

基于安德森模型的非急症患者急诊就诊影响因素研究进展

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摘 要

近年来, 非急症患者占用急诊资源的现象日益突出, 这不仅加剧急诊科的拥挤情况, 还导致医疗资源的不合理利用。本文基于安德森医疗服务利用行为模型, 总结非急症患者选择急诊就诊的影响因素。模型从“倾向因素”(人口学特征、健康信念)、“使能因素”(经济能力、医疗资源可及性)及“需求因素”(自评健康状态、症状严重程度)三个维度, 揭示患者决策的复杂性。研究发现, 低健康素养、缺乏基层医疗渠道、对急诊服务认知偏差及症状主观焦虑是主要驱动因素。本文提出未来需通过普及急诊相关健康知识及分级诊疗政策、加强基层医疗建设, 为急诊医疗资源的高效、合理利用提供理论依据。

关键词

非急症, 安德森卫生服务利用模型, 影响因素, 医疗服务利用

Research Progress on Influencing Factors of Non-Emergency Patients' Emergency Visits Based on Anderson Model

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Abstract

In recent years, the phenomenon of non-urgent patients utilizing emergency departments (EDs) has become increasingly prominent, exacerbating ED overcrowding and inefficient allocation of medical resources. Based on Anderson's Behavioral Model of Health Services Utilization, this paper systematically reviews the factors influencing non-urgent patients' choice of ED care. The model categorizes determinants into three dimensions: predisposing factors (demographics, health beliefs), enabling factors (economic capacity, healthcare accessibility), and need factors (self-assessed health status, symptom severity), revealing the complexity of patient decision-making. Key drivers include low education levels, lack of primary care access, misconceptions about ED services, and subjective anxiety over symptoms. This article proposes that the efficient allocation of emergency resources should be supported by popularizing health knowledge related to emergency care and implementing hierarchical diagnosis and treatment policies, as well as strengthening the construction of primary healthcare.

Keywords

Non-Urgent Patients, Anderson's Behavioral Model, Influencing Factors, Healthcare Utilization

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1. 引言

急诊科作为医疗机构救治急危重症的前哨及核心部门，其服务效率的高低直接关系到公共卫生安全与患者的预后状况。然而，全球范围内普遍存在非急症患者(non-urgent patients, NUP)过度使用急诊资源的现象[1]，导致急诊科拥挤、医疗成本攀升及重症患者救治延误等问题[2]。非急症患者通常指无急性发病症状或较少存在不适主诉，病情处置延迟数小时不会增加不良事件发生可能性，并可在门诊、基层卫生服务中心等急诊以外的医疗机构得到治疗的患者[3]。国外研究[4]发现，20%~40%的急诊就诊病例属于可通过基层医疗解决的轻症或慢性病管理范畴，这种“资源错配”现象，在医疗资源有限的中低收入国家尤为显著，在这些国家，非急症患者的占比通常在60%以上[5]-[7]，既往研究多从单一维度探讨非急诊就诊行为的成因，但医疗决策本质上是多因素交互作用的结果，故需要依托系统性理论框架加以解析。

非急症患者对急诊资源的占用行为本质上是多维度决策的结果，安德森医疗服务利用行为模型(Anderson's Behavioral Model)，简称“安德森模型”，将个体就医行为归因于“倾向因素-使能因素-需求因素”的动态协同，其为解构非急症患者急诊选择的复杂动机提供了理论工具[8]。倾向因素是影响一个人使用医疗保健资源倾向的特征，由社会人口统计学特征组成，包括年龄、性别、婚姻状况和种族，以及对健康和健康服务的态度、信仰、价值观和知识，这些特征创造了增加急诊服务利用的条件。使能因素则是那些能够阻碍或促进急诊就诊的因素。在个人层面，这些因素包括收入、财富、医疗保险类型和社会支持，距离医疗机构的距离，交通的便利性等。需求因素则指个人感受到的医疗卫生服务需要，是导致医疗卫生服务利用的前提和直接影响因素，包括感知需求(自评健康情况、疼痛评估、疾病判断)和

评估需求(临床上医生对患者健康状况的专业评估和客观测量)两个变量,反映主观感受与客观评估之间的关联与差异。

基于此,本文通过综述国内外相关文献,以安德森模型为分析框架,对非急症患者急诊就诊行为的影响因素进行系统化梳理,旨在为优化急诊资源配置、完善分级诊疗体系提供循证决策依据。安德森模型能够全面系统地解释患者医疗卫生服务利用的深层次原因[8],但目前还没有基于该模型对于非急症患者急诊就诊影响因素的综述。因此,本研究回顾国内外非急症患者急诊就诊原因的相关文献,根据安德森模型理清非急症人群中导致急诊就诊的因素,并提供这些决定因素的全面阐述,为未来开展相关干预研究提供理论依据。

