Medical School Costs and Its Impact on Rural Medicine

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I. INTRODUCTION

President Obama’s plan to reform healthcare by ensuring that every American is able to afford health insurance is an admirable attempt to fix the healthcare crisis that faces our country. However, this alone cannot solve the crisis. While the number of Americans seeking healthcare will dramatically increase, the number of physicians available to serve them, particularly in rural areas, will not follow suit. Providing an adequate number of primary care physicians, particularly in these underserved areas, is critical to improving the national healthcare system since they help to contain the cost of healthcare and improve the general health of society.¹ Medical school costs, however, are reaching staggering heights² and rural communities across the country are feeling the impact.

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¹ Kristine Marietti Byrnes, Is there a Primary Care Doctor in the House? The Legislation Needed to Address a National Shortage, 25 RUTGERS L.J. 799, 806-08 (1994).

Unless we relieve the financial pressures on medical students and young doctors, they have no incentives to enter primary practice in rural communities.\textsuperscript{3} This contributes to the disparities in medicine that those living in rural communities face.\textsuperscript{4} There are two ways to decrease the financial pressures on medical students and young doctors, and consequently decrease the resulting impact on rural medicine. First, the cost of medical school should be decreased in order to increase the number of physicians entering primary practice. Second, the number of loan reimbursement and scholarship programs should be increased in order to lure doctors to underserved rural communities.

To guarantee that the proposed healthcare reforms are successful and to alleviate disparities in rural medicine, we must provide financial incentives to make practicing medicine in these communities possible. Therefore, this article seeks to understand how increasing medical school debt impacts disparities in rural medicine and how to prevent these disparities. As such, Part II discusses the dramatically increasing cost of medical school and the associated debt that graduates face. Additionally, this section explains the impact that these increasing costs have on physician career choices. Part III then describes how physician career choices impact access to medicine in rural communities and the treatment disparities that people in these communities face. Next, Parts IV and V examine ways to alleviate the deleterious impact that increasing costs have on

\textsuperscript{3} See Stephanie Gunselman, The Conrad “State-30” Program: A Temporary Relief to the U.S. Shortage of Physicians or a Contributor to the Brain Drain?, 5 J. HEALTH & BIOMEDICAL L. 91, 94 (2009).

\textsuperscript{4} Id. at 95.
rural medicine. Part IV analyzes the need to decrease the cost of medical school as a means of making primary practice a more financially feasible option. Thereafter, Part V considers how loan reimbursement and scholarship programs can be used to lure physicians to underserved rural communities.

II. THE IMPACT OF THE INCREASING COST OF MEDICAL SCHOOL

According to the Association of American Medical Colleges, in 2008, 87% of medical students graduated with debt. On average, medical students graduate with about $155,000 of debt. On the other hand, the average salary of a first year resident is only $45,569. As a result, “young physicians struggling to pay off their educational debt over the standard [ten]-year period could find these payments consuming over half of their after-tax income.” According to another report from 2007, if the current trends continue, borrowers using the standard ten-year repayment period will spend half their income allotted for personal spending to pay off their medical education debt. If, on the other hand, they opt for the twenty five-year repayment period, they will still be paying off loans in their fifties.

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5 AAMC, FACTS, supra note 2, at 1.
6 Id.
7 Id.
9 Id. at 7.
10 Id.
It is no surprise then that education related indebtedness is one of the most significant factors influencing a physician’s career choice.\footnote{Byrnes, supra note 1, at 804.} As a result, young physicians frequently take into account income, hours worked, and loan repayment when considering a specialty.\footnote{Carol S. Weissert & Susan L. Silberman, Sending a Policy Signal: State Legislatures, Medical Schools, and Primary Care Mandates, 23 J. HEALTH POL’Y & L. 743, 746 (1998).} “Differentials in physician income levels cause students to pursue careers in higher-paying specialties.”\footnote{Byrnes, supra note 1, at 804.} Consequently, a “small[er] number of medical graduates [are] planning to work as primary care physicians or general surgeons.”\footnote{Gunselman, supra note 3, at 94.} Instead, they “tend to choose more lucrative specialties, in part to repay the high cost of attending medical school in the United States.”\footnote{Id.} This trend is on the rise. In 1994, “[f]ewer than one-third of American physicians [were] generalists, and fewer and fewer medical school graduates [chose] primary care careers.”\footnote{Carol Weissert et al., Education and the Health Professions: Explaining Policy Choices Among the States, 19 J. HEALTH POL’Y & L. 361, 361 (1994).} By 2008, only 2% of fourth year medical students planned careers in general internal medicine.\footnote{AM. MED. ASS’N, MEDICAL STUDENT DEBT 3 (2009), http://www.ama-assn.org/ama1/pub/upload/mm/15/cola_debt_pres.pdf [hereinafter AMA, DEBT].}

