

Prepared remarks
of

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before the
House Oversight and Government Reform Committee

regarding

“Breast/Cervical Cancer Screening Gap”

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Mr. Chairman and Members of the Committee, on behalf of RTI International, I am pleased to appear before you today to provide you with information regarding a cost analysis conducted by researchers at RTI of the *National Breast and Cervical Cancer Early Detection Program*.

I am Dr. Tom Hoerger, a Senior Fellow at RTI International and also director of the RTI-University of North Carolina Center of Excellence in Health Promotion Economics. RTI International is an independent, nonprofit research organization based in North Carolina that conducts a wide range of research and technical services for the U.S. Government and private sector clients.

The study in question was conducted by RTI researchers in collaboration with researchers from the U.S. Centers for Disease Control & Prevention. Although I am not an author of this particular study, I am very familiar with its findings and have significant experience in conducting similar studies. The study will appear in the February 2008 issue of the journal *Cancer*.¹

The study analyzed the costs associated with the Breast and Cervical Cancer Early Detection Program, established by Congress in 1990 to deliver breast cancer and cervical cancer screening to medically underserved, low-income women.

The study looked at nine participating programs in nine different states to answer three economic questions:

1. What is the cost per woman served in the program?
2. What is the cost per woman served by program component?
3. What is the cost per cancer detected through the program?

There was wide variation in the nine programs from state to state in terms of organization, reliance on in-kind contributions, and the number of women served. These and other factors contributed to a fairly wide variation in costs.

We found that the median cost in the nine state programs was \$555 per woman served. This figure includes the value of in-kind contributions such as donated goods and services. Without in-kind contributions, the cost was \$519 per woman served. The term “women

¹ Donatus U. Ekwueme, James G. Gardner, Sujha Subramanian, Florence K. Tangka, Bela Bapat, Lisa C. Richardson. “Cost Analysis of the National Breast and Cervical Cancer Early Detection Program: Selected States, 2003 to 2004.” *Cancer*, 2008.]

served,” includes the number of women screened in the program, plus the number of women who were screened outside the program and were referred to the program at the diagnostic stage for follow-up of abnormal results.

When looking at the screening alone, screening for breast cancer cost \$94 per patient, while the cost for cervical cancer screening was \$56 per patient. Those costs refer to the cost of screening a woman who received either a mammography and a clinical breast examination or the Pap test for cervical cancer. These estimates are within the range of estimates for the costs of breast and cervical cancer screening in other settings and programs.

The median number of breast and cervical cancers detected per program was 75 and 26, respectively. Based on those figures, the study found that the cost per breast cancer detected was \$10,566. The cost per detection of cervical cancer was \$13,340.

Based on the research, there is also some evidence of possible economies of scale, in that average costs may go down with the number of women screened, but the evidence is not conclusive. Only a small number of programs were surveyed; in addition, the sites were not randomly selected.

The study also assessed the program’s allocation of funds. Almost 60 percent of the NBCCEDP program funds were used for direct clinical services, which include screening and diagnostic follow-up, referral for treatment, and case management.

The remaining 40 percent of program resources were dedicated to activities including public education and outreach, professional education, quality assurance and improvement, surveillance and evaluation. These activities help address issues other than financial barriers that prevent low-income women from receiving cancer screening services.

Studying only nine of the NBCCEDP programs for just one year leaves some limitations in the findings, because the sample size is small and we know that funding and other sources of resources vary from year to year depending on activities planned.

However, as you probably are aware, we are currently conducting a second phase to this study that will provide a more comprehensive examination of the costs associated with screening in the NBCCEDP.

The study is examining all 68 NBCCEDP programs operating in the United States. Collecting cost data from all of the programs will provide a much richer understanding of program variation and will support econometric analysis of cost determinants. We will test for economies of scale and be able to control for differences in cost-of-living between

programs. The data may allow us to identify best practices and learn more about the optimal mix of spending across program activities.

This study is expected to be completed in 2009.

As always, there is still much more to learn, but I hope our research will help to answer your questions and provide you with information to assist you in your decisions.

I will be happy to answer any questions. Thank you for your time.