THE FAMILY MEDICINE PRACTICE IN TURKEY FROM THE PERSPECTIVES OF THE PHYSICIANS WITHIN THE FRAMEWORK OF NEO-LIBERALISM

A THESIS SUBMITTED TO
THE GRADUATE SCHOOL OF SOCIAL SCIENCES
OF
MIDDLE EAST TECHNICAL UNIVERSITY

BY

ZEYNEP DENİZ ŞEN

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR
THE DEGREE OF MASTER OF SCIENCE
IN
THE DEPARTMENT OF POLITICAL SCIENCE AND PUBLIC ADMINISTRATION

SEPTEMBER 2019

Approval of the Graduate School of Social Sciences

_____

Prof. Dr. Yaşar Kondakçı

Director

I certify that this thesis satisfies all the requirements as a thesis for the degree of Master of Science of Political Science and Public Administration.

_____

Prof. Dr. Ayşe Ayata

Head of Department

This is to certify that we have read this thesis and that in our opinion it is fully adequate, in scope and quality, as a thesis for the degree of Master of Science of Political Science and Public Administration.

_____

Assoc.Prof.Dr.Mehmet Okyayuz

Supervisor

Examining Committee Members

Prof.Dr.Filiz Kartal	(Ankara Uni,SKBY)	_____
Assoc.Prof.Dr.Mehmet Okyayuz	(METU,ADM)	_____
Assoc.Prof.Dr.Umut Beşpınar	(METU,SOC)	_____

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

Name, Last name : Zeynep Deniz Şen

Signature :

ABSTRACT

THE FAMILY MEDICINE PRACTICE IN TURKEY
FROM THE PERSPECTIVES OF THE PHYSICIANS WITHIN THE
FRAMEWORK OF NEO-LIBERALISM

Şen, Zeynep Deniz
MS., Department of Political Science and Public Administration
Supervisor: Assoc. Prof. Mehmet Okyayuz

September 2019, 118 pages

This thesis intends to investigate the Family Medicine Practice in Turkey within the framework of neo-liberal health policies which are Health Transformation Program and General Health Insurance. Family Medicine Model is one of the ways of organizing the primary health care services within a health care system of a country. Even if there are plenty of researches conducted, most of those were took the patient-satisfaction as the reference point to determining the effectiveness of the practice. Due to such a literature gap and the need of research on this subject, this thesis aimed to evaluate the practice of the Family Medicine Scheme in Turkey through benefiting both from the theoretical framework of the subject and the thoughts of the family physicians. One of the other motives of the thesis is to discover the reasons of the failure if the practice of Family Medicine in Turkey failed. Therefore, this thesis intended to point out the non-functioning elements of Family Medicine practice in the case of Turkey through examining the mechanisms of the model in Turkey through benefiting from the theoretical information in the existing literature and the thoughts of the family physicians who are currently working by conducting an online questionnaire on 198 family physicians all around the Turkey. This study contributes

to health policy field through discovering the points needed to be improved or the actions may be taken by the policy makers to establish and sustain a better primary health care services policy implementation both in theory and practice.

Keywords: Family Medicine, Health Policy, Neo-liberalism, Privatization, Physicians

ÖZ

HEKİMLERİN BAKIŞ AÇISINDAN VE NEOLİBERALİZM ÇERÇEVESİNDE TÜRKİYE'DE AİLE HEKİMLİĞİ PRATİĞİ

Şen, Zeynep Deniz
Yüksek Lisans, Siyaset Bilimi ve Kamu Yönetimi Bölümü
Tez Yöneticisi: Doç. Dr. Mehmet Okyayuz

Eylül 2019, 118 sayfa

Bu tez, Türkiye'deki Aile Hekimliği pratiğini neo-liberal sağlık politika dökumanlarıolan Sağlıkta Dönüşüm Programı ve Genel Sağlık Sigortası çerçevesinde incelemektir. Aile Hekimliği Modeli, sağlık sistemi içerisindeki birinci basamak sağlık hizmetlerinin sunum şekillerinden bir tanesidir. Literatürde konu üzerine yapılmış olan birtakım araştırmalar olmasına karşın, yapılan araştırmaların çoğu hasta memnuniyetini, aile hekimliği pratiğini ölçmenin temel ölçütü olarak kabul etmişlerdir. Bu yüzden, bu tez, Türkiye'deki aile hekimliği pratiğini ölçerken, hem teorik çerçeveden yararlanıp hem de güncel olarak çalışmakta olan aile hekimlerinin görüşlerini referans noktası olarak kabul etmektedir. Bu tezin temel olarak, Türkiye'de aile hekimliği pratiğinin literatürde tavsiye edilen tamamlayıcı uygulamaların eksikliği ve hekimleri rahatsız eden birtakım uygulamalar sebebiyle şu an iyi bir uygulama olmadığını varsaymaktadır. Bu tezin bir diğer amacı ise, eğer aile hekimliği pratiği eğer hekimlerce de iyi bir Pratik olarak görülmüyor ise, pratiğin kötü olmasına sebep olan etmenleri ve uygulamaları aile hekimlerinin internet üzerinden Türkiye'nin her bölgesinden 198 aile hekimine uygulanan anket aracılığı ile elde edilen görüşlerinden de faydalanarak açığa çıkarmaktır. Bu tezin literatüre katkısı, aile hekimliği pratiğinin

politika yapıcılar tarafından geliştirilerek daha iyi bir uygulama olarak uygulanmasına katkıda bulunabilecek olması ile paraleldir.

Anahtar Kelimeler: Aile Hekimliği, Sağlık Politikası, Neoliberalizm, Özelleştirme, Hekimler

To My Grandma

ACKNOWLEDGEMENTS

To initiate, I would like to present my gratitude to my master's thesis advisor, Assoc. Prof. Dr. Mehmet Okyayuz for his inspiring knowledge guiding me so naturally and magnificently during the whole thesis process of mine. He has always believe in me and it led me to better directions in the process of writing my thesis.

I also would like to express my thankfulness to Prof. Dr. Filiz Kartal for being a part of my thesis examining committe and making suggestions which contributed to improvement of my thesis in a great way.

I would like to thank also Assoc. Prof. Dr. Fatma Umut Beşpınar for her extremely horizon-broadening comments which she made with her sociology-orientation.

I deeply feel myself lucky to be a member of my family. I am proud of being daugther of my parents. Therefore, my sincere gratitude belongs to my parents, who are family physicians and my inspiration for the subject of this thesis. I would like to thank them for their infinite support, for being proud of me and making me proud of them all the time.

Finally, I would like to thank Selin Taftaf for her great support and patience to help me when I feel quite stressed. I feel lucky to have such a friend who always be there for me when I need a sister.

TABLE OF CONTENTS

APPENDICES

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

1.1. Background and the Purpose of the Study

Primary health care services have an utmost significance in a health care system due to its characteristic of being a first-contact point in a health care system which means that it composes the entry or the gate of the health care system in a country. As it is stressed in the Alma Ata Declaration (1978), primary health care services have a central role on composing and shaping other levels of health care services which are secondary and tertiary health care services. As Alma Ata Declaration (1978) suggested, a country might have a well-functioning health care system through acknowledging the significance of the primary health care services and strengthening them. There are several researches proving that the countries whose health care systems are built around the primary health care services have a predisposition to have better health outcomes (Metsemakers, 2012).

Family Medicine Scheme, as a way of organizing the primary health care services, have a potential positive effect on a country's health care system as it has a tendency to reduce the costs, providing citizens with equal and easily accessible essential health care services and impact the other type of health care services. In order to establish a well-functioning family medicine practice, several components must be established and sustained. For instance, the mechanism of chain of referral have a significant impact on reducing the health care costs and establishing sustainable cost-efficient health care system (Çelik, 2011; Ener & Yelkikalan, 2003; Aytekin, 2012; Tatar et al., 2011; Akdeniz, Ungan, & Yaman, 2009; Türkbayrak et al., 2011).

The Family Medicine Scheme started to grow in Turkey in 1980s with the establishment of first Family Medicine departments within the faculties of medicine (Akdeniz et al., 2009). With the "Health Transformation Programme" launched by the Justice and Development Party (JDP) government in 2003, a marginal change in

Turkish health care system was envisioned through the initiation of Family Medicine Scheme suggested by neo-liberal health policies within the primary health care organization in Turkey (The Ministry of Health of Turkey, 2003; Ağartan, 2012; Yılmaz, 2013). The change was considered as marginal because Family Medicine Scheme is the opposite of the previous primary health care organization of Turkey (Öcek et al., 2013; Türkbayrak et al., 2011). New primary health care services organization way was severely criticized by the scholars of the field, physicians and occupational organizations, especially, Turkish Medical Association (TMA) due to its neo-liberal stance suggesting marketization, transforming the patients into customers and deteriorating the position of the primary health care physicians in the health care system (Ağartan, 2012; Soyer et al., 2007).

This thesis aimed to evaluate the practice of Family Medicine in Turkey according to the promises and implementations of Health Transformation Programme (2003), existing literature and the questionnaire conducted on the family physicians all over the country. This thesis had a goal to understand whether latest situation of family the medicine practice which was settled through neo-liberal health policies, notably, Health Transformation Programme (2003) is functioning well or not in Turkey and it aimed to understand the reasons if family medicine practice in Turkey failed. In the light of the theoretical framework on the Family Medicine Model and the conducted questionnaire with 198 family physicians in Turkey, this thesis argue that practice of Family Medicine Model in Turkey does not function well. While evaluating the practice in Turkey, the practice of the Family Medicine Model in Turkey, both components suggested by the existing literature and personal experiences of the family physicians about the practice are going to be taken into consideration.

1.2. Significance of the Study

The research on family medicine in Turkey in the existing literature having a patient satisfaction focus outnumber the other research having a different focus. It composed of the research (Özata, Tekin, & Öztürk, 2016; Baltacı et al., 2011; Bostan & Havvatoğlu, 2014; Barış, Mollahaliloğlu, & Aydın, 2011) which tried to evaluate the practice according to the patient satisfaction. Some research among these used

EUROPEP (European Patients Evaluate General / Family Practice) Scale (Mollahaliloğlu, Kosdak, Sanisoğlu, & Bulut Demirok, 2010; Turgu, Öztora, Çaylan, & Dağdeviren, 2018; Sparkes, Altun, & Bärnighausen, 2019; Aktürk, Ateşoğlu, & Çiftçi, 2015; Mollahaliloğlu et al., 2010). The researchers of these research mostly think that patient satisfaction is a significant determinant of functionality of the family medicine practice (Karadağ, 2007; Kantarcı, 2015; Leebov & Scott, 1994; Özata et al., 2016; Sparkes et al., 2019).

Also, several researches were conducted to measure the job satisfaction of the family physcians in Turkey (Doğan, Şensoy, Mardin, & Özbaltacı, 2013; Tözün, Çulhacı, & Ünsal, 2008; Türk Sağlık-Sen, 2013; Türkbayrak et al., 2011; Pantell et al., 2019; Yaman & Güneş, 2016; Mutlupoyraz, 2010).

Some research in the existing literature were conducted to reveal the challenges that family physicians in Turkey face in their professional lives (İlgün & Şahin, 2016; Öcek et al., 2014; Algın, Şahin, & Top, 2004).

Besides, in the existing literature, there are research on violence against family physicians in Turkey (Ayrancı, Yılmaz, Balcı and Kaptanoğlu, 2006).

As it is observed after reviewing the existing literature, the number of the research aimed to evaluate family medicine practice in Turkey through consulting the physicians' thoughts and putting together with the neo-liberal health reforms are quite limited. As different to previously conducted research, this thesis does not focus on the patient satisfaction dimension while evaluating the practice. Therefore, the essential contribution of this thesis to the literature might take place thanks to its potential for revealing the current position of the Family Medicine practice in Turkey from the perspectives of the family physicians. It takes the thoughts and comments of the family physicians in Turkey into consideration and tries to understand whether the family medicine practice in Turkey functions well or not through reviewing the neo-liberal health document which is Health Transformation Program (2003). The significance of the study results from this different perspective used for evaluation of the family medicine practice in Turkey and its potential to be a significant research revealing the challenges of the practice in Turkey that physicians must encounter. This research might be a guide for policy makers to understand the difficulties family physicians experienced and the challenges of the scheme inside the Turkish health care

system. Therefore, this research might impact the policy makers to take step and measures to develop the health policy advancing the health care services quality and protect both patients and physicians at the same time.

In this thesis, in Chapter 2, the theoretical framework is going to be presented through starting to explain the primary health care services, its definitions and significance. Then, the family medicine scheme, as a way of organizing primary health care services is going to be explained with its history, development, definitions, goals, objectives, given responsibilities, duties and competencies of family physicians and what is expected from them in the world. Then the following part is going to provide the information related to the history of family medicine, its development, its objectives, duties and competencies of the family physician in Turkey. After that, in Turkey and the current practices in several countries to formulate a comparison. While providing information related to the family medicine in Turkey, it is going to be benefited from the historical critical conjunctures as they enable a systematic periodical classification through depicting the altered elements and dynamics both in theory and in practice. More specifically, "1961 Act of Socialization" including "Law on the Socialization of Health Care Services" Law numbered 224, which initiated a different health care system and socialized the primary health care services through a strengthening (Akdeniz et al., 2009; Güneş & Yaman, 2008). In order to grasp the changes through critical conjunctures better, the brief comparison part between the Law on the Socialization of the Health Care Services (1961) and the family medicine scheme's implementation initiated by the Health Transformation Program (2003) as they presented opposite structure and practice due to the injected effect of neo-liberal health policies. Then, the Health Transformation Program is going to clarified in detail through focusing on the brought alterations and its neo-liberal stance. After clarification of the Health Transformation Program (2003), "General Health Insurance" is going to be presented as it might be regarded as a complementary action to the Health Transformation Program (2003) as they both suggested neo-liberal based alterations including the change in the financing dimension in the health care system's structure and its policies in Turkey. Chapter 3 holds the information on methodology of this thesis including research design, conducting the questionnaire with family physicians in Turkey to apply their thoughts on the family medicine scheme's practice

and whether it is related to neo-liberal health policies or not and the methods of analysis. In Chapter 4, the findings of the questionnaire are going to be presented and answers of each question are going to be evaluated in a qualitative assessment technique. After the qualitative evaluation of the questionnaire, the detected issues for the physicians about the practice of family medicine in Turkey which are frequently mentioned by the participants of the questionnaire are going to be classified into sub-titles and briefly explained and interpreted. Finally, the Chapter 5 is the conclusion and some recommendations for the future policies on the field of health policy, more specifically, family medicine practice in Turkey.

CHAPTER 2

THEORETICAL FRAMEWORK

2.1. Primary Health Care Services

In the "Declaration of Alma-Ata", which is quite significant document defining health care, its objectives, the measures may be taken and the steps to be followed for all countries to have a functional health care system (World Health Organization, 1978). In the declaration, it is agreed that the way of having better health outcomes and less health expenditure are regarded possible through strengthening the primary health care systems (World Health Organization, 1978). In this quite significant document on health care, the primary health care services are defined as;

> …essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of selfreliance and self-determination. ("World Health Organization," 1978, p. 1).

