent a broader range of ages and racial and ethnic self-descriptions. This diverse student population also faces a broad range of financial challenges in paying for their medical education, and "one size fits all" financial aid strategies are neither appropriate nor effective.

- Societal lifestyle expectations have changed significantly during the past several decades, and medical students' lifestyle expectations mirror those of society and differ significantly from those of previous generations. For example, today's medical students do not live in on-campus dormitories. They also expect to, and often of necessity must have, an automobile and personal communication equipment as the move toward decentralized medical education at community hospitals located away from the home campus often requires daily use of automobiles for travel and cell phones to communicate with peers, faculty, and staff.
- Curricular innovations and information technology require students to purchase and maintain necessary and expensive equipment, including computers, personal digital assistants, and related software.
- The historically low interest rates on educational loans in recent years may have resulted in more medical students borrowing more money for their educational needs than in previous years. There is the general expectation that interest rates will rise significantly in the next few months, both on new loans and on loan consolidations.
- The median indebtedness of graduating students is projected to increase, whether tuition and fees remain constant or continue to increase (Figure 7).



- While approximately one-fifth of medical students graduated without educational debt, the educational debt of some graduates exceeds \$200,000 (Figure 8).
- Even at historically low 2004 interest rates (2.82 percent), monthly educational loan payments on a 10-year loan are substantial for physicians in repayment. Consolidating educational loans (2.82 percent for 30 years) substantially reduces monthly payments, but extends the loan to most of a medical career. These interest rates are predicted to rise significantly in July 2005. At the statutory maximum interest rate (8.25 percent) on a \$150,000 loan, monthly payments would increase by a third without consolidation and double with consolidation (Figure 9).

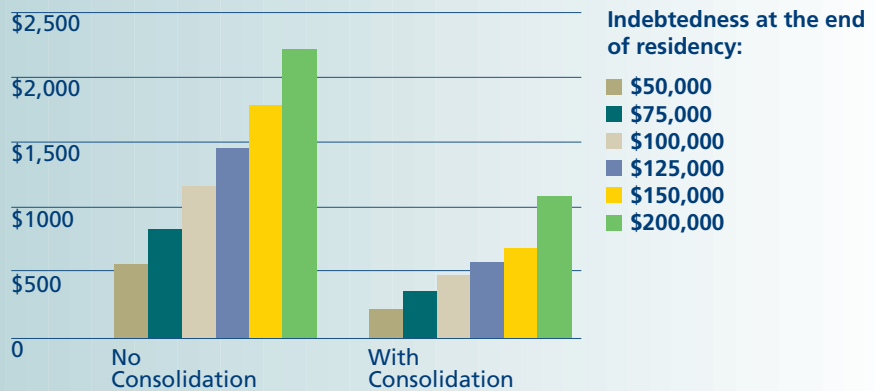
Educational Debt of 2003 Medical Graduates



