Why is this important?

Gastroscopy is used to investigate or treat conditions affecting the upper gastrointestinal (GI) tract. It can also be used to monitor conditions affecting the upper GI tract that lead to cancer in certain high-risk groups.¹⁻³

Most conditions affecting the upper gastrointestinal (GI) tract that require a gastroscopy are uncommon in people aged under 55 years. Oesophageal and stomach cancers are very rare in this age group, and even less common in people without certain risk factors, such as smoking.¹⁻³

The *Third Australian Atlas of Healthcare Variation* found substantial variation in hospitalisations for gastroscopy among people of all ages.⁴ Higher rates were seen in areas of socioeconomic advantage in major cities, and in women. These findings are not consistent with the prevalence of GI disease.

The fourth Atlas now examines gastroscopy services that are subsidised under the Medicare Benefits Schedule (MBS) in a population that has few indications for its use: people aged 18–54 years.

What did we find?

In 2018–19, there were 154,338 MBS-subsidised services for gastroscopy for people aged 18–54 years. The rate was **10.8 times as high** in the area with the highest rate as in the area with the lowest rate.

Rates were markedly higher in major cities than elsewhere. The national rate for women was 1.6 times as high as the rate for men. About six in every 10 gastroscopy services were performed on the same day as a colonoscopy service for the same person.

What can be done?

Development of national guidance on the appropriate use of gastroscopy is a priority. Guidelines should include recommendations on when gastroscopy should be done at the same time as a colonoscopy. Structured referral forms could aid assessment of appropriateness against guidelines. Health service organisations could ensure that credentialing requirements for clinicians performing gastroscopy include audit of adherence to guidelines.

Interventions are needed that focus on educating consumers and clinicians that the risk of upper GI cancer in this age group is low. Improving consumer understanding about the role of gastroscopy is also important.

More attention needs to be given to clinicians' education on the causes of iron deficiency anaemia in women aged under 55 years. Heavy menstrual bleeding, a commonly unrecognised cause, should be excluded before referral for gastroscopy.

Context

This item examines rates of MBS-subsidised services for gastroscopy for people aged 18–54 years in Australia in 2018–19.

What is gastroscopy?

Gastroscopy, also known as an upper GI endoscopy, is the examination of the upper part of the GI tract, using a small, flexible tube with a camera on the end, called an endoscope. The procedure can also include a biopsy, if needed. The procedure, requires an empty stomach for an accurate examination. It is usually quick to perform, taking up to about 15 minutes.^{1,5}

What is it used for?

Gastroscopy is used to investigate, treat or monitor certain upper GI symptoms or diseases. Recommended uses are¹:

- Investigation of suspected bleeding from the upper GI tract and upper small bowel
- Investigation of symptoms suggestive of cancer (such as difficulty swallowing, weight loss, bleeding and stomach pain) or no response to acid suppression therapy
- Tissue diagnosis of suspected cancer or coeliac disease
- Surveillance of high-risk groups with chronic conditions that can increase cancer risk (for example, Barrett's oesophagus).

Gastroscopy is also used to treat bleeding in the upper GI tract, some upper GI cancers or a narrowed oesophagus (oesophageal stricture). However, gastroscopies for treatment (therapeutic gastroscopies) are not included in this data item.

Most conditions affecting the upper GI tract that require investigation with gastroscopy are uncommon in people aged under 55 years. They become more common with increasing age, the onset of chronic disease, or the use of certain medicines such as non-steroidal anti-inflammatory drugs.^{2,3} Gastroscopy is not required to investigate uncomplicated reflux^{2,3,6,7}, a common condition that affects more than one in 10 people in Australia^{8,9}, with a few exceptions. This is because:

- Most people with reflux have heartburn or regurgitation that can be diagnosed clinically without investigation and managed effectively with dietary or lifestyle modifications, or acid suppression medicines⁶
- Only about one-third of people with gastrooesophageal reflux disease (GORD), a condition in which reflux affects wellbeing and requires treatment, have abnormalities visible on gastroscopy²
- Most reflux does not progress to changes in the cells lining the upper GI tract, which can lead to Barrett's oesophagus or oesophageal cancer.²

Investigation with gastroscopy is required if reflux does not respond to a trial of acid suppression therapy and if 'alarm features' suggestive of cancer are present, such as difficulty swallowing, bleeding, weight loss, recurrent vomiting and anaemia. It is also required if the diagnosis is unclear or there are complications such as stricture.^{2,6,7,10-12}

Upper GI cancer is rare in people of any age and even lower in people aged under 55 years. Use of gastroscopy for population-based screening for upper GI cancer is not recommended because the chance of diagnosing serious disease is low. Upper GI cancer rates are lower in women than in men, and lower in people without risk factors, such as those who have never smoked^{2,13-17} (Table 5.1). These are important considerations for the appropriate use of gastroscopy, particularly for common conditions.

