

# Health care at the crossroads: Where do we go from here?

**Phil Neal**

Millions of people lack insurance.  
Physicians battle increasing bureaucracy.  
Employers struggle with skyrocketing  
costs. Is the time finally right for reform?





Petra Musgrove enjoys a rare free moment with husband, Tony, and sons, Eric (left) and Michael. As an army veteran wounded in Iraq, Tony receives medical care through the VA, but Petra and the boys have struggled to obtain insurance and access to needed care.

## Access

**W**hen Petra Musgrove's husband, Tony, received an honorable discharge from the U.S. Army, she thought the worst of their worries were behind them. After nine years of service as a specialist in the infantry, including an extensive tour of duty in Iraq, Tony would finally be out of harm's way. He would be able to spend more time with the couple's sons, Eric and Michael, making up for all the years of long hours or distant deployments. The family would be together, safe, and ready to focus on the future.

What she didn't count on was confronting the American health care system.

In her native Germany, where she and Tony met while he was stationed there, everyone had health care coverage,

usually provided by an employer or the government. In the U.S., she discovered a very different scenario.

As a military veteran, Tony qualified for health care through the VA, a benefit he put to vital use in Dayton, where the family moved to be near Tony's relatives. Having left the war zone a hemisphere away, Tony continued to fight an ongoing battle with post-traumatic stress disorder and a traumatic brain injury caused by an improvised explosive device (IED) in Baghdad.

Tony's temporary disability pay provided enough for the family to get by each month, but very little extra. Petra helped out by holding down multiple part-time jobs, even while taking classes at Sinclair Community College and working toward a degree in chemistry. Together, they made too little to afford private health insurance, but too much to qualify for public programs. With a five-year

waiting period before Petra could apply to become a U.S. citizen, she wasn't eligible for Medicaid, and the prospect of renouncing her German citizenship troubled her as well.

Petra tried to enroll her sons in subsidized insurance programs, but they were denied multiple times. The lack of coverage became a more urgent problem in March when her younger son, five-year-old Michael, was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). The relief of learning a specific, treatable condition might be responsible for his developmental issues was undercut by intense anxiety over covering the costs of his care.

"We paid for the doctor visit and the medicine out of our pocket," Petra said, but the family couldn't afford an EEG the doctor recommended to check for brain seizures.

## Health care in the 2008 elections: Barack Obama

“We now face an opportunity — and an obligation — to turn the page on the failed politics of yesterday’s health care debates. It’s time to bring together businesses, the medical community, and members of both parties around a comprehensive solution to this crisis, and it’s time to let the drug and insurance industries know that while they’ll get a seat at the table, they don’t get to buy every chair.”

“The very first promise I made on this campaign was that as president, I will sign a universal health care plan into law by the end of my first term in office.”

— Iowa City, Iowa, May 29, 2007

### Goal: Quality, affordable, and portable coverage for all

#### Key Proposals:

- Create a **National Health Plan** available to all, including the self-employed and small business owners and employees:
  - Guaranteed eligibility, with no exclusions for pre-existing conditions
  - Comprehensive benefits similar to those members of Congress have, including preventive, maternity, and mental health care
  - Affordable premiums, co-pays, and deductibles
  - Income-based federal subsidies
  - Simplified paperwork, easy enrollment, and portability
  - Required data from insurers on quality, health information technology, and administration
- Create a **National Health Insurance Exchange** to make it easier for consumers to find, compare, and purchase coverage.
- Require many employers to provide benefits or contribute to the national plan, but offer a tax credit for small businesses.
- Require coverage for children, and allow them to remain on parents’ plans through age 25.
- Allow states to explore alternative approaches.
- Reimburse employers for some costs of catastrophic care.
- Offer disease management programs for those with chronic conditions, and promote prevention and public health.
- Require hospitals to publish cost and quality data.
- Base some compensation on outcomes rather than activity.
- Reform malpractice laws.

Finally, in June, yet another application for insurance was finally accepted, and the boys gained coverage through CareSource, a statewide public managed care plan.

