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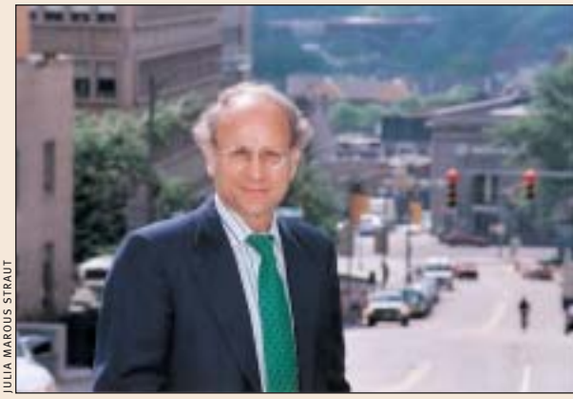
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JULIA MAROUS STRAUT

It was the best of times,
it was the worst of times. . . .
—Charles Dickens
A Tale of Two Cities

In an earlier issue, I wrote about the paradox inherent in the extraordinary recent advances in medical science and the crucial problems of health care access and cost. Since I wrote, the best has gotten better, but the worst has gotten worse. With the completion of the human genome project, we have moved quickly to proteomics—studying the structure and function of proteins—and it is there that we will have almost unimaginable opportunity for understanding and benefiting the human condition. However, the delivery of health care and its economics have become ever more chaotic. After a leveling of health care costs in the '90s, we are again seeing a dramatic increase, largely reflecting a backlash against the constraints of managed care. The drivers of the nearly $5,000 per year per person spent on health in the United States (double that in Switzerland, the next-highest country) include a rapid increase in the cost of technology and drug development; end-of-life care (where much of our health care dollar is spent); the overhead on commercial insurance; our failure to prevent "lifestyle" illness; the expense of non-evidence-based treatment; health care inefficiencies; and outlays for malpractice awards and premiums. (It is worth noting that if Americans would make a habit of constructing living wills, we would likely save enough money on end-of-life care to provide health insurance for the 42 million Americans who lack it.)

Uncontrolled health care costs greatly impact medical research—the "shortfall" in National Institutes of Health support having been compensated historically by clinical revenue. However, this revenue is dwindling with declining reimbursements; yet 50 percent of the uninsured are treated in the 6 percent of hospitals that support teaching and research. Most med school graduates are in debt ($200,000 at repayment, on average), making the choice of an academic career less likely. Malpractice insurance is a particular problem in Pennsylvania, where premiums aren't capped and there are no discounts for academic physicians. Friends in Congress hope to continue to increase the National Institutes of Health research appropriation, while the venues for research, and their researchers, are threatened in the extreme. Yet research has always been our only effective insurance against illness.

What are the possible remedies? As a start, single-payer national insurance for every American; fair but regulated malpractice awards and premiums; an increasing focus on prevention and a decreasing focus on end-of-life care; and loan forgiveness for medical graduates who spend a few years serving the nation's needs. We need desperately to overcome our national inertia and see health care as the public's right and as our moral obligation. Those who do not take the humanist's view might consider this: When full-time workers get sicker than they need to be, and stay sicker longer, the health of our national economy also suffers.

Arthur S. Levine, MD
Senior Vice Chancellor for the Health Sciences
Dean, School of Medicine