	Oesophageal cancer		Gastric cancer	
Age	Males	Females	Males	Females
35–39	0.5	0.1	1.6	1.9
40-44	1.0	0.2	3.4	2.5
45–49	2.9	1.3	5.6	1.6
50–54	7.2	1.5	11.2	5.7

Table 5.1: Upper GI cancer rates per 100,000 people, by sex and age group, 2019

Source: Australian Institute of Health and Welfare¹⁸

Coeliac disease is a common and under-diagnosed condition. Gastroscopy is used to confirm a diagnosis for people with positive coeliac serology or where the diagnosis is uncertain.^{6,10,19} Repeat gastroscopy after treatment with a gluten-free diet is controversial and is yet to be shown as cost-effective.²⁰

Gastroscopy is also used to investigate causes of suspected GI blood loss. People without a clear reason for iron deficiency should have a gastroscopy to exclude GI bleeding or malignancy (for example, postmenopausal women and most men). Menstruating women, blood donors and people with vegetarian or vegan diets should have other common causes of iron deficiency excluded first to avoid a missed diagnosis and unnecessary gastroscopy.^{21,22}

Why examine gastroscopy in people aged 18–54 years?

This Atlas examines variation in MBS-subsidised gastroscopy services for an age group in which signs and symptoms appropriate for investigation with gastroscopy are uncommon: adults aged under 55 years. Findings from the *Third Australian Atlas of Healthcare Variation* and a New South Wales study support exploration of variation in gastroscopy in this age group.^{4,23}

The third Atlas reported more than half a million (505,544) hospitalisations for gastroscopy among people of all ages in Australia in 2016–17.⁴ The rate in the area with the highest rate was 7.4 times as high as the rate in the area with the lowest rate. Higher rates were seen in areas of socioeconomic advantage in major cities, and in women. More than one-third (36%) of hospitalisations for colonoscopy included a gastroscopy.

The third Atlas findings highlighted a clear anomaly between the prevalence of risk factors for upper GI disease and gastroscopy hospitalisations, suggesting that some people are receiving care that is inappropriate and of no or little benefit.

Inappropriate use of gastroscopy in people aged under 55 years was examined in a New South Wales study.²³ Use of gastroscopy for investigating dyspepsia (indigestion or heartburn) in people aged under 55 years was considered low-value care – defined as care that provides no benefit, or a risk of harm that is greater than the benefit, or a benefit that is disproportionately low compared with its cost. About 14% of gastroscopies in adults aged under 55 years in New South Wales public hospitals were identified as low-value care in 2016–17. The rate of low-value gastroscopy increased by about 8% each year between 2010–11 and 2016–17.

About the data

Data are sourced from the MBS dataset. This dataset includes information on MBS claims processed by Services Australia. It covers a wide range of services (attendances, procedures, tests) provided across primary care and hospital settings.

The dataset does not include:

- Services for publicly funded patients in hospital
- Services for patients in public outpatient clinics
- Services covered under Department of Veterans' Affairs arrangements.

The dataset does not allow analysis by Aboriginal and Torres Strait Islander status.

Rates are based on the number of MBS-subsidised services for gastroscopy per 100,000 people aged 18–54 years in 2018–19.

Because a record is included for each service rather than for each patient, patients who receive the service more than once in the financial year will be counted more than once.

The analysis and maps are based on the patient's postcode recorded in their Medicare file and not the location of the service.

Rates are age and sex standardised to allow comparisons between populations with different age and sex structures.

What do the data show?

Magnitude of variation

In 2018–19, there were 154,338 MBS-subsidised services for gastroscopy, representing 1,247 services per 100,000 people aged 18–54 years (the Australian rate).

The number of MBS-subsidised services for gastroscopy across 327* local areas (Statistical Area Level 3 – SA3) ranged from 218 to 2,348 per 100,000 people. The rate was **10.8 times as high** in the area with the highest rate compared with the area with the lowest rate. The number of MBS-subsidised services for gastroscopy varied across states and territories, from 481 per 100,000 people in the Northern Territory to 1,312 in Victoria (Figures 5.5–5.8).

