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Document Version
Publisher's PDF, also known as Version of record

Publication date:
2004

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):

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Summary

Family medicine is in transition. The old general practitioner who works alone in a surgery is disappearing. The current problems such as a rising demand of health care, the increased load of the administrative work, the shortage of new general practitioners, the increased outflow of GPs and compensation issues force GPs to redefine their position.

The load of out-of-hours duties places high demands on the GP’s resilience. The burden of these out-of-hours duties has become too heavy. The transformation of small scale structures into large scale out-of-hours services was seen as the solution. The study of the effects of these changes provides insight into the consequences of this transition.

This is the central research question:

*What changes are noticeable after the transition from small scale to large scale GP out-of-hours care?*

This question is broken down in separate topics that each form the subject of a chapter in this thesis:

- What is the organization structure and which work methods are used?
- What is the extent of requests for health care and how are these dealt with?
- What is the nature of requests with which patients contact the GP practice?
- Is there a difference between the reasons for encounter for small and large scale service structures?
- What is the task and function of the assistant in the GP practice?
- How good is the accessibility and how long is the wait time?
- What is the influence of an expert system on the time needed for a triage?
- What is the workload on the general practitioner in large scale service structures?
- What is the patient satisfaction?
- Is there a difference between large and small scale service structures in urban and rural areas?

Chapter 2 describes the establishment of the Dokters-Diensten Groningen (General Practitioners Services Groningen, DDG), which offers out-of-hours medical care for the province of Groningen and the northernmost part of Drenthe. It does so with 277 GP’s for 605,000 inhabitants. The logistic route of requests for medical care and the prominent role of
the assistants at the practice are described. The concepts of triage, call centre, receptionist and the assessment of urgency are also dealt with.

In chapter 3 we try to gain insight in the supply and the processing of out-of-hours health care requests. Contact registration information for four years in the city of Groningen and for one year in the province is analysed. On average, the supply of health care requests is fairly constant at 240 per 1000 inhabitants a year. Around half of this number (51%) are dealt with by telephone by the assistant (36%) or by general practitioners (15%). 34% of health care requests resulted in a surgery appointment and 15% in a visit at home. In the city of Groningen, 74% of these visits take less than an hour; in rural areas this is true for 48%. Five percent of all requests were passed on to second-line health care. The workload is rather constant throughout the week. There was a noticeable peak on Saturday morning. The workload at the central GP practice in the Netherlands is comparable to similar services in England and Denmark. The workload has been rather constant in these countries as well.

In chapter 4 we attempt to gain further insight in the morbidity rate at large scale out-of-hours GP services in the city of Groningen. There is no preliminary measurement. 6413 contacts with the GP service are encoded using the ICPC, according to diagnosis and according to complaint, if necessary. The most common complaints and illnesses are from the ICPC chapters general (A), digestive tract (D), respiratory tract (R) and motor system (L). The most common complaint of patients contacting the CDDG is fever. This study shows that 8% of all visits are assessed as urgent. Most often these concern a problem of the circulatory tract. The majority (73%) of the complaints are assessed as routine. This study also shows that 6% of all contacts are passed on to second-line health care.

In chapter 5, the morbidity rate in rural areas is measured. A previous measurement is available in this case, so the influence of the transition process from a small scale to a large scale service structure on the morbidity rate with which the GP is confronted can be measured. Here too, the most common complaints and illnesses are from the ICPC chapters general (A), digestive tract (D), respiratory tract (R) and motor system (L). The ICPC chapter posture and motor system (L) occurs less frequently in the large scale structure, but respiratory problems are more frequent.

Chapter 6 outlines the social and professional characteristics of assistants who work at the OOH co-op in Groningen. We are also in search of bottlenecks in the assistants’ functioning to identify possible improvements in patient care. On the basis of literature search and
interviews with assistants (N=9), a questionnaire has been drawn up. The average assistant is 39 years old, is married and has completed an intermediate professional education. On average, she has 13 years of experience as a doctor’s assistant. The assistants at the co-op in Groningen do their work satisfactorily. They would like to receive extra training to become even better at their job. Medical knowledge and the ability to listen are named as the most important skills of doctor’s assistants at the co-op. The work hours and financial compensation are the most important motivating factors for working at the co-op. Negative factors are the load of the nightshifts, roster problems and communication with the management. At night the assistants like to have a doctor at their side who is ‘wide awake’. The continuous availability of the general practitioner, especially at night, is an important issue.

