International Journal of Engineering & Technology, 7 (3.19) (2018) 189-193

International Journal of Engineering & Technology

Website: www.sciencepubco.com/index.php/IJET

Research paper

A Review on Studies Conducted on Justice-Based Outpatient Services (Outpatient's Times of Visit)

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Abstract

Justice in health is a serious and important challenge throughout the world. Use of health & treatment services based on need is the most appropriate method to measure justice in health & treatment sector. Use of health services can be measured by the rate of visits for such services. Outpatient's visits are particularly a valuable scale for better understanding of justice-based use of health services as well as to explain regional differences.

All convenient sources were included in the paper using key words. The sources have been published in Persian and English languages. Researches indicated that studies conducted in developing countries are very extensive. Some injustices in use of health services are seen either in Iran or other countries. There is no standard for times of visits. The time of visits is recorded consistently in advanced countries which is ignored in Iran. The studies are conducted in advanced countries to change doctors' views but there are no such studies in Iran. The studies of justice-based use of health services should be conducted annually to evaluate the rate of justice growth in healthcare system. Furthermore, referral registration system is necessary to conduct better studies. As a result, it is very essential to change habits of public and doctors' view thus to reduce health costs.

Keywords: *outpatient services, justice in health, use of health services, times of visits.*

1. Introduction

Health care and health conditions are a recognized right to engage in economic activities. Access to health services can also be considered as a prerequisite for community justice. The purpose of justice is not to create absolute equality (1)**.** Justice in health does not mean that all people with the same level of health, receive the same services, and have access to the same amount of resources. Justice in health means that equal access to healthcare is provided for those who are in the same condition for access to services. Justice in health services can be defined in both horizontal and vertical directions. Horizontal equity is related to the concept that individuals with the same needs benefit from the same health care services. From the vertical point of view, equity also means that people with more needs for health services will benefit greatly from these services (2, 3). The use of health services is measurable with the times of visits for these services. An important issue in the use of health services is its distribution. When the distribution of health care needs is compared with the distribution of health care in the country, the question "whether people have been benefited from health services proportional to their needs or not" can be answered.

In this study, outpatient visits were used for two reasons: First, outpatients' visits are a relatively simple measurement for use of healthcare services due to the smaller size of outpatient services than hospital services. Secondly, outpatients' visits reflect the greater demand and preferences of patients. In fact, outpatients' visits in particular are valuable measurements to understand well the justice-based use of health services as well as to explain regional differences (4). The rate of outpatient's time of visits varies widely across the country. This difference may indicate inefficiencies in the use of health services. However, these differences can also result in several factors, including: systematic differences in health status, demand induced by health service providers, differences in facilities and the level of health care supply (5). Expenditures in all societies, whether wealthy or poor, developed or undeveloped, are considered to be necessary. Excessive and unnecessary visit is one of the factors that increases the cost of health. Unfortunately, bad habits such as direct referral to a specialist instead of visiting a general practitioner and then being referred to a specialist, the use of self-medication and the availability of medication without a prescription, urging physicians to prescribe unnecessary tests and imaging are factors that increase health costs in Iran. To control such health costs, it is urgently needed to provide a model for visits based on health needs of the community, which will provide both a justice approach in the health system and a suitable distribution of access as needed.

The aim of the research is to investigate the studies done in the world and Iran about justice-based outpatient's times of visit to find answers to the questions "whether there is a standard rate for outpatients' visits, whether outpatient 's times of visits in Iran are higher or lower than the global average, if higher, do these visits impose costs on the health system? based on conducted studies, is there justice in the use of health services?

2. Method

The texts reviewed and discussed here are articles available inside and outside the country, with the keywords "justice in utilization, outpatient's times of visits, health care costs, length of visit". This is a review article, which means that if we are to repeat the longitudinal and similar studies, the defects of previous studies will be resolved thus, extracted data does not help contradictions. This paper tries to highlight weaknesses and gaps in research works, not to undermine the intent of researchers, but to show the angles that are less noticeable and require more attention and research.