As usual, Petra herself didn’t qualify for the plan.

“I’m willing to take the risk,” she said, “but it makes me nervous, because what if something happens to me? Then I’m kind of stranded, and with me the boys, and my husband.”

### A common story in a time of crisis

Petra Musgrove and her family are unique, but their situation is all too common. According to an August report by the U.S. Census Bureau, 45.7 million people in the U.S., more than 15 percent of the overall population, were uninsured in 2007. When you factor in some 30 million additional people considered underinsured, holding coverage that doesn’t provide sufficient protection from high health care costs, according to a Commonwealth Fund report released in July, up to 42 percent of U.S. adults face serious barriers to receiving adequate medical care.

A report published in July by the Montgomery County Healthcare Safety Net Task Force documented similar trends locally. According to the report, 60,300 people in the county, 7,900 of them children, lack health insurance. This amounts to 11 percent of the total population. A large, bipartisan team of community, business, and health care leaders convened by Governor Ted Strickland also reported in July that approximately 1.3 million adults in Ohio, 12 percent of the overall population, have no health insurance, despite the fact that nearly 80 percent of them belong to working families.

These statistics are sobering, but hardly surprising, according to Richard Schuster, M.D., M.M.M., Oscar Boonshoft Chair and Director of the medical school’s Center for Global Health Systems, Management, and Policy.

The inescapable realities of an infinite desire for care and limited resources to deliver it — in every population, location, and time period — mean that health care will likely always face crises, Schuster believes. In the U.S., though, a widespread lack of access to adequate care, deep disparities in access and outcomes, and high and rapidly rising costs make our current health care crisis especially serious.

The U.S. also stands out, Schuster adds, as the only developed country that does not offer universal health care for its citizens.

“Universal health care will not solve all the problems of health care in this country,” he admitted, “but it is impossible to solve any major problems unless we have universal health care... I’m not just talking about social justice. From an economic and systems perspective, you can’t begin to solve the crisis without providing universal health care.”

Larger pools of people, he explained, help insurance providers — whether private companies or government agencies — reduce risk. Providing early and consistent care can decrease the incidence and severity of health problems, often avoiding or delaying the need for more expensive, less effective treatments. Eliminating uncompensated care would enable hospitals and insurers to stop passing along additional costs to paying customers.

Although the concept of universal health care does not necessarily imply a single-payer system or increased government involvement, many people resist the idea of sweeping change due

to fears of greater bureaucracy, loss of personal freedom, or even artificial limits on care — the dreaded specter of rationing.

Such anxieties are understandable, Schuster said, but largely unfounded. Most studies simply don't support claims that people in other developed countries face these kinds of problems. Nor is the U.S. free of them today.

"Health care is rationed any way you look at it," Schuster explained. "Here it's rationed by denying health care to populations of people. We deny care to the uninsured. We deny it to minority groups through a variety of barriers they experience. In other developed countries, health care is also limited, but it's done with more social justice."

## Cost

One of the most significant barriers to health care access in the U.S. is also a primary concern of many who do have insurance — cost. According to the World Health Organization's *World Health Statistics 2008* report, the U.S. spends more on health care per capita and a larger portion of our gross domestic product (GDP) than any other country in the world. In a 2008 analysis, the Centers for Medicare and Medicaid Services (CMS) reported total health care spending of \$2.1 trillion, or \$7,026 per person and 16 percent of the GDP, in 2006. These costs are only expected to rise, especially as millions of baby boomers grow older, experience an increased need for services, and qualify for Medicare. The CMS report predicts that health care spending will reach \$4.3 trillion annually — more than \$13,000 per person — and represent nearly 20 percent of the GDP in less than a decade.

High and steeply increasing prices for health insurance, prescription drugs, and

malpractice insurance are frequently cited as key problems with American health care, but they aren't really to blame for the current financial crisis. Although these costs are significant, they are not driving the rapid increase in overall health care spending, according to John McAlearney, Ph.D., a health economist and director of the medical school's Health Care Management Certificate Program.

