Family Medicine and Primary Care: Open Access
López Gómez HJ and García-Foncillas López R. J Family Med Prim Care Open Acc 9: 276.
www.doi.org/10.29011/2688-7460.100276
www.gavinpublishers.com

Review Article

Cross-Sectional Study of Attendance at a Primary Care Consultation in a Social Security Health System

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Citation: López Gómez HJ, García-Foncillas López R (2025) Cross-Sectional Study of Attendance at a Primary Care Consultation in a Social Security Health System. J Family Med Prim Care Open Acc 9: 276. DOI: 10.29011/2688-7460.100276

Received Date: 12 March, 2025; **Accepted Date:** 17 March, 2025; **Published Date:** 20 March, 2025

Abstract

Health systems have suffered changes trying to adapt to the evolution of societies; with European models being the most prestigious given that they have a global vision in the provision of their health services to users. But these models are not exempt from a percentage of the population misusing the services, becoming hyper-frequent users and thereby increasing health spending. Our study seeks to establish a correlation between hyper-frequent use and health expenditure. **Methodology:** Retrospective, observational, descriptive study developed in the population served in 2,023 in a quota of an urban health center in Zaragoza, Spain. **Results:** There is high percentage of hyper frequency both in primary care (PC) (22.59%) and in emergency care (HC) (49.71%) not related to age or associated chronic pathological decompensations. In addition, for the same clinical act the demand for tests, referrals, etc. is high, as is a percentage of patients who do not attend their appointment, increasing the waiting lists. **Conclusions:** Overcrowding is a problem for all health systems, both from an economic and healthcare point of view, suturing agendas and thereby reducing efficiency and effectiveness in the provision of health services. Structural changes are needed, starting with health education from the first door of entry to services to stop these practices.

Keywords: Hyper frequent use; Health expenditure; Health systems; Primary care

Introduction

Over the years, health systems have been evolving, modifying their actions and trying to adapt hem to his evolution, without losing sight of the basic principles that every health service must have.

According to the definition of the World Health Organization (WHO) [1], a health system is "a set of interrelated elements that contribute of health in homes, material and financial resources, organization od said resources end the provision of services. In addition, the population, its needs and demands must be taken into account [2]. Our study seeks to establish a correlation between hyper-frequent use and health expenditure

Health Systems

The health systems that have received the most recognition over the years have been the European ones, especially the Social Security Model which has comprehensive coverage for the population, adapting to the life cycle, although there are still deficits for certain sectors of the population users, such as women, immigrants, self-employed, among others. Also, the increase in life expectancy generates new challenges for these systems, given the chronic pathologies and disability added to it [3].

Healthcare Models

There are mainly 3 types of models [1,4] that are explained in the in the summary table.

Every health care system should meet the minimum characteristics of universality, equity and quality, and using indicators [5] (population, resource use, health expenditures, etc.) that allow resources and service portfolios to be measured and directed more accurately to users.

Among the social security models, we must comment on the concepts as health areas and basic health zones. Health areas are defined as [6] "the fundamental structures of the health system responsible for the unitary management of the centers and establishment of the Autonomous Community in its territorial demarcation and of the health benefits and programs to be developed by them." Every health area must have a reference hospital.

And forming these areas we have as a fundamental driving force the basic health zone that corresponds to the Primary Care Centers (PC), and due to the territorial extension, it is necessary to delimit hem so that the health centers are able to face the demand in a more equitable way and offer quality service.

Frequency and /or Overuse of Health Resources

Although it is true that the population has increased, life expectancy is longer, with chronic diseases with a tendency to decompensate, therefore quality and accessible care is essential.

An article by Martin M (2,023) [7] mentions that Spain 4.8% of the population attended medical visits in 2,021, which is lower than other European countries with 7.2%. In contrast to this, there are various authors [8] who observed a number of health requests that ranged between 8 and 21 annual visits.

