EDITORIALS

High-Value Health Care — A Sustainable Proposition

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Health care in the United States is at a crossroads. With health care costs representing an unsustainable 17.6% of our gross domestic product, creation of a new, higher-value health care system has never been a greater priority. Although the rate of increase in health care spending has moderated during the economic recession, some experts predict that it will rebound as the economy recovers.

Thus, the need for higher value in health care is urgent. The goal of high-value health care is to produce the best health outcomes at the lowest cost, and this goal has recently created a new alliance. Health care professionals are increasingly given incentives to deliver high-value care by virtue of such payment-reform measures as pay-for-performance policies, bundled-payment strategies, global budgets, and financial risk sharing within accountable care organizations. Likewise, business leaders are strongly encouraged to maintain healthy work forces while trying to rein in rising health care premiums, which reduce opportunities for reinvestment in their businesses and offset wage increases for their employees.

The health care community and the business community today share a fundamental interest in finding ways to achieve higher value in health care. The ultimate objective for both communities is to keep people healthy, prevent the chronic illnesses that consume a large fraction of our health care dollars, use medical interventions appropriately and only when needed, and create an economically sustainable approach to the delivery of health care. While we want to foster innovation and novel therapies against disease, we also recognize that, whenever possible, prevention of disease before it is established is the better solution.

It is in this context that we announce the launch of a novel collaborative publishing initiative between the *New England Journal of Medicine* and the *Harvard Business Review*. The focus of our pilot project is on how to achieve a high-value health care system, and we will publish articles on that topic from numerous experts across the health care and business communities. Beginning this week, on Tuesday, September 17, we will be posting new articles at the Insight Center for Leading Health Care Innovation, which will reside on the *Harvard Business Review* website (www.hbr.org), where during the pilot phase all articles will be freely available to all readers. New articles will be posted daily through November 15. All the articles will be archived at the *Harvard Business Review* website, and the articles solicited by the editors of the *Journal* will also be archived at NEJM.org.

The articles will cover three broad areas of this complex, multifaceted topic. One group of articles will address foundational principles in the formulation of a high-value health care system, a second will address the management of innovation in the organization and delivery of health care, and a third will focus on the solutions developed by physician leaders and practitioners on the front lines. Authors in all three areas will illuminate a range of relevant topics, such as organizational leadership, health information technology, leadership in accountable care organizations, redefining primary care, economic projections of health care spending, employer-sponsored health insurance, employee wellness programs, physician payment reform, the pricing

of health care interventions, the use of checklists in health care, same-day appointments, and how best to design a bundled payment.

These topics reflect critical — and rapidly changing — points of intersection between the health care and business communities. Take employer-sponsored health insurance, for example: according to a recent Kaiser Family Foundation survey, 93% of businesses with more than 50 workers now offer coverage. But since 1999, premiums have risen 196%, while wages have risen only 50%. Both employers and employees are being squeezed, and they will soon have to face the Affordable Care Act mandate that such businesses offer a minimum level of coverage, as well as the new "Cadillac tax" on high-cost plans. Articles posted at the Insight Center will explore the impact of these provisions on the future of employer-based insurance.

On Tuesday, September 24, we will host an interactive webcast with Michael Porter and Thomas Lee, focused on high-value health care, at the *Harvard Business Review* site. The webcast will also be archived there.

The collaborative publishing project between the *Journal* and the *Harvard Business Review* comes at a turning point in American health care. Never before have the interests of the health care community and the business community been better aligned. As *Journal* editors, we have already benefited from the collaboration through new colleagues, innovative ideas, and fresh perspectives. As the 2-month pilot project unfolds, we hope you will reap the same benefits. We look forward to receiving your comments about the project, and we hope to continue the collaboration in the future as key stakeholders in health care seek a high-performing health care system that can meet the country's current and future needs.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Colorectal-Cancer Screening — Coming of Age

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The Minnesota Colorectal Cancer Control Study showed 20 years ago that the annual use of the guaiac fecal occult-blood test decreased mortality from colorectal cancer by 33%.[1] A few years later, colorectal-cancer screening was endorsed by multidisciplinary guidelines[2] and was covered by insurance,[3] leading to an increase in the performance of colorectal-cancer screening tests. Two articles in this issue of the *Journal* provide evidence of what colorectal-cancer screening can accomplish over the long term.[4,5]

Nishihara and colleagues[4] found decreased risks of colorectal cancer and death from colorectal cancer associated with screening colonoscopy and sigmoidoscopy, following two well-described prospective cohorts for up to 22 years. As in other reports,[6,7] the authors found that colonoscopy, particularly with polypectomy, was associated with a somewhat greater reduction in the subsequent risk of cancer in the distal colon than in the proximal colon. This decreased risk of cancer was stable for up to 10 years after colonoscopy, except among participants who had a first-degree relative with colorectal cancer, who had their risk rise to near baseline levels after 5 years. These findings support current guidelines for screening patients with average risk every 10 years and patients with higher-than-average risk every 5 years.[8] Confirming previous reports,[9,10] the authors found that cancers diagnosed within 5 years after colonoscopy were more likely than those diagnosed more than 5 years after colonoscopy to have the CpG island methylator phenotype and microsatellite instability, a finding that suggests a biologic difference between colorectal cancers that were evident earlier versus later after screening. The cancers that become evident earlier after screening may either grow more quickly or be more difficult to detect by means of colonoscopy than later cancers, in part owing to their altered biologic characteristics. The protective effect for endoscopic screening was larger for colonoscopy than for sigmoidoscopy (multivariate adjusted hazard ratio, 0.32 vs. 0.59). In the Supplementary Appendix (available with the full text of the article at NEJM.org), Nishihara and colleagues report that aspirin offered no benefit