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ACG 2013

Vedolizumab Yields Steroid-Free Remission

By David Wild

San Diego—Pooled analyses of the placebo-controlled GEMINI 1 and 2 trials of vedolizumab revealed that nearly 60% of patients with inflammatory bowel disease (IBD) who initially exhibited a clinical response to the drug achieved steroid-free clinical remission at one year.

see Vedolizumab, page 20

UEGW 2013

Treat-to-Target Dosing Of Infliximab: Induction Versus Maintenance

By Ted Bosworth

Berlin—In patients with inflammatory bowel disease (IBD), monitoring infliximab levels during maintenance therapy, unlike induction, did not provide an advantage over clinically directed dose adjustments in a randomized trial. The maintenance therapy data were presented as

see Infliximab Dosing, page 22

The U.S. Trillion-Dollar Medical Bill

99.6% Is Not *Related to Colonoscopy*

By Victoria Stern

On June 1, Elisabeth Rosenthal's exposé "The $2.7 Trillion Medical Bill" published in *The New York Times* singled out colonoscopy as a primary driver of the national health care crisis. Ms. Rosenthal reported that costs for health care in the United States trump those of any other developed country, and furthermore, that colonoscopy is "the most expensive screening test that healthy Americans routinely undergo," amounting to more than $10 billion in annual health care costs.

Ms. Rosenthal described the many tribulations of patients throughout the country who have received enormous bills for routine colonoscopies. One patient's bill reached nearly $20,000 because it included the removal and biopsy of a polyp.

So, what's behind the excessive medical billing in the United States, and is colonoscopy the culprit?

"A major factor behind the high costs is that the United States, unique among industrialized nations, does not generally regulate or intervene in medical

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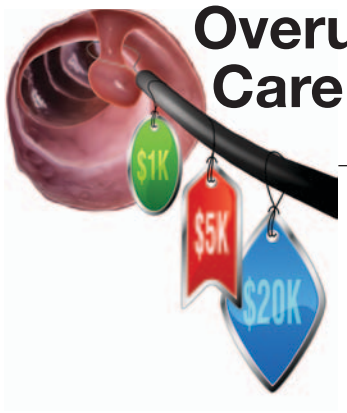

Overuse and Abuse in U.S. Health Care: Is Colonoscopy To Blame?

By Victoria Stern

This year, two major news outlets identified colonoscopy as a prime example of what's wrong with the American health care system: *The New York Times* published "The $2.7 Trillion Medical Bill: Colonoscopies Explain Why U.S. Leads the World in Health Expenditures,"

see Colonoscopy Costs, page 30

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Ashish Atreja, MD, MPH

William J. Sandborn, MD

PRODUCT ANNOUNCEMENT

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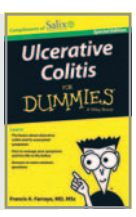
'Ulcerative Colitis for Dummies': Free Resource for Patients Now Available



PRODUCT ANNOUNCEMENT

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EndoChoice Announces FDA 510(k) Clearance of Fuse Gastroscope

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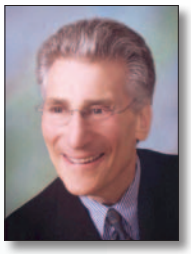

Jerome Siegel, MD
Clinical Professor of Medicine
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pricing, aside from setting payment rates for Medicare and Medicaid," Ms. Rosenthal wrote. As a result, Americans confront a system in which doctors, hospitals, pharmacies and insurers negotiate prices for individual services. This means every interaction with a health care professional represents an occasion to bill, and there is little to no consistency or transparency in pricing for a given service, procedure or test.

This lack of standardization contributes to the problem of health care costs. In the United States, insurance companies contract with individual hospitals, pharmacies and facilities, including doctors' offices and ambulatory surgery centers (ASCs), and negotiate different prices and levels of reimbursement for the same services. The prices and reimbursement scales often are based on the negotiating power of the individual hospitals, pharmacies and physicians.

Each insurance company provides a range of plans to patients—full coverage that comes with a copay and no deductible, full coverage that includes a deductible and partial coverage, such as emergency insurance. Some patients have Medicare or Medicaid, and some still have no insurance coverage at all.