Source: AMA Graduation Questionnaire

Figure 8

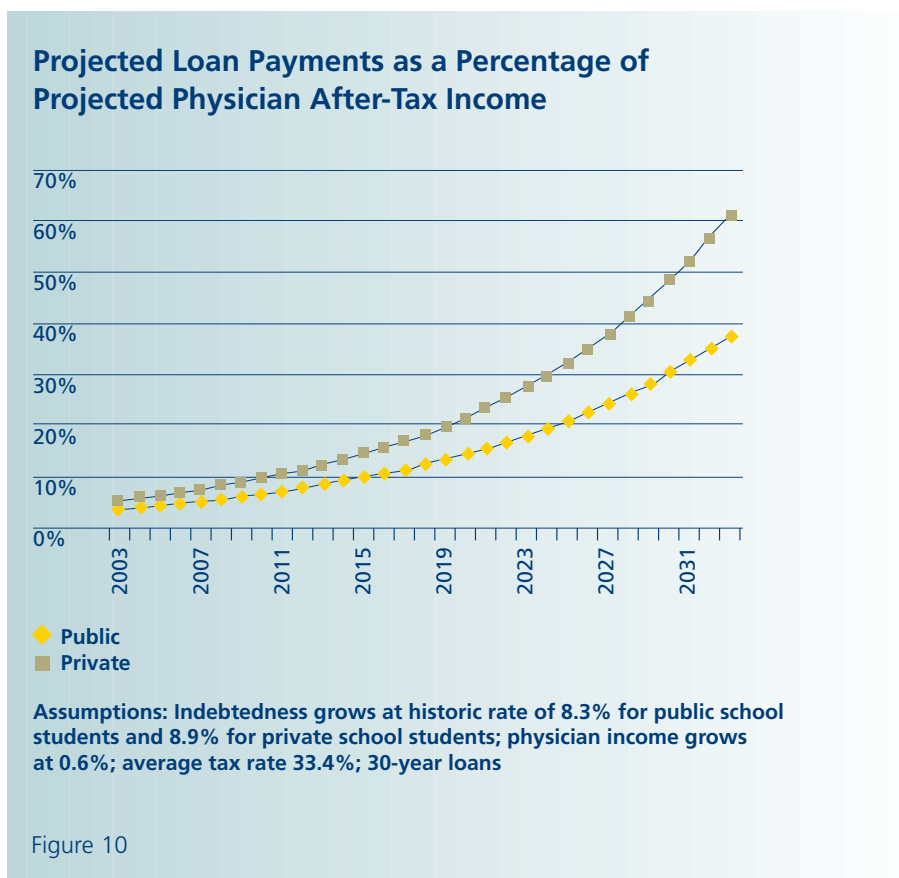
Monthly Payments Required



Source: AAMC Graduation Questionnaire and AAMC Student Financial Services Office

Figure 9

- A projection based on recent trends in growth of physician income and educational debt indicates that debt service will require an untenable percentage of physician after-tax income (Figure 10).



Working Group Charge

1. To consider the findings of the *Medical School Tuition and Young Physician Indebtedness* report; identify the need for any additional, complementary data; collect those data; and assess the implications of those data for students' educational costs and debt (e.g., determine the ability of medical school graduates, in the short and long term, to repay their total educational debt in light of current and predicted financial remuneration of physicians; determine the potential impact of educational costs and debt on the ethnic and socioeconomic diversity of future medical school classes).
2. To consider the practices of those schools with successful programs that enable their students to complete their undergraduate medical education with minimal educational debt (e.g., identify how some schools create and maintain extraordinary scholarship opportunities for medical students).
3. To consider means of ameliorating the costs of medical education on the part of schools and students, and of making those costs more predictable for students over the course of their undergraduate medical education (e.g., determine possible means of reducing the costs of schools' educational programs and students' costs of attendance).

4. To consider means of enhancing graduates' ability to repay their educational debt during their residency and early practice years (e.g., by increasing the limits of educational loan interest deductibility on federal and state income taxes or enhancing loan repayment and forgiveness opportunities for graduates in exchange for volunteer or mandatory service by physicians).
5. To make recommendations to the AAMC in each of these areas for potential consideration by member medical schools.

Working Group Process, Content, and Recommendations

Process: The working group met three times in Washington, D.C.: June 14-15, 2004; August 26-27, 2004; and December 15-16, 2004. In addition, one conference call was held on October 25, 2004.

At the June meeting, working group members reviewed the AAMC staff report on physician indebtedness. Findings from the AAMC's 2003 Applicant Study, an opinion research project that explored reasons that qualified college students apply and choose not to apply to medical school, were also examined.

To identify core issues regarding student educational costs and debt from different perspectives, two sets of caucus meetings were held. The first caucus grouped participants by their positions at their institutions (i.e., students/residents and institutional faculty/staff). The second caucus grouped participants by public and private schools. Following presentations by caucus members and resulting discussion, working group members framed a series of 19 relevant

questions (see Appendix B), the answers to which would assist them in developing a set of recommendations for consideration by the AAMC governance. Between the first and second meetings, AAMC staff provided data and other supporting documentation in response to these questions. Medical school student affairs and financial aid officers were also surveyed to collect relevant data not already available in AAMC databases (e.g., about medical schools' and medical students' participation in institutional tuition and fee-setting processes).