In addition, there are plenty of other definitions of primary health care in the existing literature. Eren and Öztek (1993) defines primary health care services as type of health care services which reach all families and individuals among the society, can solve the health problems of community and provide patients with outpatient care and sometimes in some health care systems even care at home. Primary health care services are also defined as the health care services which is provided by physicians in a constant and comprehensive way (İlgün & Şahin, 2016). Strengthening of the primary health care services is seen as the way to ensure that health care services are accessible and can be benefited by each individual equally (Tekin, Bozkır, Sazak, & Özer, 2014). The significance of primary health care services results from its nature to be a first-contact point which means the entrance of a health care system. In this respect, there

are plenty of evidences presented by several research depicting that health care systems which is built around the primary health care services have predisposition towards being more influential, effective and equal (Metsemakers, 2012). Because the primary health care services are the point of first-application or first-contact, it is able to decrease the health care costs, provides quicker and easier access to patients to the services and makes the usage of secondary and tertiary health care services more effective (İlgün & Şahin, 2016). Because of this reason, it might be argued that the primary health care services, as a first contact point and entrance or beginning of health care system, it has a tendency to affect and shape the other health care services which are secondary and tertiary care. For instance, if a primary care is capable of solving the problems of the patients without sending them to secondary or tertiary care facilities like hospitals, also, it causes a decrease in health care expenditure and it might reduce the costs within a health care system. Thanks to these functions of the primary health care services, importance of primary health care services is gradually grasped and it spreads through the health care reforms throughout many countries, especially the European countries (Kantarcı, 2015). In the light of these information on primary health care services, it can be implied that if the primary health care services can be organized and functioned well in a country, it may result in better health outcomes and indicators parallel with a decrease in health expenditure.

The development of primary health care services in Turkey has begun in 1961 through the introduction of the "Law on Socialization of Health Care Services", law number 224 (Güneş & Yaman, 2008). This way of organization of primary health care services was initiated by this law in Turkey is also referred as "Health Center Model" in several documents wrote by a host of authors, scholars, physicians and experts on the field (İlgün & Şahin, 2016; Türkbayrak et al., 2011). The law envisioned a health care system which is built around the primary health care services and according to the law, the primary health care services are positioned at the core of the Turkish health care system (Akdeniz etl al., 2009). Therefore, as Akdeniz et al. (2009) stresses, in Turkey, the significance of the primary health care is understood during that time before the publishing of Alma Ata Declaration (1978). However, Turkish health care system during that period which is built around primary health care services and initiated the implementation of referral chain could not be maintained in Turkey due

to several reasons including the absence of primary health care specialists, insufficiency of financial resources and the different understanding of health care seeking of the Turkish society leading to different expectations (Akdeniz et al., 2009). As it is going to be explained later in detail in this thesis, family medicine scheme, which is currently implementing as a type of organizing the primary health care services, is essentially the opposite of the organization of primary health care services before "Health Transformation Program" of 2003 (HTP). The HTP (2003) document built new way of providing and organizing the primary health care through initiating the "Family Medicine Model (FMM) as its central component (Özata, Tekin, & Öztürk, 2016). This new type of primary health care services distinguishes from the previous system, which is Health Center Scheme (Algın, Şahin, & Top, 2004). Family Medicine Model, as a type of primary health care services organization, is going to be explained in terms of its components, history, objectives, current situation in Turkey and other countries and its implementation in the following section. In addition, the primary health care organization before the HTP (2003) and current one, the FMM, are going to be compared and contrasted to understand stance of the FMM better.

2.2. Family Medicine Model (FMM)

2.2.1. History and Development of Family Medicine Scheme

In the 17th and 18th centuries, there were comparatively a few physicians who were available. The practice of medicine during 1800's can properly be named as "family medicine" because a single physician was taking care with patients as general practitioner, surgeon, gynecologist and so forth. This physician did know the patients as a family and took care of all the members of family most of the time they did these through home visits (Gutierrez & Scheid, 2015). This practice during the 1800's can be thought as the original implementation of practice of family medicine. In 1800's, practicing doctors generally were not trained formally they have a certain level of practical knowledge on medicine through some small trainings like workshops and some of them learnt the practice as apprentices of physicians. Because of these reasons, they know their patients very well both as individuals and as a whole family. During

that time, due to increasing challenges that are faced regarding the primary health care systems and technological and social advancements, the need of a new system in organizing primary health care broke out. In 1846, " The American Medical Association" (AMA) was founded and "The Journal of the American Medical Association" (JAMA) was started to be published (Gutierrez & Scheid, 2015).

In the middle of the 1900's, medical doctors who just graduated from the medical school and without any specialization education, started to be seen as outdated for medicine practice due to rising new medical specialties, technological advancement and the increase in the number of health care institutions like hospitals (Gotler, 2019). In 1910, "Flexner Report" was revealed by Abraham Flexner, who was an American educator who is regarded as one of the contributors of the medical and higher education reforms in both the United States and Canada (Gutierrez & Scheid, 2015). The report emphasized the development within medical specialties and the fact that their advancement started to dominate the science of medicine (Flexner, 1910). Inside the primary health care services, the need of specialization outbroke in 1923 for the first time after Dr. Francis Peabody argued that predisposition towards being specialist had reached its peak (Rakel & Rakel, 2015). Because of the increasing trend of taking specialization training within the science of medicine, the patient care has become "fragmented" and it also weakened the relationship between the physician and patient (Saatçi, Bozdemir, & Akpınar, 2006). The significance of general practice in medicine, as emphasized by Peabody during that time, results from its essence, which is being general, first point of contact and integrative, was ignored. The decreasing number of the general practitioners during that time due to shifting paradigm towards the specialization in medicine had led to outbreak of the need for a new specialty for this general, integrative health care. Therefore, the necessity of making family medicine a new medical and academic specialty came into existence. This over-specialization within the science of medicine prevented the evaluation of patients as a whole and erode the relationship between the patient and the physician. Peabody stresses the necessity of going back to general practice and formulation of new field of specialty for the primary health care. However, the significance of this warning could start to be understood after the World War II (Akdeniz et al., 2009; Tengilimoğlu, Dinçer, Menawi, Kisa, & Younis, 2016). However, the conditions

during that time are not sufficient to compose an ambiance for this new medical discipline to grow and to be recognized (Saultz, 2000). During the 1940's, general practitioners had begun to take steps towards making the general practice a separate specialty within the field of medicine. In 1952, "Royal College of General Practitioners" was established in England and it is seen as one of the milestones for the sake of historical development of family medicine as a medical and academic discipline. This new discipline was called "Family Practice" at the beginning. Starting with the 1960's, significant reports leading family practice's direction and helped it recognized as a new medical specialty. In 1966, the "Millis Report", which is one of the quite significant reports shaping the family medicine as an academic new specialty within medicine, was revealed (Saatçi et al., 2006). The report concluded that family practice should be made a separate specialty and it suggests that each individual must have a physician who is regarded as the vital point for providing continuity and integration in health services to patients (Gutierrez & Scheid, 2015). The report also stresses the significance of preventive medicine and "holistic medical approach" which were tried to be infuse family medicine. One of the other significant reports determining the direction of family practice is the "Witten Report" which was also published in 1966. The report defines the essential content of this new medical specialty of family practice. In 1967, in the United States, family medicine was recognized for the first time as a new discipline (Tengilimoğlu et al., 2016). During that time, Edward Kowalewski, who is a medical doctor and the president of the "America Academy of General Practice", encouraged his colleagues for more research on this new medical discipline (Gotler, 2019). Therefore, for the first time, family medicine was recognized as an academic medical specialization field. In 1969, several pilot implementations were confirmed family practice as the "newest" specialty in the field of medicine and this prepared family practice to be blossomed specialty later in the 1970's (Gutierrez & Scheid, 2015). After this rise of the family practice, later its name was changed to "Family Medicine". The terminology paradigm and consensus on this practice has been changed over time. Whereas, before it became a separate medical specialty, its first name was "General Practice", then it became new specialty as its name was changed to "Family Practice". Lately, the name of practice became "Family Medicine" (Gotler, 2019; Gutierrez & Scheid, 2015; Rakel & Rakel, 2015).

This shift of paradigm in understanding of the discipline, its objectives and its practice are explained by Dr. Stephens on the basis of the medicine's characteristics of being impacted and shaped by contemporary ideas and social trends of the time (Stephens, 1982). Creation of a new specialty within medicine was a milestone for the health care services and its policies in the sense that it changed many things including the organization of primary health care services and also its provision. In addition, the strengthening position and growth of the family medicine is interpreted because of the observed fact that it leads better outcomes, improved health equity and lowers the health care costs where it functions well (Rouleau et al., 2018).

In the following section of this thesis, the definition, objectives and the goals of family medicine scheme from the existing literature are going to be presented together with the duties of the family physicians in general and also in Turkey.

2.2.2. The Definition, Goals and Objectives of the Family Medicine and Duties of a Family Physician

The very first widely acceptable definition of the family medicine was done by Leeuwenhorst Media Group in 1977 through revealing a declaration called "General Practice in Europe". According to this definition, the family medicine is a primary health care services organization which provides continuous care regardless of the gender, age and illness (Leeuwenhorst, 1974). The definition of Leeuwenhorst is seen as most common definition of the family medicine which is believed by "World Organization of Family Doctors" (WONCA) that it originated from the definition of the "Royal College of Family Practitioners" in 1972 (Başak & WONCA Europe, 2003). Leuuwenhorst stresses that a general practitioner performs his/her duties through a collaboration with his/her colleagues and knows when, where and how he/she should interfere with situations of patients' health protection (Bıyıklıoğlu & Ungan, 2015). Also, a general practitioner is regarded as a graduate of medical school and who provides individuals and families with primary health care services regardless of the type of the diseases, the gender or age of the patients (Özdemir & Ungan, 2015). Leeuwenhorst suggests that the goal of a general practitioner is providing continuous

management of patients and also s/he has an occupational responsibility over the society (Bıyıklıoğlu & Ungan, 2015; Özdemir & Ungan, 2015).

One of the other significant definition of family medicine and its content was the one made by the WONCA. In a statement from WONCA which took place in 1991, it is stated that family practitioners / general practitioners fulfil their professional duties accordingly to the existing sources of the society and the health needs of the individuals (Bıyıklıoğlu & Ungan, 2015). Moreover, they are the medical doctors who have responsibility to provide any individual who is seeking a comprehensive health care and to prompt their colleagues or other health care personnel (Bıyıklıoğlu & Ungan, 2015). In the declaration of WONCA, the features of family medicine specialty were defined. These features are as follows;

- Comprehensive care
- Patient-orientation
- Family-orientation
- Provision of coordination with other health care services (secondary and tertiary health care services)
- Accessibility and resource management
- Taking responsibility over the community (Bentzen et al., 1991)

"World Health Organization" (WHO) adopted a declaration called "Framework for Professional and Administrative Development of General Practice / Family Medicine in Europe" which defined the discipline of general practice/ family medicine and its features (1998). According to the declaration, characteristics of the family medicine were clarified as "general, continuous, comprehensive, coordinated, cooperated, family-oriented and community-oriented" (World Health Organization, 1998, pg.10).

Family medicine was later defined by WONCA as a field of medical specialty and a discipline which practicing itself within the primary health care, explaining the philosophy of primary health care, having its own educational academic content (Başak & WONCA Europe, 2003). The declaration identifies the basic principles of the academic discipline of family medicine and the types of services that family physicians are supposed to provide for a cost-efficient patient care (Başak & WONCA Europe, 2003). This declaration explains the features of the family medicine in detail.

According to this declaration, the characteristics of family medicine were defined as follows;

- Composing the point of first contact with patient inside the health care system
- Helping effective usage of the health care sources
- Having a person-centered approach towards the individuals, their families and the society
- Ensuring the continuity in health care services
- Having a comprehensive approach
- Having an integrative approach (Bentzen et al., 1991; Başak & WONCA Europe, 2003).

Characteristics of family medicine field are acknowledged by the WHO per below.

- General
- Continuous
- Comprehensive
- Collaborative
- Family-oriented
- Community-oriented (World Health Organization, 1998).

EURACT (European Academy of Teachers in General Practice), which has a network with WONCA Europe, addresses the characteristics of the discipline as follows;

- Being a first point of medical contact,
- Ensuring the effective management of the health care resources through the coordination of care,
- Having person-centered approach,
- Promoting the patient empowerment,
- Having a unique consultation process,
- Managing both the acute and chronic health problems of individuals at the same time,
- Ability to diagnose at the early stages of the diseases,
- Promoting the health and well-being to the community,
- Deals with health in the patients' physical, social, psychological, cultural and existential dimensions (Holistic Approach) (Mola et al., 2005).

Also, abilities that family physicians must have related to the aforementioned characteristics of the discipline are determined by the EURACT (2005) are presented per below.

- Primary health care management
- Person-centered care
- Specific problem-solving skills,
- Comprehensive approach,
- Community-orientation
- Holistic approach (bio-psycho-social model) (Mola et al., 2005).

WONCA Europe published a notice in 2002 in Noordvijk, Holland which defines the discipline of Family Medicine / General Practice and the core competencies of the family physicians / general practitioners (Özdemir & Ungan, 2015). The declaration acknowledges the characteristics of the family medicine model as follows;

- Being first-contact point of the health care system including an unlimited access
- Having an efficient use of health care resources
- Having responsibility over both each individual and the society at the same time
- Having an holistic approach suggesting that consideration of health problems in terms of physical, mental, social, cultural and behavioral contexts (Bıyıklıoğlu & Ungan, 2015, pg.6).

As related to the aforementioned characteristics, WONCA Europe also defines the core competencies of family medicine. These core competencies are management of the primary care, patient-oriented care, unique problem solving skills, community-oriented and holistic approach (Bıyıklıoğlu & Ungan, 2015; Mola et al., 2005).

One of the other significant definitions of family medicine was made by Frede Olesen (2000). In family medicine model, family physician is supposed to manage the health resources accordingly to the benefit of his/her patients regardless of their type of existing diseases or their other personal and social features (Olesen, 2000). Also, family physician is an expert who is educated to work for the first steps and measures taken for the patients in terms of primary health care (Bıyıklıoğlu & Ungan, 2015; Özdemir & Ungan, 2015).

Furthermore, Bernard Gay, who is a professor at University of Bourdeaux-College of Health Sciences clarified the basic principles of the family medicine discipline included by the European "Academy of Teachers in General Practice" (EURACT) in its report (2005). Gay believed that there is a connection between the family medicine discipline's principles and its duties (Mola et al., 2005). Therefore, Gay tried to define the discipline through considering that relationship. Gay argues that both the type of the health care system and the existing patients in a country have certain level of influence on the duties of the family physicians (Özdemir & Ungan, 2015). However, the significance of the principles mentioned by Gay results from its differences from the ones defined by WHO and WONCA. The principles added by Gay as different from the WHO and WONCA are; the fact that serious diseases are seen with a low incidence, the fact that diseases are seen at early stages and the management of multiple pathologies simultaneously (Özdemir & Ungan, 2015, pg. 10).

In addition to these definitions of the family medicine discipline, Doug Campos-Outcalt (2004) defined five basic duties for family physicians as a part of community health system. These duties are as follows;

- Using the suggested guides for preventive health care services
- Making proper patient direction to the community health centers
- Being in a healthy communication with local health units (Campos-Outcalt, 2004).