Instead, he said, "Health economists think health care costs go up every year because of technology. To get the latest and greatest new medicine, it costs a lot of money, and the spirit of invention is alive and well."

In some cases, introducing new technology, ranging from specialized machines and medicines to innovative procedures, clearly results in better health or quality of life. This makes it easy to claim that the associated expense is justified and the investment is delivering a good value.

The problem, McAlearney says, is that new technology is seldom analyzed in terms of value.

"If something comes out and it's enormously more expensive, it may still be sold because of the marketing of the product," he said, even if there's little evidence it yields any additional benefits over existing technology.

Paying more attention to the costs of technology wouldn't require a radical shift away from a free and competitive market, McAlearney said.

"We just need to put a kind of check-and-balance on the system," he explains, "to know that we shouldn't always just embrace the newest thing. It had better have some good benefits for the people who are getting it, because we're all going to be paying for it, given that insurance pays for our access."

## Health care in the 2008 elections: John McCain

"The key to real reform is to restore control over our health-care system to the patients themselves... Too much of the system is built on getting paid just for providing services, regardless of whether those services are necessary or produce quality care and outcomes. American families should only pay for getting the right care: care that is intended to improve and safeguard their health."

"When families are informed about medical choices, they are more capable of making their own decisions, less likely to choose the most expensive and often unnecessary options, and are more satisfied with their choices."

— Tampa, Florida, April 29, 2008

### Goal: Make health insurance innovative, portable, and affordable; restore control to the patients

#### Key Proposals:

- Offer a **Tax Credit** of \$2,500 per individual or \$5,000 per family paid directly to the recipient's insurer of choice. If coverage costs less, consumers can deposit the excess in a health savings account (HSA).
- Work with state governors to create a **Guaranteed Access Plan (GAP)** to ensure coverage, limit premiums, and subsidize coverage for those with lower income.
- Increase competition, quality, and variety by bringing more people into the insurance market and giving them more choices.
- Make insurance more portable.
- Lower prescription drug costs by allowing international purchases and supporting faster introduction of generic drugs.
- Encourage prevention, early intervention, and public health to improve care for those with chronic conditions.
- Reform Medicaid and Medicare compensation to support prevention and care coordination and reduce preventable errors and mismanagement.
- Tax employer contributions to employee health benefits.
- Encourage continued experimentation and innovation by states.
- Reform medical liability laws to protect physicians who follow clinical guidelines and safety protocols.
- Publish more information about costs, quality, and outcomes to help consumers make more informed choices.

## A market where the usual rules don't apply

In any case, questions of market integrity really don't apply to health care in the U.S., according to Bryan Bucklew, president and CEO of the Greater Dayton Area Hospital Association (GDAHA). Bucklew served on the staff of the Safety Net Task Force, whose members included medical school dean Howard Part, M.D., and Gary LeRoy, M.D., associate dean of student affairs and admissions, and 17 other business, health care, and government stakeholders. Over the course of nearly two years, the

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task force studied health care for vulnerable populations, including adults and children without insurance or dependant on Medicare. Among their key findings: most hospitals in the Dayton area receive more than half of their revenue from Medicare and Medicaid.

“When you have over 50 percent of your revenue coming in from the state and federal government,” Bucklew said, “it's not a true free market. Health care, rightly or wrongly, doesn't follow any rational economic model.”

Even ignoring the source of the income, health care isn't a commodity governed by strict rules of supply and demand. People in need of care, especially when the situation is urgent or dire, may not make rational economic decisions about health care spending. On the supply side, care providers are often morally or legally obligated to render services to those in need, whether or not they have any expectation of payment.

In Montgomery County alone, the task force found that the cost of uncompensated care by “safety net” providers — area hospitals and the community clinics they operate — amounts to more than \$126 million per year. While daunting, this figure also illustrates an important achievement by local care providers.

