LETTERS

Rising emergency admissions

Managing emergency admissions is no longer the first priority

EDITOR,—Further to Richard Hobbs's editorial on the increasing numbers of emergency medical admissions,[1] I write to highlight another problem associated with the delivery of acute services. The white paper *Working for Patients* clearly stated that "emergency treatment should be available immediately and without question."[2] It is self evident that managing emergency conditions should be the first priority of any system of health care, but I contend that the changes resulting from the white paper mean that this is no longer the case.

The demands made on the NHS have always exceeded the available resources. As a consequence, emergency care has been the first priority of the service and patients with less urgent conditions have had to wait for outpatient appointments and operations. The changes brought about by the white paper have made the money to fund many elective surgical procedures directly available to the providers of primary health care, and the independent trust hospitals now compete for this money. As a consequence, emergency care no longer seems to be a priority; what has become important is earning the cash to fund hospitals by fulfilling contracts for elective surgery.

This problem has been exacerbated further by the recent reductions in the number of beds available for inpatient surgical care. Part of this reduction has been necessary to keep pace with changes in surgical practice that have reduced the length of stay for many procedures. Some of the reduction, however, has been to contain costs. The number of patients needing emergency treatment has not fallen. The beds remain to deal with surgical inpatients have high levels of occupancy, and wards and hospitals are frequently closed to admissions. For a hospital to close once or twice a year may be acceptable, but to close once a week is not. General practitioners are experiencing difficulties in admitting emergency patients and often have to contact more than one hospital, sometimes in a different district from that in which the patient lives. Will they one day fail to have patients admitted?

Unless the present funding arrangements of the health service are altered it may become necessary to ration emergency care.

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1 Hobbs R. Rising emergency admissions. *BMJ* 1995;310:207-8. (28 January.)
2 Department of Health. *Working for patients.* London: HMSO, 1989.

Age, distance from a hospital, and level of deprivation are influential factors

EDITOR,—In his editorial on the increase in emergency admissions Richard Hobbs mentions the wide variation in general practitioners' referral patterns.[1] He does not, however, consider the impact of the distance from a district general hospital on these referrals, the level of deprivation, or the age distribution of the patients in each practice; these three factors are often thought by general practitioners to influence their referrals.

In North Worcestershire we have investigated the relation between the number of general and geriatric medical emergency admissions in 1993-4 and many characteristics of general practice. These characteristics included the distance of the main practice premises from the nearest district general hospital, the level of deprivation experienced by the practice (based on the Townsend score), and the proportion of the practice population aged over 65. When correlation analysis was used the proportion of the variation that could be explained by these factors singly was 11%, 23%, and 2·5% respectively. When multiple regression was used with these three factors as independent variables 55% of the total variation in rates of emergency admission was explained.

Hobbs therefore does not mention three factors that together explained over half of the variation in emergency medical admissions among general practices in North Worcestershire. These factors should be considered by others in the NHS who want to understand the factors that affect the rates of emergency admission in their locality.

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1 Hobbs R. Rising emergency admissions. *BMJ* 1995;310:207-8. (28 January.)

Advice to authors

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.

GPs must take some responsibility

EDITOR,—Richard Hobbs fails adequately to address two reasons, which he himself cites, for the increase in emergency admission—namely, raised expectations of general practitioners and worries over litigation.[1] It would be difficult to argue that the rise in emergency admissions in recent years bears no relation to the increased demand for home visits by general practitioners, among other factors, as general practitioners pass on some of this workload to hospital doctors. In addition, faced with an increasingly litigious public, general practitioners are more often (not surprisingly) playing safe and admitting patients if in doubt.

While sympathising with the increased pressures that general practitioners are facing, we must also recognise some of the more disturbing factors that are fuelling this problem. In some situations it seems that fundholding general practitioners, who have a financial incentive to avoid paying for outpatient appointments, admit patients with semiurgent problems as emergencies. In addition, a minority of general practitioners have unacceptably high referral rates; Hobbs's justification that a threefold to fourfold variation in referral rates is acceptable because the variation in prescribing is greater seems suspect, even if allowance is made for demographic factors. Furthermore, Hobbs's assertion that hospital doctors, not general practitioners, decide on admission would probably be disputed by most junior doctors, who are wary of upsetting the general practitioners whom their consultants (and future referees) serve. Besides, many doctors would concede that most verbal referrals, if suitably phrased by the referring doctor, will be accepted whether from outside or within the hospital.

The health service will clearly not be able to cope with the rise in emergency admissions at the current rate without further compromising patients' care and increasing pressure on junior doctors. I believe that many junior doctors disagree with Hobbs's apparent view that the trend is not inappropriate and think that more rational referral policies for emergency admissions are required. If we want to avoid our health service turning into the type of expensive, demand led service seen on the Continent then general practitioners will have to take some responsibility for curbing this phenomenon.

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1 Hobbs R. Rising emergency admissions. *BMJ* 1995;310:207-8. (28 January.)

Patients have rising expectations

EDITOR,—Richard Hobbs's editorial on the increase in emergency admissions—one of the most difficult and important problems facing doctors in district general hospitals—is disappointing in its bland analysis.[1] The problem is certainly the rising tide of acute medical admissions, which reached a peak in 1993-4 but has been going on for a long time.[2] A good deal is known about these admissions (Welsh Health Planning Forum expert workshop, 1994).

In my hospital, which serves a population of 140 000 and has an integrated service (that is, no selection on grounds of age), acute medical admissions have increased by 42% since 1986. The largest increase (10%) was in 1993-4. We can now expect over 6000 admissions a year (an average of 18 a day); 53% of patients will be over 65 and 6% over 85. Currently 85% of the patients are referred by general practitioners and 18% are admitted direct from the accident and emergency department (self referrals or patients brought to the hospital by the emergency services), but the proportion of the latter is increasing. Patients seen in the accident and emergency department and discharged by a doctor or his or her representative without being admitted are not included in our figures for acute medical admissions. The rate of referral from different general practitioners varies, but by a factor of less than 3 (1·66% *v* 4·85%); there is no significant difference between fundholders and non-fundholders. Finally, our average length of