Outcalt also suggested that all family physicians are supposed to have a basic specialty degree on the discipline which means that all family physicians should be family medicine specialists (Bıyıklıoğlu & Ungan, 2015, pg. 23). At this point, Outcalt also argued that in the field of community health, there should be a four-layered specialization type including basic level, intermediate level, advanced level and leadership level (2004).

McWhinney and Freeman (2012), while defining the principles of the family medicine field, stated that family physicians see each contact with their patients as an opportunity to improve their health status and these opportunities are quite significant for the maintenance of preventive medicine. McWhinney and Freeman also stressed the fact that family physicians are evaluating their enrolled patients in according to

their risk-groups referring that a patient's predisposition towards having some certain illnesses due to their genetic, social and physical conditions (McWhinney & Freeman, 2012). McWhinney and Freeman suggests that in order to have an effective primary health care services, family physicians must share the same environment with their patients and they must be visible in this environment which means that they must be easily accessible (Bıyıklıoğlu & Ungan, 2015). Also, family medicine is a specialty in which is a discipline having a clinical practice, research and a unique scientific application (Kantarcı, 2015). In the existing literature on the definition of family medicine scheme in Turkey, the Ministry of Health (MoH) of Turkish Republic have an utmost significance. According to the definition of the Ministry, the family medicine is a primary health care services organization in which family physicians including the family medicine specialists and the general practitioners receiving the necessary education approved by the ministry, who are responsible for providing individual-oriented preventive health care services, comprehensive and continuous care without looking at the age, gender and disease of their patients (Sağlık Bakanlığı 2016, 2017). Family physician is also a medical doctor who is a medical doctor who evaluates patients in terms of a holistic approach meaning that considering their existing acute and chronic health problems but not a specific disease (Kantarcı, 2015).

As other type of defining the family medicine model, some of the significant organizations or scholars related to the field prefer defining the family physician / general practitioner, their duties, responsibilities, core competencies and features. At this point, in this paragraph, the method of defining the family medicine is going to be clarified through providing the definitions of family physician / general practitioner. In the first place, general practitioner or family physician refers to the "medical practitioner who has completed specific postgraduate training, analogous to that of other medical specialties, in the discipline of general practice or family medicine" (World Health Organization, 1998, pg. 4). Family physician is also defined as the medical doctor who is responsible for providing patients with comprehensive care to each patient, managing the other complementary health care personnel when it is necessary and s/he functions as general medical specialist who is responsible to examine each individual in need of health care regardless of their age, sex or diagnosis (Bentzen et al., 1991). Bentzen et al. (1991) explain the significance and difference of

the family physicians / general practitioners in terms of the fact that they are more accessible and ideally the unlimited access point whereas other health care providers generally limit the access. World Health Organization (WHO) defines family physician as the medical doctor who provides primary health care services with the community s/he is in regardless of the patients' personal features such as gender, age, religion and so forth (Kantarcı, 2015; Akdağ, 2004). Saran (2007) addresses the family physician as a physician, who is capable of evaluating his/her patients according to a holistic approach requiring consideration of patients' conditions, health care records in the past, their psychological conditions and knows the risks that their patients are possibly face in the future through building and sustaining a long-term relationship based on a mutual trust (Kantarcı, 2015). According to the MoH, family physician is a general practitioner who is responsible for diagnostic, treatment, rehabilitative and protective health care services and preserving the health of the patients registered to them and working through a contract by an approval of the ministry in terms of the education that they have (Algın et al., 2004).

Duties of family physician are basically addressed by the WHO as performing a significant role in the provision of integrated health promotion, disease prevention, curative, rehabilitative and supportive care (World Health Organization, 1998).

By-law of Family Medicine (2013) issued by the MoH of Turkish Republic defines the duties, jurisdictions and responsibilities of family physician. These articles included by the by-law are as follows;

1. Governing the Family Health Center (FHC), investigating the team that they are working with, providing the trainings within the health care services, governing the patient-centered health care services as the ministry envisioned,
2. Providing their registered patients with preventive, rehabilitative and curative health care services,
3. Duties, jurisdictions and responsibilities of family physicians are addressed per below.
    a. Collaborating with the Community Health Center (CHC) that they are located in for the planning of the health care services,

b. During the exercise of their profession, report the situations regarding the health of community and environment to the CHC,
c. Making home visits to complete the first evaluation of the registered patients or getting in contact with them,
d. Providing preventive health care services to the individuals and primary health care services including diagnosis, treatment, rehabilitation and consultancy,
e. Acting as a guide for the registered patients, providing health care services for the sake of the health development, preventive health services, health services related to family health and reproduction,
f. Doing periodical health examination,
g. Monitoring the registered patients according to their gender, age and disease groups,
h. Providing primary health care services to the registered patients whose care is necessarily can be done at home (care for disabled, the old and the infirm),
i. Refer patients for whose diseases could not be diagnosed inside the family health center's facilities, monitoring and evaluating the referred patients' health conditions and providing coordination among these different levels of health care services,
j. Ensuring the medical workups are done properly,
k. Keeping records of the health care services that they provide and giving feedback for these,
l. Evaluating the registered patients at least once in a year and updating their health records,
m. Keep the registered patients under supervision when it is necessary, doing their medical workups and providing treatment,
n. Issuing anticipated official documents which are accepted in the related legislation as the duty of primary health care physicians (medical reports, referral documents, prescription and so forth.),
o. Attending the on-the-job trainings,

p. Fulfilling the other duties given by the related legislation and institution (Sağlık Bakanlığı, 2016, 2017).

Özdemir and Ungan (2015) addresses the characteristics of family medicine similarly to the ones that formulated and revealed by WHO, WONCA, EURACT and MoH of Turkish Republic. These are similar in the sense that they stress the fact that family medicine is the first point of contact, provide effective health care sources management, having a patient-oriented approach, having a unique process of consultation and examining the patients, encouraging the ability of managing both acute and chronic diseases simultaneously, providing continuous care, promoting the holistic approach while evaluating the health conditions of the patients and so forth.

WONCA defines the specifications which are required for the family physicians as;

- Regarding the comprehensive care,
- Having an ability to coordinate the health care (with other services)
- Having an advocacy role for their patients,
- Treating their patients on an informative base,
- Having an ability to build and sustain a strong patient-physician relationship which is based on mutual trust,
- Being accessible to each registered patient as the point of entrance to the health care system,
- Having an ability to manage the health care resources,
- Having a clinical-decision making skill (Bentzen et al., 1991).

As parallel to these abilities which a family physician must carry, WONCA (1991) also defines the commitments should be made by the family physicians through classifying them into two different categories. According to this classification made by WONCA, a general practitioner has two types of commitments which are to the community and to the individual. The commitments to the community require a broad approach and it stresses the significance of supporting the community. The commitment made to the individual consists of comprehensive care, suggesting an orientation to the patient, having a family focus and promoting a strong doctor-patient relationship (Bentzen et al., 1991).

After the aforementioned characteristics of family medicine and core competencies required for the family physicians from existing literature, objectives and goals of the family medicine are going to be explained in the following section.

Gotler (2019) defines the main objectives of the family medicine as being or functioning as an "antidote", which means opposite, to the medical specialties which are narrowly focused, treating patients who are in need of understanding and compassion within the framework of holistic approach (pg. 71). Kantarcı (2015) addresses the goal of family medicine as provision of the "preventive and diagnostic treatment through presenting with rehabilitative aspects". Family medicine, as a last risen medical specialty, intended to "bring wholeness and humanity to the medicine during a time period when high technology and fragmented care prevailed" (Gotler, 2019, pg. 74). At this point, as Gotler (2019) stresses, it can be said that family medicine is a trial of altering the ongoing focus on the patient care through encouraging the rejection of preponderant focus on more limited medical specialties. Family medicine has four cardinal functions which are; being a point of first-contact in the health care system, providing longitudinality in health care, bringing comprehensive approach to the health care and providing a coordination between all levels of health care services (Öcek et al., 2014). As parallel to the cardinal functions of family medicine scheme, central components of it are also addressed as continuity, comprehensiveness, accessibility and coordination of health care (Öcek et al., 2014). Also, as it is stressed in the previous paragraphs of this thesis, patient-orientation is acknowledged by several significant international medical organizations and scholars in the field as one of the essential characteristics of the family medicine, improving the patient satisfaction is one of the primary motivations behind this specialty (Sparkes et al., 2019, pg. 18). One of the other important objectives of the family medicine is being a "broad-based" specialty meaning that involving all organ systems, patients from all ages and the effects of physical, psychological and cultural environments of the patients (Metsemakers, 2012).

In the light of these definitions, goals, objectives of family medicine and duties of family physician, it can be argued that family medicine's main objectives are providing an easily and equally accessible primary health care services, detailed periodical monitoring for the patients and their families, completing vaccination on

their registered patients, encouraging immunization and health promotion, taking care of them through regarding their both physical and psychological problems and leading a costly efficient primary health care services. WHO argues that a family physician might make a contribution to a high quality, efficient and effective primary health care service which also has a positive impact on quality of specialized health care services (World Health Organization, 1998).

The features and points which are included by the definitions and characteristics of family medicine together with the duties of family physician from the ongoing literature, it is beneficial to clarify the most significant ones to understand better how family medicine scheme is supposed to function inside a health care system. Therefore, the significance of the family medicine model and the factors must be regarded within the system of family medicine scheme could be grasped in broader sense.

2.2.2.1. Gatekeeping Function of Family Physician – Chain of Referral

Due to its great significance, gatekeeping function of the family physicians is evaluated and explained as a separate significant headline. Family medicine, as a primary health care system organization, provides an entrance to a health care system as a first-contact point. Family medicine is the first point to apply for a patient for any kind of health-related issues except for the case of emergencies (in case of emergencies, the ambulances would take patient to the nearest health care facility including the emergency services of the hospitals). Because of this reason, family physicians within a health care system are the "gatekeepers" who are the first responsible authority and provide coordination among all the health care services. Family physician functions as gatekeeper in the sense that they are the authority who enables the entrance to the health care system and if it is necessary, they are the ones who decide and refer patients to the specialists on the second or tertiary health care services. At this point, family physician mediates between registered patients and the whole health care system (Kantarcı, 2015). As it is stressed before in the beginning of this thesis, Declaration of Alma Ata (1978) suggests that the family medicine is the best primary health care organization model as it provides cost-efficient preventive

health service inside the primary health care system (World Health Organization, 1978; Kılavuz, 2010). However, in order to have such a functional cost efficient family medicine model as a type of primary health care organization, a well-functioning "chain of referral" is a prerequisite (Çelik, 2011; Ener & Yelkikalan, 2003). Since the chain of referral or referral chain helps controlling the health expenditure and sustain health expenditures, it is one of the most significant indispensable of the family medicine model (Aytekin, 2012). In Turkey, "Law on Socialization of Health Care Services", law number 224, (1961) started a new organization of health care through making primary care as central component of the health care system and initiating the chain of referral before the Alma Ata Declaration (World Health Organization, 1978; Güneş & Yaman, 2008). With the "Health Transformation Program" (2003) which makes the family medicine model central value of the primary health care services organization in Turkey, envisioned the existence of a chain of referral at first. However, after three months experience of a referral chain in Turkish health care system, government decided to abolish this mechanism (Öcek et al., 2014). The World Bank (2003) in its one of the reports on Turkish Health Care system argues that the chain of referral could not be used well in Turkey (pg. 77). The World Bank (2003) argues that almost nobody uses the primary health care facilities just as having a referral to the higher levels of the health care services. The World Bank (2003) clarifies the situation in terms of the non-existence of a penalty (pecuniary penalty) for the ones who bypass the family physicians and directly go to the secondary or tertiary health care facilities and it argues that this non-existence of a penalty prevents patients from applying only to the primary health care services. Therefore, the World Bank (2003) stresses the situation of family physicians in Turkish health care system do not function as gatekeepers (The World Bank Human Development Sector Unit Europe and Central Asia Region, 2003). In this sense, the World Bank (2003) summarizes the current situation of the referral chain in the Turkish health care system. This absence of the mechanism of chain of referral prevents family medicine scheme from functioning well in Turkey. Because the logic of the referral chain is reducing the health care costs and providing physicians with monitoring their patients in a coordinated context, its absence hinders the family medicine scheme in Turkey from becoming well

-

functioning one. Algın et al. (2004) conduct a research based on a questionnaire applied to the family physicians in Ankara, Turkey on the occupational challenges of the physicians including their thoughts on the chain of referral.

According to the questionnaire results, the non-existence of a referral chain in Turkish health care system is seen as a great challenge by the many of the participants (Algın et al., 2004). Also, in this thesis, the thoughts of the working family physicians on the absence of chain of referral is going to be asked in the questionnaire which is going to be presented and evaluated later.

2.2.2.2. Equal and Accessible Primary Care

As it is mentioned above, as the family physicians are the point of the firs-contact, there should not be any obstacle or difficulty for patients to have access to their family physicians (Bentzen et al., 1991). Also, this feature of family medicine suggests that a family physician does not have any value-judgement and s/he should not differentiate one from another regarding their gender, age, race and so forth.

2.2.2.3. Management of Health Care Resources

Accessible primary health care services feature of family medicine is connected to the other one which is the effective usage of the health resources in the sense that it may solve the problems of the patients within the primary health care services so it could reduce the costs of the health care system. Therefore, family medicine provides effective usage of the sources of the health care system. However, it should not be ignored that this effective usage of health care resources leading a cost-efficient primary health care is also related to the gatekeeping role of the family physicians. These two features coherently provide costly-efficient health care system.

2.2.2.4. Longitudinal / Continuous Health Care

Family physicians provide longitudinal health care services to their patients through monitoring and taking care of them through their whole lives, not for only a certain period of their lives. Family physicians have a responsibility to manage both the chronic and acute illnesses of their patients at the same time through a comprehensive approach. Holistic medical approach suggests family physicians to evaluate their patients through regarding also their physical, social, economic and psychological conditions (Başak & WONCA Europe, 2003). Moreover, family physician also has a responsibility to manage their patients' both acute and chronic diseases at the same time. This simultaneous effort of the family physicians also contributes to the provision longitudinal and continuous care in the framework of primary health care.

2.2.3. History of Family Medicine and its Development in Turkey

The specialization of family medicine in Turkey have been initiated in 1983 with the added code on Family Medicine post-graduate training to the "Medicine Specialty Regulation" (Tababet Uzmanlık Tüzüğü) (Akdeniz et al., 2009; Tengilimoğlu et al., 2016). In 1983, the Family Medicine training in terms of medical education context became necessary in Turkey (Algın et al., 2004). This is the recognition of the Family Medicine as new specialty within the field of medicine in Turkey. After post-graduate training took place in the by-law, in 1984, the first department of the family medicine was established at Gazi University and in 1985, the Family Medicine specialty started to function as new specialty in the education and research hospitals in Turkey (Akdeniz et al., 2009; Kantarcı, 2015). Family Medicine specialty education have been introduced in the MoH hospitals in Istanbul, Ankara and Izmir (Tengilimoğlu et al., 2016). In 1990, AHUD (Family Medicine Specialists Association) was established and this was regarded as the starting point of the Family Medicine's first steps in Turkey (Ünlüoğlu & Paycı, 2004).

July 1993 is regarded as a corner stone for the Turkish Health Care System as The Higher Education Council of Turkey have decided to establish family medicine departments in the universities all over the country (Başak & Güldal, 2014). This decision also promoted the recognition and development of family medicine as an academic discipline in Turkey and the occupational organization of the discipline have started with the renaming of the AHUD to the TAHUD in 1998 (The Turkish Family Physicians Association) (Akdeniz et al., 2009; Kantarcı, 2015; Tengilimoğlu et al., 2016). These developments were regarded the basis for the advancement of the discipline in Turkey.

