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Smolković, Ljiljana; Kujundžić-Tiljak, Mirjana; Tiljak, Hrvoje

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Trends in General Practitioners/Family Doctors Workload in Croatia in Period 1995–2012

Ljiljana Smolković[1], Mirjana Kujundžić-Tiljak[2] and Hrvoje Tiljak[3]

[1] Health Centre Zagreb-East, Zagreb, Croatia
[2] University of Zagreb, School of Medicine, School of Public Health »Andrija Štampar«, Department for Epidemiology, Medical Statistics and Informatics, Zagreb, Croatia
[3] University of Zagreb, School of Medicine, School of Public Health »Andrija Štampar«, Department for Family Medicine, Zagreb, Croatia

A B S T R A C T

This research aimed to present public data describing the Croatian family doctors (FDs) workload, presented as the average number of patients on the lists, and annual and daily number of consultations per *one FD team during the period 1995–2012. Croatian Health Service Yearbook for consecutive years was used as basis for data collection. Impressive increase number of persons on FD lists and significant increase of rate of persons* per *FD team were observed. Average number of contact to FD team also showed constant increase, starting at level of 5.9* per *year in 1995 and reaching 9.6* per *year in 2012. However, average number of direct consultation (including physical examination) to FD showed modest increase from level of 4.1* per *year in 1995 till level of 5.8* per *year in 2005 The number of referrals* per *one visit remain stable, but the number of referrals* per *one direct consultation decreased. The data stress problem of discrepancy of increasing number of persons on FD lists and stagnation trend of number of FD teams in Croatian primary health care. Results suggested problem of increasing workload of FD teams, but further research are needed for deeper amylases of the FDs workload.*

Key words*: primary health care, organization, family doctors, workload, Croatia*

Introduction

There is clear evidence that the number of primary health care doctor is one of the main contributors to the quality of primary health care (PHC) and to the quality of the health outcomes[1–6]. As majority of PHC doctors in developed countries are family doctors (FD) ratios of population *per* one FD represents important indicator for PHC functioning. Obviously, the grater population ratio *per* one FD brings about the heavier workload, and consecutively has certain implications on the accessibility, patients as well as on the FDs satisfaction[7]. In study done by Campbell and colleagues, the number of patients corrected for the number of doctors providing care was an important predictor of consultation length. Practices with smaller numbers of patients *per* doctor had longer average consultation lengths than those with larger numbers of patients *per* doctor. Patients from smaller practices reported improved accessibility of care and receptionist performance, better continuity of care compared with larger practices[8]. In European study, job satisfaction and burnout syndrome in FDs were strongly associated with heavier workload[9]. European study on the task profile of European FD showed what diversity of workload through Europe meant for PHC performance, as well as for functioning of FD. In depth analysis of Croatian Family Practice have been done within a frame of this study[10].

Until that time, many changes have been implemented within the Croatian health care system. Regarding the family practice, the most prominent is the introduction of the »privatization in primary health care« at the turn of 21st century. PHC doctors, mostly FD, got opportunity to become private entrepreneurs obtaining a contract with Croatia Health Insurance Fund (CHIF). Their obligations consider responsibility for the patients who freely chose them as their personal doctors (persons on

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the FDs' lists) while running their practice as a business[11,12]. Although the standard number of patients *per* one FD was set up at the level of 1700, FDs' patient lists showed to be larger due to the shortage of FDs[13]. The research done by Vrcić Kelević and colleagues indicated that, according to the Network of contracting FDs, they were shortage of 123 FDs in 2013. Consequently, the average number of patients *per* FD is increasing to 1,978 patients *per* FD, recorded in 2013[14].

Problem can be worsening after joining European Union (EU) due to broad offer of more attractive places for work within EU[15]. National health policy as well as Strategic Plan of Health Development till 2020 address this problem and express awareness of importance of PHC. Moreover, strategic goals predict increasing rate of FD *per* distinct population i.e. diminishing number of inhabitant *per* one FD[10]. During last years some health policy movement were made in that directions but gained no result. Therefore, this research aimed to present public data describing the FDs workload, presented as the annual and daily number of consultations. Special effort is done towards if any consequences for overall health system could be caused because of such workload. Also, some health policy interventions and its results have been analyzed.