In what turned out to be a seminal article ("The Bitter Pill: Why Medical Bills Are Killing Us," *Time*, Feb. 20, 2013), Steven Brill revealed that Medicare routinely reimburses hospitals for less than one-tenth of what they charge patients for the same service. Hospital charges, Mr. Brill reported, are based on the chargemaster list—a hospital's internal price list, for which there "seems to be no process, no rationale, behind the core document that is the basis for hundreds of billions of dollars in health care bills." The prices for services are so opaque that doctors often cannot tell patients what a routine procedure, like colonoscopy, will cost them.

Additionally, there are other layers in the case of colonoscopy costs. Each component of a colonoscopy can quickly add up to a huge sum, according to Ms. Rosenthal. The endoscopist's professional fee is just one component of the total bill, which also may include charges for an anesthesiologist, a pathologist and a facility fee. The facility fee varies widely depending on whether the procedure is performed in a hospital, doctor's office or ASC. Although hospitals charge the highest facility fees,

> **'At around $10 billion, these costs represent less than 0.4% of the total $2.7 trillion bill.'**
>
> ***—Ellen J. Scherl, MD***

Ms. Rosenthal pointed out that ASCs, where procedures are often billed as "a quasi-operation," also contribute to skyrocketing costs. The presence of an anesthesiologist during the procedure also contributes to high costs. One study, published by the RAND Corporation in 2012, found that "ending the practice for healthy patients could save $1.1 billion a year" (Liu et al. *JAMA* 2012;307:1178-1184). Some physicians argue that anesthesiologists are not needed during a colonoscopy. For example, in many other countries, non-anesthesiologists provide sedation for patients, and in the United States, the Department of Veterans Affairs does not routinely use an anesthesiologist for screening colonoscopies.

Although in her article, Ms. Rosenthal does not deny "screening for colon cancer is crucial," she did question whether colonoscopy prevents colorectal cancer (CRC) or CRC-related mortality better than other cheaper and less-invasive screening methods.

Reaction From Gastroenterologists

The publication of Ms. Rosenthal's piece generated a flood of comments on *The New York Times* website. Patients voiced agreement and alarm over the mounting price tag of medical care, sharing personal struggles and fears associated with maintaining health. Others, including patients and physicians, proposed possible solutions. Letters to the editor from leaders in the gastroenterology community expressed concern that Ms. Rosenthal chose to focus on colonoscopy, the best test for prevention and detection of early signs of CRC.

"The fact that the writer chose to focus her attention on the one and only preventive cancer test that has been demonstrated to significantly reduce the incidence of colon cancer and death from the disease is disappointing," wrote Ronald J. Vender, MD, then president of the American College of Gastroenterology (ACG), in a statement.

Ellen J. Scherl, MD, director of the Jill Roberts Center for Inflammatory Bowel Disease, Weill Cornell Medical College, New York City, said Ms. Rosenthal's article was misleading and did not adequately put colonoscopy costs into perspective.

"At around $10 billion, these costs represent less than

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0.4% of the total $2.7 trillion bill," Dr. Scherl said in an interview.

H. Gilbert Welch, MD, professor of medicine, Dartmouth Institute for Health Policy and Clinical Practice, Lebanon, N.H., asked, "At what point does it become a crime" to charge such outrageous prices for medical services ("Diagnosis: Insufficient Outrage," *The New York Times* July 4, 2013). After postulating that medical costs continue to grow, Dr. Welch proposed strategies to improve the health care system, including ensuring that every patient has access to a standardized set of prices, like the Medicare fee schedule, or mandating a flat-fee system in lieu of a fee-for-service one. However, he noted, "Too many of us have passively accepted the situation as being beyond our control."

The authors reported that the RVUs assigned to medical services are greatly inflated, using colonoscopy as the prime example.