2. 基于安德森模型的非急症患者急诊就诊的驱动因素分析

2.1. 倾向因素(Predisposing Factors)

2.1.1. 人口学特征:年龄、性别、教育水平差异

非急症患者选择急诊就诊的行为受多种因素共同影响,且这些因素的作用方式在不同群体中存在差异。年龄上,年轻患者更倾向于选择急诊,这一现象在多个国家研究中得到验证[6][9]-[14],统计显示年龄每增长1岁,非急症使用急诊的概率反而下降1%[15],中位(IQR)年龄为27(13~38)岁,大多数患者年龄在16~35岁(44.2%)[5]。性别差异方面,大部分研究提示,女性患者非急症急诊使用率比男性高[9][15]-[17],最高可达63.2%[5],但也有部分研究显示男性急诊就诊量更高[6][18][19]。此外,教育水平对选择急诊也存在一定的影响,高学历人群的非急症急诊使用率较高[9][12][14][19],这类人群在应对健康相关困境时往往依赖于自我效能感的主观判断,从而认为自己应在急诊就诊[13][20]。婚姻状况方面,虽然非急症患者中几乎一半的患者已婚(49.3%)[5],但研究认为,婚姻状况与急诊就诊没有明显关系[21]。种族方面,国外研究中,黑人种族相较于白人种族更容易发生非急症就诊[22],国内研究中,少数民族更易发生非急症就诊[14]。

2.1.2. 健康信念:对急诊功能的认知偏差与风险感知

对于急诊认知的偏差是导致非急症就诊的重要原因,大部分患者不信任基层医疗机构[17],认为急诊相比初级卫生保健机构,能够提供高质量医疗服务[23][24],患者能够得到全面的检查,尤其是60岁以上患者,基层首诊意愿明显低于其他年龄组患者[17]。此外急诊能够提供即时的治疗和护理,免预约,就诊时间灵活,这也是非急症患者就医的重要原因,几乎一半的患者不了解分级诊疗制度[17],所以即使明确自己病情并不紧急,也会因各种便捷性选择利用急诊资源[6][25]。

健康素养水平较低和健康知识匮乏进一步加剧了这一问题。他们虽然不认为自己的病情会危及生命,但还是更愿意急诊就诊,因为他们不想“冒任何风险”[26]。还有些患者并不觉得其病情很紧急,但仍然希望得到及时的治疗以缓解不适症状[21][27]。德国一项研究表明[28],非急症就诊患者的健康素养明显低于德国的平均水平,他们对急诊以外的医疗卫生服务了解有限,对健康信息的理解有限,会在获取有效初级保健服务时面临障碍。

2.2. 使能因素(Enabling Factors)

2.2.1. 经济能力:自费比例与医疗保险覆盖的影响

医保制度的设计对患者的就医选择具有显著影响。17%的患者因医保只覆盖急诊而放弃基层医疗[29],这凸显了医保政策在引导医疗行为中的关键作用。对于低收入群体而言,经济压力是驱动其选择急诊的重要因素之一。数据显示,41%的非急症患者选择急诊主要基于费用考虑而非病情需要[29],这反映了经

济能力对医疗决策的直接影响。然而,也有研究发现家庭收入对非急症患者的就医选择并无显著影响[9],这可能与不同国家医保政策的差异有关。在一些高福利国家或地区,医保覆盖范围广泛且自费比例较低,经济因素对就医选择的影响相对较小;而在医保覆盖不足或自费比例较高的地区,经济压力则成为决定就医行为的重要因素。

2.2.2. 资源可及性: 基层医疗缺位与急诊地理可及性

基层医疗机构的服务时间限制和资源不足是导致非急症患者转向急诊的重要原因之一。特别是在周末和节假日期间,由于基层医疗机构关闭或服务时间受限,许多非急症患者不得不选择急诊作为替代就医途径[6][30][31]。研究[32]表明,79%的非急症患者由于预约家庭医生需要等待几天甚至几周而转向急诊就医;同时,77%的全科医师的预约等待时间超过48 h[33],进一步加剧了这一现象[24][34]。

此外,初级卫生服务机构在专业人员和实验室检查设备方面的匮乏也导致其无法满足患者的诊疗需求,导致大量非急症患者被转诊至急诊部门。数据显示,在急诊就医前尝试过基层就医的非急症患者中,有67.3%被推荐到急诊就医[32][35]。地理可及性也是影响非急症患者选择的重要因素,距离急诊室越近的患者越容易发生非急症就诊行为[36]。这些因素共同作用,凸显了优化基层医疗服务资源配置和提升其可及性的迫切需求。

2.3. 需求因素(Need Factors)