After the highest and lowest 10% of results were excluded and 263 SA3s remained, the number of MBS-subsidised services per 100,000 people was 2.9 times as high in the area with the highest rate compared with the area with the lowest rate.

Analysis by remoteness and socioeconomic status

Rates were markedly higher in major cities than in other areas, and markedly lower in remote areas than in other areas. Overall, the rate for major cities was 3.4 times as high as the rate for remote areas (Figures 5.1 and 5.9).

Rates decreased with socioeconomic disadvantage in major cities, and in inner regional and remote areas. Overall, the rate of gastroscopy in the highest socioeconomic group was 1.4 times as high as in the lowest group (Figures 5.2 and 5.9).

^{*} There are 340 SA3s. For this item, data were suppressed for 13 SA3s due to a small number of services and/or population in an area, or potential identification of individual patients, practitioners or business entities.

Notes:

Some SA3 rates are more volatile than others. These rates are excluded from the calculation of the difference between the highest and lowest SA3 rates in Australia.

For further detail about the methods used, please refer to the Technical Supplement.

Figure 5.1: Number of MBS-subsidised services for gastroscopy per 100,000 people aged 18–54 years, age and standardised, by remoteness of patient residence, 2018–19



Figure 5.2: Number of MBS-subsidised services for gastroscopy per 100,000 people aged 18–54 years, age and standardised, by socioeconomic area of patient residence, 2018–19*



Notes:

For further detail about the methods used, please refer to the Technical Supplement.

^{*} Areas with a low SES (=1) have a high proportion of relatively disadvantaged people. Areas with a high SES (=5) have a low proportion of relatively disadvantaged people.

Number of MBS-subsidised services for gastroscopy and colonoscopy for the same patient on the same day

In 2018–19, 58% of MBS-subsidised services for gastroscopy were performed on the same day as an MBS-subsidised service for colonoscopy for the same patient. There were 89,399 services for gastroscopy that accompanied a colonoscopy (Figure 5.3).

Figure 5.3: Number of MBS-subsidised services for gastroscopy on the same patient and same day as an MBS-subsidised service for colonoscopy, per 100,000 people aged 18–54 years, age and sex standardised, by state and territory of patient residence, 2018–19



Analysis by sex

The national rate of MBS-subsidised services for gastroscopy for females was 1.6 times as high as the rate for males. Rates were consistently higher for females in all states and territories (Figure 5.4).

Figure 5.4: Number of MBS-subsidised services for gastroscopy per 100,000 people aged 18–54 years, age and sex standardised, by state and territory of patient residence, by sex, 2018–19



The data for Figures 5.3 and 5.4, and the data and graphs for analysis by Primary Health Network are available at safetyandquality.gov.au/atlas

Notes:

For further detail about the methods used, please refer to the Technical Supplement. Sources: AIHW analysis of Medicare Benefits Schedule data and ABS Estimated Resident Population 30 June 2018.

Interpretation

There is wide variation in gastroscopy use, probably involving overuse in some areas and underuse in others. Rates of gastroscopy were markedly higher in major cities than elsewhere. Rates were also higher for women than for men in all states and territories.

These findings are consistent with those in the third Atlas, which examined public and private hospitalisations for gastroscopy.

Variation in rates of gastroscopy is likely to be due to geographical differences in the factors discussed below.

Variation between areas may not directly reflect the practices of the clinicians who are based in these areas. The analysis is based on where people live rather than where they obtain their health care. People may travel outside their local area to receive health care.

Clinical decision-making

Variation in adherence with available clinical guidelines may influence rates of gastroscopy.

International evidence suggests that a high proportion of gastroscopies do not accord with guideline recommendations. A 2010 meta-analysis of more than 13,000 patients undergoing gastroscopy found that 22% of procedures did not align with recommended indications in European and American guidelines.²⁴ More recently, a 2018 systematic review and meta-analysis reported that up to 54% of gastroscopies in 15 countries were performed for inappropriate indications.²⁵ Despite guidelines that recommend against using gastroscopy to investigate uncomplicated GORD^{6,7,11,26}, a New Zealand study reported this as one of the most common inappropriate indications for performing gastroscopy.²⁷

Differences in clinical opinion on management where the evidence is unclear may contribute to variation. For example, further evidence is needed to demonstrate the benefit of gastroscopy after a diagnosis of coeliac disease.²⁰ Difficulties in keeping up to date with rapidly changing evidence may also influence rates.²⁵