With colonoscopy still fresh on the public's collective mind, *The Washington Post* published a provocatively titled piece, "How a Secretive Panel Uses Data that Distort Doctors' Pay" by Peter Whoriskey and Dan Keating (July 20, 2013). The authors reported that the relative value units (RVUs) assigned to medical services are greatly inflated, using colonoscopy as the prime example. In a commentary on the article, Dr. Vender along with Anil K. Rustgi, MD, president of the American Gastroenterological Association (AGA), and Kenneth K. Wang, MD, president of the American Society for Gastrointestinal Endoscopy, attempted to clarify inaccuracies in the article, stating, for example, that the author confused procedure time with the total time spent with a patient, and that Medicare's reimbursement to physicians for colonoscopy has actually decreased over the past 20 years.

To further explore the issue, *Gastroenterology & Endoscopy News (GEN)* asked five gastroenterologists to comment on Ms. Rosenthal's piece and provide insights on the current complex medical landscape in the United States.

GEN: What is your reaction to Ms. Rosenthal's article, "The $2.7 Trillion Medical Bill," published in *The New York Times?*

Dr. Nunn:

I feel that Ms. Rosenthal's article missed the point of the problem of high medical costs by focusing on colonoscopy as the sole piece of expensive medical care. What she didn't explain is that most of the high costs she references for colonoscopy are hospital charges, based on the charge-master list, which are overinflated figures, and insurance companies only pay a percentage of those amounts.

What Ms. Rosenthal did right is to highlight that prices for medical services are incredibly expensive in the United States—60% higher than anywhere else in the world—and that we need transparency in pricing.

Dr. Robbins:

Although I agree with Ms. Rosenthal that we, as a nation, face runaway health care spending and need greater transparency, her assertion that the cost of routine colonoscopy is the main reason America leads the world in health expenditures is distorted and jeopardizes the strides we have made in the war on cancer. I hope the article does not erode these recent hard-won gains.

Dr. Siegel:

Ms. Rosenthal's article was simply journalistic sensationalism. Most responses to her article showed that her data were flawed and slanted.

Dr. Rex:

Although I agree that prices for medical procedures are high and often lack transparency, overall I think that Ms. Rosenthal's article is biased and inaccurate.

One major problem is the implication that colonoscopy is not effective, or as effective, in preventing CRC compared with other tests. We know from case–control studies that colonoscopy does prevent CRC. There is no other test that has this level of evidence for prevention, and the United States is the only country in the world that has declining incidence rates for CRC, thanks in large part to screening colonoscopy.

Another issue is Ms. Rosenthal's assertion that we have moved endoscopic procedures from doctors' offices into ASCs because it's more profitable. This is incorrect. Outside of the New York–New Jersey–Philadelphia area, offices have always represented a small percentage of where colonoscopies are performed. The move from hospitals to ASCs is associated with a reduction in costs, with ASCs typically charging one-third to one-fifth of what hospitals do.

Dr. Allen:

The article by Ms. Rosenthal highlights an important topic—the range in prices for medical services—but fails to elucidate many of the reasons for price differences. Even within a single institution, the prices for colonoscopy can vary three to five times, depending on how contracts with payors are negotiated. Some payors negotiate a single reimbursement rate for all outpatient surgical procedures, so simpler procedures, like colonoscopy, are blended in with multilayer spinal surgeries, consequently driving up rates for colonoscopy.

A simplified analysis looking only at patients' bills will fail to identify true cost drivers and gives the incorrect assumption that physicians control and drive price differences. The implication that physicians' primary motivation is financial calls into question the integrity of our profession.

GEN: What factors contribute to the high costs of medical care?

Dr. Nunn:

In my opinion, there are six main reasons for the high costs of medical care:

1. Prices: Services are more expensive in the United States.
2. Provider income: It is higher in the United States than in other countries.

'Doctors may feel encouraged to diagnose and treat problems using more expensive tests and procedures because they can make more money.'
—Chalmers Nunn, MD

3. A fee-for-service system: Doctors may feel encouraged to diagnose and treat problems using more expensive tests and procedures because they can make more money.
4. Technology: We scan too much and perform too many tests, which drives up costs substantially. Period.
5. Administrative costs: These are higher in the United States because practices and hospitals have great administrative complexity.
6. Tort: Legal concerns may drive a doctor to overtest and overtreat. Many doctors may fear being sued if they fail to perform all necessary tests to rule out a serious underlying problem.

