Should GPs be fined for rises in avoidable emergency admissions to hospital?

Commissioning organisations in England face losing a quarter of the "quality premium" if they do not keep down their emergency admissions for specific conditions. **Martin McShane** supports this, but **Chaand Nagpaul** worries about possible unintended consequences

Martin McShane director for domain 2, National Commissioning Board, Leeds LS2 7UE, UK
martin.mcshane@btinternet.com

YES

Major changes have occurred in healthcare over the past 30 years. I remember, as a house officer, having to admit patients for several days just to start them on a new drug—the angiotensin converting enzyme inhibitor captopril. As a surgeon I became adept at performing vagotomy and pyloroplasty for duodenal ulcer and recently winced when a colleague pointed out that, in effect, we used to perform surgery for an infectious condition. While a general practitioner, I witnessed the closure of long stay geriatric wards and the proliferation of large residential and nursing home facilities for which GPs were expected to provide medical care, looking after frail elderly patients with complex comorbidities. We have seen startling decreases in mortality and morbidity in cardiovascular disease and improvements in cancer treatments and survival. Despite this we have also seen an inexorable rise in emergency admissions. Financial incentives will help bring about the changes required to reverse this trend.

Narrow thinking

As a clinician working in commissioning I have been struck by how "siloed" professional and organisational thinking can be. Emergency admissions account for a relatively small proportion of overall activity in specialist care, yet a large proportion of cost. If you look across the health and care system most activity occurs outside hospital but most of the cost is consumed by hospital services.[1]

For a long time there has been the mantra of "moving care closer to home," yet, except in a few isolated instances, this has not happened. Talking to a specialist recently, I asked why. His response was that there is no consistency outside hospital. "I don't know if my patients will be safe or get the care they need delivered," he told me. I was also taken aback by the response a practice gave me recently when I asked when it last looked at its emergency admissions. The staff proudly told me that they had done an audit—a year previously.

Many emergency admissions are the result of exacerbations of long term conditions, failure of coordinated care, and, increasingly, frail elderly people with comorbidities needing proactive care from primary, community, and social

Chaand Nagpaul general practitioner , Stanmore, London, UK
chaand.nagpaul@gmail.com

NO

Reducing avoidable emergency admissions is undoubtedly a desirable and worthy aim, not least because it will benefit patients. Additionally, emergency admissions are a considerable drain on NHS resources, representing about 65% of hospital bed days in England, at an annual cost of £11bn (€13bn; $17bn).[1] The health data company Dr Foster estimated that 29% of these admissions are potentially avoidable and amenable to interventions in the community.[2] Emergency admissions also have an adverse effect on provision of other hospital services—for example, by causing cancellation of elective operations at short notice—and Dr Foster says that overoccupancy of hospital beds is at "breaking point," risking patient safety.[2]

Annual emergency hospital admissions have increased by 37% over the past 10 years.[3] The NHS is required to save £20bn by 2015, and avoiding emergency admissions is a key policy to deliver this. Currently, commissioners use local referral incentive schemes to encourage general practitioners to reduce their emergency admissions. Furthermore, the recently announced quality premium[4] will reward clinical commissioning groups if they are able to reduce or prevent an increase in emergency admissions within a fiscal year. Given the financially challenged budgets of commissioning groups, and reductions in GPs' incomes, failing to hit such targets will in effect be a financial penalty.

Unfortunately, there is scant evidence, if any, that such financial levers will have any real effect on emergency admission rates. We know that financial incentives paid to GPs as part of practice based commissioning during 2005-11 were unable to stem the rise in emergency admission rates. Nor is there any conclusive evidence that the tools currently used by GPs and commissioners, such as risk stratification and case management, are effective in reducing emergency admissions.[5]

Solutions go beyond general practice

The fundamental flaw in linking financial payments to GPs to emergency hospital admissions is that the GP is only one player in a multiplicity of factors that influence such admissions. It is therefore inappropriate for GPs themselves to be held responsible for emergency admission rates. Evidence has shown that increasing age, social deprivation, morbidity, area of residence, self management, provision of community and social care services, hospital supply, and internal hospital organisation and admission policies will all influence emergency admissions.[6]

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care.[1 2] How many practices systematically analyse the root causes of emergency admissions?

