Tertiary ambulatory care: its strategic importance in future health care

There is a significant shift in the delivery of tertiary health care from 'inpatient' care to 'outpatient' care.[1] This nomenclature conjures up a past of disorganised and undignified patient care, often for the less privileged. What 'out patient' care ought now to signify is an opportunity for increasing numbers of complex patients to be cared for with less dependency on round-the-clock nursing, and with less dependency on an expensive 'motel' infrastructure. The descriptor 'ambulatory care' releases us from our preconceived notions about the 'walking wounded' and allows us to consider how new approaches in health care administration, medical informatics, biomedical engineering and clinical practice are enabling this transition to take place. Hospitals at all levels are being affected by this change, but none more than the tertiary, university or specialty referral institutions. The challenge is to identify and conserve the beneficial characteristics of tertiary care, whether for the patient in bed or the patient who can walk.

There are some important impediments to this progress. These include: progressive urban sprawl, causing people to live at increasing distances from centres of medical excellence; the fragmentation of medical expertise; the tenuous links among primary, secondary and tertiary levels of health care; and the sense of community ownership of the tertiary health care facility. Each of these impediments can be overcome. It ought to be possible to create motel-like accommodation in the vicinity of the tertiary referral hospital and to apply information technology to overcome the tyranny of distance. The barriers to high quality ambulatory care could be overcome progressively by strategies including

- joint appointments between primary, secondary and tertiary health care
- the creation of divisions of family medicine in tertiary institutions
- the provision of health promotional expertise for communities by university hospitals
- the involvement of these hospitals in the gathering of population-based health data
- the application of clinical epidemiology to clinical decision making

It will be more difficult to prevent the inappropriate use or misuse of ambulatory care in an increasingly demanding economic environment. Discharging the patient too early from the hospital bed to a community with an ever-diminishing resource for primary health care support may lead either to an increase in morbidity and/or mortality, or to readmission with attendant increased costs. There will need to be measures of health service costs across the community if we want to understand the total health-economic equation. A concentration upon acute inpatient care (measured through Australian National Diagnostic Related Groups or AN-DRGs) may present a skewed picture of an institution, a condition or a community.

Measurement of the quality of life of the ambulatory-care patient will be particularly important. One matter affecting quality will be how many encounters with the health care system are required to achieve resolution or effective management of a particular health problem. It is increasingly common for patients with multisystem disease — let us say diabetic macrovascular disease affecting the brain, heart and periphery — to visit not only their general medical practitioners, but also several medical specialists and allied health care professionals at some distance from each other. Bringing many of these activities together at the one site may save the patient time and lead to a considerable improvement in patient satisfaction; such an approach could easily prove to be a more efficient method of delivering complex, multimodality health care. Shared-care instruments, interactive consultation using information technology, and improved support for primary health care will further enhance this method of health care delivery.

It may be that the measurement of tertiary ambulatory care for funding purposes would be better based on measures of the burden of disease on the one hand, and the programs and process of tertiary health care delivery on the other, than on episodes of care.[2] For example, the development of a supportive telecommunication system for certain categories of health problem may be better than multiple visits to the tertiary health care centre with many unqualified (and unquantifiable) costs, including the cost of transport, fuel, and the cost to the patient in terms of apprehension and frustration from multiple trips to the doctor. If a community has a high prevalence of diabetes, then the tertiary centre responsible for it might receive more funds for diabetic ambulatory-care programs than one in a community that has a lower prevalence. But the tertiary care institution would also be required to monitor and seek to understand why diabetes prevalence might be rising and to demonstrate what is being done to address the underlying basis of the problem. This would cause tertiary health care institutions to develop a clinical epidemiological orientation and to engage in preventive medicine. Considerable work will be required to analyse the components of ambulatory care which should be funded, and how adjustments should be made from time to time in relation to performance indicators. The funding component profile for one program may be quite different from another. If tertiary ambulatory care is not measured, costed and integrated, and if it does not allow for ongoing research and training, the quality of our health care will falter and fail.

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References

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