Family Practice Forum

Cost Effectiveness and Emergency Medicine: What Price Triage?

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The growth of the emergency services industry over the past few years is a direct result of a policy whereby prospective patients are allowed to determine need for medical care and in what kind of facility they might receive it.[1,2] The emergency services consumer is allowed to be the sole judge of whether his particular complaint should be evaluated in an emergency facility, and the resources responsible for reimbursement are liable for as much as three times the cost of an identical service rendered in a family physician's office. A presenting complaint in such a facility is never judged to be inappropriate until after an evaluation and a fee payable. An examination of this particular patient's entry into medical care systems reveals expensive resources put to dubious use. We see increasing use of highly trained physicians with years of residency training and specialty board certification treating "convenience clinic patients" and triaging patients at the physician level.[3,4]

The position of the emergency services industry is that the appropriateness of any given complaint cannot be determined until it has been evaluated by a physician.[5] Therefore, to allow nonphysicians to triage would be to send home potentially disastrous emergencies masquerading as innocuous complaints identifiable only by a physician. Since the physician's expertise does not come cheaply, it is unfortunate, but necessary, that many nonemergency disorders are evaluated in this

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wasteful manner. The expense is justified because of the few occult emergencies salvaged.[6] Proponents of emergency physicians' services argue that if a given complaint is important enough to warrant a trip to an emergency facility, it must be significant enough in the mind of the complainant to warrant marketable advice and treatment at whatever rate the laws of supply and demand dictate.[7] Inherent in the design of this system is the concept that the treatment for a medically inconsequential ailment is to be as marketable as the involved investigation of a serious emergency.[8] Financially speaking, the point of contention involves situations in which the cost of treatment and the expertise involved in evaluation seem out of proportion to each other.

One salient question must be asked regarding these positions. Does the willingness of a medical industry to provide expensive expertise for "convenience clinic" complaints necessarily mean providers should be reimbursed at rates inflated by a technology not actually utilized? This resource utilization at the primary level of health care system entry should not be above question merely because third party payers are presently willing to pay for it. By virtue of its technology, the emergency department is a facility custom-designed to treat effectively certain specific problems. The expensive overhead of this same technology effectively prohibits economical treatment of disorders not requiring it. Patients have no conception of the costs required to support an inventory of expensive hardware and personnel and that these costs must be included in the treatment of simple, nonemergency disorders.

Encouraging inappropriate emergency department admissions is contradictory to any form of cost containment by the nature of its twofold effect on the medical economy. First, patients with nonemergency complaints are charged for an expertise and technology not needed for their treatment. They are then frequently referred to an appropriate health care provider who charges them again for services they should have received the first time around. For example, a woman finds a lump in her breast and presents to an emergency department for treatment. After an evaluation by the emergency physician, she is then referred to an appropriate office-based physician for follow-up. The fee for seeing this patient in the emergency department reflects the real cost of the entire emergency medical technology and would necessarily be substantial compared with what an office-based physician could have offered initially. During this follow-up visit, the referral physician would perform his own examination and suggest his own treatment. He would then, of course, charge the patient appropriately for his time and expertise, duplicating the original evaluation and initial treatment given in the emergency department. Instead of being seen once for a nonemergency complaint, the patient is seen and charged twice.

If a prospective patient does not know where to find appropriate treatment, encouraging him to come to a convenient, but inappropriate, facility, then billing him while telling him he has come to the wrong place leaves physicians' motives up to considerable debate. Cost-containment remedies that rely on prospective patients voluntarily diverting inappropriate complaints from emergency departments on the basis of patient education logically seem destined to fail. After all, these patients have a completely different conception of what constitutes an emergency than those bearing the cost burden for their health care. Patients have little incentive to consider the cost-benefit ratio of emergency services or seek out more cost-effective alternatives. Their priority is availability and convenience, not cost effectiveness.

From the other end of the spectrum, emergency physicians are placed in a curious position indeed. In a great number of low-volume emergency departments there simply are not enough genuine emergency conditions presented to support a full-time physician. Such physicians are not likely to discourage any admissions that pay their salary. To allow inappropriate patients to be seen in non-cost-effective facilities is to encourage it.

Emergency services as we know them are a poor substitute for family practice in terms of cost effectiveness and follow-up for a large number of ambulatory complaints.[9] Continued long-term support of economically nonviable emergency outpatient programs by third-party providers seems likely to be questioned despite the persuasive powers of the emergency services lobby. Emergency services are so expensive that it is

doubtful patients will be willing or able to fund them out of their own pockets. Office-based physicians have a minimum of expensive technology to support, and economical treatment for nonemergent complaints can be a staple commodity.[10]

We need to ask ourselves whether every community hospital really needs an emergency department staffed by full-time physicians to watch for potential emergencies? The cost of these services is a substantial hourly salary, regardless of whether the physician sees any patients, and highly inflated fees for evaluation of numerous convenience clinic patients attracted to the emergency department by advertised physician availability. Could the concept of triage by a nurse clinical specialist be utilized as an alternative in emergency departments having so little volume of true emergencies as to render them non-cost effective:[11-14] The merits of a nurse practitioner or clinical specialist in such a role lies in the supposition that the nurse's level of expertise is more appropriate for most medical complaints presented to low-volume hospital emergency departments.[15,16] A nurse practitioner[17,18] could evaluate and either treat minor problems requiring first aid, stabilize any emergency problem until the on-call physician can take over care at his level of expertise, or transfer genuine emergencies to the appropriate center by ambulance or helicopter.

The question thus becomes, how much waste is society willing to subsidize to support how much convenience? Is the emergency department evaluation of a common cold really such an emergency that consumers are going to be willing to pay triple the price of the inconvenience of the office waiting room? There seems to be gathering evidence that entrepreneurial emergency care centers can take care of these kinds of "emergencies" more efficiently and cost effectively.[19,20] Can it be made acceptable for nurses and paramedics to stabilize emergency patients for a slightly longer trip to an emergency center having enough volume to support genuine emergency services? Can we afford to have an emergency center five minutes away from every potential emergency? These questions must be answered in terms of society's willingness for pay the hidden, as well as the obvious, costs of such services. Inherent in this question is whether society can afford the overall cost of allowing medical care consumers the luxury of having convenience at the expense of cost effectiveness.

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