Family Medicine, as a primary health care organization, was envisioned and that it is planned to be implemented with the Health Transformation Program (2003). It was launched in 2005 as a pilot scheme under the "Law on Family Medicine Pilot Implementation" which was legislated in 2004 with the law number 5258 (Law no.5258 on Family Medicine Pilot Implementation, 2004). Pilot scheme was started in the province of Düzce in 2005 and then it was expanded gradually to all the provinces in Turkey in 2010 (Law no.5258 on Family Medicine Pilot Implementation, 2004; Cesur, Güneş, Tekin, & Ülker, 2017; Öcek et al., 2014; Özata et al., 2016). The initiation of a new system for the organization of primary health care services in Turkey was regarded as a major change (Güneş & Yaman, 2008). It was accepted by the scholars and the medical doctors in the field as a major change because it altered organization of the primary health care in Turkey through initiating a new scheme which was basically the opposite of the hitherto system (Öcek et al., 2014; Türkbayrak et al., 2011).

The new primary health care organization, Family Medicine Scheme was envisioned as a scheme which provides each citizen to a specific family physician offering primary health care services which are free-of-charge (Cesur et al., 2017). Family medicine divides the functions of health centers into two different categories in terms of their organizational duties. Family Health Centers (FHCs) and Community Health Centers (CHCs) are supposed to co-work whereas FHCs replaced the old Health Centers, CHCs are responsible for preventing communal diseases and promoting health to the community (Öcek et al., 2014). Family Medicine Scheme was

initiated in Turkey with the chain of referral at first but as it was stated before, after three months experience, it was abolished by the government (Tatar et al., 2011).

Family medicine was planned to be settled through remarkable the Health Transformation Program Document (2003). The Health Transformation Program was and still is seen as a "neo-liberal" document or a health reform document suggesting renovations brought by neo-liberal understanding of public management (Ergun & Dericioğulları Ergun, 2010; Pala, 2014). The Health Transformation Program, having a neo-liberal quality on the basis of suggesting health reforms, is going to be presented and evaluated in detailed later in this thesis under a separate headline due to its significance for the thesis. In order to grasp family medicine's synchronization with the Turkish health care system, it has an utmost significance to go back to the time period before the family medicine which was envisioned and initiated through the HTP (2003). Because of this reason, in the following paragraphs of this thesis, the opposite of the family medicine as a way of organizing the primary health care system which is Health Center Model is going to be presented with its features and then the HTP (2003) which enforced a replacement of this system with Family Medicine Scheme is going to be compared, interpreted and evaluated.

2.2.3.1. Law on the Socialization of Health Care Services (1961)

Before the HTP (2003) and Family Medicine Scheme that is envisioned, there was a Health Center Model which is antidote of today's organization. In 1961, the Law on the Socialization of Health Care Services started a new health care organization as it built the health care system around the primary care and initiated the chain of referral which does not exist today (Akdeniz et al., 2009). The Socialization Act was a district-oriented primary health care model which imposed the establishment of health centers providing health care services to a population of 30.000-50.000 in the cities and 5.000-10.000 to the rural areas such as villages (Öcek et al., 2014). This law is still regarded by the Turkish Medical Association and many scholars in the field as the first "integrative" health care implementation of Turkey (Türkbayrak et al., 2011). Whereas Health Center Model offered curative, preventive and both individual and community oriented care within a district-oriented and broad-based framework, the

Family Medicine Scheme provides narrowly focused and fragmented primary health care as it separated the preventive health care services as towards the individual and towards the community (İlgün & Şahin, 2016). In the Health Center Model, primary health care services were provided within the focus on curative services (İlgün & Şahin, 2016). In the following section, the comparison of the HTP (2003) and 1961 Socialization Act for providing a basis to understand better the altered elements in theory and also in practice.

2.2.3.2. The Law on the Socialization of Health Care Services vs. Health Transformation Program

Whereas Health Center Model legislated by Law on the Socialization of Health Care Services suggested a focus on curative health care services, HTP (2003) suggested the provision of curative, preventive and rehabilitative health services at the same time within the level of primary health care in Turkey. Before HTP (2003) and Family Medicine Scheme, provision of infrastructure was under the responsibility of the state, with family medicine, this responsibility became the physicians' of the primary health care (Türkbayrak et al., 2011). In the Family Medicine Scheme, Health Centers are places which are owned by the MoH and supposed to be rented by the family physicians who would run the center. It means that health centers were turned into commercial enterprises in which family physicians are responsible to pay all the infrastructural costs including the electricity, internet and even the employees in the health centers that they rented. Health Center Model provided completely free-of-charge primary health services. However, Family Medicine Scheme envisioned a contribution, even if it is argued by the state that it would provide each citizen basic health services completely free-of-charge (Türkbayrak et al., 2011). While the Law on the Socialization of Health Services of 1961 was district-oriented meaning broad-based, family medicine rejected the idea of that understanding and it suggested list system including only the registered patients (İlgün & Şahin, 2016). Until the Family Medicine Model, a teamwork was suggested and promoted. Yet, family medicine divided the health care teams into little teams which are mostly based on a doctor and a health care personnel. Therefore, it abolished the understanding of co-working inside

the primary health care services (Türkbayrak et al., 2011). Whereas Health Center Model gave an utmost role to the mechanism of referral chain, Family Medicine practice in Turkey could not be able to sustain the practice of it even if the most significant argument of the HTP (2003) is the fact that family physicians have a gatekeeping role (Akdeniz et al., 2009; Türkbayrak et al., 2011). During the practice of the Health Center Model in Turkey, general practitioners had "safer" working conditions as they were paid well on the basis of salary system and they were seen as state officers. However, Family Medicine made general practitioners contractual employees and it is based a performance-based payment system which caused differentiation in the salaries of family physicians (İlgün & Şahin, 2016; Türkbayrak et al., 2011).

2.2.3.3. Health Transformation Program (HTP)

After the general election which took place in 2002 in Turkey, the Justice and Development Party (JDP) government released the "Urgent Action Plan" (UAP) aimed to give both administrative and financial autonomy to the hospitals, establish the "General Health Insurance" (GHI), implement Family Medicine Scheme for the provision of primary health care services and promote investment of the private sector to the health care services (Soyer et al., 2007). The UAP's main goals were; restructuring the MoH both in terms of functional and administrative perspective, establishing the General Health Insurance system providing coverage to all Turkish citizens, providing administrative and financial autonomy to the hospitals, implementation of the family medicine, encouragement of the private sector for the investments (Akdağ, Aydın, & Demirel, 2009). However, in 2003, by the MoH , the Urgent Action Plan was re-revealed this time under the name of the "Health Transformation Program" which basically included old ideas of health reform since 1980s and suggesting collaboration with private sector (Yenimahalleli Yaşar, 2011). The previous planned name for the HTP (2003) was "Health Reform Project" and it was prepared through the loans provided by the World Bank under the name of the "World Bank Project" of 1987 (Soyer et al., 2007; Yenimahalleli Yaşar, 2011). The reform's aim was announced as the provision of "easy" and "equal" access to the

health care services together with its basic motivation which was the need for change due to argued advantageous position of the civil servants in terms of quality and access to the health care services (Yılmaz, 2013). One of the major objectives of the HTP (2003) was the provision of an effective usage of the production factors in the health care services including the pharmaceuticals, medical materials, buildings and human capital and it also aimed to provide equal health insurance to the whole population (Aydın, 2007; Türk Tabipleri Birliği, 2018a). The reference points of the HTP (2003) were determined as "common, easily accessible and debonair health care system", which consisted of three essential factors; strengthened basic health care services through the Family Medicine, effective and gradual chain of referral and administratively and financially autonomous health enterprises (Türk Tabipleri Birliği, 2018a). Together with these, the principles of the HTP are defined by the MoH as follows;

- Human centrism
- Sustainability
- Continuous quality improvement in health care services
- Volunteerism
- Division of power
- Decentralization and competition in the service
- Reconcilement
- Participation of all stakeholders (The Ministry of Health of Turkey, 2003).

Yenimahalleli Yaşar (2011) stresses that HTP (2003) has several essential components which are presented per below.

- New role given to the MoH
- Establishment of the GHI
- Easy access to health care services
- Strengthened primary care through implementation of the Family Medicine Model
- Autonomous health enterprises
- Motivated health care human resources
- The Chain of referral

- Supporting educational bodies, rational drug use, usage of health information system and quality of services

This new role is given to the MoH by the HTP (2003) was functioning as a planner and supervisor instead of financer and provider of the health care services. At this point, the MoH is suggested to develop policies of health care, to define the quality standards of the health care services and to ensure effective usage of the health care resources (Yenimahalleli Yaşar, 2011). It means that the MoH was discharged from financing and provision dimensions of the health care services and instead, it is given a role of functioning as "steering mechanism" which determining the standards and monitoring the implementation of the health policy. Also, the HTP's (2003) one of the aims, which was strengthening the primary health care services was planned to be achieved through the introduction of the Family Medicine Scheme (Ergun & Dericioğulları Ergun, 2010; Yenimahalleli Yaşar, 2011). The new given role to the MoH is regarded as transforming it from being an institution producing health care services to an institution only regulating and controlling the health care (Tükel, 2010).

In the first place, the HTP (2003) had an essential goal to eliminate the long-lasting problems in the health care with a central aim of setting up an effective health care system providing high quality health care services (Yenimahalleli Yaşar, 2011). The HTP (2003) declared that previous health care system of Turkey "inefficient", "inaccessible" and "unresponsive to the demands of the patients" and it caused the health care costs to rise continuously (Ağartan, 2015). The HTP's (2003) major areas of concern are stated as low coverage problems, low quality of the previous health care services, improvement of the governance for the health care policy and reducing the health care costs (Yenimahalleli Yaşar, 2011).

Since 2003, with the introduction of the HTP, Turkish health care system has been undergoing a marginal change (Yılmaz, 2013). The draft of the HTP (2003) was interpreted by some scholars of the field and by medical doctors as "privatization" or "marketization" of the health care services in Turkey but this time with a different named document instead of the past reform efforts (Soyer et al., 2007). The HTP was and still regarded as a reform document having a "neo-liberal" stance suggesting privatization of the health care services, especially the primary health care services in the framework of components and aims of the HTP. Ağartan (2012) argues that the

HTP mirrors a "social neo-liberal" approach with its suggested policies in the health care sector including privatization or marketization of the services. The HTP, together with the "59th Government Program", addressed the top priorities of the health care sector and they were considered as a key to provision of "liberalization" in the field of health care (Neziroğlu, Yılmaz & Erdem Efe, 2013; Ergun & Dericioğulları Ergun, 2010). This effort for the liberalization of the health care was aimed to be achieved through four main elements which are; establishment of the GHI through reducing the impact of the public sector and paving the way of privatization, making the the Social Insurance Institution (SSK) a financer of the health care system instead of being a provider,, implementation of the Family Medicine Scheme in the primary health care services organization and the establishment of the "Union of the Public Hospitals" (Ergun & Dericioğulları Ergun, 2010). As several medical doctors suggest, the HTP composed of privatization efforts through restructuring of the public sector via neo-liberal policies and the change in the organization and financing which puts market dynamics and mechanisms (Türkbayrak et al., 2011). Therefore, Turkish health care system has been transforming seriously through extensive reform programs which mainly altered the boundaries of the public and private sectors (Ağartan, 2012). Through the overlapping boundaries between the public and private sector in the field of health care, new system enforced by the HTP is based on a "public-private partnership" model which might be observed together with the increase in the role of private sector as its lobby organizations gained more political strength especially in the provision of the services (Yılmaz, 2013). At this point, the transformation of health care system of Turkey was tried to be made through initiation of two major components in the HTP, which are marketization and universalism (Ağartan, 2012). At this point, the HTP tried to combine or compromise universalism with markets. The HTP emphasized the significance that it gives to the universalism because the JDP promised universal coverage to all Turkish citizens (Akdağ et al., 2009). In order to achieve universal coverage in Turkey, the government made the proposal suggesting the establishment of a national health insurance scheme which is going to collect the contributions according to the ability of each citizen to pay (Ağartan, 2012). In this sense, due to aim of providing universal coverage together with the envisioned re-structuring of the MoH, the MoH argued that HTP is an important step suggesting re-

structuring of the MoH which is in favor of strengthening the "social state" (Aydın, 2007). However, on the contrary, it might be observed that the role of the state decreased due to neo-liberal characteristic of the HTP. The HTP should not be considered as a step for the strengthening of the social state because it is a reform document suggesting an increase in the role of private sector and a decrease in the role of the MoH as it is given a role for regulating and monitoring the policies. It envisioned a withdrawal of the MoH from especially the provision and financing dimension of the health care services as private sector mechanisms declared new financers and providers of the health care services. In the HTP, the suggested market elements including financial incentives and competition are escorted by a re-definition of the state which suggested withdrawal from the provision dimension of the health care services in Turkey (Ağartan, 2015). Therefore, one of the most significant alteration brought by the HTP was the separation of provision and financing of the health care services including a change in the financing model of the public hospitals, restructuring of the hospitals (Ergun & Dericioğulları Ergun, 2010; Tükel, 2010). Furthermore, the marketization element of the HTP outweighed the universalism elements envisioned in the reform document. As Ağartan (2012) suggests, marketization of the health care services taking place with privatization efforts might result in an erosion in the universalism element that was aimed to achieve by the HTP. Ağartan (2012) also argues that there are three indicators to determine the extent of marketization in health care brought by the HTP and these are "private health expenditure as percentage of GDP", "number of public and private hospitals" and "private hospital beds as percentage of total bed stock". As it is mentioned before, the HTP paved a way to all these three things as it promotes the investment coming from the private sector to the health care services as the MoH withdrew from the provision of the services.

Whereas some scholars in the field argued that the overall impact of the health care reform undertook by the HTP is egalitarian (Ağartan, 2012), the others believed the market aspects of the reform is a vail hindering the realization of inequalities in access (Yılmaz, 2013). Yılmaz (2013) argued that the HTP could abolish the inequalities resulting from the occupational status of the people but it caused a generation of new origin of inequality which is income after the HTP. Before the HTP,

civil servants were seen as most advantageous social group due to their coverage of the insurance scheme and access to the health care services. However, the occupational status is not the main source of these inequalities instead of it, income is the new cause of it. Because of this reason, even if there is a high satisfaction level with the new health care system planned by the HTP, it is difficult to label the overall impact of the HTP's reforms as "egalitarian" (Yılmaz, 2013).

