

INAPPROPRIATE ATTENDERS: MOTIVES BEHIND SEEKING EMERGENCY CARE

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INTRODUCTION

Overuse of the Emergency Department (ED) places an unnecessary workload on staff that compromises the quality of patient care and is largely avoidable with better general practitioner (GP) use. This paper aims to evaluate the motives behind patients self-referring to the ED with non-urgent complaints as a substitution for seeking treatment from a GP. A collation of the current and existing New Zealand (NZ) research with support from international sources was reviewed and found four major motives behind inappropriate ED attendance: poor GP accessibility, misperception of health concerns, financial considerations, and dissatisfaction with GPs. The role of the NZ Government, EDs, and GPs have room for further development to combat this problem. Through collaboration, these three agents of healthcare have the potential to improve appropriate use of ED and GP services through education, promoting accessibility, and improving trust in GPs.

BACKGROUND

Emergency Departments are global essential services that provide immediate emergent and urgent care at the point of access (McHale et al., 2013). The term 'inappropriate attenders' describes non-urgent patients that present for diagnosis and treatment that are unlikely to require admission which could have been managed in a primary healthcare setting (McHale et al., 2013). However, defining what is an inappropriate or unnecessary presentation is difficult. There are currently no national or international standards for appropriate attending to ED and creating one is under contention (Haltiwanger, Pines, & Martin, 2006; Kraaijvanger, van Leeuwen, Rijpsma, & Edwards, 2016; Richardson, 1999, Richardson, 2012; Thornton, Fogarty, Jones, & Ragaban, Simpson, 2014). There has been both national and international concern as the prevalence of inappropriate attenders has been increasing, due to the strain it puts on the ED system. This has potential negative outcomes on the quality of patient care, ED capacity, and management of patient flow. This strain takes a serious toll on ED staff, resources, and patient satisfaction (Haltiwanger, Pines, & Martin, 2006; Richardson, 1999). The Ministry of Health in New Zealand has historically accepted the notion that increasing demand on ED services may be partially due to inappropriate attenders and suggested that this is up between 16 to 30 percent of all ED attendees (Ministry of Health, 1999). There has been an increase in ED use at least once in the last twelve months from 8.5 percent in 2006/07 to 15 percent in 2018/19 (Ministry of Health, 2019) which amounts to 281,985 people (Statistics New Zealand, 2018). Although this would not be entirely due to inappropriate attenders, statistics show that many ED attendees are non-urgent and regularly do not require specific hospital treatment (Vecchio, Davies, & Rohde, 2018). So why do they come? It is essential to investigate the reasons that patients self-refer to ED for non-urgent medical needs instead of seeking a GP. Strategies aimed to reduce the ED utilisation should target these inappropriate attenders who choose to visit the ED directly, bypassing primary care services (Kraaijvanger et al., 2016). Whilst inappropriate attenders may have only a small influence on waiting times for emergent and urgent patients, even a small number of inappropriate attenders contributes to overcrowding (Bezzina, Smith, Cromwell, & Eagar,

2005; Richardson, Ardagh, & Hider, 2006). Inappropriate attenders can prohibit access by increasing patient load, lowering the availability of beds, creating a shortfall in resources to meet patient needs, and creating a challenging environment to work in, ultimately reducing the overall number of patients for whom the ED can provide care (Chen, Lin, Han, Hsieh, Wu, et al., 2018).

DISCUSSION

Availability

Extensive research shows that increased availability and accessibility to a GP or after-hours services are associated with significant decreases in ED utilisation (Kraaijvanger et al., 2016; Lowthian et al., 2011; Vecchio, Davies, & Rohde, 2018). A study conducted in NZ by Thornton, Fogarty, Jones, Ragaban, & Simpson (2014) out of Middlemore Hospital looked at the motives behind non-urgent patients (within the Australasian triage scale categories of 3, 4, and 5) self-referring to Middlemore Hospital ED rather than accessing a primary healthcare service. On admittance, patients were questioned as to whether they had attempted to contact their GP that day; 25.2 percent of patients confirmed they did either by phone or in person. From this group, 73.3 percent were instructed by the GP to attend Middlemore Hospital ED, 20.2 percent were told the practice was too busy to see them that day. Of the remaining, 74.8 percent did not contact their GP, 27.4 percent of these believed their condition was too urgent to wait for a GP, and a further 22.1 percent stated their GP was closed. The cost was indicated as a factor in their decision by 1.9 percent of patients. 31.2 percent gave various reasons for not contacting their GP such as ED being their preferred choice at the time (Thornton, 2014). These reasons are consistent with previous NZ studies (Begley et al., 2011; Khan, Glazier, Moineddin, & Schull, 2011; Schneider, Whitehead, LoBiondo-Wood, & Haber, 2013) with the most common being the patient's perception that the ED was the most appropriate place to go based on their condition at the time (32 percent). The next most common being a lack of access to the GP. Patients citing lack of GP access as their reason for self-referring were higher during after-hours (28.7 percent) compared with during working hours (14 percent), as GPs would more likely be open during the day (Thornton, 2014).