3. Studies Conducted on Equitable Access and Use of Health Services

Justice has many branches and includes all social affairs, one of its subcategories is health. Justice in health is one of the most important dimensions of social justice, which should be addressed explicitly. Justice in health implies that everyone should have fair opportunities to achieve their full potential of health meaning physical, mental, spiritual and social health, and more realistically, no one should be deprived from these potentials. Of course, this will be achieved if the barriers are avoided. Therefore, justice in health is associated with the creation of equal opportunities for full health and reduces health differences to the lowest possible level.

A study by Doorslaer et al in 1992 aimed at comparing the eight European countries for the purpose of justice in health. In this study, justice is defined as individuals with the equal need for health care must receive the same treatment regardless of their incomes. Two methods have been used to study the status of injustice in this research:

The first method is to measure inequality in the health and treatment costs paid by different income groups, and the second method uses single-equation and two-equation regressions to estimate the injustice in health care received by the poor and rich people. The variables used in this study are income, requirements, and utilization. Data were collected from health interviews. According to results of this study, there are inequities in the health care system of most of these countries. But there is no model to show that such injustice is similar in these countries (6).

A study by Abasolo et al in 2001 aimed to evaluate the equitable access and use of health care of general practitioners in the Spanish public sector. In this study, two criteria of horizontal and vertical equities have been used to study the status of justice. Both the horizontal and vertical equities are assessed by the interaction between the variables of requirement and access. Horizontal equity means equitable access for equal need and vertical equity means more access for more needs. The data used in this study is those collected by the Spanish health organization in 1993 Which included individual patients' reports, age, gender, geographical groups and so on. According to the results of this study, access to health services of general practitioner in Spanish public sector during 1993 was consistent with vertical equity, but conflicted with horizontal equity (2).

In the study conducted by Thabrany et al in 2004, real data as well as data derived from polynomial regression have been used to determine the effects of compulsory health insurance on equal access to outpatient cares in Indonesia. The compulsory health insurance plan has been evaluated for governmental and private employees. According to results of the study, compulsory insurance plan for public employees has had a strong positive impact on access to public outpatient care whereas the compulsory insurance plan for private employees has had a strong positive impact on either access to public outpatient care or private cares. The greatest impact has been observed among poor people. However, evidence suggests that a significant increase in access to outpatient care will be achieved by expanding insurance coverage for all people (7).

Another study by Benjakul in 2004 aimed at measuring justice in the use of health care by elderly people in Thailand. In this study, indirect methods have been used to measure inequalities in mortality and horizontal inequalities in the use of health care. This is a retrospective study that used variables of income, need (disease) and access to health services. Data were provided from the National statistics organization of Thailand. According to this study, chronic complications in lower-income elderly people are higher and income inequality remains at all times, but it is relatively decreased after the economic crisis (8).

A study by Gomeza in 2006 entitled as "The evolution of injustice in access to healthcare" was conducted in Spain. This report analyzes the evolution of inequality in access to health care in Spain from 1987 to 2001. Access measurement includes three indices of doctor's visit, use of emergency services and hospitalization. To measure these indices, individual information in the Spanish national health survey has been used. In this study, the focus index was used to examine the inequalities. According to the results of this study, the information over the period in question seems to reduce the elasticity of income for the possibility of using these three services (9).

A study was conducted by Lu et al (2007) to measure horizontal inequity in medical healthcare based on evidence from three high-tech economies in Asia (Hong Kong, South Korea, and Taiwan). In this study, horizontal equity means the principle of equal treatment for equal need. Types of services to be studied include: Outpatient services including general practitioner and specialists' visits, traditional medicine practitioner, dentist, emergency room and hospital services. Horizontal inequity index (HI) was used to measure horizontal inequity in this study. This index measures the income inequality in the use of health care after standardizing the differences in the need such as age and sex. Income inequality in access to health care is divided into several groups: (i) direct income effect. (ii) Needed variables (Self-assessment of health status, activity limitation, age and sex in terms of interaction). (iii) unnecessary variables (education, employment status, private insurance coverage, medical benefits by employer, urban and rural residential places). The results showed that there was a great deal of inequity in the use of general practitioner services and partly in the use of dental services in Hong Kong. By contrast, in South Korea, it seems that the principle of equal treatment for equal need has been met, although higher level of healthcare is needed for better access. The results of Taiwan show that, on average, wealthy people benefit more from the services of traditional medical practitioners. Horizontal equity seems to be obtained from the services of a general practitioner, specialist and dentist, and poor people have used partly hospitalization services (10). A further study by Bago et al in 2009 was conducted to measure horizontal inequity in access to health care and treatment of general physicians for eight OECD[1] member countries. In this study, the panel method was used and the relationship between horizontal inequity in the access to health care and income level of households has been investigated. For this purpose, the average annual income of households was calculated in these eight countries and a general practitioner and specialist's visit was used to measure injustice in the use of health care. According to the results of this study, there was a strong link between the income level of households and the use of health care in some of these countries (11).