In the framework of aforementioned characteristics of the HTP, it can be argued that even if the HTP aimed to abolish the inequalities including in access and increase the quality of services for all the citizens, it could not be able to achieve its all goals completely. Despite the increase in the health expenditure allocated to the pharmaceuticals and treatment, the inequalities could not be eliminated, which was one main goals of the HTP (Türk Tabipleri Birliği, 2018b). Behind these aims of the HTP addressed by the MoH, there was an effort for the marketization of the health care services through a privatization, promotion of the private sector investments in the field and enforcement of the withdrawal of the MoH from the provision of the health care services. The HTP was a vail which initiates the marketization and privatization in terms of the health care services, especially, primary health care services in Turkey through suggested neo-liberal policies such as autonomous hospitals, private investments and implementation of the Family Medicine (Tükel, 2010). One of the main basis of the privatization of the health care services under the name of the HTP was Family Medicine practice (Türk Tabipleri Birliği, 2006). Because of this health care transformation effort which was based on privatization of the services, whereas the unions and associations which represent the professionals of health care, especially, the Turkish Medical Association (TMA), strongly criticized it in terms of its neo-liberal focus on the health policies which weakens the right to health care, the World Bank and the TUSIAD (The Turkish Industry and Business Association) severely supported the HTP (Yenimahalleli Yaşar, 2011). One of the other reasons of why occupational organizations such as TMA severely criticized the HTP and its effort to exclude the unions and professional associations from the decision-making process, but it gave a place to the representatives of Chamber of Commerce (Ergun & Dericioğulları Ergun, 2010).

As concluding remarks for the HTP, it might be argued that the HTP caused incremental changes in the health care system of Turkey. These changes had direction towards the privatization of the health care services through suggested withdrawal of the MoH from the financing and provision dimensions of the health care policy. As the MoH withdrew from the finance and the provision of the health care services, it was envisioned that the GHI scheme would become the main financing institution. Some of the scholars in the field, notably the medical doctors who are members of the TMA interpreted this change in finance and the new role for the GHI as a different version of health care tax or contribution payments (Soyer et al., 2007). The altered financing mechanisms were not the only change that is strongly criticized by the TMA. The changes brought by the HTP that was criticized by the TMA were the privatization of the health care sector, brought market elements into the health care services, paving a way to a health care system which was led by the market mechanisms and rules, the competition element which was positioned inside the Family Medicine Scheme, the changing view on the patients who were started to be regarded as "customers" and the severe exclusion of the occupational organizations, especially the TMA, from the decision-making process and granted political strength of the private lobby organizations instead (Savas, Karahan, Saka, & Thomson, 2002; Soyer et al., 2007; Türkbayrak et al., 2011; Yılmaz, 2013). One of the most significantly opposed elements of the HTP was the Family Medicine Scheme as it is regarded as the result of the policies suggesting privatization of the health care services which is brought by neo-liberal reforms. The TMA argued that while the MoH privatized the hospitals, it also transformed the Health Centers due to an argument of the HTP would solve the problems in primary health care through a restructuring (Türk Tabipleri Birliği, 2018a). As a result of this reform attitude towards the health care system of Turkey, primary health care services were privatized accordingly to the rules of market including demand and supply through using the infrastructure of the Health Centers (Yenimahalleli Yaşar, 2011). Because of this reason, one of the most incremental alteration that the HTP brought was the overly patient-centered Family Medicine practice in which as TMA criticized, family physicians have to work without job

security with the uncertainties in terms of legal duties of the physicians and challenging penalties due to the importance given to the idea of patient satisfaction (Özata et al., 2016; Türk Tabipleri Birliği, 2018a).

2.2.3.4. General Health Insurance (GHI)

In 1967, the commission assigned by the Ministry of Health and Social Aid of Republic of Turkey prepared a law draft of General Health Insurance and present it to ministry but the draft was not directed to the government (Orhaner, 2006). In 1969. The law draft was directed to the Grand National Assembly of Turkey as "Law on Insurance" but it was not evaluated in the commissions of the assembly and in 1989, the first extensive study for the "Law on Health Insurance Institution" was done but it could not become a law once again (Orhaner, 2006). In 2003, draft document named "Gathering the Social Security and Establishment of General Health Insurance" which addressed the complication in the provision of the health care services and irrational inequal structure of the health care system as the major problems in Turkish case and justified the General Health Insurance as solution which was based on the "Constitution of the Republic of Turkey of 1982" Law Numbered 60 which addresses the right to social security (Türk Tabipleri Birliği, 2003). The solution to these major issues were presented as the full insurance coverage of the population and it was argued that the state would compensate the contributions of the very poor people but the criteria for determining who is poor or who is needed for the state aid and the poverty line were not designated in the law draft (Türk Tabipleri Birliği, 2003). Eventually, in 2005, the name of the law was turned into the "Law on Social Security and General Health Insurance" and it was directed to the Grand National Assembly of Turkey. The GHI was basically a social security reform which gathered health insurance and pension under a single roof of the Ministry of Labor and Social Security and it proposed the idea of establishment of the SGK (Social Security Institution) under the roof of the ministry (Aydın, 2007). The unification of the three existing insurance scheme of that time which were the "Government Retirement Fund", the "Social Insurance Institution" and the "Social Security Organization For Artisans and the Self-Employed" took place in 2006 and in 2008 it came into operation under the

Law Numbered 5510 but it started to be implemented in 2012 (Law no.5510 on Social Security and General Health Insurance, 2006). Social Security Institution stressed that every single citizen regardless of their status of working or unemployed are in the scope of the GHI. Social Security Institution declared that the citizens who are not in any insurance's scope will be automatically regarded as in the scope of the GHI (Law no.5510 on Social Security and General Health Insurance, 2006).

It should be stressed that health insurance model is one of the ways of financing the health care services of a country. When it is looked at the other countries, it might be observed that in most of them a mixed-method are used in which financing of the health care services are done through taxes, insurance premiums and out-of-pocket payments of households and private health insurances (Tatar, 2011). Tatar (2011) suggests that while classifying a country's health care financing, the weighted method that is used should be regarded. To illustrate, in Turkey, even if all methods that are mentioned above are used in the financing the health care services, weighted method is social security model (Tatar, 2011). At this point, the relationship between financing the health care services and health insurance scheme is crucial to be grasped. Because of this reason, after stressing the fact that insurance scheme is one of the types of financing the health care, the things that were altered through the GHI, which is presented below, might help having a better understanding.

The new model of financing the health care services in Turkey had essential components which are determined by the MoH are as follows;

- Gathering the pension and health insurance schemes together,
- Making one single standard for the insurance scheme through the GHI,
- Transforming the corporate structure (Aydın, 2007).

One of the other significant features can be observed in the GHI was the promotion of privatization just similar to the HTP's general idea. The reform suggested the encouragement of the private health insurances development together with the establishment of the GHI (Türk Tabipleri Birliği, 2018b).

As it was stated before in the section explaining the HTP, the General Health Insurance (GHI) was directly related to the HTP reform document as it is one of the most significant components of the transformation programme together with the Family Medicine Model. The GHI envisioned the establishment of an insurance model which

is going to be used and benefited by the citizens of Turkey accordingly to their needs in the framework of "fairness" purpose of the HTP (Türk Tabipleri Birliği, 2018b). The major aim of the GHI was solving the problems in the health care expenditure financing and ensuring that the whole community are able to benefit from the health care services (Orhaner, 2006). The other crucial goal of the GHI was enabling all citizens to benefit from the health care services commonly and effectively in terms of the future health risks regardless of their own willingness and economic power and therefore the prevention of the wasting of the health care resources was going to be achieved (Orhaner, 2006). The GHI pointed out the need for mandatory health insurance system which covers the whole population, breaks the money-oriented relationship between the doctors and the patients, providing basic health care services equally to all patients and increases the quality of the services (Türk Tabipleri Birliği, 2018b). The MoH argued that the "discrimination" among the citizens is going to be eliminated in the sense that citizens are going to be able to apply all the hospitals regardless of their insurance scheme that they are bounded to (Aydın, 2007). For instance, before the GHI, workers who were the members of the SSK (Social Insurance Institution), which was one of the public institution schemes before the unification of the all, could not apply to the hospitals which were located near to them. Instead, they only had to apply to the contractual hospitals of the SSK. MoH argued that, at this point, the GHI helped taking significant steps towards an easily accessible health care services (Aydın, 2007). However, the TMA (Turkish Medical Association) strongly criticized the GHI through arguing that GHI could not achieved its main objectives in terms of several points. In the first place, TMA suggested that the argument of the GHI over decreasing the costs of the health care services failed. On the contrary, the TMA argued that the costs of the health care services increased after the GHI (Türk Tabipleri Birliği, 2018b). Table 1, which is per below, depicts the increase in the health care costs of the SGK between the years of 2010-2016 with the implementation of GHI.

Table 1. Social Security Institution's Bills Amounts by Years (Billion TL)

Hospitals	2010	2011	2012	2013	2014	2015	2016
Public Secondary Care	6.0	7.2	10.0	11.0	12.3	12.6	13.9
Public Tertiary Care	3.6	4.2	5.9	6.6	7.2	8.1	9.5
Private	5.0	6.1	6.7	7.3	7.7	8.1	8.4
University	3.7	4.2	5.5	6.1	6.9	7.4	8.2
Total	18.4	21.8	28.3	31.0	34.2	36.3	40.0

Table from the Social Security Institution Monthly Statistical Journal November 2017

The increasing costs of the health care after the GHI was not the only fact which was criticized by the TMA. The facts mainly opposed by the TMA which were brought by the GHI are as follows;

- The citizens who are not able to provide their insurance premium could not benefit from the health care services provided to the ones who paid their premiums,
- The argument of the GHI on reducing the costs of pharmaceuticals, treatment and medical materials could not be fulfilled, on the contrary, these costs also increased,
- A system envisioned by the GHI in which the state is responsible to pay the premiums of the poor citizens which was failed,
- The goal of ending the contribution payments of the GHI was failed because the contribution payments were replaced by the additional and complementary private health insurances,
- The inequalities in access to the health care services could not be prevented,
- The number of the services became more important than the quality,
- Private share of the health expenditure became five times higher than before,
- The health expenditures became six times higher in fifteen years

- Changing status of the health care personnel from the salary-based paid personnel to contractual workers
- The fact that the retired citizens would pay the insurance premium (Türk Tabipleri Birliği, 2003, 2018b).

Therefore, the GHI was regarded by the medical authorities and organizations, especially by the TMA, as a failure as it could not achieved its goals which were included by the HTP. Family Medicine Scheme was also quite significant for the GHI in the sense that it is believed it is going to reduce the health care costs in Turkey. However, parallelly, the HTP, the other significant parts of the health care reform which were the GHI and the implementation of the Family Medicine Model in the primary health care services failed as the HTP failed in the first place. The GHI scheme is quite significant reform which had great impact on the Family Medicine Scheme as they are related to each other in the sense that both of the new implementations are based on the financial concerns. The financially sustainable health care system relies on both the restructuring of the HTP and the GHI (Aydın, 2007). That is, as the MoH suggested, the components of the HTP were crucial also for the GHI because if the payment mechanism cannot function well, the other mechanisms of the health care system would fail (Aydın, 2007, pg.62). The GHI is a directly altered financing method of the health care services in Turkey and together with the Family Medicine Model, it aimed to reduce the costs of health care through trying to provide the full coverage for the population. As it was clarified before in the thesis, the HTP, the GHI and the Family Medicine Model are quite inter-related as one of them affect the others, they are complementary to each other. Due to this inter-connection among the HTP, the GHI and the Family Medicine Model, once one of them failed, all of them also fails and as TMA argued, they all did.

2.3. Privatization of the Health Care Services in Turkey

The TMA (2003) addressed and explained the general steps in the process of privatization of any services which are regarded as the duty of the state. As the TMA stressed, the effort of privatization is originated in the time period after the Great Depression when the neo-classical economic theories were started to be doubted (Türk

Tabipleri Birliği, 2003). The first step is the restructuring of the capital which is followed by the re-definition of the role and duties of the public sector led by the state and the private sector led by the capital and then this process would result in a case in which the state opens its gates to the private sector for the policy areas of state which might bring profit potentially (Türk Tabipleri Birliği, 2003). At this point, as most profitable fields, industrial sector and service sectors investments of the state would open to the private sector. As the TMA (2003) suggested, the policy fields which are affected directly by these developments are mostly the areas of social policy, more specifically, the education and health sector (Türk Tabipleri Birliği, 2003). In most of the European countries and in Turkey, the primary health care services are the mostly affected type of health care services by the privatization. The TMA (2003) emphasized that the common characteristic of all the European countries' health reforms is the overturn of the primary health care services to the private sector and there are several common features of this turnover process. These common points are the clear separation between the providers and the receiver of the health care services, localization, increasing rivalry item, supported entrepreneurship and destroyed physician autonomy through performance-based salary system especially in the primary health care (Whynes & Baines, 2002; Saltman, Busse, & Mossialos, 2002; Magnussen, Vranbaek, & Saltman, 2009; Glenngård, Anell, & Beckman, 2011; Türk Tabipleri Birliği, 2003). As it might be observed, each characteristic of this transformation is directly related to the privatization of the health care services.

In Turkey, the effect of the private sector is mostly seen in the financing dimension of the health care services. The private sector join the health care services in Turkey through making direct payments for the service fees, donation or sometimes through private health insurance schemes (Orhaner, 2006). This contribution of the private sector to health care services fulfil the desire of the public to buy services from the private sector (Türk Tabipleri Birliği, 2003).

In Turkey, the privatization of the health care services mainly shows itself inside the primary health care under the implementation of Family Medicine Scheme envisioned by the HTP. In the Family Medicine Practice in Turkey, the state gives a certain budget to the family physicians and then it is expected from the physicians to rent the place which is going to run as Family Health Center belongs to the state or in

some cases it might be rented from the private owners in the private sector (Türk Tabipleri Birliği, 2018a). The privatized primary health care services which was built around Family Medicine Scheme is based on mostly patient satisfaction and the family physicians were forced to give up their professional autonomy which enables them to fulfil their professional duties in ethical and medical terms through enforcement of contractual working (Türk Tabipleri Birliği, 2006, 2018a).

One of the other significant changes towards privatization which was the most criticized one brought by the HTP is the change in the notion of "patient" to "customer" and the acceptability of this new notion suggesting that patients may be seen as customers caused many arguments inside the health care sector (Kantarcı, 2015). However, after the ethical controversies caused by this alteration, it seems it is decided that seeing patients as customers are not ethically wrong in such a privatized sector as Kardeş (1994; pg. 233) stated that this phenomenon is natural. Seeing the patients as customers or source of profit is the major unethical issue caused by privatization of the health care services. Especially, in the primary health care services which is organized under the scheme of Family Medicine, the services became paid ones, it would become more and more patient centered. Due to the fact that patients now technically pay for the health care services, they would like to receive maximum satisfaction which made the health care services are purchasable goods. Therefore, within the Family Medicine Scheme, physicians' autonomies are harm and family physicians are forced to meet most of the needs of the patients even if these requests are overly exaggerated. Due to settled money-based relations between the patient and the family physicians, patients started to see many things which are beyond their legal rights. Due to these changes in the primary health care system in Turkey, the workload of the family physicians and the pressure over them increased in time.

The MoH explained these changes in terms of privatization as the continuing effort for gathering all hospitals under the umbrella of the ministry and making the hospitals autonomous but still publicly owned (Aydın, 2007). TMA regarded this effort of the MoH as an intense effort to contribute to development of market economy (Türk Tabipleri Birliği, 2003). TMA interpreted the process of privatization of the health care services as "unethical" and even "threatening to community health" as members who are medical doctors argued it created market understanding and

competition environment (Türk Tabipleri Birliği, 2006). The core intention of the health reform in Turkey suggesting the privatization is considered as lightening the capital's burden and formulating a new space for health capital through running the services via private sector (Türkbayrak et al., 2011).