What conditions this attitude in patients? Although published studies [8,9] emphasize that older you are, the greater the frequency of chronic pathologies. It is a valid statement, but the reflection of Dr. Martinez Monsalve A. (2,019) [10] is also interesting. Health education is needed on the part of the population, since what has been achieved is not value but rather the deficits. In this case, despite having saved his life, the patient complained about "not having had an individual room".

And this is where the importance of PC lies, as it is the gateway to health service and makes it essential to invest in prevention and health re-education to achieve quality activity.

Health Expenditure

But what happens when the population overuses health resources? Health spending can overflow exponentially, reducing the capacity for action and the way in which said service is provided. The Organization for Economic Cooperation and Development (OECD) [11] defines it as the final measurement of health services, both at the healthcare level and preventive service and administration. This expense is conditioned by the longevity of the population and the associated chronic pathologies [12].

According to Fuentes Goñi et al (2,017) [13], the percentage of frequent patient is around 10-15%, consuming 50% of the consultations mainly for PC and these consultations generate costs of approximately 109€ per visits, while in hospital emergencies is around 251€ [14]. This not include expenses derived from requests for imaging tests analytical tests, referrals to other professionals and prescribed treatments. Regarding Temporary Disabilities (TD), we have the expenses associated with each worker are equivalent to 2,892€ [15].

Material and Method

For our study, we define frequency as 10 or more annuals visit to a health center, both primary care and hospital emergencies.

Taking as a population from 1549 a primary care center quota of an urban in Zaragoza in a calendar year (2,023). Our sample was made up of 350 patients.

The independent variables being: age, sex, nationality, demands in the clinical act, hospital admissions, pathologies for which they attended (chronic, acute, psychopathological) and temporary disabilities. As a the only dependent variable, the number of visits made.

The data were obtained from the clinical history of the patients in the selected quota; prior authorization of the ethics committee. With the information duly anonymized and consistent with the pertinent variables of the study, they were categorized. Results were grouped in a spreadsheet after tabulation by the aforementioned variables.

For statistical analysis we used the Microsoft Excel tool combined with the SPSS v.28 statistical analysis software, carrying out a descriptive inferential study of the characteristics of hyper frequent users stratified by sex and diagnosis, using the appropriate parametric and nonparametric statics (t-test, chi square).

Discussion

The purpose of the study was to determine health expenditure in a social security model derived from hyper frequency specifically in the field of PC in a calendar year (2,023). Taking into account the socio demographic characteristics and comorbidities associated with the population studied.

Hyper frequency is a concept that is not very defined, depending on the author used as reference, the number of visits can range between 6 and 12 [16,17]. We take 10 or more visits to health service both PC (including home visits, hospital emergencies, obtaining an average of 17.26±12.11 for emergency service and for primary care 19.75 (DS±15.19).

Making a comparison with other researchers [18,19], a high percentage in the range of 10 to 21 visits is reaffirmed with 77.43%. As we indicated in results regarding a test value of 10 visits or 12, the mean of our example is much higher (mean 18.53) with significant statistical differences and differences are also significant compared to a test value of 21 visits.

Contrasting our 22.3% hyper frequent use with the study carry out by Gili [20] where he states that five out a hundred hyper frequent patients use 30% of PC medical services. We agree with this statement.

Rubiera Lopez G and Riera Velasco JR (2,004) [21] describe that 88% of those over 65 years of age have some chronic pathology and therefore des compensate. Our study indicates that among 35 pathologies catalogued, they are not the chronic ones for which users have come, but rather they correspond to musculoskeletal system (74.71%) in PC and 26.9% in HE.

Many authors relate the older the age to greater the frequency [21-25], ours differs in this regard, given it ranges from 25-54 years with 58.57% in PC and 57,47% in HE.

Regarding the sex variable, it is generally female where it occurs most, as previous studies and others have reflected such as, "Social Factors Associated with Hyper Frequency Use in Primary Care Centers. A study from Health Social Work" [26] and another from Fernandez Herrero M. (2,013) [27] with percentages of visits of 64.3% and 83.3% respectively. Ours maintains this trend PC 67.14% and HE 67.82%.

