FROM THE EDITORS' DESK

Cost-Containment Redux: Time for Physicians to Engage

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After a decade or more of wintry silence, the health care cost-containment movement is springing once again to life. Many physicians practicing in the 1990s will remember the boldly conceived, rashly executed experiments in capitation, utilization review, and restrictive networking that restrained costs but in the end proved too restrictive, alarming patients and offending doctors. The ensuing public backlash ensured the demise of the most draconian forms of capitated managed care. Few physicians would wish to return to the days when the decision to refer a single patient for an expensive imaging test or surgery could wipe out a small medical group's balance sheet. And yet, with the percentage of gross domestic product (GDP) consumed by health care on an unsustainable path, there is an emerging national consensus that something must be done. And this time, instead of playing the hapless victim or stubborn obstructionist, physicians are much more deeply engaged in finding solutions. Two examples heavily influenced by internists are the Choosing Wisely campaign (spearheaded by the American College of Physicians) and the National Commission on Physician Payment Reform (organized by SGIM and slated to release its findings in early 2013). (See http://physicianpaymentcommission.org/ for more information.)

One way previous cost-containment efforts have gone astray is through the the tendency to over-reach. In this issue of JGIM, health policy luminaries **Theodore Marmor** and **Jonathan Oberlander** argue that in searching for the cost-containment "holy grail," U.S. policymakers have overlooked simple, more incremental solutions such as budgeting, fee schedules, and concentrated purchasing.[1] In an accompanying editorial, **Allan Detsky** agrees.[2] But he goes further, arguing that in light of a US political system that will *never* accede to global budgeting, we should abandon our search for a magic bullet, instead treating the health care cost problem as a chronic disease that can only be managed, not cured.

One element of a long-term management strategy surely involves education of young physicians. In their article on teaching value-based care to residents, **Patel et al**. provide a set of guideposts for imbuing residents with a sense of cost-consciousness and clinical resource stewardship, as part of a busy training program.[3]

Meanwhile, politicians continue to search for cost-free solutions to the health care cost problem. Some tout the benefits of comparative effectiveness research (CER), but for all its value, CER cannot possibly address enough clinical questions fast enough to significantly impact health care cost inflation in the short term. Others wave the prevention flag. Investing in clinical preventive services makes good public policy, but does not necessarily save money. Contrary to popular belief, services such as counseling, immunization, and cancer screening are rarely cost-saving.[4] A possible exception is colon cancer screening. One time colonoscopy screening for men aged 60–64, for example, is cost saving, and screening of other groups is highly cost-effective. Thus it is especially dismaying that rates of colon cancer screening for adults 50–75 years of age, as reported by the CDC, hover between 50 % and 75 %.

This issue of JGIM features three articles centered on colorectal cancer (CRC) and CRC screening. The first two articles remind readers that colonoscopy is not the only effective screening approach. **Zapka et al**.[5] surveyed over 1,200 primary care providers, finding that most endorsed colonoscopy but not fecal occult blood testing or sigmoidoscopy, unwittingly limiting their patients' options. Missed opportunities to engage in shared decision making also emerge in the paper by **Katz et al**.,[6] who showed that even when patients were activated to discuss CRC screening, the topic came up in just 48 of 100 visits, and there was no further discussion in 23 of those 48 visits. Finally, the article by **Shah et al**.[7] reminds us that delayed or absent screening is not the only preventable cause of tragic delays in care. They showed that 34 % of patients at a public hospital had late stage CRC cancer, compared to 16 % of patients at a comparison community hospital. 75 % of the public hospital patients were transferred from other hospitals in the community, some undoubtedly after a "wallet biopsy" indicated their inability to pay.

As we saw in the 1990s, crude incentives such as strict capitation can hold down expenditures, but at an unacceptable political and social price. The theme of this issue of JGIM is that real cost containment will come about in increments. There is no one magic bullet: not prevention, not health information technology, not shared decision-making.

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The ultimate solution will involve all these approaches and more. And this time, physicians need to get involved.

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