Unlike most major metropolitan areas, Bucklew said, in Dayton “we don't have a community hospital or a county hospital or a university hospital, so we have to be very innovative in how we meet the needs of the community with fewer resources.

“The level of cooperation and coordination among all of our hospitals is very unique and unprecedented across the country,” Bucklew said. It would be a mistake, he believes, “to make it a more competitive hospital market, because you want to continue that collaborative feeling.”

## Perverse incentives, artificial prices, and missing markets

A competitive market ideally leads to lower prices and higher quality, but in health care the economic incentives are often ineffective or even perverse.

For patients with insurance, even when coverage is quite expensive, McAlearney said, “as consumers, they're isolated from the true cost of things... so people are facing an artificially low price, like a co-pay.”

This leads to a phenomenon known as “moral hazard,” when consumers make purchasing decisions without regard for cost. Market-based measures such as high-deductible insurance plans, health savings accounts, and subsidies and tax incentives for private insurance — examples of a trend known as

“consumer-directed health care” — attempt to address moral hazard. These innovations aren’t a bad idea, McAlearney said, because they make consumers more aware of and responsible for their own spending. Unfortunately, they’re more likely to influence the actions of fairly healthy people rather than the 20 percent of patients who account for 80 percent of health care costs.

On the supply side, as strange as it sounds, physicians and hospitals typically don’t have an economic incentive to provide more effective care.

“They’re reimbursed for doing things,” Bucklew said. “For doing treatment. For doing a procedure. They’re not rewarded for preventative care or for wellness care.”

Compensation based on activity rather than outcomes is problematic, McAlearney agrees. Physicians also face a situation similar to that of patients with insurance, in that they are often isolated from the true costs of providing high-tech treatment.

Cooperation among local hospitals notwithstanding, in general in the U.S., “with technology, it’s a medical arms race,” McAlearney said. “Hospitals’ customers are oftentimes physicians whom the hospital wants to attract to do the surgery there.”

Hospitals may install expensive new technology in order to entice more or better-qualified physicians, leading rival institutions to follow suit in an endless cycle, even if a community may not need or benefit from the innovations.

Finally, market forces can’t apply if there is no market. For many people in Ohio and around the country, pre-existing conditions and other risk factors mean health insurance is simply not available at any price. Many states attempt to address this issue with guaranteed

coverage legislation or subsidized high-risk pools, but results have been varied, and insurance companies have complained of unfairly restricted business practices and warned of inevitable price increases.

While insurance companies are a common scapegoat in discussions of problems with the U.S. health care system, McAlearney can appreciate their contributions. As a private industry, he said, insurance needs a profit motive to spur innovation and efficiency. In addition, radical changes to the industry would affect far more than a handful of large corporations. A vast network of local brokers, agents, administrators, and related independent businesses would feel the repercussions, perhaps with devastating consequences to the economy.

On the other hand, said Richard Schuster, “The health insurance industry is a highly successful business enterprise that virtually does not exist in other developed countries. Studies have shown that if we eliminated the health insurance industry in the U.S., the money saved would match exactly the money needed to provide universal health care to the population.”

### **Businesses and physicians feeling the pressure**

Any viable proposal to address health care costs will also have to include the business community. The majority of Americans who have insurance, slightly more than 59 percent, according to the Census Bureau, receive it through an employer. Insurance benefits represent an enormous and growing expense for many companies and can threaten profits, global competitiveness, and even long-term viability. As a result, rates of employer-sponsored insurance (ESI),

have declined steadily for several years, resulting in increased pressure on public programs and rising numbers of working adults without insurance.

According to Paul Fronstin of the Employee Benefit Research Institute, between 2000 and 2007, premiums paid by employees increased 107 percent for individual coverage and 98 percent for families. Over the same period, average deductibles and co-pays also increased significantly. Of the 45.7 million uninsured Americans, more than 28 million are small business owners or their employees and dependents, according to Tod Stottlemeyer, president and CEO of the National Federation of Independent Business (NFIB).