At the August meeting, the working group discussed each of the 19 questions in light of available data. As the discussion became more focused, the need for more specific data became apparent. AAMC staff then collected additional data for the working group's October conference call. During this conference call, working group members further refined their discussion and requested one additional extrapolation of the data in preparation for the December meeting. In addition, working group members reiterated their concerns about the significant adverse impacts that may result from rapidly increasing educational debt, including negative effects on the future physician workforce, graduates' specialty choice, medical care for the underserved, and entry into academic medicine and medical research.

On the first evening of the final, December 15-16, 2004 meeting, working group members reviewed data from medical schools in four states about "effective tuition," the amount remaining after average financial aid amounts are subtracted from tuition. On the second day of this meeting, working group members developed a set of final recommendations, which follow:

Issue 1: A Request by Students for Increased Accountability and Transparency

Tuition and fee-setting is a responsibility of the institutions that charge and collect tuition and fee payments, but it is also a prime concern of the students who, in paying tuition and fees, incur high levels of significant educational debt. Just as other payers (*e.g.*, the federal government, private insurance companies) have required greater accountability and transparency from medical schools and their affiliated teaching hospitals for monies paid for research and/or clinical services performed, medical students request the same consideration from medical schools about the monies they pay for tuition, fees, and other costs of attendance.

With 27 schools responding to an informal working group-sponsored survey of medical school student affairs officers, two-thirds of medical school respondents reported that their schools had some voice in the tuition and fee-setting processes, but that final decisions are usually made outside of the medical school. The other one-third indicated that their schools had little influence on tuition and fee decisions. In addition, 80 percent of respondents indicated that medical students have no involvement in the tuition and fee-setting process, with minimal involvement reported by the other 20 percent. Two schools reported formal discussions with students about the rationale for increases in tuition and fees. As a possible model, one school reported that, “students are informed by the senior associate dean on an annual basis regarding tuition-setting and the institutional rationale for [any increases].”

Recommendation 1A

Medical schools, through their administrative officers, should communicate at regular intervals, and at least annually, with students about medical school finances generally and about the sources and limits of various medical school revenue streams, including tuition and fees. These communications should help students understand:

- the current challenges facing funding for medical education and the rationale for additional funding in areas of need
- the ongoing challenges of managing the costs of medical education
- the relative role that tuition and fee revenues play in funding the educational program
- the process by which tuition and fees are set at the institution
- the difference between “cost” and “price” in medical education
- how new financial resources from tuition and fees increases will be allocated.

Recommendation 1B

Medical school administrative officers should ensure that there is broad understanding, at the highest levels of the sponsoring institution (*e.g.*, Board of Trustees, the Office of the President, the state legislature), of the current challenges regarding educational cost and debt facing medical students. In this effort, medical school administrative officers should develop mechanisms by which medical student representatives are empowered to participate in an advisory capacity in the medical school tuition and fee-setting process.

Recommendation 1C

Medical students should participate earnestly in student organizations available to them, make serious attempts to understand the complex nature of funding for undergraduate and graduate medical education, and be informed about salient factors affecting their education. As part of this effort, they should engage with medical school administrative officers in well-informed and collaborative discussions regarding shared solutions to these ongoing and serious financial challenges.

Recommendation 1D

The AAMC should continue to develop the tools necessary to assist medical schools to communicate effectively with appropriate audiences about these challenging issues and their potential adverse impact on the health and well-being of society.

Issue 2: A Request by Students for Increased Predictability

Applicants and students request increased predictability regarding tuition, fees, and the total cost of the medical education program. In addition, given recent reports regarding a proliferation of joint, combined, and dual degree programs at medical schools and the resulting increase in the number of years to program completion for students enrolled in such programs, additional data are required to assist students in predicting the costs to them of enrollment in these programs.

