

**Discussion Panel: Integrating CRC screening into preventive health programs and prolonging quality life**

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Ultimately, the greatest potential for reducing morbidity and mortality from cancers that are amenable to control through early detection is for the large majority of the population to undergo regular screening. Achieving high volume, regular screening in the U.S. is a major challenge due to the lack of universal health coverage, and the absence of a system of health care. Although some health plans and health maintenance organizations have established systems that include many of the dimensions of national systems found elsewhere, i.e., call-recall systems and monitoring of quality, most screening in the U.S. depends upon encounters, upon a patient or a provider (usually the latter) recommending cancer screening during a health care visit. For most Americans, screening is not centrally coordinated, and mainly depends on an individual's motivation to be screened, or the recommendation from a personal physician. Recommendations from personal physicians are more likely to occur if the patient is having a preventive health visit, but recent data show that fewer than half of individuals over age 50 having a checkup report a discussion about colorectal cancer screening with their doctor.

Although screening rates have increased in the U.S., the rate of increase is slower than should be expected in the presence of strong evidence of screening efficacy. There are a number of problems that hinder more rapid take up of screening, and as well, the impact of screening. Current recommendations for colorectal cancer screening reflect the poor integration of screening into primary care practice, unequal access to all recommended screening modalities geographically and by insurance status (i.e., availability of colonoscopy for screening varies by region and by insurance plan), and the observation that individuals have preferences for different tests. One can speculate that a menu of tests, each with different performance characteristics, may be advantageous early in period of the population's acceptance of screening, but eventually will be counterproductive to efficiency. As noted above, the absence of organized screening is a significant limiting factor. Referring physicians complain that there is insufficient time to explain the benefits, limitations, and patient requirements for each of the separate tests, and they also complain that there is little economic incentive to do so. Greater

engagement with screening may be expected now that the NCQA has included colorectal cancer screening as a HEDIS measure. However, it also is the case that much of the screening taking place is of very low quality. Recent evidence has shown that the quality of stool blood testing in the U.S. is seriously undermined by in-office, single panel exams, poor processing and interpretation, and failure to properly follow-up positive tests. Thus, much of what is appears to be accomplished with current screening rates is of little to no consequence for reducing the burden of disease. While many key U.S. organizations are focused on raising public awareness about the importance of screening, improving screening rates and the quality of screening in the U.S. primarily will require a concerted effort to address the important roles of health care professionals.