THE LUND REPORT
Unlocking Our Healthcare System

Published on *The Lund Report* (http://www.thelundreport.org)

Medical School Costs Out of Reach for Many Students

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Created *01/04/2011 - 17:53*
OHSU has had the highest tuition and fees among public medical schools in the country for the past three years
By: Dr. Kris Alman

Icon Images

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January 4, 2011 -- I started medical school in 1980, a pivotal year in health care economicc. That year the United States diverged from the other industrialized nations in healthcare spending. My private medical school tuition almost doubled in four years, going from $7500 to $13,000 per year.

January 4, 2011 -- I'm a baby boomer and a descendant of the "Greatest Generation"— so called because that generation survived deprivations of the Great Depression and World War II. My "Echo Boomer" teen-aged kids have grown up in affluence. They aren't fully absorbing the aftershocks of the loudest and latest booms of my generation.

Then again, no shock absorbers can sufficiently deal with these reverberations. Banks used financial engineering to inflate economic bubbles. When they popped, banks strapped the resulting debt to workers—already laden with moribund wages and skyrocketing healthcare costs. As "shared sacrifice" for our naïve complicity in "The Great Recession," public education, Social Security, Medicare, unemployment insurance and other safety nets are on the chopping blocks.

Boomers like me benefited by the hard-fought opportunities and securities our parents won. Even though I was one of nine children, I could afford $350-per-semester college tuition at a public university. With scholarship aid and savings from part-time work in high school and college, I had no undergraduate debt.

I started medical school in 1980, a pivotal year in health care economics [3]. That year the United States diverged from the other industrialized nations in healthcare spending. My private medical school tuition almost doubled in four years, going from $7500 to $13,000 per year.

Before graduation, an appointment with the financial aid counselor was sobering. My $60,000 debt was far higher than the $27,000 median debt [4] other private medical school students then faced ($22,000 for public medical school). After loan repayments were deferred for three years during my internal medicine training, I was nonetheless able to pay $500 per month to resolve my debt within 14 years.

We're still intoxicated by the mantra that investments in education pay off. But when the young are left with toxic debts and underemployment, this no longer holds true. I couldn't afford to go to medical school now.

In a powerful essay [5], author Chris Hedges recently wrote, "Hope cannot be sustained if it cannot be seen." Our personal health is the best lens to gauge aggregate hope.

The fragmented, profitable healthcare industry is like a cataract that insidiously and progressively blurs our vision. It's a metaphor for predatory capitalism. We are frightened by unseen or imaginary obstacles. We move aimlessly and without direction. And we pay dearly for this obscured vision.

Health careers and care

Like the cost of healthcare, the cost of medical school has skyrocketed [6]. From 1984 to 2003, median tuition and fees [4] increased by 165% in private medical schools and by 312% in public medical schools, growing far more rapidly than the consumer price index. Medical education debt increased 4.5 fold. Indebtedness for public medical school graduates [6] is now increasing more rapidly than it is for private medical school graduates.

In 1995, state appropriations were 12% of OHSU's total budget. Now they are just 2% of its total annual operating budget and are among the lowest in the nation. This factor explains, in part, why OHSU medical school tuition has more than doubled [7] to nearly $33,000 in the past decade. This academic year, in-state students will pay $40,684 for combined tuition and fees (the highest in the nation for public medical schools for the past three years) according to the Association of American Medical Colleges [8]. Room and board estimates [9] add an additional $18,000 per year.

According to Kathleen McFall, director of communications at OHSU's School of Medicine, the average debt for the 2008-2009 medical school graduates was $172,433. This debt approximates the average debt for private medical school education [10] and is $24,000 more than the average public medical school debt. After deferments, the monthly payment for this median debt easily exceeds $2,000. But one in four of those 2008-2009 graduates incurred debts greater than $200,000. Furthermore, these debts don't include those from undergraduate education and other sources.

The social mission of medical schools [11] is to train an adequate number of primary care physicians who are distributed adequately to underserved areas and with a sufficient number of minority physicians in the workforce. OHSU is recognized for this commitment. OHSU also receives national recognition [12] for its training of primary care doctors.
Mounting debts discourage medical students from careers in primary care [13] toward more highly paid procedure-oriented specialties. Can Oregon's only medical school continue to attract students who will pursue primary care under these circumstances?