Historically, businesses have aggressively argued against broad reform initiatives, wary of expensive government mandates and eager to preserve their role as voluntary providers of employee benefits. Today, the severity of the current crisis has led many to reconsider.

“In 1994, NFIB fought against a comprehensive health care reform package,” Stottlemeyer said. “Today is 2008, and the health care situation has gotten much worse, especially for small business. Back then it was enough to ‘just say no’ to bad policy, but now we have an obligation to these hard-working people to push our nation’s leaders to find a solution that works.”

Some observers point to high physician fees as another factor in soaring U.S. health care costs. Physicians here tend to be better paid than their counterparts in many other countries, but they are feeling increasing financial pressure. With reimbursement rates falling or holding steady while expenses — including health insurance premiums for employees in a private practice — continue to rise, it can be difficult to keep up, especially for essential but

less lucrative specialties such as family medicine.

The nature of their profession also leaves physicians vulnerable to financial

loss through uncompensated or poorly paid care, according to Warren Muth M.D., FACS, a practicing surgeon,

associate clinical professor of surgery at Wright State, and current president of the Ohio State Medical Association (OSMA).

“Our oath is that we will take care of our patients,” he said. “We’re not going to deny care to a sick person. That violates everything we’re about.”

Add the fact that new physicians often enter the profession with significant debt from their education, and earning a substantial income can be a long-term prospect, if not flatly unrealistic. This economic reality is also driving many new physicians toward increasing specialization in higher-profit areas and away from primary care fields, especially in smaller markets, a trend that Muth finds alarming but understandable.

“The young folks are coming out of medical school with a debt structure of anywhere from \$100,000 to \$200,000-plus,” he said, “and then you ask them to go into a rural community in family practice where it costs them to give an immunization shot?”

It’s no surprise, Muth said, that many respond, “‘I’d love to take care of the people, but I won’t be able to survive.’ It’s not greed. It’s survival.”

## Quality

**H**ealth care in the U.S. may be extremely expensive and limit access for millions of people, but some see these problems as natural consequences or unfortunate failures, respectively, of a system that largely provides the finest health care in the world. In some ways, this is a fair statement.

“The medical research enterprise in the U.S. leads the world,” said Richard Schuster. “I think (other developed countries) are as good as we are, but we put much more money into it, and we get much more out of it... People are living longer everywhere in the world because of the American research enterprise.”

The U.S. is home to some of the world’s most advanced medical technology, which can provide unmatched care for certain patients with specific, acute needs, such as the ill elderly. Considering the population as a whole and broader measures of public health and care quality, however, the U.S. often falls far short of other countries.

In fact, Schuster said, “there is no measured evidence that health care in the U.S. is actually better than anywhere else in the developed world, and in fact, there is evidence to suggest that in some situations it isn’t as good.

“It’s counterintuitive,” he admitted. “Intuitively, you’ve got to figure that putting all this money into health care and giving the highest-technology care in the world, the most expensive drugs, is going to make it better.”

In reality, though, on many key measures such as infant and maternal mortality, average life expectancy, and outcomes for conditions including ischemic heart

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disease and diabetes, the U.S. ranks among the worst of 30 developed countries in the Organisation for Economic Co-operation and Development (OECD), a coalition of governments dedicated to democracy, free markets, and economic development. Despite spending nearly 2.5 times more per capita on health care than the OECD average, using more and newer pharmaceuticals, and performing many advanced procedures more often — and in contrast to some high-profile successes in individual cases — the U.S. health care system as a whole simply isn't achieving world-class results.

Elizabeth McGlynn, Ph.D., M.P.P., associate director of RAND Health for the RAND Corporation, emphasized these quality shortfalls in her June 3 testimony before the U.S. Senate Finance Committee. She cited a 2003 RAND study that found that Americans receive just 55 percent of recommended care (based on 439 quality indicators in 30 clinical areas) for the leading causes of death and disability. Diagnostic, screening, preventive, acute, chronic, and follow-up care rates were all below 60 percent. Perhaps more troubling, another national study by McGlynn and her colleagues, which was published in the *New England Journal of Medicine* in late 2007 and based on data from 1996-2000, found that children received even less care — some 47 percent of recommended care overall and a mere 41 percent of preventive care. Surprisingly, results for adults and children showed little variation based on region, race, age, gender, or income level. The lack of quality care is a consistent problem for all people throughout the country.