2.3.1. 自评健康状态: 主观症状焦虑与客观医学指征的偏离

患者的自我健康评估与其实际医学指征之间的偏差是驱动非急症患者选择急诊的关键因素之一。研究发现[31],许多家长因认为孩子的病情紧急而将其送往急诊科接受诊疗和护理。然而对1812例非急症患者的调查显示[25],尽管76%的患者主观认为自身病情需要紧急干预,但经医务人员评估显示这其中64%的患者实际并不符合急诊指征。这种主观与客观评估的显著差异可能与患者的疾病知识匮乏有关[37][43],也可能源于疾病状态下躯体不适引发的焦虑情绪,从而导致其对疾病严重程度的高估。国内研究同样支持这一观点,感知到疾病的严重程度和紧急治疗需求是非急症患者最常见的就诊原因[14]。所以提升公众健康素养和优化疾病认知教育可能是减少不必要急诊使用的有效途径。

2.3.2. 疾病特征: 轻微疾病为主

非紧急病例的疾病需求多样化。最常见的主诉是肌肉疼痛(25.2%),然后是上呼吸道症状(19.7%)[21]。就具体症状分布而言,腹痛是最普遍的症状,其后依次为肌肉骨骼疼痛、胸痛、呕吐、恶心、头痛、头晕、发热、麻木、骨折和上呼吸道感染等十大常见健康状况[19]。值得注意的是,80.3%的非紧急患者在平时健康状况良好且无任何慢性病史的情况下仍选择急诊就医[21]。

从具体就诊原因来看,常规检查/检查占主导地位(40.9%),其次是药物补充需求(14.6%)和上呼吸道感染/症状管理(9.9%)[5],此外,17.1%的非紧急患者在2周内因相同主诉反复就诊[7],这一现象可能与患者习惯性就诊有关。

3. 非急症患者急诊就诊决策的复杂性

非急症患者的急诊就诊决策是多种因素共同作用的复杂现象。其复杂性在倾向因素层面,主要源于患者个体层面的认知偏差[17]、经济条件差异[29]及健康需求评估的冲突[37],也与使能因素中的医疗系统资源配置[32][35]、医保政策[9][29]等结构性因素密切相关,同时在需求因素层面,患者对自身症状的主观焦虑常与客观临床指征不符,导致过度依赖急诊寻求即时确认[25],进一步扭曲了就医选择,使急诊功能从“急危重症救治”转向“综合性健康服务”。这种决策机制既反映患者对医疗系统的认知局限,也

暴露分级诊疗制度的执行缺陷，需通过优化基层医疗服务能力、完善医保政策导向及强化公众健康素养教育实现系统性干预。

4. 减少非急症患者急诊占用的干预策略

减少非急症患者占用急诊资源，需要基于安德森模型的三个维度采取多层次的综合干预措施，可以系统性地解决导致非必要使用急诊资源的根本问题，从而优化资源配置并提高整体医疗服务效率。

从倾向因素及需求因素方面，需要提升公众健康素养，普及健康知识。Herman [38]等人的研究，发放了有关如何在家中管理 50 种常见儿童医疗问题的手册，6 个月后，儿童非急症就诊率减少了 30%。类似地，通过对因耳痛到急诊科就医的患儿家长进行健康教育干预后，一年内因非急症耳部疾患到急诊就医的比例较对照组减少了 80% [39]。表明通过增强公众对常见疾病的识别能力和自我护理能力，可以有效减少不必要的急诊使用。

使能因素方面，优化基层医疗服务体系是减少非急症患者占用急诊资源的重要途径。首先家庭医生需要加强与患者之间的联系，以增强患者的信任感和依从性，而降低其因轻微症状转向急诊的可能性 [40]。其次基层医疗机构可通过设置夜间门诊及周末门诊，满足上班人群的就医需求 [41]，缓解其在常规工作时间外的就医压力。然而值得注意的是，在急诊科设置全科医生的效果有限，英国在 40 家医院的急诊中调查显示，急诊中设置全科医生对非急症就诊率及病人等待时间没有明显的影响 [42]。此外远程医疗也是减少非急症患者的一项重要措施。远程医疗服务中，患者可以借助电话、视频或在线平台与医生进行沟通，得到医疗诊断和健康教育，多个国家及地区在积极推进远程医疗的发展 [43]。研究显示，使用了远程医疗后，30% 患者不再前往急诊就诊，有效降低了非急症患者急诊就诊量 [44]。同时建立完善的社区转诊机制，将符合条件的非急症患者从急诊科转诊至社区医疗机构，也是控制急诊就诊率的有效策略之一 [45]。

5. 小结

本文基于安德森模型系统解析非急症患者急诊就诊行为的影响因素，揭示其决策是人口学特征、健康信念、资源可及性与社会心理需求交互作用的结果。鉴于非急症患者的急诊就诊决策受到多种复杂因素的共同作用，建议未来依托安德森模型进一步研究三大维度之间的相互作用及深层次机制，为系统化、长效解决非急症患者急诊就诊问题提供理论依据。

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