Diversion of emergency acute workload to primary care: an attractive private sector alternative to public hospital emergency departments?

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Emergency department (ED) attendances, 111 ambulance calls, and acute admissions to hospital are all showing signs of year on year growth leading to concerns about future sustainability of the system. One response to this rising demand in acute care is increasingly seen to be moving as much acute work as possible into primary care away from hospitals.

Treating patients with acute illness or injury in the community is marketed as easing the pressure on overcrowded emergency departments, reducing preventable admissions to hospital, and saving money through efficient gate-keeping and resource utilisation. Local initiatives now underway in Auckland to this end include the removal of cost barriers to out-of-hours care, the diversion of ambulances to Accident & Medical (A&M) clinics and funding schemes that pay for some treatments and tests in the community such as ultrasound for DVT and intravenous antibiotics for various infections. Elsewhere in the country, there have been suggestions that “inappropriate patients” should be turned away at the door of emergency departments and re-directed to primary care.

However, while there is considerable broad support for increased access to primary care and community based treatments, especially out-of-hours and to disadvantaged communities and groups, there is mounting concern about the promises that it will all be paid for by savings in the secondary care sector. Not surprisingly concern is coming especially from those charged with maintaining front-line secondary services such as emergency departments, who believe that the overall health-dollar savings may be marginal or non-existent.

Reliable, high quality evidence for significant numbers of patients being seen at emergency departments or admitted to hospital unnecessarily who could be equally or better managed in primary care alone is lacking, certainly in Auckland. Furthermore, the use of emergency departments for primary care problems is widely regarded as a relatively minor issue by ED clinicians generally compared to access block (waiting for inpatient beds) for example.

There are some significant potential pitfalls in steering acute workload away from emergency departments unless there is a genuine, clinically-driven focus on determining “right patient, right place, right time” consistently. These include:

- **Double-handling**
  There is a significant risk that a group of patients diverted away from ED to a primary care centre (especially following 111 ambulance call) will later need to be transported to the hospital secondarily if the problem lies out with the ability of the primary care centre to deal with it. This is especially the case for
A&M centres operating without the benefit of an intimate knowledge of the patient. The potential negative effects of such on-referrals include:

a. Wasted expense of initial primary care visit.
b. Pressure on the ambulance service (two journeys vs one) leading to reduction in response times for other status 1 and 2 patients.
c. Delays in care which may be significant for time-sensitive conditions such as sepsis, dislocations, anaphylaxis, asthma, acute coronary syndrome, stroke.
d. Overload of inpatient teams now required to work up a primary care referral rather than accepting a pre-packaged patient from the emergency department.

• Hidden costs
In addition to the cost of additional transfers (as above), the potential savings from treatment in primary care versus an emergency department are likely to have been miscalculated and over-estimated. Some preliminary planning reports used the inter-district flow figure for the cost of treating an emergency room patient, but this is based on an average of the cost of treating an ED patient, not the cost of treating one that may be suitable for equal or better management in primary care. In fact such patients often consume minimal resource, are often managed by nurse practitioners and contribute little to ED gridlock.

Furthermore, although several decades ago emergency department patients were managed predominantly by inexperienced trainees leading to over-referral and over-investigation, patients now are likely to be treated expeditiously and according to best evidence under direction of senior medical staff working on the shop-floor. There is evidence that senior emergency doctors can act as very effective gatekeepers to the inpatient beds, and order only investigations that are important decision levers, saving both time and the risks of unnecessary intervention.

The cost-effectiveness of centralising the observation of certain groups of patients in ED short stay units such as intoxicated head injury, renal colic and gastro-enteritis is also lost if care is devolved into multiple primary care facilities each operating to look after individual cases. The same is likely to be true of the ease and success of performing procedures that are common in emergency departments such as lumbar puncture and fracture manipulation, but less commonly performed in primary care, even if the expertise was uniformly available.

• Privatisation
The transfer of workload away from the public hospital emergency departments into private primary care shifts money from the public sector to the private. There may well also be additional cost shifting through more private radiology and specialist clinic follow up. Although this can be marketed as “easing the burden on the public system”, and will clearly be welcomed by those businesses that stand to gain financially, the private costs will need to be met either by the patient, ACC or the DHB or some mixture of the three.
Initially, while such initiatives are heavily publicly subsidised (such as through “Primary Care Options” or the “After-hours Initiative”), the DHBs will most likely be asked to try to recoup their costs from secondary care budgets, probably through recruitment freeze in front line services in anticipation of a reduction in the acute workload. Any such planning blight risks a reversal in the recent substantial improvements in emergency department care, especially if staffing levels or skill mix become compromised and the actual reduction in true clinical workload proves to be relatively negligible.

A weakened public emergency system may not deal as effectively with more major emergencies, that clearly require hospital level care. In addition, should the scheme become unaffordable for reasons given above, it is likely that over time, some costs would be transferred from the DHB to the patient in the form of co-payments.

Many reports into the workings of efficient health systems have at their core an effective medical home, and good access to primary care. Certainly, well organised primary care would appear to be able to deliver a continuity of individualised healthcare that can minimise the duplication and communication problems that characterise expensive poor quality episodic care. However, the only truly proven evidence-based community interventions to reduce hospital admissions relate to chronic disease management, and illness prevention such as smoking cessation, health screening and teenage health issues rather than acute demand management.

Conversely, international evidence for reducing emergency department attendances through ambulance diversion, expanded primary care options and the provision of walk-in centres is highly inconclusive as determined by several international literature reviews. It would therefore seem that in order to achieve the goal of reducing acute admissions using primary care as the agent of change, that the emphasis should not be on diversion once an acute problem has occurred, but well before, in terms of chronic disease management plans such as COPD, LVF and mental health, or illness prevention such as immunisation. Certainly, the support of primary care to rest home, palliative care and private nursing home patients would be regarded by many in hospital practice as the single most useful intervention in terms of both saving costs and improving care.

Instead of being seen as the problem to be solved, the efficiency of the acute secondary care system should not be undervalued, but celebrated and supported. Some acute problems now are best managed by any measure as a one-stop emergency hospital visit, such as PCI for unstable angina, or acute cholecystectomy for cholecystitis. The patient returns to the medical home rapidly after a fully competed acute episode without the need for multiple referrals, investigations and visits. Indeed, most of the innovations in reducing hospital bed days have resulted from increased effectiveness of secondary care, and the recent dramatic reductions in ED length of stay prompted by the 6 hour target have allowed the absorption of much of the additional ED workload.

Most patients who currently attend an emergency department do so out of perceived urgency rather than any other reason, and usually with good reason. They by-and-large get good, timely care delivered in a cost-effective way. Therefore, changes that
improve access to primary care should be welcomed for their own sake, and funding provided as an investment to develop those proven systems like chronic disease management.

If the ideological re-direction of acute emergencies is pursued over-zealously, the consequences may be to distract primary care from more effective initiatives to reduce the burden of disease, emasculate the effectiveness of emergency departments, and increase overall health spending at considerable additional clinical risk.

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Disclaimer: Views expressed represent the author’s own personal professional opinion, and do not necessarily reflect the views of Auckland District Health Board.

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