Editorials

General practice patients in the emergency department

Mostly, it is more appropriate for patients to seek care in the emergency department rather than visit a general practitioner

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One of the mysteries of public policy is that at times the public discourse settles on a perspective that is based on flimsy or even contradictory evidence. One such discussion relates to the factors that contribute to the congestion of hospital emergency departments (EDs) in Australia.

In Australia, 30% of people attend EDs each year and that rate is growing at 2% per annum.[1,2] The reasons behind this are unclear; however, demographic factors (eg, ageing population), epidemiological factors (eg, rising rates of chronic disease), health system changes (eg, the scope and availability of primary care) and individual factors (eg, socioeconomic status) are likely contributing factors. The relative contribution of these factors is unknown. The growth in ED attendance is across all age groups, among more urgent categories and highest for trauma.[3]

There are more people seeking care in EDs (increased demand) and EDs continue to experience difficulty obtaining access to ongoing care for their patients (access block). Access block is a direct consequence of diminishing per capita hospital bed numbers and inefficient bed use in an environment of increasing demand for inpatient care. However, despite the clarity of the evidence, many still believe that a major contributor is the "inappropriate" use of the ED by "general practice-type" patients.

In this issue of the Journal, Nagree and colleagues[4] compare four different methods of determining the proportion of general practice-type patients attending EDs; one of which is that used by the Australian Institute of Health and Welfare (AIHW). These data are often cited in the public debate. The study found that three of the methods based on diagnostic and outcome criteria arrived at similar figures (about 10%), whereas the AIHW approach relatively overestimated the proportion (about 25%).

The study highlights the dichotomy between the tone of the public debate and the evidence. The public and political discourse maintains that ED congestion is contributed to significantly by "inappropriate" attendance by general practice-type patients. Some imply that this view is a deliberate ploy by politicians and health bureaucrats to shift responsibility between tiers of government.

However, each method used by Nagree and colleagues is potentially flawed. They are all statistical methods that do not (and cannot) take into consideration the particularities of each case. Additionally, each is based on diagnosis or outcome, neither of which is predictable by the patient when deciding where to obtain urgent medical advice. Extensive international research into the concept of ED attendance by general practice-type patients demonstrates not only a variable rate ranging from 4.8% to 90%[5] but also exceptional variability between clinicians.[6]

While it is clear that some ED patients can be treated in a general practice setting, we reject the premise on which the methods of determining general practice-type patients is based. Interviews with actual patients have shown that the vast majority genuinely perceive that they have a serious illness and need urgent advice.[6-8] It is absurd to expect patients to make clinical judgements when they do not have the expertise to do so.

The authors of the article conclude that the AIHW method grossly overestimates the load of general practice-type patient attending EDs. The use of the Australasian Triage Scale categories 4 and 5 as a surrogate indicator of inappropriate attendance represents a misunderstanding of the concept of triage.[9] The Australasian Triage Scale assesses urgency, which is different from complexity and severity. These three concepts are distinct, although complementary.

The problem is complicated further by the definition of a general practitioner and therefore of a general practice-type patient. Reasonable patients may well seek attention from GPs if those services are available when the illness occurs and the GP has the requisite skills and facilities to meet the patient's needs. Further, the nature of community care means that investigations require further appointments and travel. It actually represents a sound and sophisticated choice for many to seek care in an ED for purely practical reasons of timely access to all of the services required at a single location (one-stop shop), even when they could otherwise be treated in general practice.

It is also important to emphasise that notwithstanding the difficulty in defining general practice-type patients, these patients are not a significant contributor to ED congestion or burden. They account for less than 5% of ED length of stay[1,10] and a very small proportion of ED costs.[11]

We appeal for a more rational basis to this discussion and thank the authors for their contribution.

First, we contend that there are not general practice patients or ED patients; there are just patients, who need medical care. The onus is on our health system to understand those needs and to provide accessible, affordable

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and quality services that meet those needs. Patients should not be blamed for our failure to do so.

Second, we need to understand that demand for acute health care is growing among those who need it. We should understand that need, and attend to the capacity constraints that are the real cause of the current system-wide congestion.

Finally, we need to better compile the evidence to inform the public debate and identify ways in which that evidence can be made accessible to those responsible for policymaking.

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