A study was carried out by Torres entitled as "Economic analysis of vertical equity in providing health care in England in 2012. In this study, vertical equity means treatment proportional to the need, in other words, more treatment for more need and less treatment for less need. Because in most studies, the horizontal equity is evaluated in utilizing health services, and the vertical equity is less appealing, the purpose of this study was to evaluate and improve the vertical equity appraisal technique and to provide evidence of the vertical equity condition in the English health care system. In

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this study, vertical inequity (VI) was used to measure and analyze the status of vertical equity in use of health services. Instead of focusing on dual measurements such as self-assessment of general health or limiting the illness condition, the health index has been calculated based on data and information from cancer-related EQ-5D from the Health Survey of England (HSE). This approach allows to analyze all inequalities in health, in addition to analyzing social and economic inequalities in health. The results show that there is a vertical injustice in use of health services in socially and economically poor groups, and those who need more suffer mostly from this injustice. (12).

A study by Kazemian and Tajbakhsh in 2013 was conducted as "Vertical inequity in the use of healthcare in the Health Services Insurance Program in Iran" (13). In this study, the comparison of provincial groups classified according to the need for health care, the relationship between the need for health care and the use of health care have been evaluated in a five-year period (years 2004-2009). The purpose of this assessment is to explain the changes made by the development of health services insurance in the situation of provincial groups with more (or less) need of health care. In this research, the provincial data of birth life expectancy index was used as an indicator for need of health care in the provinces, as well as the index of healthcare use in health insurance services. Then, correlation coefficient for each group was calculated by explaining regression correlation between need and access (use) variables in provincial groups. Comparison of correlation coefficients between need of health care and the use of these care services showed that the correlation coefficients between these two variables were different in provincial groups. Based on the condition of vertical inequity (i.e, the use of cares in a manner that meets the needs), these correlation coefficients should be the same for all provincial groups. This research shows that the expansion of health insurance services from 2004 to 2009 did not lead to vertical inequity between the provincial groups classified according to the need for health cares. The reason is the effect of social factors on maintaining the utilization level of provinces in the base year during five years (13).

4. Studies Conducted on Outpatient's Times of Visits

A study was conducted by Maftoon et al in 2005 entitled as "Demand and times of visit for medical services in Tehran". The aim of this study was to determine the demand and times of visit for receiving medical services in Tehran and in different regions. Random multi-stage cluster sampling was used respectively in five areas of Tehran (north, south, center, west and east). The data were demographic information, physical and mental complaints of individuals and their referral or no referral to receive medical services, which were collected by a questionnaire. 5973 people were studied, which included 1416 households. According to these results, every 100 people in Tehran had 122 demands for treatment services, 102 of which had access to services, and in fact, 20 out of 122 have not taken any action in receiving services. Also, the results indicate that there is a statistically significant difference in the frequency of demand in different age and sex groups. The difference in the frequency of demand, times of visits and the level of access in different parts of Tehran was statistically significant. In this study, after influenza and cold, cardiovascular diseases, musculoskeletal and neurological disorders were the most frequent demands (14).