\section*{III. Disparities in Rural Medicine}

For a significant number of Americans, access to healthcare is denied simply because of a shortage of physicians.\footnote{Byrnes, supra note 1, at 799.} Although there is a surplus of physicians, they are concentrated in affluent sections of major cities and primary
care physicians are still in short supply.\textsuperscript{19} “Approximately [sixty-five] million Americans lack access to a primary care provider because of shortage – many of whom are rural Americans.”\textsuperscript{20} According to the National Health Service Corp (NHSC), “nearly [fifty] million Americans currently live in health professions shortage areas (HPSAs) – underserved communities which lack adequate access to primary care services – and that 27,000 primary care professionals are needed to adequately serve the people living in HPSAs.”\textsuperscript{21}

However, “[t]his shortage of physicians disproportionately affects patients living in rural areas.”\textsuperscript{22} Although “[20\%] of the United States population lives in rural areas, only [9\%] of physicians practice in rural areas.”\textsuperscript{23} People in small, rural communities are “left with few doctors and long waiting periods to see a physician.”\textsuperscript{24} Additionally, they must often drive long distances for basic healthcare and wait in crowded emergency rooms to get treatment for minor problems.”\textsuperscript{25} Consequently, this vulnerable population suffers from consistently poor health and regularly has no access to necessary healthcare.\textsuperscript{26}

\textsuperscript{19} Id. at 800.
\textsuperscript{22} Gunselman, supra note 3, at 95.
\textsuperscript{23} Id.
\textsuperscript{24} Id. at 91.
\textsuperscript{25} Byrnes, supra note 1, at 800.
\textsuperscript{26} Id.; Gunselman, supra note 3, at 95.
IV. DECREASING MEDICAL SCHOOL COSTS TO INCREASE PRIMARY PRACTITIONERS

In general, “although the United States is headed for a significant physician surplus, inequity in access to high-quality primary care still remains.” 27 Primary care physicians are “doctors who provide ‘first-contact’ care, or the generalized services patients receive on an ongoing basis.” 28 In many areas, such as rural communities, primary care as opposed to specialty care is provided most of the time. 29 Therefore, “primary care physicians play a key role in the delivery of health care because they provide truly accessible, continuing, comprehensive, and coordinated care for most problems of unscreened patients.” 30 Generalists could treat approximately 85% of all medical conditions. 31 Their services are more utilitarian because of their ability to treat a wide variety of patients. 32 However, “the majority of medical school graduates [are] not entering primary care fields but [are] opting for specialty practice instead.” 33 Given primary care practitioners’ vital role in the healthcare system, the decreasing number of physicians choosing this field is particularly problematic.

While the decreasing numbers of primary care doctors is alarming, it is not difficult to understand why this problem is occurring. As discussed above, the average medical student is graduating with an almost insurmountable amount of

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28 Byrnes, supra note 1, at 801.
29 Id.
30 Id. at 801-802 (internal citations omitted).
31 Id. at 802.
32 Id.
33 Id.
Consequently, debt is a very influential factor in specialty choices for many young physicians. Because there are extreme inconsistencies in physician income levels, students tend to choose more lucrative specialties to repay the high costs of medical school. According to the American Medical Association, “[p]rimary care doctors on average make only 55% of what all other specialists make.” Therefore, as fewer and fewer physicians choose to practice primary medicine, rural communities are suffering the repercussions.

By decreasing the cost of medical school, young physicians would be less burdened by debt. As a result, physicians who would otherwise be limited by financial constraints would have more freedom to choose primary medicine over higher paying specialties. Thus, rural communities would benefit from an increased number of primary care doctors. Although doctors’ salaries in rural communities are somewhat lower than those in urban areas, it would be less prohibitive for young physicians looking to practice primary medicine, particularly in rural communities, if they were weighed down by less debt.

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34 AAMC, FACTS, supra note 2, at 1 (Students graduate with an average of $155,000 of debt and will likely be strapped with monthly loan payments that eat almost half of their expendable income or end up paying their loans into their fifties.).
36 Byrnes, supra note 1, at 804; Gunselman, supra note 3, at 94.
38 AMA, DEBT, supra note 17, at 3 (In 2008, only 2% of medical students planned to practice general internal medicine.); Gunselman, supra note 3, at 95.
40 AMA, DEBT, supra note 17, at 15.
V. INCREASING DEBT REPAYMENT AND SCHOLARSHIP PROGRAMS TO LURE DOCTORS TO RURAL COMMUNITIES

In addition to decreasing the cost of medical school, increasing the number of debt repayment and scholarship programs would help ease the harmful impact that increasing costs have on rural medicine. These programs provide financial incentives to debt-ridden medical students in order to lure them into practicing rural medicine. While there are already a few federal and state programs offering loan repayment and scholarship payment in exchange for several years of service in an underserved community, we must commit more resources to these programs in order to affect the growing disparities in rural medicine.  