Some clinicians may perform gastroscopy in low-risk people, such as those aged under 55 years, to relieve patient anxiety and reassure them that they do not have GI cancer. However, this reassurance may be short lived, and the procedure has a low chance of diagnosing significant disease.²⁸⁻³⁰

Fear of litigation for not investigating symptoms may influence clinicians' decisions about use of gastroscopy, particularly if they are unaware of current recommendations or evidence about the incidence of upper GI cancers. Concerns about late diagnosis and subsequent litigation, as well as few disincentives for over-testing may also contribute to overuse of gastroscopy.²⁵

Higher rates of gastroscopy in women than in men may be related to higher rates of iron deficiency in women. Gastroscopy might have been used before exclusion of dietary causes of iron deficiency, or heavy menstrual bleeding in menstruating women. Higher gastroscopy rates in women raise concern of delayed diagnoses and treatment, because common causes of iron deficiency are being missed.

Gastroscopy and colonoscopy performed on the same day

The ease of performing a gastroscopy at the same time as a colonoscopy may contribute to variation. About six in 10 gastroscopy services were performed on the same day in the same person. Both procedures should be performed concurrently for only a limited number of conditions, so the high rates suggest inappropriate use.

Australia's National Bowel Cancer Screening Program offers a two-yearly faecal occult blood test (FOBT) for people aged 50–74 years. Guidelines recommend colonoscopy for people who have a positive FOBT to assist with diagnosing disease.³¹ Some clinicians performing gastroscopies may be unaware that a FOBT only detects lower GI tract bleeding.

Higher rates of both procedures may also reflect investigation of iron deficiency in menstruating women before excluding diet or heavy menstrual bleeding as the cause.

Referral practices

Variation in gastroscopy rates may be due to referral practices. A New Zealand study found that 42% of referrals did not follow American Society of Gastroenterology criteria. No cancers were found in gastroscopies from inappropriate referrals.²⁷ Surveillance of healed benign lesions was the most common inappropriate reason to request a gastroscopy among hospital-based clinicians (31% of consultant requests). Investigation of symptoms considered functional in origin (heartburn) was the most common inappropriate reason among general practitioners (GPs) (25% of requests).

Consumer expectations

Consumer expectations and perception of cancer risk may contribute to variation in rates of gastroscopy use.^{26,32} People often have incorrect beliefs about their cancer risk.^{32,33} This may influence their perceptions about the benefits of interventions such as screening to detect GI cancer, and their preference and demand for investigations, even when their risk of cancer is low.

In the United Kingdom, the 'Be Clear on Cancer' campaign in 2015, which aimed to raise awareness of GI cancers, increased demand for gastroscopy by 48% but did not affect the rate of cancer diagnosis.³⁴

Access to services and number of clinicians providing services

Access to clinicians may influence the likelihood of people seeking care and the rates of gastroscopy use. The practice styles of individual clinicians may be more likely to affect rates in areas with fewer clinicians, such as rural and regional locations, than in areas with more clinicians. Availability and affordability of services may also influence patterns of use. Ability to pay out-of-pocket costs for gastroscopy is likely to be lower in areas of socioeconomic disadvantage, and access is likely to be more difficult in areas with fewer services. Open-access endoscopy services, where GPs are able to request gastroscopy without specialist review, may also influence patterns of use.

Financial incentives

Greater remuneration for providing a service rather than consultation may lead to variation and over-servicing in some areas.

Promoting appropriate care

Unwarranted variation in the use of gastroscopy in people aged under 55 years could be addressed by reducing the rate of inappropriate gastroscopies and increasing access in areas that are under-served.

Australia's finite health resources should be directed to high-value care, and away from low-value care such as use of gastroscopy to investigate reflux in people aged under 55 years, where it will not change the diagnosis or management. Improving awareness of the causes of iron deficiency unrelated to the upper GI tract will reduce unnecessary gastroscopy and avoid delays in diagnosis. Reducing inappropriate referrals for gastroscopy could also free up resources to reduce waiting times for public colonoscopy services.

Guideline and resource development

Development of national guidance to support appropriate use of gastroscopy is a priority. These could be used to assess appropriateness of referrals and for clinical audit of clinicians' gastroscopy practices. The guidelines should cover guidance on appropriate use of same-day upper and lower GI endoscopy, as recommended by the Medicare Benefits Schedule Review Taskforce.³⁵

Integration of cancer mortality and lifestyle data into healthcare pathways, training guidelines, and specialist and consumer resources could also support appropriate use of gastroscopy.