Dr. Robbins:

I don't necessarily think the cost of colonoscopy is particularly high in this country, but there is a range in price and quality. At $1,200 on average in the United States, colonoscopy has been modeled in dozens of cost-effectiveness studies and its lifesaving potential has been shown to save health care dollars by abrogating the need for much more costly cancer care. The price of a colonoscopy needs to be compared with what it aims to prevent—CRC—and not just considered in the abstract.

'Even within a single institution, the prices for colonoscopy can vary three to five times, depending on how contracts with payors are negotiated.'
—John Allen, MD, MBA

Dr. Siegel:

I believe the high cost of medical care in the United States is largely due to duplications or redundant services and the high cost of administrators. Devising a system to eliminate both is preferred. In 10 years, redundant or repeated procedures and tests will amount to $1.6 trillion,

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and administrative costs will approach $1.5 trillion. Some of these high costs are a result of "defensive medicine."

Dr. Rex:

The biggest culprit driving health care costs is hospitals. Additionally, colonoscopy is just one of a long, almost endless string of medical procedures that are subject to high and variable charges, all of which contribute to the high costs of medical care. Colonoscopy is being targeted in large part because of how frequently it's performed, which in turn reflects its great value to patients and cancer prevention. Ultimately, colonoscopy is targeted because of its success as a medical procedure. However, there's little point in singling out colonoscopy to make a point about health care costs in general.

Dr. Allen:

Some of the main contributors to high medical costs are:

- Obesity, smoking, traumatic accidents and alcohol use;
- Overuse and misuse of medical procedures and tests;
- Threat of litigation;
- Lack of a single, coordinated billing language and system, estimated by health care economist Uwe E. Reinhardt, PhD, to cost about $70,000 per physician;
- Excessive regulations that do not add benefit to patients' health outcomes;
- Duplication of high-margin services;
- A lack of clinical integration and information transfer for patients who are chronically ill or have multiple medical comorbidities;
- Administrative costs of institutions and payors; and
- Lack of political will to overcome barriers to a patient-focused health care system.

GEN: Do you think reimbursement for colonoscopy is fairly priced?

Dr. Nunn:

Overall, I agree with the response from the ACG, which stated, "Medicare reimbursement rates for colonoscopy do not accurately reflect its value for CRC prevention," in terms of savings in cost of cancer treatment, improvement in quality of life and reduction in deaths from CRC.

> **'No, I don't think the fee for a sophisticated, resource-intensive and potentially lifesaving test is fairly priced.'**
>
> ***—David Robbins, MD***

Dr. Robbins:

The Medicare professional fee for colonoscopy is $220, or about what one would pay to have dents removed from a car's rear quarter panel. So no, I don't think the fee for a sophisticated, resource-intensive and potentially lifesaving test is fairly priced.

Dr. Siegel:

Reimbursement for colonoscopy from Medicare is totally insufficient, and if the payment remains this low or lower, doctors will opt out or perform more procedures than should be done. The customary fee should be $1,500 to $2,000. If physicians opt out of Medicare, they can charge what they feel is fair, if patients wish to pay it. If a doctor is out of network and the patient pays more for an out-of-network doctor, the doctor can receive his or her usual fee and the patient will pay the 20% balance.

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Dr. Rex:

What gastroenterologists receive for their professional performance of a colonoscopy is only a small fraction of the total bill. If we reduce gastroenterologists' reimbursement for performing colonoscopies, it may disincentivize doctors from performing the procedure, which will have negative consequences for the prevention of CRC.

'Medicare's reimbursement to physicians for colonoscopy has decreased by 16% since 1992 (49%, when adjusting for inflation).'

—John Allen, MD, MBA

Dr. Allen:

Medicare pays gastroenterologists $220, on average, for their time, expertise and clinical care. This is certainly not excessive. In fact, Medicare's reimbursement to physicians for colonoscopy has decreased by 16% since 1992 (49%, when adjusting for inflation). For every patient who does not develop CRC because a large precancerous polyp was removed during a colonoscopy, I imagine this price is acceptable. The AGA is developing a model to help gastroenterologists negotiate a fixed price with payors for care before, during and after a colonoscopy. With bundled payments, providers share risk and have financial incentives to be prudent.