2.4. Comparison: Family Medicine Througout the World

Even if the basic principles and major aims of the Family Medicine Model are mostly similar throughout the world, the practice varies across the countries. This variance results from the different dynamics of the different countries such as political factors, socio-economic development and even the mindset of the people living in. To start with, Başak and Güldal (2014) stressed the significance of number of the Family Medicine departments in the universities and their effectiveness as an indicator for the academic development of the practice. For instance, in most of the European countries, the Family Medicine departments are present almost their all universities and their effectiveness are increasing gradually (Başak & Güldal, 2014). Whereas almost all universities have Family Medicine departments in the European countries, in Southern Europe and Mediterranean countries, Family Medicine is not recognized much as an academic discipline as most of the universities do not have Family Medicine departments (Başak & Güldal, 2014). In contrast to Southern European countries and Mediterranean countries, European countries mostly gave an utmost significance to Family Medicine Practice inside their health care systems. Undoubtedly, there might not be a correlation between the number of the FM departments and the significance given to them. To illustrate, as similar to the European Countries who give mostly important role to Family Medicine in their health care, even if many of the universities have the department of Family Medicine (Başak & Güldal, 2014), the its practice is not quite effective one in the United States. This is because in the United States there is no regular aliasing among the levels of health care services and due to the fact that the health care services might be thought as primary care mostly consists of private clinics and the absence of a mechanism of referral chain (Kantarcı, 2015), there is no

functioning scheme like Family Medicine. In the United States, family physicians are functioning less as gatekeepers than in the other European countries and Canada which have effective Family Medicine Practice (Arya et al., 2017).

In Germany, the whole population is under the coverage of the social security insurances which provide a direct access to the all levels of health care services as there is no gatekeeping function given to the family physicians. It means that the patients might apply specialists without applying to primary health care services (Kantarcı, 2015).

In Poland, the Family Medicine was started to be implemented in 1996 and in the Polish Health Care system, if a family doctor refer a patient to the secondary or tertiary health care facilities, no payment would be charged (Kantarcı, 2015).

Inside the Western European countries, the Netherlands has one of the most effective practice of Family Medicine Scheme due to several reasons composing of crucial components of the Family Medicine in theory. In the Netherlands, the position of the family physicians is quite strong and they have a great importance to the health care system as they manage the mechanism of referral chain inside the health care services (Kantarcı, 2015; Metsemakers, 2012). Therefore, family physicians' significance results from their mandatory duty of formulating the gate of entry which may be achieved through a chain of referral (Metsemakers, 2012). It means that each patient has to apply their family physicians first before applying other health care facilities and this is an example of a proper first contact point characteristic as a primary health care which is related to having a well-functioning chain of referral mechanism. The exceptions of this case are the emergency cases. In the case of emergencies, such as accidents or cases requiring immediate intervention, ambulatory services would take the patient to the nearest health care facility (Kantarcı, 2015). The effectiveness of referral chain is quite essential to reduce the health care costs and to have better health outcomes. At this point, as Starfield (1998) stressed, if the chain of referral would not function well, the health care system of the Netherlands would be so expensive and costly one. In the Netherlands, the selection of the family practitioner is similar to Turkey in the sense that even if in the beginning a family physician is assigned generally near to the patient, then after a time period, patient have a right to choose any family physician (Metsemakers, 2012). A family physician who works full

day have between 2.300 – 2.500 patients (Kantarcı, 2015; Metsemakers, 2012; Korukluoğlu, 2014). As Metsemakers (2012) suggested, this number is an optimal one for a family physician to work effectively through having an opportunity to allocate enough time for each patient of his/her. The payment of the family practitioners is based on both their number of registered patients and a per medical work such as medical analysis (Metsemakers, 2012). As Metsemakers (2012) argued, this means a salary which is fair enough to pay the salaries of assistants and nurses working for them, the rent of the Family Health Center and the other related costs. Also, family practitioners now are allowed to work part – time which brought quite significant outcomes such as increasing the willingness of the medical school students or new graduates towards the discipline and expanding the women employment throughout the country as it gives opportunity to new-moms to continue to work (Arya et al., 2017). In addition to these, the %9 of the Netherlands' GDP is allocating for the health care services and the 4% of it is allocated only to the Family Medicine (Arya et al., 2017). It means that almost half of the share of GDP allocated to the health care services is allocated for merely Family Medicine. It might be regarded as one of the most crucial evidences which proves that Netherlands gives great importance to its practice. All of these characteristics, it might be reasonably argued that the Netherlands has an effective and cost-efficient Family Medicine practice.

In the Central and Eastern Europe and also in Russia, there is a general pattern of the Family Medicine Scheme consisting of an issue which is the insufficient recognition of it as a separate academic discipline (Arya et al., 2017). In most of these countries, there are private clinics belonging to physicians individually and clinics which are impersonal and mostly led by physicians who are not family medicine specialists (Arya et al., 2017). To illustrate, in Slovenia, Slovakia and Czechia, generally pediatricians and gynecologists are regarded as primary health care physicians which means that there is no settled Family Medicine Practice due to "decentralized" primary health care and the lack of the gatekeeping role inside the primary care (Arya et al., 2017).

In Latin American countries, except for the Cuba, which has merely based on public system, they have combined health care system in which public and private sector exist coherently (Arya et al., 2017). In Latin America region, mostly in all

countries the Family Medicine education was introduced and the practiced of Family Medicine exists in every country except for Honduras (Arya et al., 2017).

In Turkey, Family Medicine's history roots back twenty-five years ago when it was recognized as a separate academic discipline inside the medical specialties (15) (Başak & Güldal, 2014). In this point of view, Başak and Güldal (2014) argued that Turkey is positioned somewhere between the United States and Western European countries and the rest of the European countries.

CHAPTER 3

METHODOLOGY

In the existing literature, there are plenty of research on the family medicine practice in Turkey. Research on practice of the Family Medicine in Turkey might be categorized into two basic categories. The first category of research contains the research which have a specific focus on patient satisfaction. Some of these researches aimed to analyze or evaluate the practice of the Family Medicine in Turkey basing on the views of the patients on the practice (Özata et al., 2016; Baltacı et al., 2011; Bostan & Havvatoğlu, 2014; Barış et al., 2011). Some of these used the EUROPEP (European Patients Evaluate General / Family Practice) scale which is a widely used measure for the patient satisfaction with the Family Practice while evaluating its practice in Turkey (Mollahaliloğlu et al., 2010; Turgu et al., 2018; Sparkes et al., 2019; Aktürk et al., 2015). The second category of the research on this topic includes the research having a specific focus on the family practitioners' standpoints and their thoughts on the practice of Family Medicine in Turkey. Some of these researches are designed specifically to measure the job satisfaction of the family practitioners (Doğan et al., 2013; Tözün et al., 2008; Sevimli & İşcan, 2005; Türkbayrak et al.,2011; Türk Sağlık-Sen, 2013; Tekin et al., 2014; Pantell et al., 2019; Yaman & Güneş, 2016; Mutlupoyraz, 2010). The other research which focused on the family physicians rather than patients on Family Medicine practice in Turkey specifically tried to determine the occupational challenges of the family practitioners and their views on the functionality of the practice (İlgün & Şahin, 2016; Öcek et al., 2014; Algın et al., 2004). Also, some research in the literature on this topic tried to discover the thoughts of the family practitioners on the convenience of the Family Medicine Model to Turkey (Tengilimoğlu et al., 2016). Besides, in the existing literature, beyond the ones mentioned above, there are also research on the topic of violence against the general practitioners (Ayrancı et al., 2006). In the existing literature, it was observed that there is no specific research aimed to reveal whether the Family Medicine practice in Turkey

functions well or not. Most of the studies conducted in Turkey on the practice of Family Medicine Model aimed to evaluate the functionality of the model in the framework of the patients. As İlgün and Şahin (2016) stressed, in the existing literature, there are limited number of studies which tried to evaluate the Family Medicine Model from the standpoints of the family physicians. Many studies attempted to investigate the Family Medicine practice through patient satisfaction because their researchers believed that patient satisfaction is one of the most significant factors to evaluate health care services (Karadağ, 2007; Kantarcı, 2015; Leebov & Scott, 1994; Özata et al., 2016; Sparkes et al., 2019). However, this thesis significantly argues that the patient satisfaction is not an appropriate factor for evaluation of the Family Medicine Scheme because patients do not have to know what is for their best interest for their health. The real authorities who have an adequate education and because of this reason who should be seen as expert of the field are the family physicians. Because of this reason, a more proper research on evaluation of the Family Medicine may be conducted through asking family physicians' thoughts on the practice. Therefore, this thesis had an objective to examine the practice of Family Medicine in the framework of the views of family physicians who are the experts of the field.

Also, there is no specific research which aimed to grasp on the what grounds and which components of the Family Medicine it does not function well according to the family physicians. Due to this gap in the existing literature, this thesis aimed to achieve to fulfil this gap through conducting a questionnaire designed to understand vital points for the functioning of the scheme in Turkey.

3.1. Research Design

In this thesis, the data collection instrument was questionnaire due to its advantage in the sense that it requires less time to answer for the participants and it is easy to systematically collect data and categorize the information collected.

The aim of applying questionnaire in the framework of this thesis was to ask family physicians' opinion on the practice of family medicine in Turkey. As different to the research questionnaires which were designed to measure the job satisfaction of

the family physicians, the questionnaire of this thesis did not specifically focus on the job satisfaction. Even if the job satisfaction of the family physicians is a significant part of grasping the thoughts of them towards the functionality of the Family Medicine Model, the questionnaire of the thesis includes a question on job satisfaction but the real focus of it is not limited to job satisfaction dimension. Beyond the job satisfaction measurement, this questionnaire aimed to understand the thoughts and attitudes of the family physicians towards the Family Medicine practice in Turkey including its functionality and the relationship between the model and privatization of the health care services. Therefore, the questionnaire aimed to reveal whether family physicians think about whether the Family Medicine Model functions well or not in Turkey. Also, if the family physicians generally think that the practice of Family Medicine does not function well in Turkey, the questionnaire also aimed to the detect and point out the factors or components of the model which currently does not work as they are supposed to be as the existing literature suggests.

While the questionnaire was prepared, the applied questionnaires in the existing literature and the articles of the significant authorities such as scholars in the field and specific occupational organizations, especially the TMA were taken into consideration. The questions / statements in the questionnaire were prepared in the light of applied questionnaires to the family physicians in Turkey, together with the revealed challenges of the Family Medicine Practice in Turkey found out by several research (Doğan et al., 2013; Tözün et al., 2008; Sevimli & İşcan, 2005; Türk Sağlık-Sen, 2013; Tekin et al., 2014; Öcek et al., 2014).

3.2. Conducting the Questionnaire

The conducted question contained eighteen questions including two basic categories of the questions related to the theoretical framework intending the evaluate the practice according to the suggested components / goals and the questions about the personal experiences of the family physicians about the practice. The first seventeen questions / statements were asked / with the 5 Point Likert Scale ranging from 1 (Totally Disagree) to 5 (Totally Agree) and the last one was asked as open-ended question. An approval for the conduct of the questionnaire was taken from the Middle

East Technical University Human Research Ethics Committee and it is presented in the Appendices. The informed consent from the participants of the research questionnaire were taken in the beginning of the questionnaire document. The questionnaire was conducted to the family physicians and family medicine specialists who are currently working as family physician in the primary health care services in Turkey (https://docs.google.com/forms/d/e/1FAIpQLSegQm7fUf_inlS-9JARBfN160F_Hh_03xAPxZu3VnqvMRUFXw/viewform?usp=sf_link). Through skipping the gatekeepers in this research, my parents who are currently working as family physicians in Turkey, sent the questionnaire to their colleagues from all over the Turkey via internet. Some of the family physicians also sent it to their other colleagues thanks to the mail and contact chains that they are included by the medical communities such as the Turkish Medical Association's provincial level headquarters and the informal chains among the physicians. Therefore, in this thesis, the snowball sampling was used to collect the data. The questionnaire was applied online through an online questionnaire platform. The data collection was done between 05/06/2019 and 06/01/2019. At the end of the data collecting process, 198 physicians who are currently working as family practitioner answered the questions in the questionnaire. The respondents' demographics were not asked in the questionnaire because this thesis did not aim to consider the demographical differences as determinant while evaluating the family medicine practice in Turkey as it is not a regional implementation but it is a standard single one at a country level.

3.3. Method of Analysis

An interpretive qualitative approach was adopted during the data collection and analysis periods. Data analysis in this thesis was done in the framework of a qualitative assessment consisting of the interpretation of the data collected through a questionnaire. Therefore, no statistical computer program was needed during the data analysis in this thesis. In the following section, the results of the questionnaire are going to be investigated question by question and the findings are going to be clarified through interpreting the answers given in the questionnaire.

CHAPTER 4

FINDINGS

In this chapter, the findings of the questionnaire are going to be presented and interpreted. 17 of the questions were asked with "5 Point Likert Scale" and these are going to be categorized into three titles as they are referencing three dimensions in the evaluation of the Family Medicine Practice in this thesis. The first category of the questions is the "Objectives of the Family Medicine", the second category is entitled as "Neo-liberalism" and the last one is named as the "Personal Experiences of the Family Physicians". The last question, which was asked as open-ended question is going to be evaluated again categorization based on the frequency of the answers given. The most frequent answers given by the respondents are going to be categorized under the separate titles. The findings of the open-ended question are going to be evaluated under the five titles which are; "Patient centrism of the Family Medicine System", "Bureaucracy and Administrative Issues", the "Issue of Violence Towards Family Physicians", "Official Documents given by the Family Physicians" and "Decreasing Physician Dignity". Under these categories, the interpretation of each question is going to be presented in a systematic way through linking the findings with the theoretical framework.

4.1. The 5 Point Likert Scale Questions

4.1.1. Objectives of the Family Medicine

Question: The Family Medicine Scheme provides family physicians with more detailed monitoring of the patients (detailed monitoring of each registered patients).

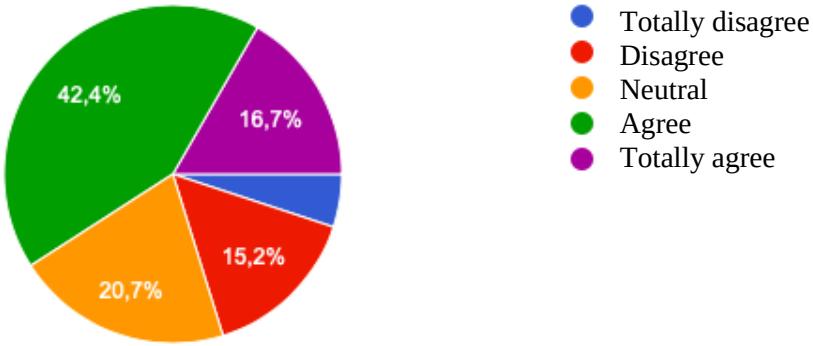

Figure 1. The thoughts of the respondents on detailed patient ponitoring in the Family Medicine Model

The 16.7% (33) of the respondents totally agreed and the 42.4% (84) of the respondents agreed that the family medicine scheme enables the family physicians to monitor each registered patient in detail. Therefore, the majority of the respondents think that the family medicine offers a primary health care services in which patients may receive detailed health care services. As one of the powerful basis of the family medicine, the MoH stated that each citizen is going to receive primary health care services from a specifically assigned family physician and this situation was stated as "a family physician for everyone" to the public and the TMA argued that it is a misleading statement for the patients (Cesur et al., 2017).