After Hours Health Care

A study conducted in the Netherlands showed that patients have difficulties accessing an appointment with a GP within a timely manner, encouraging them to self-refer to the ED. This study also stated that almost a fifth of the self-referrals to the ED are due to the major national issue of unavailable GP appointments, especially after hours. The GP is usually only open during working hours, whereas the ED is a 24-hour service, therefore the ED is deemed a lot more accessible and appropriate for those with demanding work schedules. This may aid the expectation that patients can be seen sooner in the ED than at the GP. Similar results are present in Kraaijvanger, Rijpsma, van Leeuwen, and Edwards (2015) and Wachelder et al. (2017). Other international studies show that the high use of ED services suggests problems with GP accessibility, affordability and inability to provide an appropriate diagnosis (Begley et al, 2011; Khan et al, 2011; Schneider et al, 2013). Unavailability of a GP is an important factor in the use of the ED, as patients with non-urgent complaints that reside near emergency facilities tend to treat these as an after-hours GP substitute (Richardson, 2012; Thornton, 2014).

Financial Considerations

The high cost of after-hours services in the community and co-payments in primary care, compared to the free ED services is a contributor to choosing the ED above primary care (Kraaijvanger et al., 2016; Thornton, 2014). Investigations into the relationship between socioeconomic status (SES) and GP utilisation in NZ have found that people living in deprived areas, those with lower than average incomes and those with low SES, generally have higher engagement with GP services than those with a higher income (Scott, Marwick, & Crampton. 2003). Studies have found low SES patients visit the GP more than high SES patients (Loh, et al., 2015; Scott et al.,

2003; Wachelder, et al 2017). Although high GP attendance is considered a preventative measure for decreasing inappropriate attenders, it is important to note that low SES patients also use the ED services more regularly and are admitted into the hospital more than those with high SES. The high ED attendance of low SES groups cannot be fully accounted for by inappropriate attenders and is more closely linked with the adverse health outcomes of living in poverty.

Recurrent Costs of Ongoing Healthcare

Health inequalities, lower life expectancy, and more frequent complex and chronic conditions have already been strongly associated with low SES as an important determinant of health compared with those who are privileged (Agardh, Allebeck, Hallqvist, Moradi, & Sidorchuk, 2011; Clark, DesMeules, Luo, Duncan, & Weilgosz, 2009; Saydah & Lochner, 2010; Stringhini et al., 2017; Janati, Matlabi, Allahverdipour, Gholizadeh, & Abdollahi, 2011). Furthermore, these vulnerable low SES groups are more likely to bypass their GP due to postponing seeking care for too long because of the cost of regular GP appointments. Many described situations where they had to delay or avoid seeking care due to cost (Arpey, Gaglioti, & Rosenbaum, 2017). This predictably caused a deterioration of their health, worsening their condition which resulted in self-referral to the ED. This demonstrates that 'lack of primary care access' does not necessarily mean a lack of available appointments—for socioeconomically deprived individuals, recurrent costs prohibit access to essential ongoing healthcare. Patients who are socioeconomically deprived are marginalised, vulnerable, and have high health needs which require complex consultations (Loh et al, 2015).

Exaggeration of Cost

A study by Jones and Thornton (2013) showed that the cost of primary healthcare as a major factor for increasing ED attendance is exaggerated in NZ. There were 11 articles in Jones and Thornton's (2013) review with a total of 5850 participants with minor illness or injuries who were asked a direct question about cost. Only 119 patients (2 percent) cited cost being a reason for attending ED instead of a GP. This is extremely similar to the 1.9 percent found in a similar study by Thornton (2014). These studies suggest that cost may be a less common consideration in NZ compared with other countries. However, although two percent of the overall population may be low, it could be assumed that this is mostly comprised of the most vulnerable populations in the country (Loh, et al, 2015), such as low SES individuals. The inability of this proportion of the population to access primary healthcare should not be overlooked.