Materials and Methods

Study is based on data search of official medical and health statistics reports regarding Family Practice in Croatia covering period 1995 to 2012. For that purpose Croatian Health Service Yearbook published by Croatian National Institute of Public Health has been studied[16]. Selection of data were made towards observing official figures which represent structure and process of work in GP/FP. Structure analysis was supported by data: number of FD teams practicing in observed year and number of persons on FD teams' lists as well as the number of patients annually receiving a care in observed years. Analysis of working process was based on data: total number of visits to FD teams, total number of direct consultations to FD and total number of referrals. Total number of visits to FD represents overall number of visits to FD team done by any patients in one year regardless if one patient visited FD team once or ten times in one year. The same principal covers total number of direct consultations to FD, but direct consultations to FD meant »face to face« consultation to doctor which usually included physical examination. Upon that basic numbers, average yearly number of visits *per* one FD team and average daily number of visits *per* one FD were calculated. Calculation of average daily number of visits was made according considerations that average number of working days *per* year in Croatia is about 250 days. The same calculations were done for the average numbers of »face to face« consultations. Additionally, the calculations were performed on the relative numbers of patients' visits *per* referral and »face to face« consultation *per* referral. Relative number of referrals *per* visits represented ration of total yearly number of visits to FD teams (as explained previously) in correlation to total yearly number of all refer--rals performed in one year. Also, relative number of referrals *per* direct consultation to FD represented ration

TABLE 1
ANNUALLY RECEIVING A CARE IN CROATIA, 1995–2012

Year	No persons on FD lists	No of patients receiving care	Number of FD teams	Utilization rate*
1995	3.817.316	2.958.640	2.047	77%
1996	3.891.029	2.913742	2.111	75%
1997	3.924.208	3.020.758	2.146	77%
1998	4.233.604	3.316.508	2.328	78%
1999	3.724.076	2.999.050	2.350	81%
2000	3.740.801	2.946.555	2.358	79%
2001	3.759.247	2.992.197	2.373	80%
2002	3.802.312	3.031.630	2.377	80%
2003	3.869.472	3.088.823	2.372	80%
2004	3.921.373	3.136.331	2.375	80%
2005	3.905.606	3.114.588	2.328	80%
2006	3.881.865	3.065.504	2.299	79%
2007	3.877.177	3.053.316	2.276	79%
2008	4.085.458	3.146.745	2.304	77%
2009	4.083.780	3.166.083	2.305	78%
2010	4.116.562	3.093.749	2.279	75%
2011	4.207.291	3.225.826	2.278	77%
2012	4.274.104	3.226.011	2.308	76%

* Utilization rate = rate of persons who contacted FD team/number of patients patients who receiving care

of total yearly number of »face to face« consultation to FD (as explained previously) in correlation to total yearly number of all referrals performed in one year.

Figures were collected for each year and specific trends were analyzed. Descriptive statistical method was used. Trends were analyzed in correspondence to healthy policy interventions such as policy changes in public health insurance and organizational changes in PHC.

Results

Basic data describing the number of persons on FDs lists and number of patients annually receiving a FD care showed slight to significant variation in observed period. Details are presented in Table 1.

Figures showed that round 75–80% of persons on the FDs lists have contacted FD team every year during period from 1999 to 2007. Rates are lower in last years of last century: period from 1995 till 1998. In first years of new century rates increase to 80%, but decrease again in period 2008 till 2012. Trend in utilization rates correspond to average number of persons *per* FD team in the way that utilization rate increase when number of persons *per* FD team decrease. Variations of utilization rates were not higher than 6%, but trends related to average number of persons *per* FD teams cannot be overseen.

Figure 1 clearly showed that number of FD teams increased during 18-year period while rate of persons *per* FD team is the same period varied significantly. Trend was not stabile reviling that rates of persons *per* FD were rather low in period 1999 to 2001 reaching lowest rate of 1585 persons *per* FD team in 1999. In next ten years rates of persons *per* FD gradually increased by 300 persons *per* FD team (Figure 1).

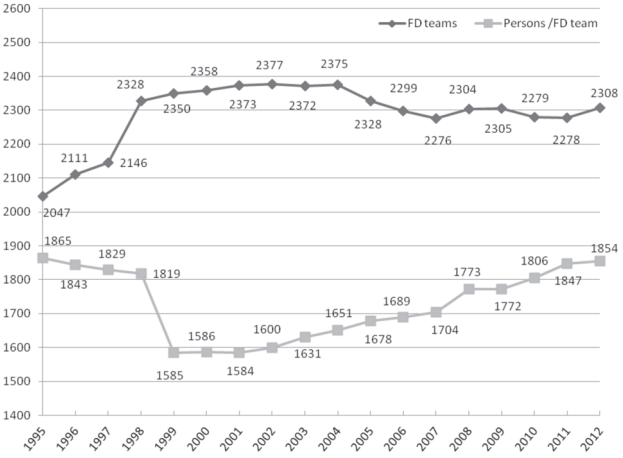

Fig. 1. Number of FD teams and average number of persons per *FD team in Croatia, 1995–2012.*