Generally, health professionals in rural areas earn less than their urban counterparts, “making it difficult to repay school loans, buy malpractice insurance, and earn a decent living.” As a result, “hard-to-fill posts . . . will probably never independently attract physicians.” This furthers the extreme shortages in primary care providers that rural communities face. However, loan repayment and scholarship programs will, at least in the short term, provide physicians to underserved areas.

Programs already in existence include the federal government’s NHSC and a number of state programs. The NHSC, which was “created in 1970 to provide primary health care clinicians for the underserved, aims at spreading

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41 See id. at 14.
42 Weissert et al., supra note 16, at 367.
43 Byrnes, supra note 1, at 845.
44 Id. at 845-46.
clinicians more evenly.’’\textsuperscript{45} Under the program, “[i]dealistic young doctors and other health workers would serve voluntarily in ‘doctor-deficient areas.’”\textsuperscript{46} The program, however, has “strings or substantial penalties if the student defaults on his or her promise to serve in an underserved area for the specified period of time.”\textsuperscript{47}

The NHSC has two programs to fund medical school and simultaneously provide primary practitioners to underserved rural communities.\textsuperscript{48} First, the NHSC Scholarship program pays tuition for scholars while they are in school and, as repayment, the scholars commit to serving as physicians in an underserved community after graduation. Specifically, the scholarship pays tuition, required fees, and some other education costs tax free, as well as a monthly living stipend for up to four years.\textsuperscript{49} Thereafter, the scholars are committed to serve as primary care physicians one year for each year of support (minimum of two years service) at an approved site in a high-need HPSAs.\textsuperscript{50}

Second, the NHSC Loan Repayment program is for recent graduates, who have already accrued debt. The Loan Repayment program “provides $50,000 (or the outstanding balance of qualifying student loans if they are less than $50,000),

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\item \textsuperscript{45} Politzer et al., \textit{supra} note 27, at 71.
\item \textsuperscript{46} \textit{Id.} at 73.
\item \textsuperscript{47} Weisssert & Silverman, \textit{supra} note 12, at 748.
\item \textsuperscript{48} HHS.gov, Key Facts About the National Health Service Corps, http://www.hhs.gov/recovery/programs/nhsc/nhscfactsheet.html (last visited November 6, 2009).
\item \textsuperscript{49} Nhsc.hrsa.gov, National Health Service Corps Scholarship, http://nhsc.hrsa.gov/scholarship/ (last visited November 6, 2009).
\item \textsuperscript{50} \textit{Id.}
\end{itemize}
tax free, to primary care medical, dental, and mental health clinicians in exchange for two years of service at an approved site in a [HPSA].”

Additionally, there are a number of state programs that provide scholarships or loan repayment in exchange for service as a primary practitioner in a rural community. The terms of these programs differ in each state.

This year, with the American Recovery and Reinvestment Act (ARRA), the government significantly increased the amount of funding the NHSC received. According to Secretary Sebelius, of the U.S. Department of Health and Human Services, the “new funds are expected to double the number of Corps clinicians and make 3,300 awards to clinicians that serve in health centers, rural health clinics, and other health care facilities that care for uninsured and underserved people.”

While it is commendable that the government has increased funding available to the NHSC through the ARRA, in order to end the disparities in rural medicine, even more resources should be committed to these programs. “[T]he

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54 HHS, News Release, supra note 53.
NHSC meets only a fraction of the overall need for health professionals.”\textsuperscript{55} According to the Association of American Medical Colleges, “[w]hile the NHSC supports a field strength of over 4,000 practitioners, the Health Resources and Services Administration estimates that an additional 30,000 practitioners are needed to achieve the target HPSA practitioner/population ratios.”\textsuperscript{56} Thus, although 3,300 practitioners will help to end the primary practitioner shortage in underserved communities, it is by no means enough.

VI. CONCLUSION

There is no denying that rural communities face disparities in access to medical care. Providing healthcare coverage for people in rural communities, as the health reform plan proposes to do, however, is not enough. As a country, we must also ensure that there are a sufficient number of physicians to serve everyone in these communities. The cost of a medical education is increasing at an astounding rate. Therefore, the debt has become prohibitive and forces young physicians to choose specialties, not based on what they would like to do, but on how they can most easily pay off debt.

However, decreasing the cost of medical school and providing additional funding to scholarship and loan repayment programs can provide incentives to encourage physicians to choose primary practice in rural communities by relieving the financial pressures on medical students and young physicians.

\textsuperscript{55} Politzer et al., supra note 27, at 71.

While this will likely not be the ultimate solution, it will nonetheless help to end the inequality in access to medicine that rural communities face.