The GI Bill for GIs
Removing Barriers and Providing Access to Colorectal Cancer Screening
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Summary

Colorectal cancer (CRC) is frequently called the "most preventable" cancer, but it is the second leading cause of cancer related deaths for men and women. Only approximately 60 percent of at-risk adults (those over the age 50) are currently screened for CRC in accordance with national guidelines. Efforts to improve awareness have resulted in a gradual increase in screening, yet colorectal cancer remains largely undiagnosed, leading to unnecessary costs and burdens to families and the U.S. healthcare system.

A critical issue that must be overcome to continue expanding access to CRC screening is the pending shortage of gastroenterologists (GIs). According to a new report commissioned by Olympus, the United States will face a shortage of 1,050 GIs by 2020 based solely on the growth of individuals aged 50 and older.

Olympus is committed to increasing access to CRC screening and ensuring that there is a sufficient supply of trained gastroenterologists. **The GI Bill for GIs is an innovative legislative initiative lead by Olympus to overcome the looming shortfall of trained gastroenterologists. The proposed legislation will leverage federal resources to increase gastroenterology fellowship opportunities across the country, resulting in newly trained GIs who can provide access to CRC screening for more people.**

CRC Today

The American Cancer Society estimates that 148,810 new cases of colorectal cancer were diagnosed in the United States in 2008, and that this cancer was projected to kill approximately 49,960 men and women last year. As the second leading cause of cancer-related deaths,[1] sadly, only 39 percent of colorectal cancer cases are detected at an early stage, when they are easily treatable, due largely to low screening rates.[2]

If CRC is detected early, the survival rate is higher than 90%. Some estimates indicate that if screening rates were increased to 80% of the at-risk population (people over 50 and those with a family history of CRC) colorectal cancer deaths could be cut in half.[3,4] Most health groups, including the American Cancer Society, the National Colorectal Cancer Roundtable, the U.S. Preventive Services Task Force, and the GI Consortium Panel, support routine screening for average-risk persons age 50 and older.

In 2006, however, only 60.8% of respondents the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS) survey aged 50 years or older reported having received a screening test within the recommended guidelines.[5] This is an increase over the levels reported in 2004 (56.8%) and 2002 (53.9%), but is still far below screening goals, such as the benchmarks outlined in the U.S. Department of Health and Human Services' Healthy People 2010 plan.[6]

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[1] American Cancer Society, "What are the Key Statistics for Colorectal Cancer?" Revised March 5, 2008. www.cancer.org/docroot/cri/content/cri_2_4_1x_what_are_the_key_statistics_for_colon_and_rectum_cancer.asp.
[2] American Cancer Society, "Number Three Cancer Killer is Largely Preventable," February 28, 2007. http://www.cancer.org/docroot/COM/content/div_OH/COM_1_1x_2007_Number_Three_Cancer_Killer_is_Largely_Preventable.asp.
[3] Sullivan, Michele. "Colorectal Cancer Deaths Could be Halved," *GI & Hepatology News*, Vol. 1, No. 3. March 2007.
[4] Grady, Denise. "How To Halve the Death Rate from Colon Cancer," *New York Times*, 1 May, 2007, http://www.nytimes.com/2007/05/01/health/01cancer.html?_r=1.
[5] "Use of Colorectal Cancer Tests --- United States, 2002, 2004, and 2006," *Morbidity and Mortality Weekly Report*, 14 March 2008, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5710a2.htm
[6] "Healthy People 2010 Operational Definition: Objective 3-12a" ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/DATA2010/Focusarea03/O0312a.pdf

Other CDC sponsored research reported in 2005 that 41.8 million Americans aged 50 and older have not been screened in accordance with accepted guidelines.[7]

In response to the burden of CRC on its patients, Medicare began covering screening for its enrollees age 50 and older in 1998. Data compiled by The Carolinas Center for Medical Excellence from 1998-2005 indicate that only 45% of eligible Medicare enrollees had claims indicating they were current with their CRC screening. An estimated 16.1 million enrollees were not taking advantage of the coverage benefit. [8]

CRC screening is both medically effective and cost-efficient. A 2003 study from The Lewin Group, commissioned by the American Cancer Society, analyzed the costs of colorectal cancer screening in terms of the Per Member Per Month (PMPM) costs – a standard figure that determines the "price tag" of a new benefit to individual health insurance plan members. The report showed that fecal occult blood tests (FOBT), sigmoidoscopies and colonoscopies cost less per member than mammography, the highest current standard for breast cancer screening.[9]

Barriers to CRC Screening and the Need for Additional Trained GIs

Today's efforts to increase screening rates focus on barriers to access, such as the lack of awareness among at-risk populations, disparities in screening among minority and low income populations and patient apprehension regarding the tests. **However, a less well-known but equally critical barrier to screening is a shortfall in the number of properly trained gastroenterologists who perform screenings, particularly in underserved communities.** Several studies have concluded that the U.S. healthcare system does not have the capacity to meet national screening goals, much less provide screening for the entire unscreened population.[10,11] Some researchers have concluded that risk factor trends, such as the percentage of overweight adults, are a growing problem that will make more aggressive screening goals necessary to meet the goals of reducing CRC mortality.[12]

Screening rates have risen to a limited degree this decade, but even this moderate increase has placed strain on the gastroenterological medical community. A 2003 *New York Times* report showed that as people became more aware of the importance of CRC screening and the value of colonoscopies, demand for the procedure increased which led to delays in obtaining access to screening tests.[13] After Katie Couric became a public advocate for CRC screening and underwent a colonoscopy on television, colonoscopy rates nationwide increased more than 20% in the days and months that followed. Patient interest overwhelmed medical resources in some areas and individuals were forced to wait over a year for the procedure.[14]

With a rapidly growing aging population, the demand for CRC screening will only increase. A 2008 study commissioned by Olympus and conducted by The Lewin Group shows that the United States will face a shortage of approximately 1,050 GIs by 2020 based solely on the expected population growth of individuals aged 50 and older.