Average number of FD contact and consultation *per* patient in each year during observed period are presented in Figure 2. Average number of contact to FD team showed constant increase starting at level 5.9 *per*

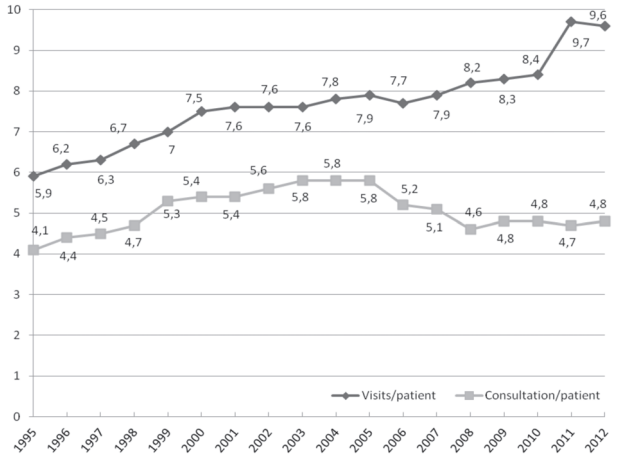

Fig. 2. Average number visits to FD team and face to face direct consultations to FD per *patient in years in Croatia, 1995–2012.*

year in 1995 and reaching 9.6 *per* year in 2012. However, average number of direct consultation to FD showed modest increase from level 4.1 *per* year in 1995 till level 5.8 *per* year in 2005. From 2005 on, average number direct consultations to FD decreased to level 4.8 *per* year in 2012.

Other figures describing FD teams' process indicator regarding trends in workload are presented in Table 2.

Total number of visits to FD team in Croatia exceeded total number of direct »face to face« consultations to FD for about 5 millions at the beginning of observed period. Trends were not parallel during observed period resulting in almost double total number of visits to FD team than direct consultation to FD in 2012: 31,115,427 versus 15,324,465. Consecutively, yearly and daily workload to FD team strongly increase, from 34.1 visits *per* working day in 1995 to 53.9 visits *per* working day in 2012. Same trend could not be noticed in observing direct »face to face« consultation to FD: 23.6 consultations *per* working day in 1995 increased modestly to 26.6 consultations *per* working day in 2012. It was interesting to notice trend in number of direct »face to face« consultation to FD during observed period: daily number of direct consultation it started to increase in period 1999 to 2005 and then decrease. Temporally increasing trend correspond to years when rate of patients *per* GP team showed to be lower and utilization rate showed to be higher (period from 2000 to 2005).

Specific process figures describing job performed in FD revile some important data and trends are presented in Table 3.

Figures showed stabile trend in referring practice in relation to number of visits to FD teams: variation around one referring to every four contact: There is an evident difference in years 2011 and 2012: one referring to every 4.71–4.84 contacts. When number of direct consultations to FD is related to referrals, trend reviled significant changes. One referring to every four to six direct consultations to FD was trend till 2008, but in period 2009–

TABLE 2
SPECIFIC FD TEAMS' PROCESS INDICATOR IN CROATIA, 2001–2012

Year	Total number of visits to FD team	Total number of direct consultations	Visits/FD team		Consultations/ FD	
			Year	Working day	Year	Working day
1995	17,430,278	12,077,813	8515.0	34.1	5900.2	23.6
1996	18,184,220	12,781,608	8614.0	34.5	6054.8	24.2
1997	19,105,734	13,548,974	8902.9	35.6	6313.6	25.2
1998	21,445,225	15,666,797	9211.9	36.8	6729.7	26.9
1999	21,822,529	15,900,670	9286.2	37.1	6765.9	27.1
2000	22,060,088	15,917,779	9355.4	37.4	6750.5	27.0
2001	22,730,802	16,255,165	9578.9	38.3	6850.0	27.4
2002	23,040,061	16,997,561	9692.9	38.8	7150.8	28.6
2003	23,503,717	17,888,212	9908.8	39.6	7541.4	30.2
2004	24,570,721	18,334,890	10554.4	42.2	7719.9	30.9
2005	24,723,313	18,009,248	10619.9	42.5	7735.9	30.9
2006	23,721,686	15,898,820	10318.3	41.3	6915.5	27.7
2007	24,219,961	15,635,866	10641.5	42.6	6869.9	27.5
2008	25,729,168	14,395,553	11180.2	44.7	6248.1	25.0
2009	26,183,246	15,263,633	11359.3	45.4	6622.0	26.5
2010	26,111,559	14,894,617	11457.5	45.8	6535.6	26.1
2011	31,213,732	15,290,219	13702.3	54.8	6712.1	26.8
2012	31,115,427	15,324,465	13481.6	53.9	6639.7	26.6

