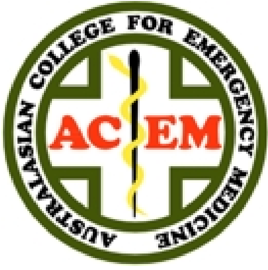

Media release

Political and public misconceptions of triage and GP patients based on flawed definition

Flawed definitions of triage and what constitutes GP cases by the Australian Institute of Health and Welfare (AIHW) have resulted in poor political decisions and public misconception, according to an editorial published in the latest issue of *Emergency Medicine Australasia*, the journal of the Australasian College for Emergency Medicine.

The authors of the editorial are Professor Yusuf Nagree (Department of Emergency Medicine, University of Western Australia at Fremantle Hospital), Professor David Mountain (president of the Australian Medical Association in Western Australia), Professor Peter Cameron (head of the Prehospital, Emergency and Trauma group in the Emergency Medicine Department at Monash University), Professor Daniel Fatovich (Centre for Clinical Research in Emergency Medicine at the University of Western Australia), and Dr Sally McCarthy (Medical Director of the NSW Emergency Care Institute and President of the Australasian College for Emergency Medicine), all senior emergency medicine specialists as well as senior members of the Australasian College for Emergency Medicine.

Last year, the AIHW reported that 41% of ED attendances were potentially general practice (GP) cases.

“The AIHW purports that all Australasian Triage Scale triage category 4 and 5 patients attending EDs, who are not admitted or conveyed to the ED by ambulance or police, are potentially GP cases,” the editorial says.

“It should be noted that there has been almost no clinical input into the determination of this definition, and no attempt to gain the Australasian College for Emergency Medicine (ACEM) opinion on this definition.

“The definition was made up by NSW Department of Health Consultants without significant clinician input, and has since been widely used without any effort to validate it.

“We believe that the definition used by AIHW is flawed for a number of reasons.”

One is that the triage category is an urgency, not a complexity scale.

Many attendances fitting the AIHW definition occur overnight, when there is no availability of any other medical service other than in the ED. Therefore, they cannot be regarded as inappropriate as no suitable alternative facility exists.

Attempts to staff or maintain late night general practices generally fail, because of lack of patient numbers to maintain a viable practice, security issues and the complex nature of what is seen.

“The AIHW definition includes patients who have been referred to the ED by their GP, and are thus regarded as non-GP patients by GPs themselves!”

The authors of the editorial report that attendances to EDs have increased by 21.2% between 2005/2006 and 2009/2010, an annual rate of 4.9%, which is well in excess of population growth.

“Numerous reasons have been postulated for this growth including the ageing population, rising incidence of chronic illness and decreasing availability of general practice consultations, especially urgent and after-hours consultations.

“This in turn has been used to suggest that overcrowding in EDs is often due to GP-type patients inappropriately attending EDs.

“This unfortunate myth has been extremely difficult to dispel, and is due to poorly validated definitions of inappropriate attendances.”

The authors contend that the calculation of ED attendees who are suitable for a general practice is difficult and experienced researchers have made many attempts to quantify these GP-type patients in EDs.

“There is only one validated method in the Australian literature, which found a much lower rate (15%) of potential GP attendances than the AIHW methodology.

“However, to date no researcher has studied or validated the methodology used by the AIHW.

“A more robust definition commonly used and accepted by clinicians is that of self-presenting Australasian Triage Scale category 4 and 5 patients discharged within 1 hour of being attended to by a doctor.

“Given that the average general practice consultation is 10–15 minutes, even this definition will overstate the true burden of potential GP-type attendances.

“It will also be an overstatement as it includes overnight patients, when the reality is that a general practice service overnight is unlikely to be available for a number of years and EDs will continue to provide all overnight medical care.”

The inaccurate estimate of GP patients in EDs is of significant concern, the authors say, as it leads to misguided strategies to reduce ED overcrowding that will be doomed to fail.

“These unhelpful strategies include after-hours general practices located in close proximity to the EDs; afterhours telephone consultations; and GP Superclinics.

“Such strategies are often well funded and widely promoted as a ‘solution’ to ED overcrowding. Unsurprisingly, the same issues are seen in New Zealand.”

The federal government funds general practice consultations whereas ED attendances are funded by state governments; therefore, political tension exists regarding classification of general practice patients in the ED, with state governments blaming the federal government for not providing sufficient GP consultations (because of a lack of GPs, inadequate consultation rebates or inadequate after-hours loadings).

“This supposedly explains ED overcrowding and dysfunction.

“It is in the political interest of state governments to ensure that any definition of general practice patients seen in EDs yields high numbers. This helps perpetuate the myth that EDs have too many GP patients.”

A key component of the federal government’s Health Reform agenda is 100% funding of all primary care patients regardless of location of care delivery.

This means that the federal government would reimburse state governments for patients presenting to the EDs who are classified as requiring general practice services.

“Under the current system, state governments fully fund these patients. There is now another incentive for state governments to overstate the true burden of general practice patients in EDs,” the authors say.

“Patients attend EDs for multiple reasons and the literature clearly shows that after-hours general practice clinics, Superclinics and Polyclinics fill a gap in medical services, but do not take any pressure off EDs.

“It is access block, or the inability to move admitted patients to the ward in a timely manner, that is the predominant factor that causes overcrowding, ambulance diversion, ramping and long waiting times.

“Strategies to reduce access block will be the only effective means of reducing overcrowding and improving ED functionality.

“The inappropriate definition for GP-type patients is not only wrong methodologically, but is highly likely to lead to further misdirected policies and poor outcomes for patients.

“A robust methodology for determining the true burden of general practice patients in EDs (free from political interference) must be developed to enable implementation of correctly targeted ED overcrowding mitigation strategies.”

FURTHER INFORMATION:

Professor Yusuf Nagree, phone 0437 482 566

Professor David Mountain, phone 0411 746 418

Professor Peter Cameron, phone 0405 500 397

Professor Daniel Fatovich, phone 0409 103 818

Dr Sally McCarthy, phone 0410 600 302

Australasian College for Emergency Medicine, phone 03 9320 0444

Issued for the Australasian College for Emergency Medicine by Marilyn Bitomsky, Impact Promotions & Publications, phone 07 3371 3057 or 0412 884 114. Media please note: I am overseas for a couple of weeks so if you need assistance, please contact Kerry Reeves, 07 3882 1068, 0407 036 791, kreeves@bytesite.com.au.