



Access to Digestive Health Care in Canada

- from the *Canadian Association of Gastroenterology* -

The Canadian Association of Gastroenterology (CAG) is the National professional organisation for Gastroenterologists, related health care professionals, and researchers with a mandate focused on education and research related to digestive health and disease.

Gastrointestinal diseases have an enormous, yet largely unappreciated, financial impact. The economic burden of digestive diseases exceeds that of all other disorders, including mental, cardiovascular, respiratory, central nervous system diseases and cancer.¹ Gastrointestinal diseases are responsible for 15% of the total direct economic burden of Canadian health costs.¹ Unlike many other diseases that are associated with advanced age, digestive diseases often strike individuals in their prime years. In addition to markedly impairing quality of life, the resulting loss of productivity costs Canadian business and taxpayers \$1.14 billion per year.

A human resource plan to ensure adequate delivery of gastroenterological health care services is of vital importance to all Canadians. Because of concerns about timely access of patients to quality digestive health care, the CAG has committed substantial time and money towards the development and implementation of a Human Resource Planning Project. We are pleased to have progressed extensively with this project, and delighted to share this information.

Initiative #1: The CAG has established evidence- and expertise-based recommendations on maximal, medically-appropriate waiting times for 24 different reasons for referral.² Maximal recommended waiting times were stratified into four acuity categories; urgent/24 hours, 2 weeks, 2 months, or 6 months. Patient support of these recommendations has been demonstrated by a nation-wide survey in which 96% felt that the maximal wait to see a Gastroenterologist should be less than 3 months.

Initiative #2: The CAG has measured actual wait times (from GP to specialist consultation and from specialist consultation to procedure) across the country. One half of patients had a total waiting time (time between GP referral and specialist test/procedure) of almost 4 months (15 weeks) and 1 in 4 patients waited more than 7 months.² Compared with the 2 month target set by the consensus, this is indeed a troubling finding. While the CAG recommends that all patients with 'alarm' symptoms be assessed within 2 months, data show that only half of the patients with alarm symptoms were seen within this recommended timeframe, and 1 in 4 waited more than 4 months.

Initiative #3: The CAG has assessed national human resources in Gastroenterology³. Based on 2002/2003 data, Canada has a total of 550 gastroenterologists or 1.83 specialists per 100,000 population; markedly below that of the U.S., France or Australia. On their own these data are cause for concern. However, assuming a retirement age of 65 years, 18% of GI specialists are due to retire in the next five years and a whopping 33% will retire over the next 10 years. Based on the number of new Gastroenterologists currently being trained, it is estimated that we will have 10% fewer Gastroenterologists within 10 years time. These findings are very alarming, given that we are currently failing to provide Canadians afflicted with digestive illness with timely care. In addition, implementation of colon cancer screening programs across the country will markedly increase the demand for gastroenterological services.

A Multi-Faceted Approach is Needed: To avert the forthcoming crisis in digestive health care, the CAG has estimated that at least a two-fold increase in gastroenterologists is required. One straightforward means to begin to address the problem is to increase the number of residency positions in gastroenterology. The CAG strongly recommends that this be implemented immediately as one part of a multi-faceted approach which also includes any or all of the following; nurse endoscopists, physician extenders, quality assurance and efficiency programs in endoscopy, and increased physical resources (endoscopy suites, equipment, etc.).

1. Beck IT. *Clin Invest Med* 2001;24:12-36. 2. Paterson WG, Barkun AN, Hopman WM, et al. *Can J Gastroenterol* 2006;20(Suppl. A):58A.

3. Moayyedi P, Tepper J, Hilsden, R, et al. *Amer J Gastroenterol* 2007;102:478-481.