Clinical decision-making

Strategies to improve clinicians' skills in provisional diagnosis could improve the assessment of reflux symptoms and iron deficiency, and reduce unnecessary gastroscopy.

Use of medicines that can cause GORD symptoms should be excluded in people presenting with reflux.

Dietary causes and heavy menstrual bleeding should be excluded in women with iron deficiency. Improved awareness and application of the *Heavy Menstrual Bleeding Clinical Care Standard* may reduce delays in diagnosis of heavy menstrual bleeding and the rates of unnecessary gastroscopy in menstruating women.^{4,36}

Improved use of medicines to manage GORD symptoms may help reduce inappropriate gastroscopies. Proton pump inhibitors (PPIs), which are commonly used to manage GORD symptoms, are most effective when taken at least half an hour before the first meal of the day.⁶ Taking PPI medicines at the wrong time can lead to poor symptom control, and may contribute to unnecessary use of gastroscopy to investigate symptoms.

Consumer education and reassurance

Informing people aged under 55 years about the limited role of gastroscopy in the management of most upper GI symptoms, and reassuring them that their risk of developing upper GI cancer is very low may reduce demand for inappropriate gastroscopy. Interactive tools that identify a person's risk or the incidence of cancer – such as the Australian Institute of Health and Welfare cancer summary data tool (see 'Resources' on page 264) – may help clinicians when having conversations with their patients about upper GI cancer risk.¹⁸

Consumer education for women about the importance of considering heavy menstrual bleeding or diet as a cause of iron deficiency anaemia may also reduce unnecessary demand and use of gastroscopy.

Reducing risk factors

Making lifestyle changes to reduce the risk of GORD, upper GI cancers and bowel cancer should be the focus for people aged under 55 years presenting with reflux symptoms who are concerned about cancer, rather than having a gastroscopy. For example, weight loss can reduce GORD symptoms. In women, a 3.5 kg/m² reduction in body mass index can result in a nearly 40% reduction in the risk of frequent GORD symptoms.^{37,38} Improving a person's understanding about their cancer risk – particularly in people aged under 55 years – is important to reduce anxiety and dispel myths about cancer.³⁹

Public health initiatives that address diet, smoking, obesity, excessive alcohol consumption and sedentary lifestyle should be targeted to areas with a high prevalence of risk factors for upper GI disease.

Clinical audit and clinician education

Clinical audit is a tool that could be used more widely to support appropriate use of gastroscopy in Australia.

Health service organisations could ensure that credentialing requirements for clinicians include a clinical audit against evidence-based guidelines. Audits in this area could form part of continuing education requirements for clinicians.

A study of Australian GPs found that participation in clinical self-audit against Gastroenterological Society of Australia recommendations improved management of GORD.⁴⁰ Referral for gastroscopy fell from 48% to 45% of patients during the audit program. Other aspects of management improved – for example, identification of risk factors that triggered symptoms (such as medicines), and recommendations for lifestyle changes such as weight loss and dietary changes.⁴⁰

An indicator to measure gastroscopies performed after a positive FOBT (which is contrary to guidelines which recommend a colonoscopy only) could be developed for clinical audits.

Structured referral forms and checklists for GPs could support appropriate requests for gastroscopy in younger adults. Using guidelines to assess the appropriateness of referrals could also increase the likelihood that the procedure will assist with providing a diagnosis.

Educational programs for gastroenterologists and GPs could improve the appropriateness of requests for gastroscopy. Education could cover the:

- Non-GI causes of iron deficiency anaemia
- Low risk of upper GI cancer in people aged under 55 years
- Limited role of gastroscopy in GORD
- Low chance that gastroscopy will diagnose significant disease for simple upper GI symptoms.

Appropriate prioritisation of colonoscopy and gastroscopy

Health service organisations need to examine the volume of gastroscopies that may be tying up resources needed to perform colonoscopies. Colonoscopy for people with a positive FOBT should be prioritised over gastroscopy for people whose management is unlikely to change as a result of the gastroscopy, such as people aged under 55 years with typical symptoms of reflux. Better use of resources according to clinical need would improve the likelihood of diagnosing significant disease and reduce delays in diagnosis.