Recommendation 2A

Medical schools should disclose fully to potential applicants and applicants realistic information about the cost to the student of the educational program leading to the M.D. degree, including information about:

- the expected costs of attendance for the full length of the educational program, or the sources and magnitude of uncertainty, if prediction is not possible
- the amount and types of financial assistance typically awarded to students, including scholarship awards without repayment requirements, grants with repayment requirements, and loans
- the average amount of educational debt incurred by program graduates.

Recommendation 2B

Medical schools should:

- provide letters containing “best estimates” of the type and amount of financial aid to be awarded as early as possible to accepted applicants
- consult with students regarding the impact on students of potential changes in the price of a medical education
- develop options to ensure greater predictability for students regarding the full cost of their medical education (e.g., a “cost of degree” model, guaranteed annual tuition and fees for the length of the educational program for each entering class).

Recommendation 2C

The AAMC should assist medical schools by providing expert advice regarding alternate tuition and fee structures for the undergraduate medical education program and the advisability and effectiveness of these alternatives. The AAMC should also publish resulting “best practices” for consideration by medical school officials.

Recommendation 2D

The AAMC should refine its annual data collection tools (e.g., the LCME 1-B Survey, the Graduation Questionnaire) and related tracking programs (e.g., the Student Records System) to ensure that separate and specific data can be collected about medical student enrollment in joint, combined, and dual degree programs (e.g., M.B.A., M.P.H., J.D.) and the cost to these students of the M.D. degree program alone vs. the cost of the other graduate degree program.

Issue 3: A Need for Required, Ongoing Financial Education of Medical Students

Ongoing educational activities to help medical students understand and master the financial aspects of their medical education, both while in school and in practice, are essential. These activities should address the full cost of a medical education, including tuition and fees, other costs of attendance (e.g., books, equipment, transportation, living expenses, insurance), and costs associated with licensure examinations and related expenses (e.g., preparation, travel), as well as the financing options for, and future ramifications of, resulting debt.

Recommendation 3A

Medical schools should mandate that students who are incurring educational debt participate in educational activities regarding financial, debt, and loan management at multiple points in the medical school curriculum. These activities should be appropriate to the year of medical education in which the student is enrolled. To date, these educational activities at most schools are usually voluntary, infrequent, inconsistent in quality and content, and easy to avoid, with understandably variable results.

Recommendation 3B

The AAMC should assist medical schools in carrying out this responsibility by creating, periodically updating, and distributing appropriate educational materials (e.g., the AAMC's *Financial Wellness for Medical Students* program) to medical school student affairs and financial aid officers and students.

Recommendation 3C

Students should participate in these educational activities with the goal of enhancing their mastery of their financial situations and developing the financial competencies necessary to manage responsibly their educational loan repayments and other aspects of their financial lives.

Issue 4: Financial Challenges and Their Effect on Diversity in the Physician Workforce

Medical schools recognize that:

- the well-being of an increasingly diverse society depends upon the education and training of a diverse medical workforce
- they have a responsibility to recruit and educate a diverse group of students needed to meet society's health care needs
- financial aid policies should not contribute to a historically disproportionate representation of medical students from financially advantaged backgrounds.

Data from the AAMC's 2003 Applicant Study also indicate that some applicants from racial or ethnic groups underrepresented in medicine do not choose medical careers because of their concerns about educational costs.

Therefore, additional sources and types of financial aid must be identified, particularly in the areas of need-based scholarships and loan repayment and forgiveness programs. Decisions about tuition, fees, and scholarship support should consider potential unintended impacts upon the diversity of the medical school applicant pool and medical student population.