Misconception of Health Concerns

Data has suggested that the term 'Emergency Department' is interpreted differently between medical staff and patients (Carret, Fassa, & Domingues, 2009; Rocovich & Patel, 2012). A significant issue faced by the ED is the patient's inappropriate or incorrect perception of their condition's severity. Due to the appropriateness of presentation usually being defined by the medical staff's perspective, there could be a gap of knowledge in the patients understanding of when urgent care is necessary (Lowthian et al., 2011). Previous international studies are in agreement that there are difficulties for patients to accurately perceive and determine the urgency of their condition (Burchaard, Oikonomoul, Soost, Zoremba, & Graw, 2019; Doran et al., 2014; Penson, Coleman, Mason, & Nicholl, 2012). Burchaard et al. (2019) compared how medical staff assess the condition of a patient who self-referred to ED with how those patients self-assess their condition. Interestingly, 63.1 percent of the patients thought that their condition required urgent diagnosis and treatment. Comparably, the ED staff believed that 28.0 percentage of the self-referred patients had appropriate conditions for the ED. Nearly 80 percent of patients had mis-evaluated the severity of their condition. Although 74 percent did not believe that their condition could have been managed by a GP, the ED staff stated that the GP could have helped with a significant proportion of the health concerns presented. Interestingly, only 2.4 percent of patients expected to be admitted to the hospital as an inpatient for additional treatment, indicating ED is perceived as predominantly a rapid treatment outpatient

facility of the hospital. Similar findings from other international hospitals, support this idea showing most patients will consider their medical problems as urgent while medical staff will evaluate them as non-urgent (Tiller, Herzog, Kluttig, & Haerting, 2015; Mason, Tarle, Osibin, Kinfu, & Kaigler, 2014; Redstone, Vancura, Barry, & Kutner, 2008).

Seeking Advanced Diagnostic Investigations

Lowthian et al. (2011) found that preferential attendance of the ED in NZ, Europe, and Australia is often motivated by the perception of the ED as the superior healthcare provider. The ED's accessibility and convenience encourage it to be perceived as a 'one-stop-shop' which can provide total care along with access to advanced diagnostic tools and specialists. This is supported by a NZ consumer survey carried out by Hutt Hospital ED to identify motives for seeking emergency care (Lewis, 1988). Fifty percent of participants in the study cited that they thought that the ED was the most appropriate place for them, largely due to the possibility or expectation of receiving advanced diagnostic investigations such as radiological imaging and laboratory tests. Additionally, 24 percent cited availability as a reason, and a further 16 percent cited accessibility (Lewis, 1988). Similar results were found in a Dutch study by Brasseur et al. (2019) where 51.3 percent of the self-referrals believed that the ED was appropriate for their current condition due to possessing the right resources (advanced diagnostic investigations) and an additional 23.8 percent citing accessibility to care. This again expresses that patients believe that the ED is the only place where they can access the best treatment.

Dissatisfaction with General Practitioner

The findings stated above show that patients can be attracted to the accessibility of the ED alongside the perception that it possesses superior resources and quality of care, but this also speaks to the public perception of the GP. Reports both within NZ and internationally show that many patients believe that their symptoms were too severe for a GP to handle and that their condition was outside the scope of a GP's training and management capability. This can lead to a distrust in the abilities of a GP and encourages GP avoidance in preference of the ED (Kraaijvanger, et al., 2015; Lewis, 1988). Patients also commonly report that they have more trust in the ED than the GP services (Doran et al., 2014; Kraaijvanger et al., 2016). Knowing that all possible advanced diagnostic investigations can be done within the ED, it could be deemed rational to avoid the GP to self-refer to the ED, potentially reducing cost, time and effort. GP appointment time may contribute to the perception that the GP is not able to sufficiently manage a patient's health problem. General Practitioners suggest that short consultations compromise their ability to provide adequate care, reducing the range of services that can be provided which produce poorer health outcomes for patients (Irving, Neves, & Dambha-Miller, 2017). The normal allocated length of a NZ GP consultation is considered to be fifteen minutes. Osborn et al. (2015) show that GPs in Australia, Canada, France, Germany, the Netherlands, Norway, Sweden, the UK, the USA, and NZ report that over one third of all GPs are dissatisfied with time allocated per patient. Short consultation length may be assisting the misconception that GPs cannot manage complex conditions. Patients with non-urgent health conditions may decide to substitute inaccessible GP services with the ED, even though primary care does have the provisions to manage patients within the Australasian triage scale 3 – 5 (Thornton, 2014; Vecchio, Davies & Rohde, 2018).