A study was conducted by Dr. Tabibi et al in 2009 entitled as "Quality of services provided in outpatient clinics based on SERVQUAL model in Tehran's hospitals". The study was performed on 242 outpatients referred to hospitals in Tehran in 2009 using the standard SERVQUAL questionnaire (1988). The results showed that there was a significant difference between the perceptions and expectations of patients about the five dimensions of service quality (tangible factors, reliability, assurance, responsiveness and empathy) in the hospitals. Patients referred to the clinics rated the assurance (4.41 points), and the staff responsiveness (21.2 points) as the most and the least important dimensions respectively. The results of this study indicate that by employing SERVQUAL model, hospital managers were able to evaluate the quality of services from the viewpoint of patients as the most important customer, and it will be possible to reform disorganizations as well as to improve the quality of services by proper planning (15).

Another study was conducted by RamezanKhani.et al in 2014 entitled as "Investigating the waiting time of the patients in the emergency department of educational hospitals of Kerman University of Medical Sciences". In this study, 375 patients referred to the emergency department of educational hospitals of Kerman University of Medical Sciences were chosen by convenient sampling. The data collection tool is a revised form of "timing and emergency workflow". Results showed that the mean of waiting time, task assignment, resuscitation triage, and emergency triage was respectively 3.5, 133.8, 1.7 and 6.8 minutes longer than the global mean. In order to achieve international standards, it is suggested to review and modify patient's service delivery in the emergency department as well as to train service providers (16).

A study by Esther Hing.et al was conducted in 2007, and referrals to outpatient departments of US hospitals were reviewed from 1997 to 2007. During this period, there were about 88.9 million visits. Of all 100 visits, 30 visits were related to women and 23 cases were related to men and the rest were related to children. For every 100 visits, 58 cases were related to black people. About a third of the clients were holders of Medicare insurance and health insurance of under 18-year-old children. For the prevention services, these two types of holders have had, on average, 4 times of visits more than other people. The results have shown that the number of patients referred to outpatient departments of hospitals has changed from native to non-native as well as from white to black people (17).

Unfortunately, there are no formal studies on the rate of outpatient visits in Iran. In the United States, all visits for outpatient, paraclinical and hospital services are published annually in form of book based on different sexes, ages, races, educations, etc. and they are available online. This has made it very easy to study the downward or upward processes of visits over the long terms, but unfortunately there are no similar sources in Iran.

5. Studies Conducted on Health System Costs

Equitable funding in health systems means that the risks the household faces due to the health system costs are distributed in terms of their ability to pay, rather than the risk of illness itself. A system with fair financing ensures that everyone is financially protected. Increasing expense of the Samet sector in the country will increase out of pocket expenses. A study was conducted by Heydarian and Vahdat in 2015 entitled as "The Effect of implementation of health System Reform Plan on out of pocket expenses in selected State Hospitals in Isfahan". The first service package in the Health System Reform Plan is a program to reduce the payment of hospitalized patients in hospitals affiliated to the Ministry of Health and Medical Education. The purpose of this study was to determine the extent to which this program was implemented. The income information of five governmental hospitals affiliated to Isfahan University of Medical Sciences and Health Services was evaluated in the first 9 months of the implementation of the plan which included most of specialties. Considering the inflation rate, the average rate of out of pocket expenses decreased by 17.43%, which could be due to mean of 18.8% and standard deviation of 82.1% as well as due to government subsidy payments. The analysis of results showed that the government was able to significantly reduce the amount of out of pocket expenses and to make an effective step towards achieving its goals. Howev-

er, it seems necessary to evaluate the causes of increased costs and times of visits (18).
Increasing health care costs affect patients across the country. As employers and insurance companies are facing high costs, they may be moving toward a cost sharing strategy that can potentially increase the cost of patients. In this situation, doctors may consider themselves as medical and financial advisers for their patients. Clinical complications in which patients suffer from financial problems can be unpleasant and frustrating for both sides. Physicians should learn to talk about cost-effective and alternative therapies. In this regard, an essay was published in 2005 by James Hardy.et al. This paper describes the authors' experiences using various communication skills that can help patients in terms of health care costs. The main skill, empathetic relationships, including the statements of "we" and "I wish ...", was created to provide a platform for joint decision-making, negotiation and search for alternatives (19). Studies like Hardy.et al are very useful to influence on doctors and to prevent induced demands that lead to an increase in unnecessary rate of visits, but unfortunately no such study has ever been done in Iran.