Recommendation 4A

Medical schools should develop and implement creative means of generating monies on local, state, and national levels, as appropriate to their educational missions, for financial aid programs for medical students. These programs should be specifically related to efforts to address the health care needs of society. Such activities could include:

- alumni fund-raising activities for medical student need-based scholarships and low-cost loans
- fund-raising efforts directed at local and regional foundations with missions related to health care improvement
- legislative activities to expand state-funded and federal loan repayment and forgiveness programs involving service in under-served areas and in the military, and expansion of those programs to a broader range of medical specialties to reflect fully the unmet needs of under-served populations
- seeking financial sponsorship by cities, towns, and counties of students who commit to return to designated areas following completion of their training.

Recommendation 4B

The AAMC should assist medical schools with these efforts by supporting federal legislative activities to:

- expand existing federal loan repayment and forgiveness programs, including efforts to expand eligibility for physicians in non-primary care areas
- explore new areas of potential support for loan repayment and forgiveness programs (e.g., an additional Medicare and Medicaid incentive for physicians who contract to devote a significant proportion of their clinical practice to medical services for Medicare- and Medicaid-funded patients)
- expand the deductibility of interest on educational loans by, for example, removing/raising existing income caps or by relating these caps to the amount of interest paid as a percentage of earned income.

Recommendation 4C:

The AAMC should assist schools in addressing this issue by generating collaborative efforts on a national level with other health professions educational associations and by representing promising proposals to appropriate governmental officials and agency heads and the officers of appropriate philanthropic organizations.

Recommendation 4D:

Indebted students should consider fully those loan repayment and forgiveness avenues available to them as a means of reducing their level of indebtedness while also providing much needed medical services to under-served populations and fulfilling the social contract between medicine and society.

Issue 5: Variability in Costs of Attendance among Medical Schools

Working group members were impressed with the significant variability in the various components of costs of attendance across member medical schools, even schools located in the same city (see Appendix C). Since these costs of attendance are directly related to the amount of money that students can borrow for their educations, and thus to the educational debt levels of graduates, additional information about the way in which these cost of attendance components are determined, and a rationale and justification for inter-school variations, are sought.

Recommendation 5A

Medical schools should engage in a thorough, periodic review of all components of their costs of attendance to ensure that these costs are appropriate.

Recommendation 5B

The AAMC should assist medical schools in comparing the components of their costs of attendance by collecting cost-of-attendance data in a systematic manner across schools nationally and making these data available to schools for purposes of internal review and decision-making.

Conclusions

The issues of escalating medical student debt and rapidly rising tuition and fees for both public and private medical schools are part of the larger problem facing health professional education and higher education in general. This report has demonstrated, we hope convincingly, that, unless significant changes are made, careers in medicine may not be affordable or attractive within the next few decades, and that applicants from lower socio-economic groups may choose not to pursue careers in medicine because of their concerns about educational costs. The report contains recommendations for:

- greater accountability and transparency in the tuition and fee-setting process
- greater predictability about the cost to students of a medical education
- the ongoing financial education of medical students
- enhanced programs of financial aid for medical students, with an emphasis on need-based scholarships and loan repayment and forgiveness programs, and
- periodic and comprehensive review of costs of attendance by medical schools.

More specifically, the members of the working group believe that a new look at funding for medical education should include more creative ways for physicians-in-training to provide service to the uninsured and underserved of this country as part of their understanding of, and commitment to, the important social contract between the medical profession and society.

Acknowledgements

Members of the working group wish to acknowledge the assistance of the following AAMC staff who assisted in this effort: Paula Crow, Paul Jolly, Jack Krakower, Collins Mikesell, Le'Etta Robinson, Robert Sabalis, Rajeev Sabharwal, Elisa Siegel, Charles Terrell, Donna Williams, and Shelley Yerman.

**Appendix A. Working Group on
Student Educational Costs and Debt
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Appendix B. 19 Questions

1. On what basis do medical schools set tuition rates? Which institutional leaders are involved in the tuition-setting process? What is the role of students in the tuition-setting process?

a. What is the “true cost” to an institution of a medical education?

i. What are the financial components of this “true cost?”

ii. How are funds generated by the institution to cover the “true cost” of a medical education – student tuition, state allocation, institutional endowment income, clinical revenue, other?

b. What are the implications for the student, the graduate, and the institution of 1, a, ii above?

c. What degree of autonomy do medical schools have from their parent institutions in the tuition-setting process?

d. How are students informed about the tuition-setting process?

