Lower the cost of producing doctors, not just the price of going to medical school

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Medicine has become a profession accessible mainly to the rich. Just look at the price tag for medical school.

In the 1960s, the four years of medical education needed to earn an M.D. in the United States could be had for about $40,000 in today's dollars. The price is now $300,000, a 750% increase. About 70% of students take out loans to pay for medical school, graduating with an average of $200,000 in debt. One in five graduates who finance their medical education with loans accumulate more than $300,000 of debt. That average debt is increasingly concentrated in fewer people who individually owe more.

That's not the right direction to be going in at a time when the U.S. aims to make the medical profession more inclusive. Clinician diversity improves patient care, and access to high-status professional roles in society should be available for all.

Those dollar amounts, however, reflect only the *price* of medical school. Reducing the price has been the focus of many efforts to put a career in medicine within broader reach. Scholarships supported by philanthropy can lower it, for example, as they have at New York University and Weill Cornell Medicine.

But as we argued recently in the New England Journal of Medicine, price is not the same thing as cost.

Trying to bring down the price of medical education tackles the issue from the wrong end. What we should really target is a reduction in the actual *cost* of producing a physician: the faculty time, course materials, classrooms, and administrative time. If we can lower the cost of medical education, we can lower its price and redirect the philanthropy behind those scholarships to other needed areas.

The Covid-19 pandemic is pointing to ways to do that.

Early in the pandemic, medical instruction that used to happen in physical classrooms went online. In March, medical students at the nearly 200 U.S. medical schools began learning subjects like reproductive endocrinology through Zoom or another virtual platform. Couldn't they all use the same lectures?

Undergraduate teaching across the U.S. also went online in March, but the issues aren't identical. Yes, the same lectures might run across the nation, reducing costs. But the point of college is only partly about learning Shakespeare and chemistry, which can largely be delivered online, and mostly about growing up and developing independence, which requires more presence. In the first few years of medical school, the ratio is reversed: It's mostly about learning reproductive endocrinology, then later developing into an independent doctor.

In fact, many medical schools have long put online their preclinical courses, the period before students spend much time with patients. Few students even show up for the in-person sessions, viewing them on their own time and often at twice the speed, compressing an hour of lecture into 30 minutes of instruction. Why recreate that instruction 200 times each year at 200 medical schools?

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Sharing lectures is just one way to lower the cost of producing doctors. Another is to shorten medical school from four years to three, as schools like NYU, Wisconsin, Duke, and others already strive toward, saving the cost of that instruction (paid by future doctors) by $160,000 to $230,000. That reflects one less year of tuition, an additional year of earning, and adding a year's medical practice for the community.

The high *prices* of medical education and the high *costs* of medical education are both important. High prices have been linked to doctors avoiding lower-paying specialties, like primary care, where they may be needed most. High prices also partly explain why 73% to 79% of students entering medical school between 1988 and 2017 came from households in the top two income quintiles.

If it were less costly to produce doctors, it would be less pricey to become one. Philanthropic scholarships remain essential for a diverse workforce because it's unlikely that the cost of medical education will fall low enough to eliminate its effectively exclusionary pricing. But by insulating students from the price of medical education, scholarships inadvertently insulate schools from the cost of medical education and risk perpetuating old ways.

The way we produce doctors is expensive, and we all benefit if we can do it at lower cost. The costly production of doctors is part of the reason what doctors do is so expensive. It is part of the reason a more diverse population doesn't enter medicine. It is part of the reason that

philanthropy going to making medical school less pricey isn't available for making cancer care better.

And so, while we are achieving some success in lowering the price of medical education, we need to put more effort toward reducing its cost.

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