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[7] "Colorectal cancer screening failing to reach 41.8 million Americans at average risk," *Reuters*, 17 Dec. 2004, http://www.oncolink.com/resources/article.cfm?c=3&s=8&ss=23&Year=2004&Month=12&id=11385

[8] The Carolinas Center for Medical Excellence, "Colorectal Cancer – Testing the Medicare Population for 1998-2005," http://www2.thecarolinascenter.org/crc/crc.aspx?tabid=219.

[9] The Lewin Group, "Short-Term Cost-Impact Analysis of Colorectal Cancer Screening," Prepared for the American Cancer Society, March 13, 2003.

[10] Brown, M., Klabunde, C., Mysliwiec, P., "Current Capacity for Endoscopic Colorectal Cancer Screening the United States," *The American Journal of Medicine,* August 1, 2003, Volume 115.

[11] SeeTangka et.al.

[12] "Using Mathematical Models for Cancer Control: An Example of Colorectal Cancer" http://www.sph.umn.edu/about/pubs/brief/brief0107.html

[13] Kolata, Gina, "50 and Ready for Colonoscopy? Doctors Say Wait is Often Long," *New York Times*, December 8, 2003. http://query.nytimes.com/gst/fullpage.html?res=9905E3D8103DF93BA35751C1A9659C8B63

[14] Healy, Michelle, "'Katie Couric Effect' Boosts Colonoscopy Rates," *USA Today*, July 14, 2003. http://www.usatoday.com/news/health/2003-07-14-katie-usat_x.htm

Growth in size of the elderly population is projected to increase demand for the number of GIs by 1,890 (18%) by 2020 to 12,510 full-time equivalent GIs. By contrast, supply is only expected to grow by 1,070 (10%) between 2008 and 2020 to 11,460. The gap will worsen if the United States makes progress toward its screening rate goals.

The GI Bill for GIs

If we are to effectively combat colorectal cancer through expanded screenings, a bold national commitment is needed to dramatically increase the number of trained GI physicians in the United States. One option to increase screening capacity is to train additional gastroenterologists via fellowship programs. However, limited funding for such programs exists today, making it difficult to expand training capacity.[15]

The GI Bill for GIs proposes to leverage federal resources to increase gastroenterology fellowship opportunities across the country, resulting in newly trained GIs who can provide access to CRC screening for more people.

Under the proposed legislation, the U.S. Department of Health and Human Services (HHS) will provide resources to public and private hospitals, schools of medicine and other public or private institutions to facilitate the planning, development, and operation of approved professional training programs for GIs. The program will include grants to medical teaching facilities, financial assistance to medical students and training programs for physicians who plan to teach in the gastroenterology field. Additionally, HHS will be directed to conduct another GI manpower study within five years of the program's inception to determine the affect on the GI shortage and produce recommendations for future GI training.

While it is difficult to allocate already scarce federal resources in this time of economic uncertainty, investing in GI training now can yield significant healthcare cost savings in the future. To put the funding for the GI Bill for GIs in perspective, the cost of CRC care is approximately $8.4 billion each year, with Medicare paying approximately $2.4 billion of this total. These figures represent an increase from a 1999 study which found that colorectal cancer treatment costs over $6.5 billion per year and, among malignancies, was second only to breast cancer at $6.6 billion per year.[16]

As a condition of receiving assistance, new GIs trained in the program will be required to practice in a government affiliated hospital, medically-underserved area, or other high-priority setting for a three-year period. It is not sufficient to simply expand the pool of GI resources; rather, we must make CRC screening as widely available as possible and provide access to a trained GI physician regardless of location or economic status.

Income, education level, insurance and geographic location can affect CRC screening rates and mortality. Within the Medicare population, for example, non-white persons are less likely to be screened; older women are less likely than men to be screened; and lower income whites are less likely to be screened.[17] There are considerable disparities among racial and ethnic groups. CRC incidence among African American men and women is about 17% higher than in white men and women.[18] These gaps can be addressed in part by expanding the supply of trained gastroenterologists to meet our growing population's screening needs.

For more information, please visit http://www.olympusamerica.com/crcadvocacy or contact Elizabeth Sullivan at Elizabeth.Sullivan@olympus.com or Matt Bennett at mbennett@golinharris.com.

[15] See Tangka et. al.

[16] Schrag, D., Weeks, J., "Costs and Cost-Effectiveness of Colorectal Cancer Prevention and Therapy," *Seminars in Oncology,* 1999. Vol. 26.

[17] Ananthakrishnan, A.N. et al. "Disparities in Colon Cancer Screening in the Medicare Population" Arch Intern Med. 2007;167(3):258-264. http://archinte.ama-assn.org/cgi/content/abstract/167/3/258

[18] American Cancer Society, "Cancer Disparities: Key Statistics," Revised April 1, 2008. http://www.cancer.org/docroot/SPC/content/SPC_1_Minority_Cancer_Unequal_Burden_Sidebar1.asp