In relation to TD in our sample, 114 patients (38.91%) had between 1 and 6 TD, with only one of highest percentages (71.93%). Adding all the TD, they have constituted 5,666 days of absenteeism. A study by Mancera Romero J., Muñoz Cobos F. et al (2,001) [24] corresponds to 13.2%. It is important to clarify: the active population is 83%, 57 patients (<16 and >67 years) are excluded.

At the business level, work absences have a negative influence, as well as the socioeconomic level [28], given that there are other handicaps involved in the duration. Although it is true, there are many points of the work that coincide with others researches carried out, they provide a basis for future studies that clarify the implicit conditions that favour these attitudes in users of health services.

Results

A population of many patients was studied, of which 350 were frequent users, the majority being women. Regarding the sample collected, we have that 182 patients went to hospital emergency rooms and then we observe the percentage that required hospital admission.

The following table shows the respective percentage by nationality, with greater hyper- frequency. The demands generated in each clinical act allow us to assess the healthcare costs that each one entails. We should also highlight that a significant percentage of users in our sample (n=92) request an appointment and do not attend, generating more days of waiting for other users (Tables 1-6).

	LIBERAL[1,4]	**SOCIALISTA**[1,4]	**MIXTO**[1,4]	
			BISMARK	**BEVERIDGE**
Example Country	USA	Cuba and North Korea	Germany	Spain
Financing	Consumer good	Budget	Mandatory Fees	Budget and Taxes
Agreement	Private Insurance	State Funded	Businessmen and workers	State
Coverage	Status Disadvantaged		Beneficiaries	
System	Private	Public	Public and Private	Public
AIM	Economic Profitability	Universal Coverage	Universal Coverage	Universal Coverage

Table 1: Table prepared by J. López (2024).

	Total	Men	Women
Primary Care Assistance			
Patients (>10 or more visits)	350	115 (32.86%)	235 (67.14%)
Age	48.03±17.59	49.66±17.89	47.23±17.42
Number of annual visits	18.55±13.83		
Hospital Emergency Care			
Patients	174	57(32.19%)	117 (67.81%)
Age	45.28±18.10	45.12±18.12	45.41±18.06
Number of annual visits	5.78±4.27		

Table 2: Percentage with respect to number of patients, age and number of visits, differentiating between men and women, both for primary care and hospital emergencies.

INCOME	%	Nº
YES	25.86	45
NOT	74.14	129
		174

Table 3: Percentage of hospital admissions of the 182 patients who used this service.

	Total%	Men	Women
Nationalities Primary Care			
Spain	52,00	77	182
Nicaragua	18,00	6	57
Colombia	5,71	6	14
Others	24,29	26	59
Nationalities Hospital Emergency			
Spain	51,14	37	52
Nicaragua	17,24	37	27
Colombia	9,19	5	11
Others	22,99	12	28

Table 4: Nationality by sex.

	Total %
Assistance request	
Analytical tests	76.00
Tests	65.14
They do not attend the appointment	26.28
Electronic prescription	18.57
Temporary disability	19.14

Table 5: Demand for care in each clinical act.

	Total %	
Pathologies	Primary care	Hospital emergency
Traumatology	16.97	15.13
Digestive	13.67	12.18
Pulmonology	12.14	14.29
Dermatology	10.36	9.63
Gynecology	7.88	13.87
Others	29.96	40.34

Table 6: Percentage of pathologies in primary care and hospital emergencies.

Regarding pathologies (by systems), we have that the highest percentage represents musculoskeletal and not due to decompensations of chronic diseases.

Conclusions

- The Social security model constitutes a health system that attempts to provide services to the entire population.
- The results show us that the health expenditure generated by excessive use of the services increases, especially because it is not caused by a decompensated chronic pathology, both in primary care and in hospital emergencies.
- Not only is the type of health model important, but health education is also essential so that users make good use of health care and thereby reduce the expense that hyper frequent use generates.
- In order to establish with firm foundations what drives the population to carry out these practices, it is necessary to continue lines of research in this sense.

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