

Chronic Saturation of Emergency Departments: They Should Not Be Flooded by Patients With Chronic Diseases

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Winter after winter we witness the sad spectacle of saturated public hospital emergency departments, a problem the authorities have been unable to solve. In the best of circumstances palliative solutions are adopted, usually by increasing human and material resources for emergency departments. These may be either temporary (seasonal programs) or structural (enlarging the facilities). Although such an increase in resources is often necessary, it turns out to be insufficient from the start for various reasons. One we should emphasize is the rise in the prevalence of chronic illness that comes with population aging. Another is the large number of inappropriate consultations that tend to come with the present public health system, with its lack of access barriers and proper turnover of patients requiring hospitalization. One reason for this last problem is the absence of alternatives to conventional hospital care for patients with exacerbated chronic disease. Let us take a look at the factors involved in this inappropriate use of emergency care.

In the United States of America, 100 million people have at least 1 chronic disease (half of them have more), and 80% of the population older than 65 years of age suffer at least 1 chronic disease.¹ Respiratory diseases account for a large part of the problem. In Spain, for example, the prevalence of chronic bronchitis is 11.6% (7.2% have chronic airflow obstruction) and that of asthma is 3.3%.²

The number of visits to emergency departments is definitely high and on the rise in all developed countries. From 1984 to 1994 in Spain, this meant an increase from 9.2 million visits to 15.3 million³ and in 2002 and 2003 that trend led to a rate of 4.5 emergency visits per family per year.⁴ The only Spanish community that is an exception is Navarra. Moreover, 1 out of every 2 citizens attends an emergency department once a year,⁴ and in 80% of the cases it is the patient who has

decided to make the visit.⁵ A large proportion of such visits are inappropriate—whether they represent attempts to solve trivial problems, reflect social problems, arise because other health care services are disorganized, or imply patients have less confidence in primary caregivers. The numbers of inappropriate visits are variable: rates of 78.9%⁶ and 58.6%⁷ have been reported and even smaller percentages have been observed recently (26.8% for example⁸). Yet whatever the load was, a third of the visits could have, or should have, been avoided. And among all emergency department visits, up to 34% have been found to state respiratory illness as the discharge diagnosis.⁹

An additional problem is repeat visits, which range in frequency from 3.4%¹⁰ to 9.36%.¹¹ To combat this, observation units have been created for patients admitted to emergency departments. Again, it is respiratory patients who are among the most frequent users: in some cases they account for 11% of admissions.¹²

One factor that aggravates the inadequacy of chronic care is the increased demand for this type of medical attention in a system geared to providing rapid, efficient care of acute conditions.¹³ This is the so-called “tyranny of the urgent.” We should remember that the present health care system places acute need before severity.^{1,14}

Rising health care costs are attributable as much to the progressive increase in life expectancy as to the care needs of the aging population,¹⁵ and increased spending is higher for chronic processes than for acute ones. Thus spending on hospital care has doubled in the USA while home care costs rose 13-fold during the last 2 decades of the past century.¹⁶

Diverse estimated chronic care costs are reported in the literature depending on the country studied and whether a bottom-up or top-down research method is used. The latter is less reliable. In any case, the following data on chronic obstructive pulmonary disease (COPD) is illustrative. Britton¹⁷ found that COPD generated direct costs of £149, £307, and £1307 for treatment of patients considered to have light, moderate, and severe disease, respectively. Those costs in Spain were found to be €55, €114, and €413,¹⁸ 40% to 70% of which is reported to be associated with

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hospitalization¹⁹ following emergency care. Therefore, optimization of resources hinges on reducing the length of hospital stay.

Increased expenditure does not necessarily mean better quality health care.¹⁶ Experience shows that when resources are increased with no specific focus in a health care system designed primarily for acute care, the clinical criteria and tests appropriate for acute care often wind up being the ones used to attend to chronic patients too. That situation generates what some call “pseudo illnesses”¹⁶ and does not contribute to improving health care for chronic patients. In short, more is not always equivalent to better.

Thirty-five years ago, pioneers like Runyan and coworkers²⁰ were already talking about the idea that chronic care required a redesigned health care system. Since then reports have increasingly emphasized the availability, safety, patient satisfaction, and cost-effectiveness of alternatives to traditional emergency department hospital admissions.²¹⁻²⁴ Bodenheimer et al²⁵ found that focusing on chronic care enabled notable cost reduction and a decrease in the number of emergency department visits, as shown in 18 of 27 articles reviewed. These findings are consistent with our experience.^{22,23} However, the literature includes contradictory reports—in part because of the lack of reproducibility and comparability of some studies.²⁶

Consequently, physicians should take action to decrease visits to emergency departments and stays in observation units, both of which come about partly because of the lack of alternative services. Moreover, since visits to emergency departments take place mainly on the chronic patient’s own initiative, attitudes must change if user choice is to shift to alternative modalities and thus effect a qualitative change in demand. Research shows that chronic patients usually make visits during normal working hours,²⁷ and alternative health care centers created to take advantage of that preference have already proven efficient.^{21,22} Finally, it is important to emphasize that the person who manages chronic diseases is the patient, not the physician, contrary to common belief. It is the patient who is in control and who decides how, when, and where to seek medical attention.²⁸ Therefore, it is important to design health care services based on disease management programs that target a population with a specific disease in an effort to promote continuity and coordination of care while lowering consumption of resources.²⁹ Such services are not to be confused with programs of case management, use management, or demand management. New technologies that are useful in controlling chronic diseases³⁰ and technologically advanced home treatment³¹ should facilitate change.

The opinion of many authors is that physicians should understand and participate in the social debate on form and quality in medical practice in order to combat misuse of health care resources—both over- and underuse.³² Specialists certainly play a fundamental role, but we should remember that it is coordination between different levels of the health care system, and

with primary care physicians in particular, that will enable organizational change to be truly as efficient as society requires.³³ We must be creative so that this time, finally, more will mean better.

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