

Why are we still rushing to hospitals when it's not an emergency?

Misconceptions about A&E departments and the need for quick solutions are driving people to hospitals when they could easily see a GP.

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Waiting times at many accident and emergency (A&E) departments in public hospitals went up recently, when there was a surge in the number of respiratory infections during a new Covid-19 wave.

Public hospitals in December 2023 urged individuals with mild to moderate symptoms to visit a general practitioner (GP) clinic or polyclinic near their home amid an increase in such infections that put a strain on their operations.

Yet this phenomenon of overcrowding at A&E departments is not new. In Singapore, studies have previously shown that non-urgent patients actually accounted for more than half of the A&E cases at our public hospitals.

Hospitals are well aware that not everyone who turns up at A&E requires urgent attention, and so they have established triaging procedures to determine which patients require immediate medical attention, and which are not urgent and could be handled by GPs, though the waiting time will typically be longer.

However, every healthcare worker at A&E who is taken away to triage or care for non-urgent cases does so at the expense of patients truly in need of emergency medical attention.

So why is it that people are still

rushing to hospital A&E departments, even when the underlying medical conditions do not warrant urgent care?

UNDERSTANDING WHY

A research study at the Saw Swee Hock School of Public Health led by Ms Valerie Koh and Professor Jason Yap delved into this problem from the angles of social psychology, healthcare financing and health policy.

At the heart of the problem is the issue of perceptions.

The first is the perception on the severity of the medical condition, either by the patient or by family members with good intentions. This is especially so when the medical problem involves either a young child or an elderly parent. Stronger emotions come into play and create a greater sense of urgency.

Most people do not have the necessary medical knowledge to determine whether the symptoms point to a more serious medical condition, or simply one that is non-urgent.

The result is that they rush to seek assurance or relief from any bleeding, pain or discomfort for their vulnerable loved ones. This feeds into the second perception – that an A&E department, being an integral part of a comprehensive tertiary hospital set-up, is better equipped with a range of medical specialists and services to handle a range of

medical problems.

This perception is a natural human response when someone fundamentally does not understand the cause of the symptoms being experienced, and whether the condition is life-threatening.

So while medical professionals may be able to immediately classify such cases as non-urgent, well-intentioned family members with insufficient knowledge and information may not want to take the chance of underestimating the severity of the problem.

This is linked to the perception of the inadequacy of GPs to properly diagnose and treat the medical problem, and that the patient ultimately would need to be transferred to A&E anyway.

No wonder people prefer to go directly to A&E instead of the GP, to reduce any unnecessary delays.

In addition, they may be concerned that GPs don't have the support to return test or X-ray results quickly for a diagnosis. Hospital services, on the other hand, usually can produce the results during the same visit, although that might mean a longer wait.

There is also the perception that going straight to A&E is a cheaper option. This can arise from different reasons.

For example, if one first visits the GP and is subsequently referred to A&E, there is the problem of having to pay two medical bills instead of one.

Some people may have medical insurance coverage that directly covers the costs of A&E visits instead of GP consultation fees. For others, there is the worry of expensive GP fees, especially when the consultation happens after-hours, and any necessary

treatment or tests are unsubsidised and charged separately with limited opportunity for claiming from insurance.

Our research also revealed there were patients who knew their conditions were not urgent, yet were willing to wait at A&E to benefit from lower or subsidised fees, or to claim the fees from private health insurance.

If we understand what drives non-urgent visits to A&E, what are the solutions that can provide psychological assurance to patients and their families on the quality of care and on the financial worries of going to GPs?

HOW TO TACKLE THE PROBLEM

First, we can strengthen the relationship between an individual and the family GP, because the latter usually has the records of past medical conditions, and our research indicates prior knowledge of the medical conditions by GPs as a key driver for seeking help from them first.

Healthier SG has been encouraging every resident in Singapore to establish a trusted relationship with a GP of their choice, although the context there was not about redirecting non-urgent A&E visits to GP clinics.

Yet this is a tangible benefit if the overall level of health literacy in the population increases because of better medical education and counselling that follows because people are visiting their GPs more regularly for health screening and lifestyle advice.

There are also family GPs who provide their personal contacts

for after-hours consultations in emergency situations, often as a way to triage whether the condition requires escalating to A&E or can wait for a GP to see during regular hours.

However, that involves a trusted GP-patient relationship. Most after-hours primary care still relies on 24-hour GP clinics, which some people might see as being as impersonal as an A&E department.

If the role of family GPs in perceived emergency situations is to triage and advise, the question is whether the right technology can also perform this function.

Already there are overseas pilot programmes where paramedics responding to emergency calls are equipped with virtual reality headsets in order for relevant medical specialists based off-site to assess the situation and provide clinical guidance on administering medically complex life-saving care.

The reverse could also be trialled – where the use of video conferencing and other mobile applications easily accessible to the average person augment a mobile or digital health concierge to guide patients to the right facilities for care.

Clearly this comes with additional questions around the set-up and medical liability of such a health concierge, but Singapore is one of the few locations in the world where this can succeed, given the high mobile Internet penetration and the fact that our healthcare regulatory framework is comparatively more nimble and responsive to new technological advances.

Tackling the perceptions on costs requires a concerted effort

in public education.

For example, there needs to be an increased awareness that A&E fees cannot be claimed from MediSave unless the patient is actually admitted. This means the vast majority of non-urgent cases will have to pay hospital A&E fees out-of-pocket, except for those with private insurance that covers A&E bills.

The Ministry of Health has also introduced the GPFirst programme that subsidises the costs of A&E fees (by \$50) if the patient is subsequently referred to A&E after first seeing their GP, specifically aimed at allaying the concern of being charged twice.

But perhaps a more permanent solution may need to come in the form of developing integrated care systems at hospitals, where hospitals with A&E departments are also supported by other ancillary services, including 24-hour GP clinics where non-urgent cases showing up at A&E can be channelled.

While such integrated systems have a larger mandate than tackling non-urgent visits to A&E and hospital waiting time, the UK's National Health Service, which has rolled out a similar system, has reported encouraging evidence that such integration can indeed reduce A&E wait times.

Singapore has already introduced integrated general hospitals that combine acute and community hospitals in the same setting.

This could be extended further to incorporate 24-hour GP clinics for non-urgent cases, to help tackle the need to curtail unnecessary demand at A&E.

Public education can help assure people about any concerns on care quality and healthcare financing. And the health system can continue to explore the use of new technology and innovative policies. Otherwise, no set-up in the world will ever be enough if non-urgent cases persistently show up at A&E departments.

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