Opportunity for change

The advent of clinical commissioning groups and health and wellbeing boards presents an opportunity to tackle the complex issues relevant to emergency admissions. The recent analysis of trends in emergency admissions by Bardsley and colleagues tells us one thing—we need to ask more and better questions and work collectively across the continuum of health and social care, if we are to move care closer to home and reverse the trend in acute admissions.[3]

Clinical commissioning groups will be commissioning the community and mental health care that can support that move, as well as the acute services, which are under pressure. To avert emergency admissions to hospital they will need to work in partnership with social care and some of the wider services that frail elderly people and their carers are so dependent on. The construct of health and wellbeing boards provides an opportunity to foster and forge a coherent and consistent common purpose across primary care. The responsibility of commissioning groups and the NHS Commissioning Board to improve the quality of primary care creates a new dynamic in the system which, if approached in the right way, can build on the potential of general practice to support collaborative coordinated care and reduce emergency admissions, especially if aligned with commissioning in the rest of the health system.

Success will require a range of enablers, levers, and incentives to help leaders to change attitudes, behaviours, and ways of working right across the system. The fact that colleagues say that most emergency admissions are out of hours or self referrals, as if that absolves them from any responsibility, is worrying. Clinicians have a responsibility to improve care no matter where a patient is on a pathway. There is no better way of articulating the role of primary care than to quote from the Francis report: "It will be important for the future that all GPs undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services . . . A GP's duty does not end on referral to hospital but is a continuing relationship. They will need to take this continuing partnership with their patients seriously if they are to be successful commissioners of services. They should exploit to the full this new role in ensuring their patients get safe and effective care."[4]

No part of the system is an island. In my experience, through better use of data, planning, service redesign, contracting, and monitoring performance—that is, good commissioning—it will be possible to improve quality while managing costs. The quality premium is one instrument in the toolbox to support new thinking and ways of tackling deep rooted problems. To consider the premium in isolation, or to label it as a fine, perpetuates a fragmented view of a complex adaptive system in which clinicians have now got a real opportunity to lead change and improve outcomes for patients.

Competing interests: I have read and understood the BMJ Group policy on declaration of interests and declare that I work for the NHS Commissioning Board and one of my key objectives is supporting clinical commissioning groups to reduce emergency admissions.

Read the opposing side in the debate by Chaand Nagpaul, doi:10.1136/bmj.f1391.

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Furthermore, the 2004 GP contract transferred the responsibility for out of hours care to primary care trusts, and therefore hospital admissions during the out of hours period (70% of weekly hours) fall outside the control of general practices. Additionally, numerous other primary care access points, from telephone advice via NHS Direct, to other unscheduled care settings such as walk-in centres and new 111 urgent care services will also refer patients directly to hospitals, bypassing GPs. Similarly, GPs have no control of direct patient admissions from emergencies such as road traffic incidents. And some increases in admission rates could reflect national policies—for example, efforts by emergency departments to avoid breaches of the target of a four hour maximum wait may have increased short term hospital admissions.[5]

Another problem is that the relatively small number of patients in general practice lists could result in variations in admission rates by chance or volatility in the external environment (for example, infection outbreaks). Providing financial rewards or penalties to GPs as a result of erroneous interpretation of admission rates will unfairly discriminate against patients.

Unwanted effects

The division of GPs and hospital specialists into commissioners and providers, with payment of an activity tariff to hospitals, provides no incentive to hospitals to reduce emergency admissions, nor to collaborate with GPs. This creates the perverse effect of supplier induced demand.[5]

Making payments to GPs to reduce emergency admissions may also cause patients to mistrust the motives of GPs in managing their care, and risks breaching General Medical Council principles of good medical practice by adding a perverse financial incentive not to refer patients to hospital. Overzealous attempts to reduce hospital admissions could have unintended consequences. For instance, two recently published high quality randomised controlled trials of interventions designed to keep people out of hospital showed increased deaths among the intervention groups.[7 8] Nor can we assume that avoiding admission is always cost effective, since the expense of keeping patients in the community may not necessarily reflect a cost saving.

The logical way forward should be a whole system approach, bringing together all stakeholders so that all influences on hospital admissions are aligned. There is evidence that hospital admissions can be reduced by integration between health and social care, as well as between primary and secondary care, and by improved internal hospital organisation of admission units staffed by

The GP is only one player in a multiplicity of factors that influence emergency admissions

more senior doctors.[6 9 10] We need to jettison the current unhelpful competitive purchaser-provider spit between primary and secondary care and replace the tariff system of payment by results with a system of collaboration and shared financial ownership with goals aligned across primary, secondary, and social care. Wider determinants that influence hospital admissions must be addressed.[6 9]

Proposals to financially reward or penalise GPs as either providers or commissioners in their own right on the basis of emergency admission rates is likely to squander precious public resources on unproved ideology at a time of harsh fiscal austerity. It also carries the possibility of counterproductive effects and potential to do harm through unintended consequences.

Competing interests: I have read and understood the BMJ Group policy on declaration of interests and declare I am a negotiator for the BMA General Practitioners Committee with lead roles in commissioning and IT and a member of BMA Council.

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