A research conducted by Öcek et. al. (2013) showed that the family physicians participated in the research expressed that they are not able to allocate sufficient time for each patient due to several reasons including the high population registered to them and the workload of the family physicians. In one of the interviews contained by the research of Öcek et. al. (2013, pg. 79), a family physician stated that s/he can allocate maximum five minutes for examination per registered patients and s/he addressed the

difficulty of multitasking as a family physician who tries to conduct medical examination, prescribe and provide medical education to the patients at the same time. Also, one of the other interviewees stated that s/he sometimes realizes that s/he examined hundred patients a day and the average examination period allocated to a patient was less than four minutes under these circumstances (Öcek et al., 2013, pg. 102). Deveugele, Derese, Van den Brink-Muinen, Bensing and De Maeseneer (2002) measured the average consultation length in the six European countries via a cross-sectional study. Deveugele et. al. (2002) observed that the examination lengths derive from 7.6 minutes (Germany) and 15.6 minutes (Switzerland) in six European countries chosen for the research and which is presented below on Table 2 (Deveugele et. al., 2002; Öcek et. al., 2013).

Table 2. Length of Consultation with a General Practitioner

Country	Mean (SD) time (minutes)
Germany	7.6 (4.3)
Spain	7.8 (4.0)
United Kingdom	9.4 (4.7)
Netherlands	10.2 (4.9)
Belgium	15.0 (7.2)
Switzerland	15.6 (8.7)
Overall	10.7 (6.7)

Source: Deveugele et. al., 2002

The same research (Deveugele et. al., 2002) revealed that the general practitioners in Germany and Spain see averagely two hundred patients in a week which is regarded as quite high number for a family physician to examine. Öcek et. al. (2013) found out that an average examination conducted by a family physician in Turkey per day is eighty. Even if a family physician in Turkey works without any break in a day, s/he can be able to allocate six minutes for each patient which is quite

less than the European average which is measured as 10.7 minutes Deveugele et. al. (2002) (Öcek et. al., 2013). The findings of questionnaire conducted in terms of this thesis challenged these findings of the research conducted before in the existing literature on the issue of detailed patient monitoring and examination. Whereas, the participants of the questionnaire conducted with 198 family physicians and family medicine specialists believed that they can monitor their patients well in the Family Medicine Scheme, Öcek et. al. (2013) argued that the average length of consultation in Turkey which was estimated as 6 minutes is quite less than the European average can potentially affect the quality of the care given to the patients in Turkey. Also, the average number of the family physician per 1,000 people revealed statistically by the World Bank is one of the other significant indicators for the evaluation of the functionality of the primary health care services in a country. Once the average number of the family physicians per 1,000 population increased, the more detailed patient examination and monitoring can be achieved in the Family Medicine Scheme. The colored map in the Figure 2, which is presented below, depicts the average number of the family doctors per 1,000 population in the world.

Figure 2. Number of generalists and specialists medical practitioners per 1,000 people in 2014 by countries. Figure from World Health Organization., Global Health Workforce Statistics, OECD, supplemented by country data.

The world map in shown in the Figure 2, referenced from the WHO's statistical data on all kinds of medical doctors per 1,000 population taken by the OECD and how their number varies by country ("World Health Organization's Global Health Workforce Statistics," 2014). Whereas the darker blue countries depict the higher number of the physicians, the lighter blue countries show the lower number and the non-color (white) countries are the ones whose data in the year of 2014 are not known ("World Health Organization's Global Health Workforce Statistics," 2014). According to the data, the highest value belongs to Cuba, which is 7.519 physicians per 1,000 population. The data shows that Turkey is one of the countries having low number of physicians per 1,000 population with a value of 1.749. Even if the questionnaire results of this thesis challenged the previous research on the topic (Öcek et. al., 2013). In the questionnaire of the thesis, several respondents addressed the insufficient number of the family physicians or another words, high population as the greatest challenge in the Family Medicine practice of Turkey. As it can be inferred from the Figure 2 depicting the average number of medical doctors per 1.000 population, the number of the family physicians in Turkey is also quite low as the total number of the all medical doctors is even low per 1.000 population. Even if it seems that majority of the family physicians responded to the questionnaire believe that they are able to monitor their registered patients in detail, in the open-ended question some of them suggested that it is hard to monitoring their patients due to high population, high number of policlinics that are made and other duties given to the family physicians such as reporting data of the patients to the electronic information system of the MoH and prescribing. The respondents stressed the concentration of the patients, high number of the policlinics that they have in a day (80-100), high number of the registered patients to a family physician (high registered population) as the major reasons hindering detailed care for each registered patient to them. They stated that these facts prevent them from giving a detailed care to each registered patient to them. Therefore, under these circumstances, it might be justifiable to argue that the well-functioning Family Medicine practices belong to the countries with lower populations as it is directly related to the detailed monitoring capacity. This thesis argues that one of the challenging issues in the Family Medicine practice in Turkey is the high population of the country which stresses the difficulty of detailed patient monitoring in Turkey as

the statistical data of the World Bank (2014), the several research in the existing literature and conducted questionnaire in the framework of this thesis support this argument with the number of the family physicians per 1,000 population, which can be regarded as low around the world.

Question: The Family Medicine Scheme provides primary health care services which have lower costs.

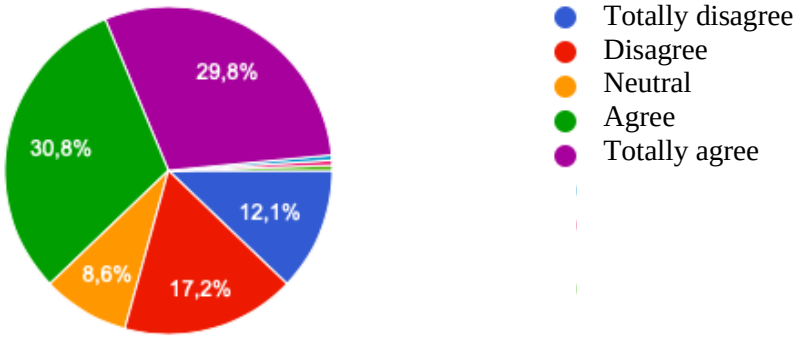

Figure 3. The thoughts of the respondents on cost-efficiency of the Family Medicine Model

The 29.8% (59) of the participants of the questionnaire totally agreed and 30.8% (61) of the participants think that Family Medicine Scheme in Turkey provided primary health care services of lower cost than the previous practice before the Family Medicine. The 12.1% (24) family physician totally disagree and 17.2% (34) disagree that Family Medicine practice lowered the primary health care costs in Turkey. One of the participants made a comment arguing that if there is a well-functioning chain of referral is established the costs lower. As stressed before in this thesis, in the part explaining the objectives of Family Medicine Scheme and the duties / specifications of the family physicians, cost-efficient primary health care services are envisioned to be achieved through the health care resource management might be achieved by the physicians. Family physicians are regarded as potential contributors to the cost-effectiveness for the primary health care services (World Health Organization, 1998). The effective usage of the health care resources is regarded as one of the most

significant duties of the family physicians (Bentzen et al., 1991; Bıyıklıoğlu & Ungan, 2015; Kantarcı, 2015; Özdemir & Ungan, 2015; Başak & WONCA Europe, 2003; Olesen, 2000). It was suggested that the cost-efficiency of the primary health care services might be achieved through Family Medicine as Alma-Ata Declaration stated that the Family Medicine is the most-effective system in terms of cost-efficiency (World Health Organization, 1978; Kılavuz, 2010). However, in order to establish a cost-efficient primary health care services organization, a well-functioning chain of referral mechanism is a necessity as a significant component (Aytekin, 2012; Çelik, 2011; Ener & Yelkikalan, 2003). Due to the relevance of cost-efficiency objective of the family medicine and the mechanism of referral chain, answers given by the participants to this question is going to be evaluated also together with the one of the other questions contained by the questionnaire which is related to the chain of referral.

Question: Family Medicine System requires an effective mechanism of chain of referral.

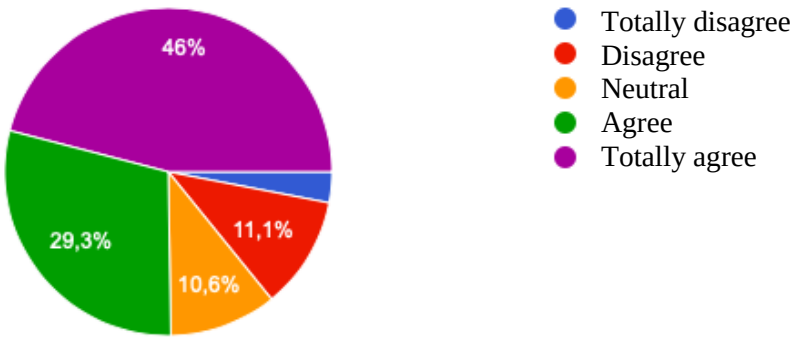

Figure 4. The thoughts of the respondents on the necessity of the chain of referral mechanism in Family Medicine

The 46% (91) of the participants totally agreed and 29.3% (58) of the participants agreed that Family Medicine Practice needs a well-functioning mechanism of chain of referral, whereas 3% (6) of the participants totally disagree and 11.1% (22) disagree. The majority of the participants agreed that the pre-requisite of the Family Medicine practice is the mechanism of chain of referral, which is also stated by the several

authorities in the existing literature on the issue (Metsemakers, 2012; Starfield, 1998; Aytekin, 2012; Çelik, 2011; Ener & Yelkikalan, 2003). Also, the several respondents of the questionnaire addressed that the absence of a mechanism of chain of referral as the greatest challenge in the Family Medicine practice in Turkey in the open-ended question. Before the implementation of the Family Medicine Scheme in Turkey, in the old form of organizing the primary health care services, which was Health Center Model foreseen by the Law on the Socialization of Health Care Services (1961) suggested and initiated the chain of referral (Law no.224 on Socialization of Health Care Services, 1961). With the Health Transformation in Turkey, the HTP declared that one of its essential components was the chain of referral (Yenimahalleli Yaşar, 2011). Even if HTP made the chain of referral mechanism as one of the central values of the envisioned Family Medicine practice in Turkey, after three months implementation, the government decided to abolish the mechanism (Öcek et al., 2014). The World Bank (2003) argued that chain of referral mechanism in Turkish Health Care System which was foreseen by the Law on the Socialization of Health Care Services (1961) as non-functioning one on the ground of non-existence of a penalty for patients who directly apply the secondary or tertiary health care services without applying a primary care physician, that is, family physician. In the case of Turkey, it might be argued that the absence of enforcing mechanisms which might be applied through legal measures makes the chain of referral mechanism inside a health care system poorly functioning. The absence of the referral chain implementation hinders the Family Medicine practice in Turkey from being well-functioning one as the World Bank (2003) suggested that the logic of the referral chain is reducing the health care costs.

Also, together with the mechanism of chain of referral, the gate-keeping function of the family physicians are essential to achieve a cost-efficient primary health care services and waste of the health care resources. The mechanism of chain of referral is quite significant in the sense that family physicians' one of the vital duties in Family Medicine practice, which is gate-keeping function, might be fulfilled (Metsemakers, 2012). Starfield (1998) stressed that Netherlands have a cost-effective health care system which is comparatively cheaper than the other European countries thanks to a well-functioning chain of referral mechanism through a serious

enforcement. The results of this questionnaire on the issue of chain of referral is similar to the existing literature suggesting that it is a quite important component for the Family Medicine Scheme. The majority of the family physicians responded the questionnaire think that an effective / well-functioning referral chain is a pre-requisite for the Family Medicine System. Answers given to this question in this research are parallel to the research conducted before by Algın et al. (2004). Algın et. al. (2014) also found out that the majority of the family physicians participated in the research believe that non-existence of the referral chain mechanism in Turkey is a great challenge in the Family Medicine practice.

One of the other related issues, which is also asked as different question to the respondents, is the Family Medicine's objective of preventing the accumulation in secondary and tertiary health care services which depends on the referral chain and cost-effective health care system.

Question: Family Medicine Scheme prevents patient accumulation in secondary and tertiary health care services.

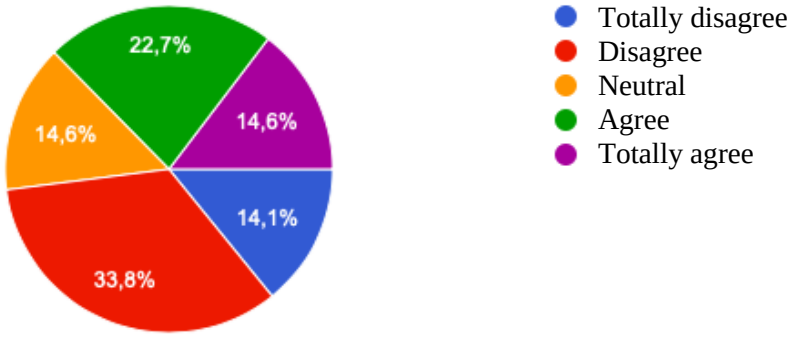

Figure 5. The thoughts of the respondents on prevention of patient accummulation in secondary and tertiary health care services

14.1% (28) of the respondents totally disagree and 33.8% (67) of the respondents disagree the argument of Family Medicine practice suggest that it prevents the patient accumulation in the secondary and tertiary health care services. As it is stated in the analysis of previous question, family doctors are regarded as the physicians who has a

duty of acting as gate-keepers to the secondary and tertiary health care facilities but this understanding was abandoned in Turkey with the abolishment of the chain of referral after a short period of trial at the beginning (Sparkes et al., 2019). One of the suggested goals of the Family Medicine practice is providing cost cutting in health care system through preventing the accumulation of the patients and benefiting from well-applied chain of referral (Kantarcı, 2015). The goal of the Family Medicine is providing access and shortening the waiting times of the patients together with increasing the quality of the health care services and relieving the overburdened health care institutions, especially the hospitals (Akdağ et al., 2009; Dağdeviren & Aktürk, 2004; Fulton et al., 2011).

