

Australasian College for Emergency Medicine

FACT SHEET

RE: URBAN EMERGENCY SERVICES – ATS 4 AND 5 PATIENTS



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It has been suggested that GPs should take up more of the acute care workload thereby reducing demand on emergency departments, especially after hours. This stems from a belief held in some quarters that ATS categories 4 and 5 patients are, in fact, general practice-type patients who are inappropriately attending emergency departments. The National Health Strategy Paper No 10 (1992) concluded, after a retrospective provider review of casenotes, that in the sample studied, approximately 15% of emergency department attendees could be classified as “general practice-type” patients, although, in the absence of any consumer input declined to classify them as “inappropriate”.

A number of facts are pertinent to consideration of this issue:

1. The BEACH study (1999) (100,000 patients, 1000 GPs) showed that in general practice:
 - Less than one patient per 1000 is sick enough to require immediate referral to an emergency department. Less than one patient per 100 in general practice needs admission to hospital on the day of presentation.
 - There is negligible crossover between the top ten complaints in general practice and the top ten complaints seen in Emergency Departments.
 - Urban GPs have a relatively low exposure to minor/moderate trauma and associated procedures.
 - Urban GPs have a low exposure to common emergency department presentations such as abdominal pain, all acute cardiovascular conditions, and acute neurology.

Overall, it can be concluded that general practice and emergency medicine practice are markedly different, based on:

- Reason for encounter
- Diagnosis
- Complexity (investigations, procedures and referral needs), and
- Severity (admission rate 35% vs <1%)

The Australasian Triage Scale has been scientifically validated for application in emergency departments only. In the ATS, categories 4 and 5, although described as “semi-urgent” and “non-urgent”, have acuities of less than one hour and two hours respectively, which is less than the reported waiting times for scheduled or unscheduled appointments in the majority of urban general practices in Australia.

2. The casemix of ATS 4 and 5 is objectively different to urban general practice as shown in the Tables 1 and 2 below.

The admission rates in all ATS categories are higher in tertiary referral hospitals.

Table 1

Emergency Admission Rates – National Data 1997/8

ATS 3	ATS 4	ATS 5	GP	Locum Service	Balmain GP Cas
43%	20%	5 – 10%	<1%	2%	2%

Table 2

Average Doctor Consultation Time (Minutes) (ACRP Data)

ATS 3	ATS 4	ATS 5	GP
65	40	25	5 - 10

ATS 4 and 5 patients have a significant mortality rate. Dent et al at St Vincents Hospital, reported 112 deaths amongst the 33% of ATS 4 patients admitted to that hospital after Emergency Department presentation in 1997. ATS urgency, and severity of illness, are not necessarily synonymous especially in relation to end of life illness.

3. Many ATS 4 and 5 patients require radiology, pathology or procedures not available in the “average” general practice without additional travel. Locum services, used after hours by at least 60% of urban GPs, have even less access to this infrastructure.
4. A large proportion of NTS 4 and 5 patients are actually referred directly (referral letter, phone call) or indirectly (answering machine, disease management plan) to an Emergency Department. In an Ambulatory Care Reform Program project at the Princess Alexandra Hospital in 1997 it was found that “the most prevalent reason for attendance (of ATS 4 and 5 patients) was that an outside doctor had advised them to come.
5. The waiting times for ATS 4 and 5 patients in Australia are reasonable and consistent with nationally agreed benchmarks. In 1998, 185 hospitals reported their waiting times for 2.5 million emergency department attendances under the ACHS Care Evaluation Program.

Table 3**Waiting Times (1998)**

ATS 4	67.7% of 1,021,572 patients seen within one hour
ATS 5	87.4% of 479,104 patients seen within two hours

The vast majority of patients attending an Emergency Department in Australia are seen within two hours.

6. There is no published, population-based evidence that there are major problems for urban Australians in accessing acute/emergency medical care.
7. There is no evidence of overutilisation of EDs in Australia compared to international norms, nor is there evidence that the growth in ED attendances and admissions is unusual by OECD standards.
8. The cost of treating ATS 4 and 5 patients in emergency departments is reasonable. The National Health Strategy Paper No 10 concluded:

“the marginal cost of treating a primary care encounter in the emergency department setting is considerably lower than the cost of providing the same care in the general practice setting”

This has been confirmed in a number of clinical costing studies undertaken by the Commonwealth and the states showing that the marginal cost of an ATS 5 attendance in urban hospitals is between \$17.90 and \$35.00 (not including radiology, pathology or pharmacy).

9. Because of the relatively small numbers involved, fee-for-service payment makes virtually any extended hours/24-hour general practice a financially challenging proposition. Issues relating to after hours GP services include:
 - Lifestyle choices
 - Level of rebate for A.H. attendances
 - No “on-call” payments
 - Need to bulk bill to avoid bad debts
 - No payment for telephone consults. (Note: only 1% of calls to locum services are managed by phone advice)
 - Personal safety issues
10. Emergency Departments with extended hours/24-hour general practices in close proximity (<200 metres) (eg RBH) have similar proportions of ATS 4 and 5 patients to those that don't.
11. In some metropolitan areas, the largest numbers of ATS 4 and 5 patients have been found to come from postcodes with the highest density of GPs.

12. The majority of ATS 4 and 5 patients attend during business hours when GPs are most available.
13. Studies of Australian consumer attitudes to Emergency Department attendance are lacking. In the USA, Derlet et al showed that, in considering appropriateness, about 50% of consumers in a large stratified sample applied a strict definition while the other 50% believed that “any medical condition, anytime” or “any medical condition after hours” were appropriate reasons to attend an Emergency Department. In the same study, it was found that, in looking at 30 chief complaints, 100 non-emergency department health care workers were more likely to rate a complaint appropriate for Emergency Department attendance than were consumers, with the only conditions being agreed to be relatively inappropriate were:
 - Flu symptoms
 - Cough – mild
 - Sore throat
 - Allergy/Hayfever
 - Prescription refills
 - Minor foot problems

Given the above, it is at least arguable as to whether any new service model is needed (or would be viable), to provide for the acute care needs of metropolitan and major provincial centres. Any proposed model would need to be evaluated against the option of marginal upgrades to Emergency Departments where minor difficulties exist. In summary, it is unlikely that significant numbers of emergency department patients can or should be deferred elsewhere and there is no good evidence that GP workforce or access issues are a relevant consideration in ED workloads in the urban environment in Australia.

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