Unmet Needs

Information collected from the 2018/19 NZ Health Survey has found many people have had negative experiences with primary healthcare services resulting in unfavourable outcomes. The three largest affecting issues that are 'experienced include one or more unmet needs for primary healthcare,' 'unable to get an appointment within 24 hours,' and 'does not have definite confidence and trust in GP.' If a large percent of the population are not getting what they need from the GP due to any of the six reasons listed, it may be increasing the perception that GPs are not the place to go for serious health concerns. This may cause people to look to the ED as a preferred substitute, or even delay or avoid seeking healthcare entirely.

RECOMMENDATIONS

This section provides recommendations to resolve or lessen the extent of an excessive non-urgent patient load in the ED at the operational level between government, emergency department and primary healthcare services.

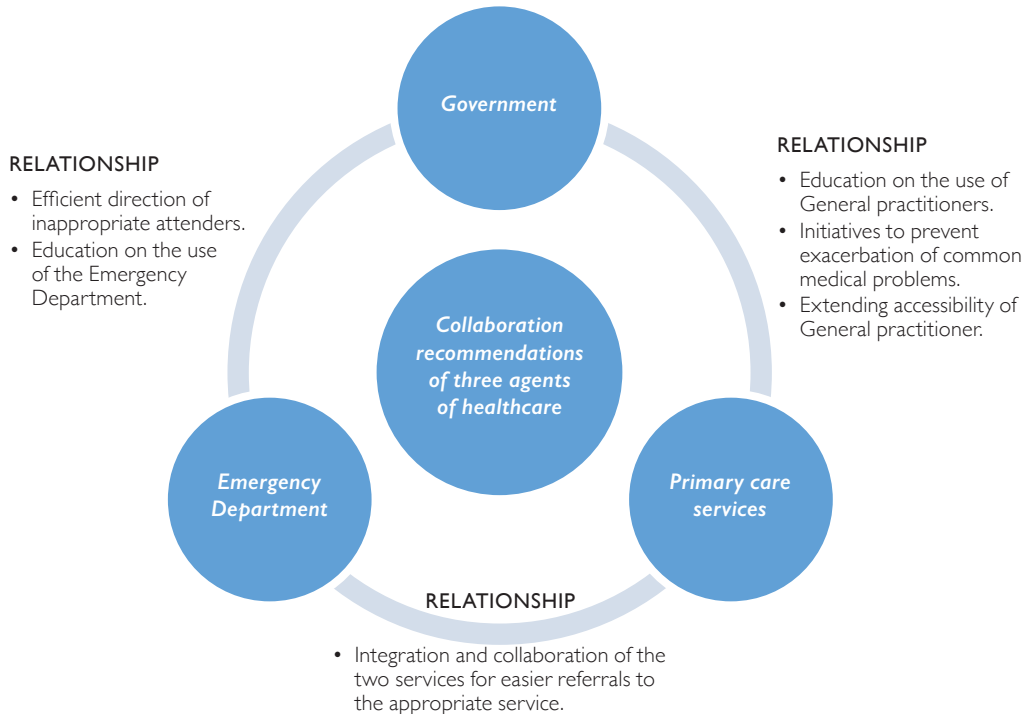


Figure 1. Collaboration of three agents of healthcare. Source: Author.