6. Studies Conducted on Outpatients' Length of Visit and its Outcomes

One of the most important components of physician-patient relationship is patients' length of visits. The outpatient's length of visit is defined as follows: "The patient's arrival time in the examination room until the patient leaves the examination room" (20). In fact, Patient's visit is the starting point for the provision of services to patients (21). The length of visit is one of the most important variables in the field of outpatient services. This variable is influenced by several factors and it is considered as one of the important factors affecting patient satisfaction and quality of outpatient services (22). Short length of visit can affect the quality of the visit and the relationship between the doctor and the patient, and these effects can also increase the cost of insurance. In this regard, a descriptive-analytic study was conducted by Hassanpour. et al in a cross-sectional manner in Qazvin's hospitals in 2013 (23). According to the results of this study, it has been determined that the length of visits in Iran has been shorter than developed countries and other developing countries. The length of visit is of little interest in Iran, and this has been observed among general practitioners and specialists. Hassanpour et al have considered the consequences of reducing the time (insufficient length of visit) in Iran as follows: It will increase the injection and prescription services as well as the demand for imaging tests and other tests thus patient costs. On the other hand, they have argued that a short length of visit would reduce the accuracy and diagnosis of the disease by the physician. As a result, the patient's trust in the physician is reduced and the patient's disease recovery is impaired (23). This is despite the fact that studies have shown that a longer length of visit is more efficient and reduces the number of subsequent visits (24). But the point that some doctors point out as a reason for reducing the length of visit is the patient's initial speaking time. Doctors do not interrupt in patient's initial speech which leads to a prolonged period of medical visits.
A study by Labaf et al. in 2015 investigated the initial speaking time of patients referring to Emergency department of Imam Khomeini Hospital in Tehran. Based on the results of this study, it has been determined that the amount of initial talk of patients is too low to increase the length of medical visits (25). Also, the study by Maftooh et al. in 2015 regarding the effect of family physician plan on outpatient services showed that the outpatient's length of visits in the family physician plan is almost acceptable, however, in some cases, such services should be improved. They stated that improving the patient's length of visit, especially in urban areas, is an important step towards improving demand management, visits, and selecting an appropriate population for each healthcare center. The greatest shortage in this study was the insufficient length of visit via doctors (26).

7. Conclusion

As mentioned above, it can be concluded that justice in health sector is a serious and important challenge not only in Iran but also in most countries of the world. The most appropriate method for assessing justice in the health sector is to evaluate justice in health based on need. Social justice, which is one of the pillars of national development, is resulted when health care is distributed according to the needs of those in need. So, promoting health is the main goal of a health system. The ability to achieve and to make the smallest differences between people for healthcare services as well as fairness of the system are very important, which means that a health system responds correctly to what people expect, and the system meets the needs for each individual without any discrimination.
In order to evaluate the health system's fair responsiveness, it is a good way to study the justice in use of health care based on the needs of the people. In Iran, this issue has been addressed in recent years, but it is better to carry out annually this series of studies so as to compare and follow the justice process in use of health services in Iran. Regarding the issue of rate of visits for health services, since there is no coherent statistics on outpatient visits throughout the country and each insurance organization registers individually the number of visits to its insured persons, it is very difficult to study on this topic and to collect data. So, if the Ministry of Health has an integrated system like many countries to record data, it will be easy to conduct such studies. However, according to Dr. Harirchi, the spokesman of the Ministry of Health, in 2015, about 48.5% of the patients referred to the specialist in their first visits. While in advanced countries, general practitioners are used as gatekeeping physicians, patients will be referred to specialists if it is diagnosed by general practitioners. This will prevent unnecessary visits and reduce the cost of medical care. As previously mentioned, one of the reasons for increasing the unnecessary visits is induced demand (induction of the physician to the patient for subsequent visits or imaging services, laboratory, etc.). To reduce this, we need to have an impact on doctors and to change their perspective. To do this, studies such as that of Hardy et al have to be conducted in Iran.

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