2. What are the academic and non-academic components of the cost of attendance (COA)? (From annual LCME 1-B questionnaire)

a. Tuition?

b. Fees?

c. Books and equipment?

d. PDAs and computers?

e. Living expenses?

f. Health insurance?

g. Transportation (e.g., rural rotations, community hospital rotations, etc.)

h. Miscellaneous (e.g., costs associated with the residency application process and the licensure examinations)

3. What is the distribution of educational costs and debt levels among medical students and graduates?

a. Tuition: Public v. private schools

b. Fees: Public v. private schools

c. Non-tuition costs of attendance: Public v. private schools

d. Educational debt levels:

i. Students with educational debt v. students without educational debt

ii. Students in public schools v. students in private schools

iii. Debt levels by racial, ethnic, and gender self-description

iv. Are debt levels increasing as a function of need or financial convenience/savvy?

4. Apart from tuition rates, how do the components of “cost of attendance” differ among schools?

a. Public school v. private school?

b. Rural school v. urban school?

c. Primary care-oriented school v. research-oriented school?

d. HBCU-affiliated medical school v. majority medical school?

e. By geographical region?

5. How do school policies differ regarding eligibility for in-state tuition and fee status for enrolled students?
6. Have recent educational enhancements and recent technological developments affected students' educational costs and debt?
7. What sources of funds are available to students? What is the utilization of these resources among students? Are some funding sources (e.g., National Health Service Corps, Armed Forces Health Professions Scholarship Program) over- or under-subscribed? What are the demographics of the students who participate in these programs?
 - a. Grants (without a service component)
 - i. Institutional
 - ii. External
 - b. Loans
 - i. Stafford
 1. Subsidized
 2. Unsubsidized
 - ii. Other federal loans
 - iii. Private/alternative
 - c. Repayment programs
 - i. State
 - ii. Federal
 1. Military
 2. NHSC
 3. Indian Health Service
 4. Family contributions
 - d. Credit cards
8. Is there a difference between private and public medical schools in the socioeconomic status of their students?
 - a. What are the borrowing patterns of these students?
 - b. Are costs affecting applicants' decisions about which type of school to attend?
 - c. Are costs preventing applicants/students from attending medical school?
9. What models are available for reducing tuition costs by means of student service/employment during medical school?
10. What options are available to institutions to reduce/manage the costs of their educational programs?
11. Are current medical students and/or recent graduates able to "service" current levels of educational debt?
 - a. Default rates on educational loans?
 - b. Number of months to "paid in full" status for educational loans?
 - c. How much is too much (i.e., what percentage of gross income can reasonably be allocated to educational debt service over various income levels)?
 - d. If physicians' incomes remain at current levels and if educational costs and debt continue to increase, what is the impact on medical students and graduates? Projecting from current trends, at what point in the future would educational costs and debt not be sustainable by physician incomes?
- e. What is the impact of educational debt of different levels on other personal/family choices: children, home purchase, lifestyle, etc.?
12. Do educational cost and debt have a differential impact on majority and minority students regarding their:
 - a. Decision to pursue a medical education?
 - b. Ability to matriculate in medical school?
 - c. Choice of which school to attend (e.g., personal preference v. cost)?
 - d. Specialty choice?
13. How will current trends in educational costs and debt level affect future applicants, medical students, and graduates?
 - a. How would a significant increase in interest rates affect graduates' ability to service their educational debt?
 - b. How would a significant increase in interest rates affect potential applicants' willingness to apply to medical school?
14. How does the educational indebtedness of medical students compare to that of other graduate, professional, and health science students?
15. What is the impact of educational debt on specialty choice? [Literature survey, GQ, etc.]
 - a. Have specialty societies addressed this issue?

