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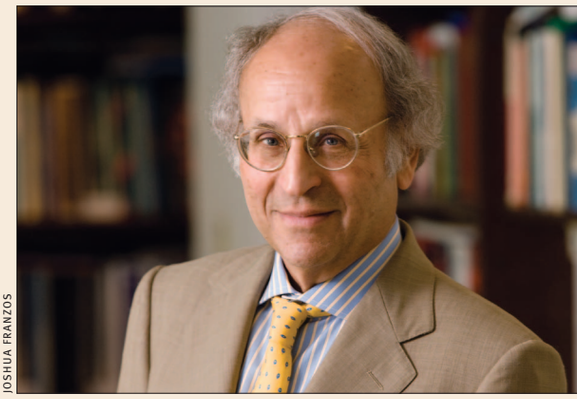
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JOSHUA FRANZOS

*He that will not when he may,*
*When he will he shall have nay.*
—Robert Burton

A few months ago, it seemed all but certain that some version of health care reform would become law this year. Now, if we are to believe the news coverage of the past few months, the possibility exists that reform in this country is dead. Those of us in academic medicine should be very concerned about this, and we cannot remain aloof from the political process unfolding around the issue of reform.

To consider the death of health care reform less than a tragedy is to discount the 45,000 Americans who die prematurely each year because of gaps in insurance coverage and the one million Americans in bankruptcy because of health care bills. We spend more on health care than any nation on Earth (now 17 percent of our total economy ), and yet we lag far behind in many important metrics of health. We spend enormous amounts of money on unproven medicine and unnecessary interventions, some of which harm the patients they are supposed to help.

A dysfunctional health care system damages the entire country. It frustrates our competitiveness and our ability to take on new problems, such as investing in the science that could solve many problems that challenge all of humanity. If health care costs continue on their present course, every penny that Americans might gain in productivity or wages in the coming years is already spoken for.

Health care in America is marked by lack of access, high costs, and questionable quality. Access could be addressed by extending coverage to the 15 percent of Americans who have inadequate or nonexistent coverage. Addressing issues of cost and quality will require experimentation and analysis ("comparative effectiveness research"). This is where academic medicine excels. We must ask and answer questions. For example, won't patients benefit if their doctors are no longer paid for each individual service and test? Can we reduce cost and improve quality by paying doctors salaries and offering incentives for good outcomes? In fact, can't some primary care be offered by nurse-practitioners in drugstore clinics? Our faculty member Dr. Ateev Mehrotra has shown recently that for otitis media, pharyngitis, and urinary tract infections, quality of care in these retail clinics is as good as in emergency rooms and doctors' offices, and much cheaper.

As Atul Gawande pointed out last June in *The New Yorker*, these are empirical questions, not ideological. They are testable. Some medical centers, including ours, have explored these questions for years, but we must do better. Academic medicine has always been enthusiastic about the benefits of finding a new drug, discovering a new gene, or developing a new surgical procedure. We must become equally passionate about finding innovative ways to serve our patients.

Without it, I fear we will next year, and for years afterward, lament like Robert Browning: *This could but have happened once,—And we missed it, lost it forever.*

Arthur S. Levine, MD
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