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Challenges of delivering medical care in resource-poor countries; thoughts on personalized medicine in US

Dr. Friedman,

I read your commentary "Personalized Medicine in the Resource-poor World" in the November 2016 issue of RIMJ and I wanted to write to express my appreciation to you for making these comments in the journal. My experiences as a Brown medical student in Ghana and later as a Fogarty Global Health Fellow in Tanzania in 2016, and your description of the hospital conditions, ring absolutely true to what I observed there and in other similar resource-limited settings in Africa.

Regarding the "thin layer" of health insurance as you describe, I traveled to Apam, Ghana for summer research at Apam Catholic Hospital and saw just exactly how thin and tenuous the health insurance layer really is. The Catholic association of hospitals (overseeing 100+ facilities nationwide) had not received insurance reimbursements from the government, for up to 6 months in some instances, so decided to boycott accepting the national insurance. What this meant at the local level in the case of Apam Catholic Hospital was an immediate overnight plummeting of patient attendance the next day. Seeing this and wondering just how impactful it was, I reviewed hospital records of the outpatient attendance counts for that first week in June when insurance acceptance stopped and the prior calendar year in June. While not an extensive review, the difference was nearly an 80% drop in attendance from the year prior, a staggering figure. Over the coming weeks it trickled up slightly and returned to normal once the insurance was accepted again, but it reminded me how precarious the situation is for so many.

So in reading your piece, I was reminded of this in Ghana and what I've seen in Tanzania.

I also thought that your analogy of institutionalized personal medicine in the US and the health care access in resource-limited settings was particularly insightful. When I first read of personalized medicine and later hearing former President Obama praise it so highly as the future of health care I was left confused, scratching my head that voices of criticism weren't louder against this movement. How would it make any sense that multi-thousand dollar tests and diagnostics and specialized medicines would somehow not only be more available to people but also not cause the system more money? Such specialization would both require more R & D and create smaller markets, and thus higher costs. That we will run this test for Jane with her individualized genetic mutation, and design a medicine specific to her, and then run the test for Jill and design a different medicine specific to her – this will somehow be a boon for healthcare? So, I think it's exact how you've depicted the potential of this model to create a practice as you have seen in developing countries if expanded to its logical conclusion: that only the minority who can afford it will obtain it, creating a two-tiered healthcare system, and leaving the majority to fend for themselves. But, as you also say, perhaps that is already here.

Zachary Tabb, MD '18
Alpert Medical School of Brown University

Importance of screening for prevention, early detection of colorectal cancer

Dear Editors,

On behalf of the members of the Rhode Island Colorectal Cancer Advisory Committee, I am pleased to submit this letter and fact sheet for publication in the *Rhode Island Medical Journal*.

Colorectal cancer is the third most common, excluding cancers of the skin, and second leading cause of cancer death in Rhode Island when men and women are combined according to the American Cancer Society. Screening for colorectal cancer can help to prevent and detect cancer early. There are several reliable screening methods for colorectal cancer, but the best screening test is the one that gets done and reduces the burden of this largely preventable disease.

The goal of Rhode Island Colorectal Cancer Advisory Committee is to increase the rate of colon cancer screening in Rhode Island. We share a commitment to eliminating disparities in colorectal cancer screening and access to care by focusing on underserved, underinsured populations in Rhode Island. We also want to increase knowledge and awareness of CRC screening through patient education and to raise participation for those with adequate insurance to make sure they take advantage of the screening option that best fits their individual circumstances.

We are striving to meet the National Colorectal Cancer Round Table (NCCRT) of 80% by 2018 and beyond. The NCCRT 80% initiative involves over 1,500 organizations including the American College of Gastroenterology, American Cancer Society, Rhode Island Department of Health, Blue Cross Blue Shield of RI, Lifespan, RI Health Center Association, RI Medical Society and others committed to working towards a shared goal of 80% of adults, aged 50 and older, screened for colorectal cancer. As such, our organization will work to empower communities, patients, providers, community health centers, health systems, health plans, employers and others to develop partnerships to deliver coordinated, quality colorectal cancer screening and follow-up care.