### Isolated success and the constant challenges of bureaucracy

The confounding disconnect between advanced medical capabilities and poor public health outcomes can make it difficult for some physicians to perceive serious problems with the status quo. For those who practice in well-funded or high-demand specialties, or who have minimal contact with uninsured or underinsured patients, the system might seem to be working well.

“You see the bureaucracy, and it frustrates you,” Schuster said, “but you don't see the issues related to infant mortality or life expectancy or the costs of health care.”

The bureaucracy alone can be a significant barrier to quality care, however, according to Warren Muth. With policy and practice decisions often dictated by insurance compensation formulas, coverage details, approval processes, and other external factors, the traditional concept of personalized care can easily get lost.

“The only two elements left out of that decision-making,” he said, “are the patients and the physicians... The question becomes for physicians, ‘Do I still feel like a doctor treating my patients, or am I just fulfilling a business-insurance algorithm?’”

Many insurance companies and other health care stakeholders advocate an increased emphasis on evidence-based medicine, studying patient and population data to determine the effectiveness of various treatments. When used properly, as with the information shared among GDAHA

hospitals, evidence-based medicine can give care providers a powerful way to improve their practices. Unfortunately, health care data today is often incomplete, inconsistent, and ill-suited to the creation of rigid rules regarding care. This makes abiding by restrictions and requirements imposed by third-party payers frustrating and difficult, Muth said.

“It's really the government, and insurers, and now even the business community,” Muth said, “in a sense practicing medicine without a license.”

“On the other hand,” he admitted, “the physician community has to take

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some responsibility along the way in what we order.”

With tort reform in Ohio, physicians probably don't feel as compelled to practice defensive medicine. Even so, it can be tempting to use all of the resources at one's disposal, and patients sometimes clamor for costly tests or treatments that may be unnecessary or inappropriate. Physicians should strive to employ their expertise and judgment, Muth said, to continue to provide the best possible care despite pressure from patients and insurers alike.

“I think we're still a leader in good delivery of our expertise,” he said, “despite all the restraints from multiple outside forces.”

It is especially important to encourage patients to take more active responsibility for their own health and medical care, Muth feels. Lifestyle factors such as diet, activity level, and specific positive and negative behaviors can have a tremendous impact on overall health. In fact, cultural and lifestyle differences can contribute a great deal to varied health outcomes among different countries.

Muth said, “I think part of this should be our duty as physicians and organized medicine to try to educate the public, to try to nudge them along.”

As a patient, Muth said, “You should be expecting the very best of care when you are really sick. And on your part, you should be expected to do everything you can to lead a better, healthy lifestyle.”

## The Path Ahead

**W**ith health care spending, insurance prices, and the ranks of the uninsured and underinsured all at or near record levels, the health care crisis has become an urgent national issue. Media coverage of the crisis and reform efforts is consistently strong, and both major presidential candidates have made health care a key campaign issue and have outlined proposals for reform. The U.S. Senate Finance Committee held a health reform summit in June as part of a year-long effort to prepare to implement changes as early as 2009. Numerous industry and professional groups, broad coalitions of organizations, and citizen activist groups have all joined the call for change, and many have identified specific goals or promoted detailed reform agendas.

The Association of American Medical Colleges (AAMC) and dozens of other organizations, including many related

to health care and medical education, have endorsed a “Divided We Fail” platform designed to raise awareness of the issues and to encourage government and private-sector leaders to work toward real solutions. The platform states, among other beliefs, that “all Americans should have access to affordable, quality health care.”