I. Government and Emergency Department

NZ Government and EDs need to collaborate to accurately and appropriately provide diagnosis, treatment, and care to patients that require it. An efficient and defined method to manoeuvre inappropriate attenders who present to the ED needs to be developed. Though it is difficult to define what an inappropriate or necessary presentation to ED is, it is important to bridge the gap between patient and healthcare worker understanding of urgency in order to lessen the volume of non-urgent patient presentations (Kraaijvanger et al., 2016; Lowthian, et al., 2011). It is also important to bridge the gap between patient and clinician understanding of 'urgency' of a health concern with the aim of lessening the volume of non-urgent patient presentations (Kraaijvanger et al., 2016; Lowthian, et al., 2011). Standardisation of the definition of appropriate attendance distinguishing between urgent and non-urgent patients is important in differentiating care requirements for patients and allocating appropriate best care to all who need it. Education around self-triaging could be introduced to increase the health literacy of the public. A triage system for public use could direct them to the appropriate setting to receive care for their condition. The collaboration between the Government and the ED could produce structure and consistency for healthcare workers who encounter patients with both urgent and non-urgent medical problems to best allocate healthcare resources and give all patients the care that they need.

2. Government and Primary Care Services

The reduction of inappropriate attenders presenting to the ED is heavily subject to the availability of primary healthcare services. The NZ Government and GP services need to collaborate to reduce inappropriate attenders by providing educational interventions to enhance the public's health literacy, specifically in regards to the correct use of both the GP and ED. The public needs to understand when it is necessary to seek emergency care and which conditions a GP can manage. Initiatives like this have been attempted in NZ before at national, district health board, and primary healthcare levels, but a larger emphasis is required (Ministry of Health, 2016; Waitemata District Health Board, n.d.; Riccarton Clinic, 2020). This would largely involve bolstering confidence in GPs through extending consultation time, better access and availability to GP appointments and education of the scope of a GP's capabilities including their ability to manage patients who fall in the Australasian triage scale 3–5 (Lewis, 1988, Richardson, 2012; Thornton, 2014). Increasing public trust in the GP is essential to encourage patients to use primary healthcare before the ED or to avoid treatment entirely.

Multiple initiatives have been piloted with a specific focus on the prevention of common non-urgent medical problems exacerbating to need emergency care. These include the 'Chronic Care Management Programme' (Richardson, 2012), 'extended care' (Corwin et al., 2005) and 'Primary Care Options for Acute Care' (Aish, Didsbury, Cressy, Grigor, & Gribben, 2003).

Finally, government resources being funnelled into extending GP availability and accessibility is essential to decrease inappropriate attenders in the ED (Kraaijvanger et al., 2016; Lowthian et al., 2011; Vecchio, Davies, & Rohde, 2018). Keeping GPs open outside of working hours and reducing the cost could reduce a significant barrier for low SES working individuals.

3. Emergency Department and Primary Care Services

Integration of EDs and after-hours primary care services in Norway show a significant reduction of 13 to 22 percent of overall ED use. Seventy-five percent of all self-referred patients were seen by a hospital GP, creating more time for emergency staff to focus on higher urgency patients and improving quality of care for all (Smits et al., 2017). A hospital-based primary care clinic that receives diverted patients from the ED could reduce the impact of inappropriate attenders on the ED. To avoid this type of service becoming overrun, it is important to prioritise preventative measures as described in the previous recommendations.

Establishing alternative services within the ED could differentiate acute care from primary care within the ED. To support patients accessing the correct services, an ED-based GP or primary care nurse practitioner seeing non-urgent patients is a cost-effective method to considerably lower patient processing time and considerably increase patient satisfaction with no statistically significant difference to incorrect diagnoses (Bosmans, 2012; Richardson, 2012).

CONCLUSION

The problem of inappropriate attenders at the ED is complex and integrates many different factors ranging from SES to health literacy disparities between the healthcare field and the general public. This literature review brought into light the vast variety of reasons that patient's access the ED for non-urgent medical problems that a GP could have treated. It highlights that from the patient's perspective, inappropriate attenders to the ED is understandable and even logical at times. However, regardless of intention, inappropriate attenders place an unnecessary burden on staff, hospital resources, and the quality of care for all patients. A superficial solution such as turning away inappropriate attenders at the ED would offer little benefit to the overall health of the country. Innovation through collaboration of the NZ Government, EDs, and GP services could drastically reduce

the burden of inappropriate attenders. At the ED, healthcare staff need a direct and systematic way to treat both inappropriate and appropriate attenders, at the GP more preventative measures can be taken, while the Government oversees and supports these procedures. Promotion of health literacy, education of the abilities and purposes of different facets of the healthcare system, and expanding GP availability and accessibility (especially for vulnerable populations with low SES, limited non-working hours, and chronic health concerns) offers a much more holistic long-term approach. Change is in the hands of the operational facets of healthcare.

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