Regardless, the primary care physician's practice is changing to offset practitioner shortages. Increasingly, we'll trade off appointment delays to be seen by nurses, physician assistants and nurse practitioners in team-based delivery. "E-coaching for boomer health [14]" offers virtual healthcare. Health plans like Kaiser already give members access to healthy lifestyle programs [15] that use health risk assessments to customize online programs that can help patients reduce stress, quit smoking and manage back pain. Whether any of these changes actually improves care is dubious.

Some patients pay more for "concierge" care, but surveys [16] show that even they are increasingly dissatisfied with access to and communication with their primary care physician.

To address escalating health care costs, Oregon is experimenting with "value-based" insurance [17]" for state employees. These plans are a template for the commercial market on Oregon's healthcare exchange. Preventive and "high-value services" are essential benefits [18] covered at low or no cost, while higher tiers of "low relative value" require higher co-pays. The highest tiered care may be uncovered because it is considered less effective or because symptoms resolve without treatment. Those visits could be completely out-of-pocket. They will present financial burdens on lower income members and can interfere in the doctor-patient relationship.

Consider potential bad outcomes from these "low relative value" examples:

- A newborn has a cough and fever. A cold or pneumonia? As the self-limited cold is not covered, parents may be reluctant to bring their baby in for evaluation. This decision could be lethal for the newborn baby.
- An athlete injures his ankle. A sprain or a fracture? A minor sprain would not be covered. Without x-ray vision, the athlete with a broken bone might gamble against a doctor's visit to avoid paying for the visit.

To cast or to caste, that is the question

We're more likely to get depressed, smoke, overeat, or engage in violent behavior when we're stressed and anxious. Public health experts and authors of *The Spirit Level* [19], Richard Wilkinson and Kate Pickett argue that the most powerful indicator of a well functioning and healthy society is the gap between the richest and poorest. The smaller the gap, the better functioning and healthy the society will be.
That gap is measured by the Gini coefficient [20]: the higher the number, the more inequality. America's income inequality was lowest in 1968.

Our income inequality [20] now is higher than the level preceding the Great Depression. Among the 34 democratic and industrialized countries of the Organization of Economic Co-operation and Development (OECD [21]), America has a Gini coefficient [22] (as measured by the CIA) that is topped by only two countries—Mexico and Chile. America's income inequality exceeds that of Jordan, Japan, China, Russia and India.

Income inequality in America [23] is highest in the District of Columbia and the state of New York. The most billionaires [24] (403) reside in the United States, while 4,715,000 American millionaires own 56% of our total wealth. It's no mathematical coincidence that, generally speaking, more millionaires cluster [25] in states with higher income inequality.

When the investor class wins the race to top incomes, they concentrate power and call the shots in local, state and federal legislatures. In doing so, they also propel the rest of us on a race to the bottom. They accomplish this when they disable regulatory oversight and enable preferential exemptions, credits, deductions and tax rates that deplete general funds. Consequently, income inequality is pervasive in the United States. Oregon's income inequality [23] is similar to Kenya's.

The American minimum wage at $7.25 per hour [26] is grossly insufficient to pay for food, shelter, transportation, and child and healthcare. As inadequate as the federal minimum wage is, there are many incidents where it is not even met. Tipped employees in many states can be paid $2 to $3 per hour. In Massachusetts, agricultural employees are paid as low as $1.60 per hour.

America's increased income inequality comes with a price. To keep poverty rates from rising, social spending on welfare programs must increase. The Earned Income Tax Credit and the Child Tax Credit are also designed to assist the poor, but they must correctly file their taxes in order to benefit from them. Even so, conservative organizations like the Cato Institute [27] clearly feel the credits are not deserved. The deepening recession strains state coffers already suffering from revenue shortfalls. Consequently, poverty rates [28] are at a 15-year high.

Dr. Kris Alman retired from healthcare to become a citizen activist for a healthier democracy. She advocates for fair taxation to invest in our common goods--prioritizing education, renewable energy, campaign finance and healthcare policies and laws.

Body Images

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