In chapter 7 we look at the clock. We try to determine the wait times at the GP service for the province of Groningen and the north of Drenthe. It appears that calls are answered within 25 seconds. 5% of the callers hang up (74% of these within 25 seconds). The assistant assesses around 40% of health care requests within 2 minutes and 80% within 15 minutes. In general, 6% of the patients have to wait longer than 30 minutes for an assessment. During the day this percentage rises to 18. Half of all visits are carried out within an hour, 15% take longer than two hours to complete. The accessibility of the DDG is therefore good. The wait times for the assessment of health care requests during the day are often too long. For emergency visits, the cooperation with the ambulance service turns out to be of prime importance.

In chapter 8 we draw attention to triage supporting expert systems. After entering the patients’ replies in the computer, the assessor receives new questions from the computer. Professionals abroad have extensive experience with this type of system. In England and the United States, hardly any triage takes place without computer. The assessor formulates an advice with the assistance of the computer. The assumption is that the use of the computer takes (much) more time. The goal of the present study is to compare the duration and the results of the triage, and the influence of these results on the time it takes to provide health care at GP large scale out-of-hours services with and without an expert system. The out-of-hours co-op in Tilburg, who have an expert system, and the co-op in Groningen, who do not, are suitable for a comparative analysis. This study reveals only small differences in triage durations between practices with and without expert systems, namely less than a minute.
In chapter 9, the general practitioners in the province of Groningen and the north of Drenthe are queried about their satisfaction and the workload at the services of the DDG. The GPs are satisfied with most aspects of the large scale services. They are not satisfied with the distances they have to drive during visits in the province. 77% think that the out-of-hours services form an integral part of the profession. There were no large differences between the various practices in the distribution of satisfaction and workload. Night duties are still considered to be a (very) heavy load (especially older GPs think so). Night duties are less frequent in the DDG than in small scale surgeries. In a norm practice, this is around seven times a year. Especially older GPs should be given priority in selling night duties. The role the GP wants to play in the cooperation with hospitals remains unclear. The quality of service and the cooperation with other workers in the chain of urgent health care deserves extra attention.

In chapter 10, patient satisfaction about various forms of out-of-hours GP service is dealt with. We look for determining factors that might play a role. The large scale service structure of Groningen is compared with the small scale service structure of Zwolle. This study reveals no large differences between large and small scale services. Around 83% are satisfied with the care they received. Although the accessibility of the large scale service is better and patients are being helped sooner, this does not cause a difference in satisfaction. Neither is there a difference in satisfaction about advice given by telephone. The most important determining factor about the satisfaction is the patients’ expectations of health care. The question is how these expectations about out-of-hours health care can be influenced. It is likely that good information can prevent dissatisfaction.

In chapter 11 we attempt to gain insight in patient satisfaction about the out-of-hours GP care in rural areas. Here we have a pre-post study, which compares the large scale and small scale out-of-hours GP care in rural areas of the province of Groningen and the north of Drenthe (more than 400,000 inhabitants). After contacting the GP service, 77% of the patients are satisfied about this contact. A study before the transition to large scale structures revealed a satisfaction of 89%. This means that the satisfaction about out-of-hours GP care is significantly lower in rural areas. It is possible that habituation plays a role here, because the study took place shortly after the transition. It is striking that there is no difference in satisfaction between patients who live near the practice or patients who live farther away. In rural areas, dealing with emergencies is only possible by cooperating closely with the ambulance service.
Final observations and conclusions
In this study we have attempted to gain insight in a number of aspects of the transition from small to large scale service structures. The following items were dealt with:

1. The workload and the morbidity rate;
2. The patient’s perspective: patient satisfaction and an analysis of complaints;
3. The work floor perspective: the general practitioner and the assistant;
4. The quality of the health care provided;
5. Organization forms, the cooperation in the chain of urgent health care.

These are the most significant conclusions of our study:

• The number of people calling in the help of a general practitioner out-of-hours has been fairly constant during the years: around 240 per 1000 inhabitants. The morbidity rate has remained almost unchanged after the transition.

• The satisfaction in the city has remained constant, but it has decreased in rural areas. The most important determining factor for satisfaction, however, is what the patient expects. The satisfaction may increase if the expectations become more realistic. Patients who live far away from a practice are not more dissatisfied than those who live near by. A regular evaluation of satisfaction and complaints is important.

• GPs are satisfied with the new structure. The workload has clearly dropped. The night duties and the long distances they have to drive on visits in rural areas are sometimes felt as a burden. This is especially true for older GPs. It would seem desirable to introduce measures to relieve older GPs from night duties.

• Practice assistants manage people and materials, and they need to be well trained and coached. They also have a right to a BIG registration (law on professions in individual health care).

• The accessibility of the DDG is good. This is largely due to the receptionists, who determine the urgency of health care requests (primary prioritisation).

• Many GPs are ambivalent about the cooperation with hospitals and the admittance of patients at accident and emergency centres. A close cooperation with the ambulance service is very important.