***GEN:* What is your opinion of the *Washington Post* article, "How a Secretive Panel Uses Data that Distort Doctors' Pay," which explores inflated RVUs and medical costs?**

Dr. Nunn:

The American Medical Association (AMA) Specialty Society Relative Value Scale Update Committee (RUC) process seems to be a good one, but the underlying system is open to debate, as is our flawed fee-for-service system. I suspect if you looked at every procedure and the estimated procedure lengths, the values often would be inflated. But time is just one relative measure. You could make procedure times more accurate, but then change the rate of payment, for example. I don't have an answer as to what would be better. We could debate that for a long time.

'The idea of a profession setting its own fee schedule is neither secretive nor objectionable. One could not expect a layperson—or even a physician in an unrelated discipline—to understand the complexities and relative value of a colonoscopy.'

—David Robbins, MD

Dr. Robbins:

The idea of a profession setting its own fee schedule is neither secretive nor objectionable. One could not expect a layperson—or even a physician in an unrelated discipline—to understand the complexities and relative value of a colonoscopy. Congress sets its own wages, but somehow that's not newsworthy.

Dr. Siegel:

Medicare is not secretly setting fees. The AMA has a committee made up of several specialists who establish the Current Procedural Terminology codes and try to set reasonable fees. Unfortunately, the codes do not reflect degree of difficulty: If a colonoscopy is more complex and several polyps are removed, the reimbursement is the same, more or less, and the reimbursement for an esophagogastroduodenoscopy (EGD) is only a few dollars less than for a colonoscopy. One can probably do four or five EGDs in the time it takes to perform one-and-a-half colonoscopies. So don't burp too much or you'll be getting an EGD! Colonoscopy, or any procedure, carries risks—including the likelihood of having a million-dollar lawsuit. Is it worth $220 to the doctor to take that risk?

Dr. Rex:

The RUC has a difficult job balancing the interests of and lobbying for many specialties. Certainly, the RVU for colonoscopy does not reflect the undue influence of gastroenterologists on the RUC, because gastroenterologists have not had a seat on the RUC for a long time.

RVUs for procedures should not be based on time alone. The current RVU for colonoscopy is not out of line considering the intensity and risk of the procedure and the time that's involved with preprocedure preparation, postprocedure patient instruction, pathology follow-up and other factors beyond the actual procedure. Reductions in colonoscopy RVUs might reduce the availability of colonoscopy for screening.

In my own practice, I spend a lot of time performing complex endoscopic mucosal resections as well as colonoscopies in patients who have previously had incomplete colonoscopies with other doctors. Many gastroenterologists provide services of this type. Further reductions in the professional fee for colonoscopy will threaten our ability to provide these important and cost-saving services.

'RVUs for procedures should not be based on time alone. The current RVU for colonoscopy is not out of line considering the intensity and risk of the procedure and the time that's involved with preprocedure preparation, postprocedure patient instruction, pathology follow-up and other factors beyond the actual procedure.'

—Douglas Rex, MD

Dr. Allen:

The article focuses on time as the leading factor in how values are assessed, but time is only a small component of the overall equation. Physician work and intensity during procedures, as well as the type of patient treated, are valued more, and rightfully so. To say that procedures are misvalued based on time calculations alone is inaccurate and does not adequately capture the process.

The AMA and the RUC have provided an enormous service to the field of medicine, and the current process allows physicians' input. One can argue with the outcome and the basic structure, but has anyone come up with a better alternative to balance the "relative" reimbursement of more than 7,000 service codes?

We are working toward a value-based reimbursement system that recognizes the importance of primary care management. But when do I get to see the plan, and how can I help move this needle forward without disrupting current health care delivery?

***GEN:* Is cost linked to quality of health care?**

Dr. Nunn:

The answer to this question depends on how you measure "quality." If you're referring to individual care—immediate care using the most tests and highest-tech equipment—we are the absolute best. But if you mean care of a population, then no, we're not getting our money's worth. For example, our ability to manage diseases, such as diabetes or hypertension, on a population level is not good. Additionally, costs that vary by location are not linked to quality of care: For instance, although a colonoscopy will cost five to eight times more if performed in a hospital versus a physician's office, patients will not get an eightfold better product.