Specific reform proposals vary widely in their source, scope, and approach. Some advocate immediate, sweeping overhaul of the current system to reinvent health care in the U.S., while others favor incremental adjustments to build on the strengths of the status quo and ease the transition. Some support a greater government role, ranging from legislation mandating coverage to increased involvement in insurance regulation, or even service as a single payer or sole provider.

Others prefer market-based reforms such as tax incentives, consumer subsidies, or insurance exchanges that emphasize and empower the private sector. Many reform advocates focus on a specific aspect of health care such as information technology, preventive and wellness care, better coordination among providers, evidence-based medicine, or compensation based on quality or outcomes.

One of our greatest strengths, technology and innovation, may also hold significant promise. Most reform plans include a role for health information technology (HIT) as a way to reduce errors, expenses, and inefficiencies caused by the unique, usually incompatible, and often paper-based records still used by medical

offices around the country. Some estimates indicate that standardized, national, patient-centered electronic medical records could generate up to nearly \$80 billion in savings annually, eliminate thousands of harmful errors such as incorrect or conflicting prescriptions, and even avoid preventable deaths.

## Preparing tomorrow's physicians to take the lead

The medical school is working to prepare the future physicians who may one day benefit from HIT. Medical students today face a deeply troubled health care system and the likelihood of dramatic, ongoing changes. To help address these challenges, the school of medicine developed the Boonshoft Leadership Development Program, which provides extensive training in management, business, and political practices to complement a traditional medical education. The school also offers a master's degree program in public health and a certificate program in health care management.

“You can't just be a good doctor anymore and expect to be a leader in the health care system,” Schuster said. “All physicians need more sophisticated administrative, management, and systems education. Some physicians need additional specialized training

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Second-year student Sandeep Palakodeti welcomes the opportunity to help reform the U.S. health care system to give more people access to effective, affordable care. Among other attempts to make a difference, he often volunteers at Reach Out of Montgomery County, a clinic for underserved and uninsured patients.

in management and leadership. And together, those two levels of education would allow for a much more sophisticated health care system.”

Sandeep Palakodeti, a second-year student enrolled in the leadership program, welcomes the challenges and is eager to enter medicine during a time of transition.

“Maybe it’s just idealistic thinking,” he said, “but it seems like it’s come to a breaking point now. That’s what’s exciting for us as students, that we get to be part of this revolution that I feel is inevitable.”

Personally, Palakodeti favors a single-payer system administered by the federal government, or possibly a shift to a non-profit private insurance industry. He also supports increased use of evidence-based medicine and an emphasis on primary and preventive care.

“It’s been a goal of mine to modify the system,” Palakodeti said, “because this is a great, amazing country, and we’re the richest country in the world. We have a lot of amazing thinkers. We have progressive people.”

Despite all this talent and potential, Palakodeti believes, people can easily feel complacent, uncertain, or powerless to affect a system so vast and complex. In confronting these obstacles to reform, Palakodeti feels he and his classmates have a unique opportunity — and obligation — to make a difference.

“I feel like as the next generation of physicians we should be taking the lead in that,” he said. The leadership program especially, “breeds a sense of responsibility and a sense of duty and purpose. It gives us the confidence to be leaders and to take an active role, to not just sit and let things happen to us, but actually go out and make a change.”

In March, Palakodeti and his fellow students organized local events for the national Cover the Uninsured Week,

including a free health fair held in downtown Dayton. At least one of the hundreds of people who attended the fair found it potentially life-changing — Petra Musgrove was there with her son Michael, looking for new options following his recent ADHD diagnosis. She met with a representative of Care-Source who encouraged her to submit another application for insurance for her sons — an application that was eventually approved. With the new coverage, in June, Michael was finally able to get the EEG his pediatrician had recommended, which fortunately ruled out more serious issues.

Helping people like Petra and her family is a primary reason Palakodeti chose to become a physician. The opportunity to do so, either in spite of the system or as one small step toward reforming it, makes him confident that even in a time of crisis, medicine is and will continue to be among the most vital and fulfilling of all professions.

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