SUMMARY

Upper gastrointestinal endoscopy is an easily performed diagnostic procedure that is well-tolerated by patients. Although the majority of endoscopies are done by general internists and gastroenterologists, the procedure is performed by physicians in many specialties.

Indications for upper gastrointestinal endoscopy are very broad, and there are few clinical contraindications to the use of the procedure. It is difficult, at best, to document improved outcome as a result of performance of an endoscopy, although the procedure does provide additional diagnostic information in many cases. The ability to obtain biopsies of suspicious tissue is one of the main values of endoscopy. The reassurance to the patient that he or she does not have cancer is a valuable, if difficult to measure, result of the procedure.

The cost of performing an endoscopy is relatively low, Given an efficient production process, the estimated cost to a physician group practice is approximately ***$41*** to $83 per endoscopy, depending on volume. The median charge in California in 1977 for the physician services component of the procedure was approximately $240. Thus, charges are from three to six times the cost of performing the procedure. It is estimated that at least 500,000 endoscopies are performed each year in the United States, for total annual physician charges of at least $122 million.

The value of an upper gastrointestinal endoscopy is generally limited by our current understanding of and lack of effective treatments for the major disease processes of the upper gastrointestinal tract. As our understanding increases and treatments become more effective, so may the value of an endoscopy increase. However, existing financial and clinical incentives undoubtedly encourage the performance by physicians of many more endoscopies than can be clinically justified at this time. Physicians, health insurers, and regulators must define discrete a priori indications for performance of the procedure, levels of competence to perform the procedure must be established, and perhaps most importantly, relative reimbursement for performance of an endoscopy must be lowered to more closely approximate the cost of performing the procedure (and possibly to take into account the circumstances under which the procedure was performed, such as routine or emergency). Without such changes, physicians may continue to perform endoscopies on many patients with upper gastrointestinal symptoms—for most of whom there will be little or no direct benefit.

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