Dr. Robbins:

I am unaware of any convincing data linking the cost to quality of health care, to the extent that spending more money results in better outcomes. The problem with asking, "Does cost correlate with quality?" is the complexity of what defines both "costs" and "quality." At first blush, it stands to reason that outcomes might improve if we reward folks for doing quality work rather than being paid on the volume of their work. But so many factors are at play.

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Dr. Siegel:

Cost is not linked to quality of care. The United States simply is not the best. Too many of our colleagues are performing more procedures than are indicated, perhaps because they are getting paid $220 when the overhead exceeds the payment. There's also a crazy quirk in Medicare reimbursement where procedures performed in an accredited office are reimbursed at 100% to the practitioner, but there is no facility reimbursement; however, the physician receives 50% of the professional fee when he or she performs the same procedure in an ASC or hospital.

'Too many of our colleagues are performing more procedures than are indicated, perhaps because they are getting paid $220 when the overhead exceeds the payment.'

—Jerome Siegel, MD

Dr. Rex:

It is obviously not the case that cost is linked to quality of care in the United States. There is no evidence that we have better care or outcomes compared with a number of other developed countries.

Dr. Allen:

There are very few examples of successful linkage of cost to quality. We have struggled for a generation simply to define "quality." Is quality patient satisfaction, reduction of mortality, or restoration of health?

A gastroenterologist on call can end up in an emergency room at 2 a.m. performing a high-risk endoscopy on someone with a piece of steak blocking his or her esophagus. For this, the payment is the same as a simple endoscopy performed during usual waking hours. One could argue that this represents a nonlinkage of cost to outcome. I realize that the overall cost of health care in the United States is substantially more than in other developed countries, but one has to carefully analyze the methodologic derivation of those data. Additionally, the political and social mandates in the United States, the devastating lifestyle choices so prevalent here and the fact that tens of millions of people do not have insurance and lack access to care—our lack of universal health care is shameful.

***GEN:* Should colonoscopy be the gold standard for CRC screening, or as Ms. Rosenthal questioned, are other cheaper and less-invasive tests equally effective?**

Dr. Nunn:

I think if you look at the data, colonoscopy is the best screening test for CRC. The other tests do appear to represent a step down in their ability to detect lesions. But is the difference between them worth the costs and the risks? Now, that's a value judgment.

Dr. Robbins:

I believe there is little disagreement that colonoscopy is the gold standard for CRC screening. The cheaper and less-invasive tests Ms. Rosenthal refers to are inferior and do not afford the opportunity to treat cancer at its earliest stages. That said, it is important to respect a patient's preferences, and ultimately the best test is the one that actually gets done.

Dr. Siegel:

I think we know that colonoscopy is the gold standard. Computed tomographic colonography requires the same bowel preparation; exposes patients to radiation; cannot detect small lesions; and if there is a lesion, requires a subsequent colonoscopy. Sigmoidoscopy is good for part of the left side of the colon—like having a one-breast mammogram. Fecal tests don't identify the source of bleeding.

Dr. Rex:

We've got strong evidence that colonoscopy both prevents CRC and causes a decline in cancer incidence rates, and there is no solid evidence that other, cheaper tests, such as flexible sigmoidoscopy and fecal immunochemical testing (FIT), are equally effective. For example, the first randomized controlled trial comparing FIT and colonoscopy showed that colonoscopy identified more patients with advanced lesions (Quintero E et al. *N Engl J Med* 2012;366:697-706).

Dr. Allen:

This is the wrong question. Some people may prefer other screening tests, which is their absolute right and there is evidence to validate these choices. However, colonoscopy is the final common pathway of all positive screening tests.

GEN:* What is your opinion of Dr. Welch's op-ed piece, "Diagnosis: Insufficient Outrage," published in *The New York Times?

Dr. Nunn:

Dr. Welch has many valid points. The prices in our health care system are out of control. As Dr. Welch explained, hospitals are buying up physician practices and converting them into hospital outpatient facilities where they can charge exorbitant hospital rates for the same services instead of more reasonable office fees. I see this trend happening in specialties like cardiology, urology and oncology.

'The fee-for-service model is antiquated and has the potential to reward people for essentially gaming the system.'