TABLE 3
RELATIVE NUMBERS RELATED TO REFERRING PRACTICE IN FAMILY PRACTICE SERVICE IN CROATIA, 2001–2012

Year	Visits/referral	Consultation/referral
2001	4.19	4.14
2002	4.08	3.40
2003	3.98	3.51
2004	4.04	3.59
2005	3.66	4.40
2006	3.42	4.59
2007	3.46	5.52
2008	3.66	6.74
2009	3.86	10.07
2010	3.86	16.90
2011	4.71	16.23
2012	4.84	17.45

2012 this figure increase i.e. one referring occur in every 17.45 direct contacts to FD. Overall, number of referrals related to direct consultations to FD decrease fourfold in 12-year period.

Discussion

Collecting data about each contact to patient »in-time« is long-standing tradition of health statistics method in Croatian PHC. One can argue that such method do not offer best solution in recording working process in PHC. There were some disagreement between official national data and data from other sources and researches which was attributed to less precision in everyday's data collecting[17,18]. However, this study concerns trends in period of time during which data collecting method did not changed. Trends can be clearly noticed without statistical bias.

Two congruent trends emerge in structure of FD work in period from 1995 till 2012: impressive increase of number of persons on FD lists and significant increase of rate of persons *per* FD team. Trends were not stabile due to specific problems in Croatia.

Republic of Croatia suffered during war that ended in 1995. The war caused substantial migration of people as well as problems in organizing health care. Period from 1995 till 2000 was characterized by struggle for better health coverage and reorganization of PHC according to population health needs[19]. Reorganization of PHC included privatization of FD service in the way that private ran FD's teams became contractors to national health insurance fund (CHIF). The process was gradually introduced at the turn of the century. FD teams were remunerated through capitation fee and revision of patients' list of each FD team was made in 1999. Result was impressive decrease of number of patients *per* FD team in 1999: from 1819 patients *per* FD team in 1998 to 1585 patients *per* FD team in 1999[11,12]. During next years, patients' lists were carefully assessed with same attention. In that way, there is no doubt that number of persons *per*

FD team recorded continuous increase till the end of observing period. When compared to best years at beginning of the century, number of persons *per* FD team increased by over 300 persons or 16.97% in 12-years. This disturbing observation must gain interest of every Croatian citizen and deserve full attention of health policy stakeholders. Intervention on resolving this problem did not gain any positive result till now and problem could get worse by Croatia entering EU[13,15,20].

Observation of process figures reviled workload characteristics of FD teams. Some of observed trends deserve further explanations. Diverse trends in number of visits to FD teams versus direct consultation to FD *per* patient could be noticed from 2006 till 2012. It can be attributed to health insurance policy change introduced in 2006. Direct participation with on-site payment for each direct consultation to FD doctor became obligatory for most of insures in 2006. At the same time, visit to FD team without consultation to medical doctor remained free-of-charge[21]. Patients noticed difference and started to use FD facilities in the way to avoid direct contact to FD if not necessary. On the other hand, FD team also took more care in recording different type of contacts. Drop in one consultation to FD yearly (from 5.8 in 2005 to 4.6 in 2008) may be result of recording shift done by FD team[18,22]. Although mandatory direct participation lasted no longer than two years, different figures between direct consultation and visits to FD team remained. Number of doctors' consultations was slightly less than five *per* year, but number of visits rose by almost two visits: from 7.9 in 2005 to 9.8 in 2012. Important CHIF project on e-health in PHC resulted by electronic medical record and electronic prescription practice. Project e-health started years before but it became in overall use from season 2008–2009[23]. This movement surly offered easier access and more contact to FD team. However, easy access to FD team did not produce diminishing of team workload but totally opposite, more contact to deal with and more procedure to perform. Sharp increasing trend in number of visits to FD team strongly support idea that more different procedures are offered, among them a lot of administrative work[23–26].