16. How should schools prepare students to be able to manage well the financing of their medical education and the repayment of their educational loans?
 - a. What evidence exists regarding the educational needs of medical students in the area of financial planning and management?
 - b. What services/programs are currently available?
 - c. What is the utilization of these programs at schools?
 - d. Do institutions recognize the level of need for these programs for their students? Have they allocated sufficient resources to address this issue?
 - e. Are these voluntary or mandatory programs? If voluntary, should they be a mandatory component of the curriculum?
17. What political solutions could be proposed to assist those categories of students/graduates most challenged by educational debt?
 - a. Residents?
 - b. Financially disadvantaged students?
 - c. Graduates in public service medicine?
18. What financial aid challenges and opportunities exist for international students accepted to a U.S. medical school?
19. What are the public's perceptions of:
 - a. Physicians' incomes?
 - b. The cost of higher education?
 - c. The role of government in providing support for higher education?

Medical Educational Costs
and Student Debt



Appendix C: Cost of Attendance: Selected States and Medical Schools, 2002-2003

Residents	Tuition & Fees	Books and Equipment	PDA's/Computers	Living Expenses	Health Insurance	Transportation	Miscellaneous	Total COA
(In-state medical students)	All years	All years	All years	All years	All years	All years	All years	All years
All Schools Average	82,654	5,653	973	44,069	4,097	8,165	8,893	154,153
Public Schools Average	56,444	6,031	980	42,659	3,465	8,652	9,538	127,431
Private Schools Average	121,445	5,094	963	46,156	5,051	7,454	7,938	193,702
State A Average	79,681	6,180	1,671	47,791	3,598	10,359	6,717	155,339
School A-1	121,600	8,950	NA	31,390	NA	13,545	6,130	181,615
School A-2	142,360	5,500	2,800	45,740	2,376	6,720	9,340	214,836
School A-3	152,086	4,250	2,700	64,890	6,048	7,765	1,084	238,823
School A-4	41,587	5,318	0	44,638	3,864	8,854	7,656	111,917
School A-5	49,382	6,646	2,800	45,672	0	10,511	0	115,011
School A-6	38,882	5,070	3,400	48,694	2,992	17,888	16,607	133,533
School A-7	43,870	7,196	0	33,534	3,984	11,390	11,900	111,874
School A-8	47,678	6,510	0	67,773	5,920	6,200	1,020	135,101
State B Average	119,051	5,676	429	48,876	4,614	6,053	6,054	190,752
School B-1	146,960	5,778	0	65,986	7,228	0	1,070	227,022
School B-2	128,644	7,562	0	45,614	4,400	8,322	970	195,512
School B-3	139,992	8,568	3,000	68,628	8,757	6,665	4,845	240,455
School B-4	123,168	2,620	0	55,900	6,278	5,680	4,300	197,946
School B-5	76,464	2,944	0	31,535	0	3,821	13,592	128,356
School B-6	133,470	7,624	0	44,142	5,400	14,713	7,700	213,049
School B-7	84,656	4,635	0	30,328	232	3,168	9,904	132,923
State C Average	74,255	5,015	2,553	37,558	5,357	4,385	11,729	140,851
School C-1	128,069	5,596	3,400	33,840	4,252	0	15,802	190,959
School C-2	18,452	4,150	3,034	33,495	5,384	3,535	12,460	80,510
School C-3	28,381	5,925	3,778	42,907	3,800	5,413	16,287	106,491
School C-4	122,116	4,390	0	39,990	7,990	8,591	2,365	185,442
State D Average	120,201	4,841	900	46,136	6,203	5,520	9,078	192,728
School D-1	130,488	3,700	3,000	39,600	7,200	7,100	19,930	211,018
School D-2	127,832	4,451	400	50,052	7,896	3,971	6,630	201,232
School D-3	95,800	5,427	0	31,680	4,800	6,788	7,410	151,905
School D-4	111,896	3,700	NR	51,885	6,732	4,600	7,190	186,003
School D-5	114,064	7,456	0	54,096	3,868	8,760	2,350	190,594
School D-6	141,128	4,310	1,100	49,500	6,720	1,900	10,960	215,618