Triage systems

Many states and territories are introducing evidencebased triage systems for prioritising and allocating people for gastroscopy and colonoscopy, with the aim of reducing variation in use of these procedures:

- Victorian health services require clinicians to refer people for gastroscopy according to the categorisation guidelines; these guidelines specify the appropriate use of gastroscopy in people aged under 55 years who have symptoms of GORD with no alarm features, and surveillance of people with Barrett's oesophagus⁴¹
- Tasmania has adopted the Victorian categorisation guidelines and formed a statewide endoscopy network to monitor the quality of its services⁴²
- Queensland and Western Australia have introduced clinical prioritisation criteria for many clinical areas, including gastroenterology, to triage patients referred to public specialist outpatient services.^{43,44}

Wider use of these triage systems could result in more appropriate prioritisation of gastroscopy and colonoscopy.

Rates by local area

Figure 5.5: Number of MBS-subsidised services for gastroscopy per 100,000 people aged 18–54 years, age and sex standardised, by Statistical Area Level 3 (SA3) of patient residence, 2018–19



Notes:

Triangles (a) indicate SA3s where only rates are published. The number of services are not published for confidentiality reasons.

For further detail about the methods used, please refer to the Technical Supplement.

Rates across Australia

Figure 5.6: Number of MBS-subsidised services for gastroscopy per 100,000 people aged 18–54 years, age and sex standardised, by Statistical Area Level 3 (SA3) of patient residence, 2018–19



Notes:

For further detail about the methods used, please refer to the Technical Supplement.

Rates across capital city areas

Figure 5.7: Number of MBS-subsidised services for gastroscopy per 100,000 people aged 18–54 years, age and sex standardised, by Statistical Area Level 3 (SA3) of patient residence, 2018–19



Notes:

For further detail about the methods used, please refer to the Technical Supplement.

Rates by state and territory

Figure 5.8: Number of MBS-subsidised services for gastroscopy per 100,000 people aged 18–54 years, age and sex standardised, by Statistical Area Level 3 (SA3) of patient residence, 2018–19



Notes:

Triangles (A) indicate SA3s where only rates are published. The number of services are not published for confidentiality reasons.

For further detail about the methods used, please refer to the Technical Supplement.

Rates by remoteness and socioeconomic status

Figure 5.9: Number of MBS-subsidised services for gastroscopy per 100,000 people aged 18–54 years, age and sex standardised, by Statistical Area Level 3 (SA3) of patient residence, 2018–19



Notes:

Triangles (A) indicate SA3s where only rates are published. The number of services are not published for confidentiality reasons.

For further detail about the methods used, please refer to the Technical Supplement.

Resources

- Australian Institute of Health and Welfare, Cancer summary data visualisations¹⁸, aihw.gov.au/reports/cancer/cancer-data-inaustralia/contents/cancer-summary-datavisualisation
- Gastro-oesophageal Reflux Disease in Adults: Clinical update (2011)²
- Clinical Practice Guidelines for the Diagnosis and Management of Barrett's Oesophagus and Early Oesophageal Adenocarcinoma¹⁶
- Therapeutic Guidelines: Gastrointestinal, version 6⁶
- Gastro-oesophageal Reflux Disease and Dyspepsia in Adults: Investigation and management (clinical guideline)³
- Suspected Cancer: Recognition and referral upper gastrointestinal tract cancers⁴⁵
- Guidelines for the diagnosis and management of gastroesophageal reflux disease⁷
- The role of endoscopy in the management of GERD¹¹

Australian initiatives

The information in this chapter will complement work already underway to improve the use of gastroscopy in Australia. At a national level, this work includes:

- Royal Australasian College of Surgeons, Choosing Wisely recommendation 4: Do not use endoscopy for investigation in gastric band patients with symptoms of reflux⁴⁶
- A review of the impact of the changes made to the MBS items for gastroenterology services in response to the Medicare Benefits Schedule Review Taskforce.³⁵

Many state and territory initiatives are also in place to address access to gastroscopy, including:

- Upper Gastrointestinal Endoscopy Categorisation Guidelines for Adults, Victoria⁴¹
- Endoscopy Action Plan, Queensland⁴⁷
- Clinical prioritisation criteria: endoscopy⁴⁸ and Clinical prioritisation criteria: gastroenterology⁴³, Queensland
- Referral Guidelines: Direct Access Gastrointestinal Endoscopic Procedures, Western Australia⁴⁹
- Urgency Categorisation and Access Policy for Public Direct Access Adult Gastrointestinal Endoscopy Services, Western Australia⁴⁴
- Statewide endoscopy care network, which monitors and assesses the quality of endoscopy services, Tasmania.⁴²

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