In Rhode Island, close to 75% of individuals age 50–75 (CI:72.5, 76.4) reported being appropriately screened for colorectal cancer in accordance with U.S. Preventative Service Task Force's (USPSTF) Guidelines according to the 2014 Behavioral Risk Factor Surveillance System (BRFSS) data. While our screening rates are some of the highest in the country, these rates do not consider the disparities in colorectal screening. These disparities are clearly articulated in data from the Federally Qualified Health Centers (FQHCs). Since 2012 FQHCs have reported colorectal cancer screening rates for average-risk individuals ages 50–74 as part of their Uniform Data System (UDS) measures. Among the eight FHQC organizations in Rhode Island, which serve ethnically diverse populations and where greater than 90% of their overall patient population earns below 200% of the Federal Poverty Level (FPL), the average colorectal screening rate in 2016 was 44.7%.

Our committee seeks to address the disparities in colorectal cancer screening through the widespread adoption of multiple forms of screening, including FIT testing, and the development of a program modeled after SCUP (Screening Colonoscopies for Underserved Populations) created by Dr. Joseph DiMase in 2009. Seeing a need for increased access to colonoscopies for under- and uninsured Rhode Islanders, Dr. DiMase enlisted the support of local specialists and institutions who shared his vision of increasing screening rates among underserved populations. In less than two years, the program provided hundreds of screening colonoscopies with the support of 9 hospitals, 2 endoscopy centers, and 65 GI physicians and surgeons. For his work, he was presented the RI Department of Health's Community Partnership Award and the 2011 National Community Service Award from the American College of Gastroenterology. Dr DiMase was a visionary humanitarian in his passion to bring the power of screening colonoscopy to eradicate colon cancer.

Colorectal cancer is a major public health problem that cannot be ignored. The good news is that we have been making progress and we have the means to tackle this problem. As Rhode Islanders, we already have the tools at our disposal to overcome colon cancer. By

working together, we will exceed 80% by 2018, and we can set an example for the rest of America and largely eliminate the burden of colon cancer in RI.

Sincerely,
Samir A. Shah, MD, FACG, FASGE, AGAF
Eric Lamy
Melissa Campbell, MPH

Members of the RI Colorectal Cancer Advisory Committee

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Goal: 80% in 2018

Why are organizations committing to 80% by 2018?

Colorectal cancer is a major public health problem. Colorectal cancer is the second leading cause of cancer death in the U.S. when both genders are combined and a cause of considerable suffering among nearly 135,000 adults diagnosed with colorectal cancer each year. The good news is that when adults get screened for colorectal cancer, it can be detected early at a stage when treatment is most likely to be successful, and in some cases, it can be prevented through the detection and removal of precancerous polyps. About 1 in 3 adults between 50 and 75 years old – about 23 million people – are not getting tested as recommended.

What will an 80% screening rate achieve?

In Rhode Island, our colorectal cancer-screening rate in 2014 was nearly 75%. We are close to our goal. It is estimated that 772 cancers and 529 deaths from colon cancer will be avoided in RI by 2030 if we get to 80% by 2018. Let's all commit to increasing our screening rate to above 80% and decrease the incidence and death from colorectal cancer in RI. There are several recommended screening test options, including: colonoscopy, stool tests (guaiac fecal occult blood test [FOBT], fecal immunochemical test [FIT] or stool DNA test) and CT colonography, but *the best test is the one that gets done.*

We know what we need to do to get more people screened for colorectal cancer, prevent more cancers and save lives, and we share a commitment to eliminating disparities in access to care. Our organizations will work to empower communities, patients, health care providers, community health centers, health systems, health plans and other partners to close the screening gap.

What can you do to help achieve 80% by 2018?

If you are a health care provider:

- Make sure you advise your eligible patients to get screened
- Harness the power of your electronic medical record to track and improve the screening rate for the patients you follow and publicize this in your offices and send reminders as you do for office visits or vaccinations
- If you encounter barriers, reach out to the Department of Health to help overcome them

If you are a health system or insurer:

- Publicize the importance of screening for colorectal cancer as part of routine health care maintenance and the fact that screening is fully covered by insurance
- Notify by mail and email beneficiaries who are in the age range appropriate for screening

If you are a state representative or senator, Mayor of a city or town, Governor:

- Join the RI State legislature of declaring March as colorectal cancer screening awareness month and encourage your constituents to go for screening and speak to their health care provider
- Pass legislation to ensure enough funding for preventative care including colorectal cancer screening

If you are an employer big or small:

- Encourage your employees to go for screening and give them the time to do so

If you are over age 50 or African American over age 45:

- Get screened now! Talk with your health care provider about the best option for you

If you are a Rhode Islander:

- Remind your friends, neighbors, and families about screening and join us in March at the State House to raise awareness.
- Talk to your health care provider about when should you be screened for colorectal cancer

Visit: www.NCCRT.org for more information on 80% by 2018

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