Integration of emergency department and primary care workload

Tim Parke’s editorial in the 16 December 2011 issue of the NZMJ is a timely one as it articulates the resistance of the Clinical Director of Auckland Hospital Adult Emergency Department (ED) to efforts that seek to provide more appropriate care for primary care type patients who currently visit their service. That this is the view also held by the clinical directors of the EDs of all our major hospital EDs is a matter of concern that needs to be addressed.

With sensible moves to integrate the care of patients, primary and secondary, overseas and in New Zealand the interface between EDs and primary care was always going to receive attention.

The document “Guidance for New Zealand EDs regarding the interface with primary health care” published in June 2011 by the Ministry of Health is a useful summary of a considered way forward.

Tim has argued several points of view as to why it is appropriate for primary care type patients to be seen when they self refer to ED. While I agree that these patients usually are not the cause of delays in ED and in most cases can be seen quickly and easily there, I do not agree that it is clinically appropriate or financially sustainable for this practice to continue unchallenged. The persuasive logic of the patient care integration movement necessitates a close look at how EDs operate and are funded in this country.

I suspect many readers will be surprised to hear that New Zealand EDs are funded $326 currently for each patient that they see and discharge within 3 hours of first clinician contact. This funding from the Ministry of Health is officially labelled as ED06001 or Emergency Dept Level 6 funding. Within this group are the majority of patients who might also have been seen and treated in Primary Care at a cost of less than one third of this figure.

In Wellington Hospital’s ED last year there were 19,531 patients funded under this category. It is useful that Tim, in his editorial, points to the potential loss of funding to EDs if this group of patients are seen in primary care. This is the stumbling block that exists if we are to expect EDs to cooperate with the integration of primary and secondary care at their interface with patients. It is the elephant in the room that has been left unaddressed for too long with the recent growth and expansion of ED services in our hospitals.

By funding EDs $326 for each primary care appropriate patient seen, we operate a disincentive for sensible moves to integrate health provision. Instead of putting forward other arguments for primary care appropriate patients being seen in their departments, it would be more helpful if ED clinicians advocated widely for change in how the Ministry of Health allocates their funding. They should be appropriately funded for patients who require the secondary level of acute emergency care they are
expert at providing not tied to seeing primary care patients and then having to mount a clinical defence for this way of operating.

We now have much improved hospital front door emergency care for critically ill patients in New Zealand and we should only applaud and support this. The funding for this should be transparent and not involve a perverse incentive for primary care appropriate patients to continue to be seen in our EDs.

Ken Greer
Northland Village Surgery
Wellington