A relatively recent phenomenon in medical training in New Zealand is the significant level of financial debt that currently burdens medical graduates. Although a subject of ongoing debate and speculation, firm data to quantify and explore the possible effects of this debt are lacking.

The article1 in this issue of the *Journal* by Verstappen and Poole helps to bridge this gap by estimating the magnitude of debt currently taken on by medical students. Their findings suggest that not only is this magnitude significant, it is increasing over time: 46% of medical students graduating from the University of Auckland in 2014 and 2015 reported a student loan of greater than $90,000, whereas in 2006 and 2007 only 12.5% of medical graduates reported a debt of this magnitude.

These figures support the current reality that, for the majority of medical students, it is a necessity of their training that they enter into significant debt. The current annual tuition fee for each of years 2–6 of the medical degree of the University of Auckland is $15,082.80.2 In addition, access to government-funded student allowances is limited to a select group. Most notably, in 2012 the eligibility criteria for student allowances changed to effectively exclude graduate-entry medical students.3 Entering into employment during university holidays is an option, but the nature of the course makes part-time employment during semester difficult, particularly in those years with a significant clinical component. It is therefore unrealistic to expect any more than a small minority of medical students to cover their course fees and living costs without entering into debt in order to do so.

As a recent medical graduate, currently paying off a student loan myself, my perspective does include a vested interest. Clearly, for myself and my peers, we would be currently financially better off if we did not have to take on debt as a requirement of medical training.

Putting this perspective aside, there is an argument to be made that it isn’t unreasonable to expect medical students to make some form of financial investment in their training. The direct financial impact of having a student loan is not truly felt until after graduation (when repayments generally start), and one could argue that eliminating student debt for medical students would simply amount to a taxpayer-funded financial subsidy for doctors.

It is also worth noting that a government student loan does not function like a “traditional” loan. Since 2006, government student loans have been interest-free for all graduates who remain in New Zealand.4 (The introduction of this policy does appear to correlate with the findings of Verstappen and Poole:1 students graduating in 2006 would have spent the majority of medical school believing that their loans would accrue interest on graduation; students graduating in 2015 would not). In addition, repayments are made, not in proportion to the magnitude of the loan, but in proportion to the income of the graduate. So regardless of whether the loan is $10,000 or $100,000, the annual repayment requirement is the same—12% of all income earned over $19,084 per annum.5 Given the interest-free nature of the loan, there is no incentive to make any further repayment above this minimum amount. The effect of a larger loan, then, is not to make a graduate any financially worse off immediately after graduation, but rather to burden them with repayments for a longer period of time.

So there is a spectrum of perspectives here. It is difficult to argue that the current loan repayment schedule for a medical graduate is excessively onerous (at least on a per annum basis), and ultimately it is a question of personal philosophy as to whether medical student debt is viewed as inherently undesirable.

We must also be cautious, in that not all measures to reduce student debt are
necessarily beneficial to the students in question. Most notably, the “7 EFTS” policy, announced in 2010, threatened to limit access to government student loans to seven years of study. It is easy to envisage this policy reducing the size of the average government student loan—but at the expense of cutting off all governmental financial support to graduate-entry medical students in their later years of study.

However, the sheer magnitude of debt now affecting medical graduates should give us all cause for some degree of alarm. As evidenced in the Journal article in question, this is a recent and emerging problem, the effects of which are yet to be fully understood. But it is something of which we should all be cognisant, particularly when it comes to workforce planning.

Although student debt does not have any direct financial impact until after graduation, it is worth considering how the possibility of debt can influence medical school applicants. My concern relates to potential applicants from disadvantaged backgrounds, or who would be the first in their family to go to university.

It is relatively easy to argue for the merits of taking on a student loan to an applicant from a privileged background. Yes, you enter into a significant level of debt, but as a pathway into a profession that currently provides reasonable financial security, and with a manageable repayment schedule.

If you have not grown up surrounded by models of financial success, or in an environment with a stable income, the concept of debt may become noticeably more intimidating. Worse still, imagine a bright potential medical school applicant from a disadvantaged background, where debt has played a significant role in creating and perpetuating that disadvantage. It is not implausible that, for this group, the necessity of taking on a debt of potentially six figures, as a requirement of medical training, may be too intimidating—and potentially decisive when considering whether to apply for medical school. Yet this very group is already under-represented in medical school entrants.

Moving along the training pathway, for medical graduates this emerging system carries the implication of entering into an unwritten social contract. Medical students enter into large student loans on the understanding that doing so will be rewarded with eventual financial security. To be fair, even in the absence of student debt, most medical students would probably still expect a stable and well-paying job after graduation. But it is not unreasonable to speculate that this expectation has now heightened, to the extent that some graduates may now feel that they are owed such a job. After all, they’ve made their financial contribution—now it’s time to get something back in return. Should workforce pressures result in graduates working in a job different to what they were expecting during medical school, then this unwritten contract could create significant friction.

Of course, this perspective largely ignores the reality that, currently, for every $1 contributed by students towards their training, the taxpayer contributes $3—a social investment that acknowledges the necessity of having well-trained doctors to serve the public good.

Yet this may be precisely the problem. Although there is an absence of local research, it has been speculated previously in the Journal that significant medical student debt may reduce altruism among graduates. Verstappen and Poole discuss research from the US, which does support such an association in that context. Certainly it is harder for a medical graduate to appreciate the significant taxpayer investment in their training when they themselves had to pay $15,082.80 for each year of it. How this plays out in career aspirations and attitudes is yet to be seen. However, if increased student debt does truly impair altruism then efforts to encourage graduates to work in underserved communities may be undermined.

There is also the practical aspect of working overseas. Under current student loan rules, if a graduate moves overseas for a period of greater than six months, then they will generally start to accrue interest on their loan. This can become a significant disincentive—and so, the student loan effectively helps to “bond” that graduate to remaining in New Zealand. This is arguably not a bad thing, but what about areas where it is helpful for a doctor in training to work abroad for some period of time before returning to New Zealand? If this is something to be encouraged and valued in certain
contexts, then we must have some awareness of the potential impact of student debt.

Putting all such speculation aside, what can we be sure of? Well, as Verstappen and Poole\(^1\) have demonstrated, medical student debt is increasing and having a significant financial impact on a considerable number of medical graduates. This is an emerging issue that does merit further exploration. But clearly, although the exact effects of such debt are yet to be defined, it is likely to have influence in a number of areas—so we should all be aware of its presence. And, regardless of the justifiability of asking medical students to take on debt, there should be some alarm raised at the rate at which this debt is increasing.

### Competing interests:
Nil.

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