

# “Social admissions” to hospital are not personal failures but policy ones

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In research published in this issue of *CMAJ*, Mah and colleagues summarize clinicians’ experiences of providing care for patients whose presenting illness is not acute and for whom admission to hospital is not warranted, and yet complex health needs and a background of inadequate social supports mean they cannot safely be discharged.<sup>1</sup> The article’s authors use the term “social admissions.” Yet, the pervasive, pejorative term often used is “failure to cope,” which implicitly blames the person for their circumstances.

In an era when hospitals routinely exceed 100% occupancy, “socially admitted” patients are seen as a problem by clinicians, hospitals, and governments.<sup>1</sup> Providers perceive that such patients receive suboptimal care, yet they experience frustration that hospitals have become the place where all roads lead for an increasing number of people who cannot manage in the community. However, patients are not to blame for the fact that home care is inadequate, long-term care is unavailable for a patient who really needs it, or lack of access to secure housing means managing a chronic condition in the community is impossible. We discuss how reframing this problem as a policy failure and applying evidence-based upstream policy investments could help to address it.

Many hospital quality committees use the percentage of patients admitted to hospital who no longer need acute care (they occupy 10%–20% of hospital beds in many parts of the country) as a quality indicator, and “alternate level of care throughput ratio” is now a priority metric for Ontario Health’s 2024/25 Quality Improvement Plan.<sup>2,3</sup> The urgent need to open up hospital beds and mitigate emergency department crowding has led some governments to tell patients who are occupying an alternate level of care bed that they will be transferred to a long-term care bed many kilometres from where they live; if they do not wish to go, they will be charged for the hospital bed.<sup>4</sup> Without other options available and amid unprecedented crowding, emergency department providers are also discharging patients to situations they know are likely harmful and hazardous. In almost all cases, clinicians and not the policy-makers are tasked with telling patients they need to go to a location that is unsafe, undesirable, or both.

Punitive policies like these cause distress to patients, families, and providers and have not restored hospital occupancy to manageable levels. These policies are also at odds with most health care workers’ deep commitment in wanting to do better for patients who are otherwise let down by the broader health and social care systems.<sup>1</sup>

Nonpunitive approaches are better for patients and decrease hospital admissions and costs.<sup>5</sup> One approach is to embed personnel and programs that address the complex care needs of patients at risk of needing “social admission” within emergency departments.

Emergency department pilot programs of peer support workers are underway, whereby people with previous or current lived experiences of marginalization, such as homelessness, mental illness, or substance use, help patients with similar lived experiences establish trust with the clinical team and navigate social supports within the community and avoid hospital admission. Recent literature on peer support workers in hospital-based settings shows that they provide critical support for patients accessing social supports and harm-reduction services.<sup>6</sup>

Geriatric emergency medicine nurses and multidisciplinary geriatric teams are increasingly commonly embedded in Canadian emergency departments and help manage and coordinate the care of frail older adults with declines in function or cognition. These initiatives reduce admissions and decrease repeat visits in a cost-effective manner.<sup>7</sup> However, they are not a replacement for community-based supports, such as adequate home care or access to long-term care.<sup>7</sup>

Hospitals are also expanding health care teams to include community health workers to help vulnerable people connect with health and social services. Often lay people living in the same community, community health workers tailor supports to the physical and mental health needs of the individual and assist with tasks such as helping with access to income supports, or accompany people to medical appointments. This shift aligns with the long-standing evidence of health and social care being shaped by conditions outside clinical settings.<sup>8,9</sup>

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A review from the World Health Organization concluded that community health workers extend health care services to vulnerable populations, meet health needs in a culturally appropriate manner, improve access to services, address inequities in health status, and improve health-system performance and efficiency.<sup>10</sup> However, these gains are contingent on community health workers being integrated through public policy measures that include linkages to planning for health human resources and data sharing, and processes for addressing the myriad of governance, legal, and financing issues that arise when building strong community health worker programs.<sup>10</sup>

Canada's health systems are fragmented, uncoordinated, and underresourced, and its social safety nets are frayed. Despite the promise of the programs described herein, they do not address the social determinants of health that can drive presentations to emergency departments. To restore human dignity in health care — to properly address the barriers experienced by patients and the moral distress of health providers — structural factors causing health disparities must be confronted as policy failures, not personal ones.

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**Competing interests:** [www.cmaj.ca/staff](http://www.cmaj.ca/staff) (Varner and Laupacis). Andrew Boozary serves on the board of Inner City Health Associates.

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