Medical Educational Costs
and Student Debt



Residents	Tuition & Fees	Books and Equipment	PDAs/ Computers	Living Expenses	Health Insurance	Transportation	Miscellaneous	Total COA	Non-Tuition COA
(In-state medical students)	All years	All years	All years	All years	All years	All years	All years	All years	All years
State A									
Public Schools—Average	44,280	6,148	1,240	48,062	3,352	10,969	7,437	121,487	77,207
School A-4	41,587	5,318	0	44,638	3,864	8,854	7,656	111,917	70,330
School A-5	49,382	6,646	2,800	45,672	0	10,511	0	115,011	65,629
School A-6	38,882	5,070	3,400	48,694	2,992	17,888	16,607	133,533	94,651
School A-7	43,870	7,196	0	33,534	3,984	11,390	11,900	111,874	68,004
School A-8	47,678	6,510	0	67,773	5,920	6,200	1,020	135,101	87,423
Private Schools—Average	138,682	6,233	2,750	47,340	4,212	9,343	5,518	211,758	73,076
School A-1	121,600	8,950	NA	31,390	NA	13,545	6,130	181,615	60,015
School A-2	142,360	5,500	2,800	45,740	2,376	6,720	9,340	214,836	72,476
School A-3	152,086	4,250	2,700	64,890	6,048	7,765	1,084	238,823	86,737
State B									
Public Schools—Average	80,560	3,790	0	30,932	116	3,495	11,748	130,640	50,080
School B-5	76,464	2,944	0	31,535	0	3,821	13,592	128,356	51,892
School B-7	84,656	4,635	0	30,328	232	3,168	9,904	132,923	48,267
Private Schools—Average	134,447	6,430	600	56,054	6,413	7,076	3,777	214,797	80,350
School B-1	146,960	5,778	0	65,986	7,228	0	1,070	227,022	80,062
School B-2	128,644	7,562	0	45,614	4,400	8,322	970	195,512	66,868
School B-3	139,992	8,568	3,000	68,628	8,757	6,665	4,845	240,455	100,463
School B-4	123,168	2,620	0	55,900	6,278	5,680	4,300	197,946	74,778
School B-6	133,470	7,624	0	44,142	5,400	14,713	7,700	213,049	79,579
State C									
Public Schools—Average	23,417	5,038	3,406	38,201	4,592	4,474	14,374	93,501	70,084
School C-2	18,452	4,150	3,034	33,495	5,384	3,535	12,460	80,510	62,058
School C-3	28,381	5,925	3,778	42,907	3,800	5,413	16,287	106,491	78,110
Private Schools—Average	125,093	4,993	1,700	36,915	6,121	4,296	9,084	188,201	63,108
School C-1	128,069	5,596	3,400	33,840	4,252	0	15,802	190,959	62,890
School C-4	122,116	4,390	0	39,990	7,990	8,591	2,365	185,442	63,326
State D									
Public School—Average	95,800	5,427	0	31,680	4,800	6,788	7,410	151,905	56,105
School D-3	95,800	5,427	0	31,680	4,800	6,788	7,410	151,905	56,105
Private Schools—Average	125,082	4,723	1,125	49,027	6,483	5,266	9,412	200,893	75,811
School D-1	130,488	3,700	3,000	39,600	7,200	7,100	19,930	211,018	80,530
School D-2	127,832	4,451	400	50,052	7,896	3,971	6,630	201,232	73,400
School D-4	111,896	3,700	NR	51,885	6,732	4,600	7,190	186,003	74,107
School D-5	114,064	7,456	0	54,096	3,868	8,760	2,350	190,594	76,530
School D-6	141,128	4,310	1,100	49,500	6,720	1,900	10,960	215,618	74,490