—David Robbins, MD

Dr. Robbins:

I think Dr. Welch raises some excellent points. There is no denying we are facing runaway health care costs, and it is a multifactorial pandemic. I agree that the fee-for-service model is antiquated and has the potential to reward people for essentially gaming the system. Dr. Welch also makes an excellent point about the overuse of routine tests, including colonoscopy. Although I agree that "medical care is intended to help people, not enrich providers," the facility fee that hospitals and other health care centers legally charge is not an extra payment—rather it covers the ever-increasing cost of delivering health care, including staff salaries, rent, equipment, etc.

'Set a reasonable fee to cover the physician's fee, not like the ridiculously low Medicare payment, and safeguard the guidelines.'

—Jerome Siegel, MD

Dr. Siegel:

Regarding the Welch article, it's a shame, but he's right: Set a reasonable fee to cover the physician's fee, not like the ridiculously low Medicare payment, and safeguard the guidelines.

Dr. Rex:

I agree with many of Dr. Welch's points. It's absolutely true that hospitals are trying to buy up ASCs and other practices. Hospitals, through their lobbying efforts, have managed to have reimbursement to ASCs reduced. ASCs became less profitable, and many sold out to hospitals. As a result, hospital-owned, former ASCs often bill like hospitals. Hospitals are interested in controlling market share and want to have a large percentage of patients, physician practices and ASCs in their control.

Dr. Allen:

Dr. Welch's piece is inflammatory, perhaps rightly so, but it does not really add to a constructive discussion or solution. The article seems to cast dedicated physicians, providers, nurses and administrators together in a single, damning light.

***GEN:* What are potential solutions to the rising cost of health care in the United States, and what are some of the impediments to implementing them?**

Dr. Nunn:

In his book "Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform," Paul Starr, PhD, described three major reasons why it's so difficult to make changes in our medical system: 1) complexity—our system is so complicated and convoluted that no one person can tackle it; 2) an overabundance of special interest groups—everyone

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has a vested interest in the health care system, which means that even a small change will benefit some and hurt others; and 3) values—the United States is built on principles that focus on the individual (independence and capitalism), which makes it difficult to manage populations; however, we need a population approach to managing health care.

One potential solution would be to do away with fee-for-service: If doctors were salaried, our decision making, regarding the most prudent tests and procedures, would change.

> **'The United States is built on principles that focus on the individual (independence and capitalism), which makes it difficult to manage populations; however, we need a population approach to managing health care.'**
> ***—Chalmers Nunn, MD***

Dr. Robbins:

How much time do you have? The traditional fee-for-service model needs to be overhauled and replaced with a system that fairly compensates providers for delivering health care in a cost-conscious, but not cost-limited, fashion. This needs to take place alongside tort reform; medical school education debt reform; competitive and open market pricing for medical products and services; and training programs for new providers to deliver it all.

Dr. Siegel:

We really should be more careful as physicians to adhere to the guidelines of screening and surveillance. Some doctors are overusing colonoscopy and not following screening guidelines. It is imperative that we reprimand gastroenterologists who do so. Another idea is to adjust physicians' fees according to the cost-of-living index.

Dr. Rex:

I'm not a health care economist, but I see a few potential solutions. Importantly, there needs to be transparency in pricing. People need to be able to understand what a procedure or test will cost before they have it so they can shop around. Patients also should understand the basis for pricing. In terms of colonoscopy, reference pricing—like what Safeway implemented—or bundled pricing could help make colonoscopy prices reasonable. Additionally, reference or bundled pricing could put financial incentives in place for gastroenterologists to once again administer sedation—including propofol—themselves, and to institute the resect-and-discard policy for diminutive colon polyps. Such changes would help reduce cost and improve effectiveness of colonoscopy.

Dr. Allen:

Potential solutions include an emphasis on people taking responsibility for their own health, which means controlling the true drivers of health care costs: obesity, smoking, traumatic accidents and alcohol use. Another solution would be to slowly transition to a system that pays for outcomes and emphasizes clinical integration.

Impediments to reaching these goals can be traced, in part, to the federal government, which has taken over regulation of health care. We have, essentially, a single regulatory system that rests within a dysfunctional and politically divided governing body. ■