Colon Screening Nonmedical Costs Are a Barrier

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Although the nonmedical, one-time costs for colonoscopy are substantially higher than those for fecal occult blood testing, the two approaches to colorectal cancer screening have very similar nonmedical costs when screening frequency and follow-up costs are factored in.

"Health care planners designing CRC [colorectal cancer] screening programs should use this information to design programs that minimize nonmedical costs and possibly improve screening uptake," Dr. Steven J. Heitman and associates reported.

The nonmedical costs of CRC screening may be important, because CRC screening is done in asymptomatic people, many of whom are working and need to take time off work for the procedure. If people believe that the nonmedical costs of screening are high, they may decide not to get screened, wrote Dr. Heitman of the department of medicine and community health sciences at the University of Calgary (Alta.), and his colleagues.

Nonmedical costs might also influence the type of screening selected, they noted.

The study was a cross-sectional survey of Alberta residents who presented for CRC screening. In Alberta, all direct medical costs are covered by a universal, provincial insurance plan. A self-administered survey was distributed to consecutive patients at four urban, community laboratory collection sites, which formed the fecal occult blood test (FOBT) group, and to patients at two hospital-based endoscopy units, the colonoscopy group.

The survey included 11 questions relating to sociodemographics, reasons for screening, time off from work, travel details, the presence of an accompanying helper, and type of bowel preparation used (a patient-borne cost).

The survey was given to FOBT patients during January-June 2006, and to screening colonoscopy patients during May-October 2006. Surveys were distributed to 604 people undergoing FOBT, with 60% completed and returned. Surveys also went to 723 people undergoing screening colonoscopy, with 42% returning a completed form.

The average age of those in the FOBT group was 62 years, and for those in the colonoscopy group, it was 56 years. Of those screened, 43% in the FOBT group and 66% in the colonoscopy group were actively employed. Two-thirds of the colonoscopy group were at increased risk for CRC because of family history, compared with 23% in the FOBT group.

The average total time traveling to and from the test and undergoing the test was just over 1 hour for FOBT and just over 4 hours for colonoscopy. In the colonoscopy group, 80% of patients required a helper, compared with 5% in the FOBT group. On average, those undergoing colonoscopy said they and their helper needed about another 4 hours of time off beyond traveling or receiving the test, whereas the FOBT group generally required little additional time.

Total nonmedical costs were calculated, in 2006 Canadian dollars, by applying a fixed wage rate for time spent by patients and their helpers, then adding travel costs. This averaged out at $308 a person for colonoscopy and $36 a person for FOBT. The average out-of-pocket cost for colonoscopy preparation was an extra $17.10.

The nonmedical costs for colonoscopy were substantially higher than those for FOBT, but 2%-3% of people undergoing FOBT will have a positive result that will lead to colonoscopy. As such, the true nonmedical cost of FOBT that takes into account this additional expense was $44 per person screened, the authors noted (Clin. Gastroenterol. Hepatol. 2008;6:912-7).

Screening colonoscopy is generally done every 10 years and FOBT every 2 years, and for some, annually. The cumulative nonmedical cost for FOBT over 10 years is $220 if done every 2 years and $440 if done annually. The cost for annual screening can be discounted by 5% a year to $357 over 10 years as a more accurate comparison with coloscopy done every 10 years, they added.

Thus, when the need for repeat screening is taken into account, the nonmedical costs for the two options are similar. However, those costs may affect the uptake of medical care, especially for CRC screening.

Efforts to reduce or disclose the true cost of screening could increase CRC screening uptake, said the authors. "[Making] screening more accessible for the working public, such as extending clinic hours or subsidizing transportation services, might make some modalities including colonoscopy more acceptable." ■