A burden of different administrative tasks of Croatian FDs should also be taken into the consideration while analyzing the workload. For example, the Portuguese FDs spent an average of 430.1 min on effective work *per* patient daily. Out of it, 278.2 min allocated to face-to-face direct contacts to patient when any interruptions to perform other activities were excluded. In the same study 143.6 min were devoted to perform tasks other than direct patient contact. In comparison to Croatian FDs, they saw a mean of 19.1 patients *per* day and spent 15.9 min *per* one consultation while this research reviled 25–30 direct consultations *per* day among Croatian FDs[27]. It is important to notice that burden of administrative workload have been recognized as factor of dissatisfaction with job and burn-out promoter among FD[7,28–31].

Finally, FDs' workload should not be analyzed without the analyzing the reasons for encounter: if they were somatic, psychological or social[17]. In the study of Zantingen and colleagues, they found patients with psychological and social problems make heavy demand to the workload. Such patients contact their practices almost twice as often comparing to patients with only somatic problems[28]. Looking at the Croatia morbidity patterns, the psychological and social problems are frequently seen in family practice[32].

Increased number of contacts/visits to FD team is not isolated Croatian experience. In Danish general practice the number of contacts increased by almost 20% between 1993 and 2009. Most of this increase can be ascribed to an increase in direct consultations. Regarding referrals they noticed increase proportion of contacts leading to a referral, mainly due to a more pronounced use of outpatient clinics and diagnostic imaging. The authors have paid attentions to the facts that a 20% increase in the number of contacts, was followed by 42% increase in referrals during the 16-year period of observation[33]. The ratio of referrals *per* patients visits remain almost the same in Croatia during observed period. Trends in Croatia could be related to few health policy changes introduced by CHIF. On the side of PHC, possibility to demand several procedures through one single referring was introduced. Additional effect was gained through stimulation of performing specific diagnostic and therapeutic interventions in FD office by broadening list of »fee-for service« payment procedures. On the side of secondary care, CHIF introduced more rigorous control of financial limitations in number of procedures performed by secondary care service. One can also argue that project of promoting »in-service« and regular vocational training for FD in Croatia (resulted in around 500 more doctors working in PHC finished FD vocational educational program till 2010) could attributed to decreasing referring trend to secondary care[34]. However, according to Danish experience, it should be taken into the consideration that rising number of patients contact could produce more referrals in future.

It is evident that workload of Croatian FD increased at the beginning of 21st century, but there is a need for further research and analyze for getting better insight to its extent and its meaning for functioning of Croatian health system.

Conclusion

In conclusion, this 1995–2012 trends observation study reviled (1) significant increase of rate of persons *per* FD team, (2) impressive increase of number of contacts of patients to FD teams while stagnation of number of direct consultation to FD, (3) modest increase in total number of referrals but fourfold decrease of referring rate when rate of direct consultation to FD *per* one referral is calculated during 12-year period. There is en evidence that health policy changes influenced observed trends. Health policy stakeholder should be aware of problematic trends and importance of positive intervention in reversing negative trends.

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H. Tiljak

School of Public Health »Andrija Štampar«, Rockefellerova 4, 10 000 Zagreb, Croatia
e-mail: htiljak@gmail.com

TREND OPTEREĆENJA POSLOM LIJEČNIKA OPĆE/OBITELJSKE MEDINE U HRVATSKOJ U PERIOD 1995–2012

SAŽETAK

Cilj istraživanja je bio ispitati opterećenost liječnika obiteljske medicine (LOM), iskazanom brojem pacijenata na listi liječnika te brojem posjeta i pregleda u periodu 1995.–2012. godine. Podaci su prikupljeni iz Hrvatskih zdravstveno-statističkih ljetopisa za te godine. Rezultati su pokazali, da prosječan broj pacijenata po jednom LOM raste i da se posljedično smanjuje postotak korištenja obiteljske medicine. Također pokazuju, skoro dvostruki, porast broja posjeta, tako da je dnevni broj posjeta porastao s prosječnih 34,1 posjetu na 53,9 posjeta. U isto vrijeme, broj pregleda nije značajno porastao: sa 23,6 na 26,6 pregleda. Također nije značajno porastao omjer upućivanja u odnosu na posjete. Prikupljeni podaci su bili dostatni za analizu trendova, međutim za dublju analizu dnevne opterećenosti LOM bi bila potrebna dodatna istraživanja.