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L'ASSOCIATION CANADIENNE DE GASTROENTÉROLOGIE

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< <Sent by email to: fnihb-dgspni@hc-sc.gc.ca, original by courier> >

I write in my capacity as President of the Canadian Association of Gastroenterology (CAG) to express our concern with regard to the recent changes to the Non-Insured Health Benefits (NIHB) program.

The CAG is the national organization of Gastroenterologists in Canada focused on educational and research initiatives for Canadian physicians and researchers in the field. In addition, the CAG liaises with the regional Gastroenterology associations as a formal committee of the organization, and many of these regions are currently served by the NIHB Program.

We are not aware of any direct communication from your Department to the regional or national Gastroenterology Associations, but we understand that you have instituted new regulation with respect to the access for appropriate acid suppressive treatment. We have a number of concerns with this new regulation. It is worth noting that we have corresponded with both the British Columbia and Nova Scotia governments regarding similar policy changes – and as a result their intended policy was adjusted to accommodate our concerns.

We are primarily concerned with patient and physician access to medications, particularly the choice of medication. Your policy indicates that all patients taking Proton Pump Inhibitor (PPI) therapy will be switched from their current medication to a generic form of therapy for a period of 60 days. Further, if failing the initial period of therapy, they will be switched to a 60 day trial of rabeprazole. This is of serious concern to the CAG, as patients whose disease is currently being treated safely and effectively could be forced to discontinue their current treatment. Disruption of treatment in a patient who is doing well cannot be justified for a number of reasons:

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1. Government is intervening in the therapeutic relationship between patient and physician. A course of therapy has been decided in confidential discussion between the two parties. We strongly feel that a Government agency has no ethical right to interfere in treatment without the consent of **both physician and patient.**
2. These patients may become symptomatic and have worsening of their disease upon switch of medication. If they do, it is likely, given the waiting time for gastroenterology consultation for NIHB constituents, that their symptoms will not receive prompt attention.
3. Even if they do not become symptomatic (which is the case in a large proportion of patients with reflux disease) they may be exposed to the risk of complications from their underlying illness. Since head-to-head efficacy studies have not been performed for the PPI's they cannot be assumed to have equivalent effects.
4. Many of these patients are likely taking NSAID's. We are concerned that forced substitution may result in gastrointestinal complications such as hemorrhage. The literature is not decisive on the efficacy of all PPI's in this setting. This is particularly a concern as there is likely to be confusion surrounding the dose, particularly with rabeprazole, 10 mg o.d., 10 mg b.i.d. and 20 mg o.d are possible (20 mg o.d. is the standard treatment dose in these patients). Should such a complication occur we would like to make it clear that the medico-legal responsibility will rest entirely with the NIHB and not with the Gastroenterology Associations.
5. We know from a national study that access to gastroenterology consultation and procedures is poor, even in urban areas where most physicians are located. The access issues will be even more difficult in northern and rural areas making this policy all the more unwise.

We have corresponded with other governments surrounding this same issue. In BC for example, it has been documented that such a forced switch approach will incur patient suffering, additional health care costs (in physician visits – at both primary care and specialist levels), and serious adverse clinical outcomes. Further to this, the CAG has recently completed a substantial National Wait Time assessment, and the picture is absolutely unacceptable across the country. The policy that you have put in place will do nothing but further adversely affect the already unacceptable wait time situation.

We trust that you will take full note of the above serious shortcomings with respect to your current policy change. The CAG would be pleased to discuss this with you further, and we would encourage you to consult with us in the future before implementing such policies that have a direct and detrimental affect on our members and their patients. We look forward to establishing a meaningful dialogue with you in the future to work together to resolve this worsening state of affairs.

Sincerely

Des Leddin, FRCPC, MRCPI, MSc
President, CAG

Cc Federal Health Minister Dosanjh
Provincial Ministers of Health
Dr. Richard Hunt, Chair, CAG Advocacy Committee
Provincial Gastroenterology Association Presidents