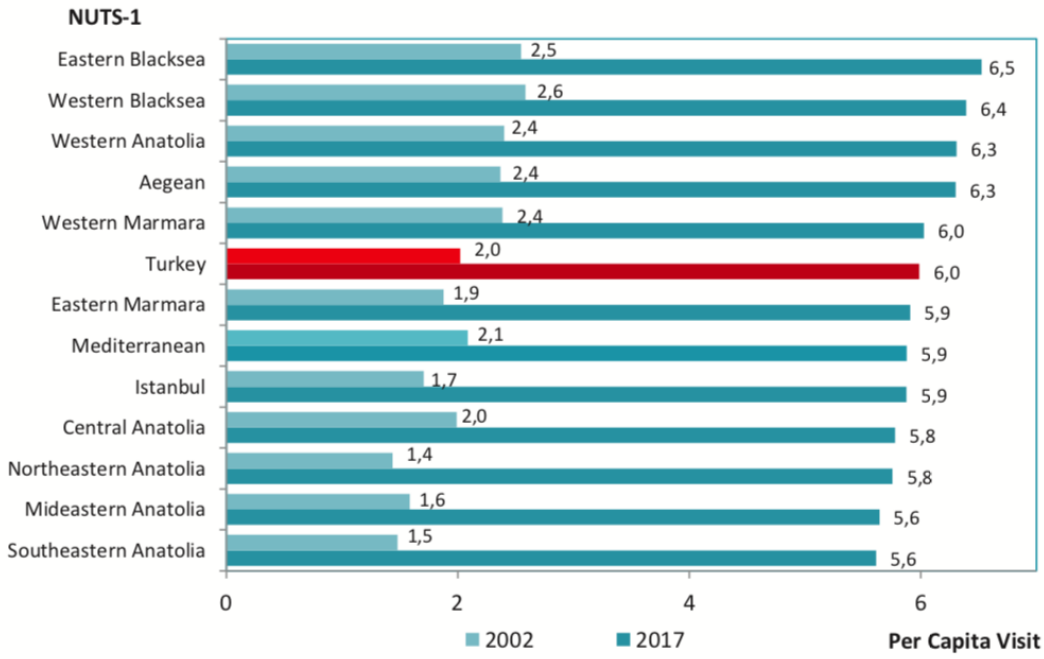

Figure 6. Ratio of Total Number of Visits to a Physician in Health Care Facilities by Years, (%), All Sectors. Graph from Berrak Bora Başara et al., *Health Statistics Yearbook 2017*, (Kuban Matbaacılık, 2018), 161.

The Figure 6, which was taken from the MoH's "Health Statistics Yearbook 2017", depicts the numbers of per capita visits to a physician in the secondary and tertiary health care services in Turkey in comparative framework containing the data of 2002 and 2017 (Bora Başara, Çağlar, Aygün, & Özdemir 2018). The Figure 6 shows that in the year of 2017, the per capita visit to a physician at the secondary and tertiary

health care services facilities seriously increased comparatively to the year of 2002. Whereas the number of per capita visits of the patients to a physician working in the facilities of secondary and tertiary health care services in 2002 was 2,0, in 2017, this number increased to the 6,0 at the country level in Turkey.

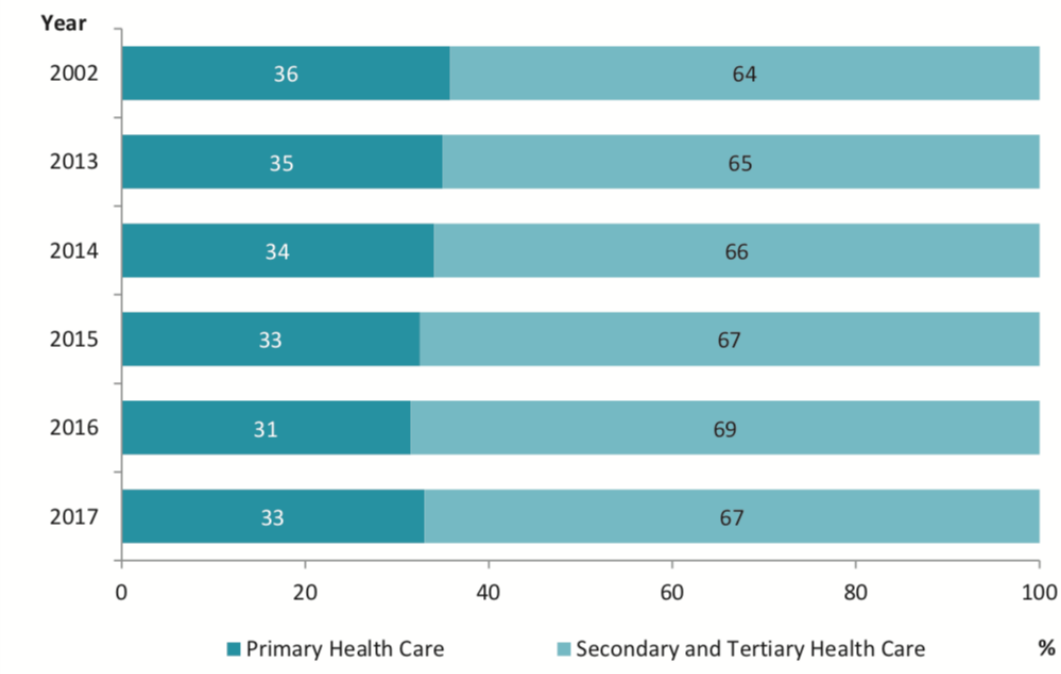

Figure 7. Ratio of Total Number of Visits to a Physician in Health Care Facilities by Years, (%), All Sectors. Graph from Berrak Bora Başara et al., *Health Statistics Yearbook 2017*, (Kuban Matbaacılık, 2018), 159.

Also, the Figure 7, which was also taken from the MoH's Health Statistics Yearbook of 2017, indicates the ratio of total number of visits by patients to a physician in all health care services facilities containing primary, secondary and tertiary health care services in Turkey (Bora Başara et al., 2018). The Figure 7 shows that the visits by patients to a physician in the facilities of secondary and tertiary health care outweighs the visits to a physician in primary health care facilities. Higher number of application to the secondary and tertiary health care services than the primary health care services suggests that there is no achieved prevention of accumulation in the higher levels of the health care services. Therefore, the statistical data showing the number of application to a physician in all sectors containing the all levels of health care services in Turkey and the results of the questionnaire conducted in the framework

of this thesis are parallel on the subject of patient accumulation in the secondary and tertiary health care services. The thought of majority of the participants of the questionnaire, who are working as family physicians currently, is the Family Medicine Scheme cannot prevent the patient accumulation in the secondary and tertiary health care facilities. The answers of the next two questions of the questionnaire, which are about the easily accessible and equally accessible primary health care services in Turkey in the framework of Family Medicine Scheme, are going to be evaluated and interpreted together.

Question: Family Medicine Scheme provides every citizen with equally accessible primary health care services.

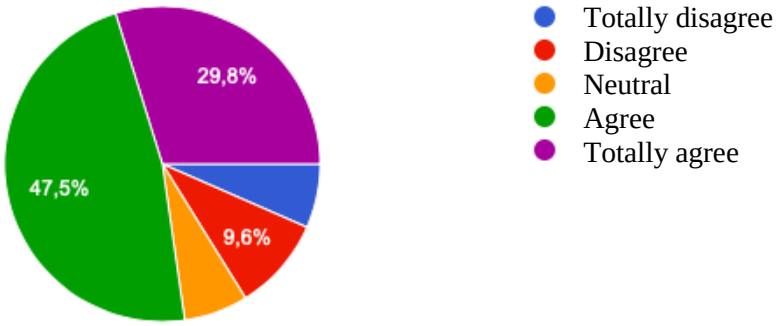

Figure 8. The thoughts of the respondents on equity in access to the primary health care services through the Family Medicine

The 29.8% (59) of the respondents totally agreed and 47.5% (94) of the respondents agreed that Family Medicine provided citizens with equally accessible primary health care services. Bentzen et al. (1991) addressed accessibility as one of the features of the Family Medicine field (World Health Organization, 1978). The findings of the questionnaire which are based on the family physicians thought on the issue of accessibility suit to the theoretical ground suggesting that equally access is one of the major goals that can be achieved by the strengthening the primary health care services through implementing Family Medicine System.

Question: Family Medicine Scheme provides every citizen with easily accessible primary health care services.

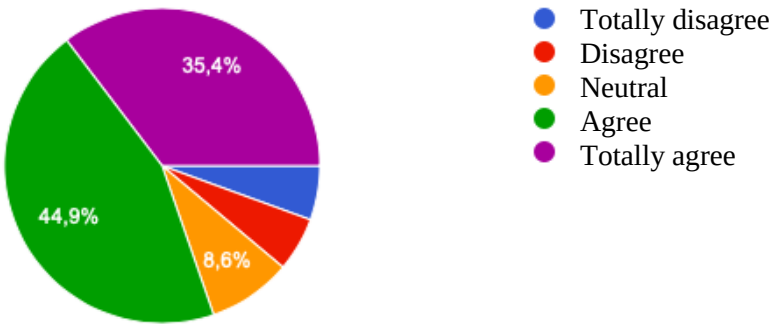

Figure 9. The thoughts of the respondents on easy access to the primary health care services in the Family Medicine

The 35.4% (75) of the respondents totally agree and 44.9% (89) of the respondents think that Family Medicine practice in Turkey provided each citizen with equally accessible primary health care services. The theoretical background of the existing literature which explained the main goals and basic logic of the Family Medicine Scheme suggested that family physicians are supposed to be positioned as easily accessible by every citizen (Bıyıklıoğlu & Ungan, 2015). Also, as Yenimahalleli Yaşar (2011) stressed that one of the main components of the HTP was easy access to the health care services. The reform in the framework of HTP had an announced aim which was providing easy and equal access to the health care services through reforming the primary health care services organization (Yılmaz, 2013). Therefore, the existing literature suggested that one of the main objectives of the Family Medicine Scheme is providing easily and equably accessible primary health care services. In the framework of these information suggested by the existing literature on the issue, the majority of the family physicians responded to the questionnaire of the thesis think that Family Medicine practice in Turkey could achieve the goal of providing easy access to the primary health care services. According to the 164 of the family

physicians out of 198, who responded to the questionnaire of this thesis, think that Family Medicine in Turkey provided easily and equally accessible primary health care services to each patient.

Question: Family Medicine System strengthened the physician-patient relationship.

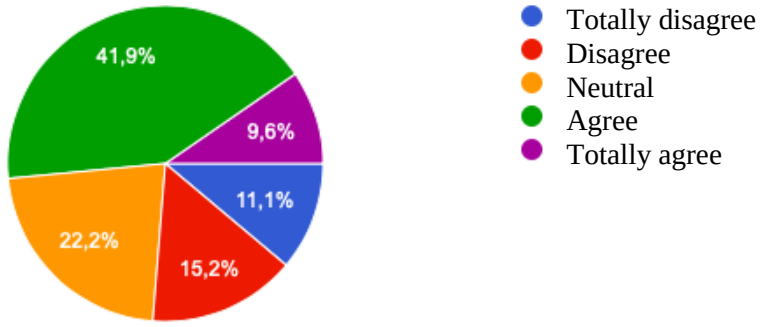

Figure 10. The thoughts of the respondents on physician-patient relationship settled by the Family Medicine

The 9.6% (19) of the respondents totally agree and 41.9% (83) of the respondents agree that the Family Medicine Scheme strengthened the physician-patient relationship. Strengthening the relationship between the patient and physician were addressed in the literature as one of the specifications and competencies of the family physician (Bentzen et al., 1991; Bıyıklıoğlu & Ungan, 2015). One of the basic elements of the Family Medicine System is addressed as community-based care and this element suggesting building a trusty relationship (Öcek et al., 2014). The findings of this thesis affirmed that the Family Medicine practice in Turkey could fulfilled the suggested achievable element which is building a trusty relationship between the doctors and the patients. Majority of the respondents of this thesis' questionnaire think that Family Medicine practice in Turkey could strengthen the relationship between physician and patient.

4.1.2. Personal Experiences of the Family Physicians

Question: As a family physician, my salary satisfaction is high.

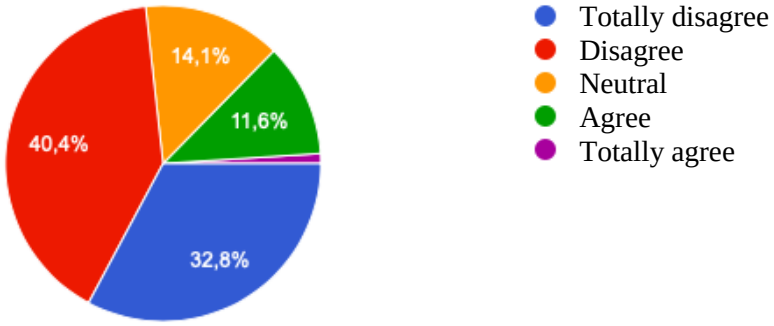

Figure 11. The thoughts of the respondents on salary satisfaction as family physicians

The 32.8% (65) of the respondents totally disagreed and 40.4% (80) disagreed that their salary satisfaction is high as a family physician. With the HTP, one of the most significant changes was the type of employment of the primary health care services personnel (İlgün & Şahin, 2016). Whereas before the Family Medicine practice initiated by the HTP, the primary health care services personnel worked on a salary basis, after the health care reform, with the initiation of the Family Medicine practice in Turkey, they were started to be paid on the basis of the number of the working days and performance as they were employed as contractual worker (İlgün & Şahin, 2016). With the Family Medicine practice in Turkey, the family practitioners were forced to work without job security through the contractual working enforcement. It is stated by the MoH that capitation plus performance-based system of payment raised the family physicians' salary by 138% (Akdağ & Erkoç, 2012; Cesur et al., 2017). However, this increase in the salaries of the family doctors took place only at the beginning. Later, the reel salaries of the family physicians decreased year by year when they finally started to think that after years of labor that they effort, they were getting payments which are closer to the numbers that they deserved (Algın et al., 2004; Cesur et al., 2017). Also, due to the fact that in the Family Medicine Scheme, the family physicians

are responsible for the payments made to the other health care personnel working together with them, the rent of the family health center that they are working in it, the bills and expenditure related to the working place and their job such as electricity, water, internet, the computer that they have to use during the examinations and so forth, their salary continued to decrease (Türkbayrak et al., 2011). Türkbayrak et al. (2011) used the metaphor of "craftsman" for the new enforced position of the family physicians. Also, as Türkbayrak et al. (2011) stressed that there is an income inequality among the family physicians in Turkey just as many other areas have and they have to have extra jobs to live in dignity. The results of this questionnaire depict that the great majority (148 out of 198 respondents) of the respondents are not satisfied with the salaries that they get as family physicians. The result of the question on the salary satisfaction of the questionnaire is parallel to the research conducted before (Türkbayrak et al., 2011). Türkbayrak et al. (2011) revealed that 46.7% of the respondents attending to the research were not satisfied with the salaries that they were paid as family physicians. The questionnaire of this thesis supported to the findings reached before on the issue of salary satisfaction. These findings depict that the great majority of the family physicians (198) who attended to the questionnaire of this thesis do not have a high job satisfaction while practicing their occupation in Turkish practice of the Family Medicine Model.

Question: My job satisfaction is high as a working family physician.

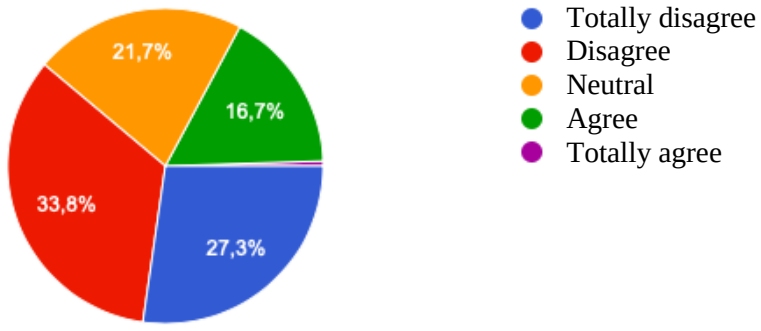

Figure 12. The thoughts of the respondents on salary satisfaction as family physicians

Whereas 27.3% (54) of the respondents totally disagree with the proposal stating that the family physicians' job satisfaction is high, the 33.8% (67) of the respondents disagree with it. Only 1 of the 198 respondents (0.05%) totally agreed that s/he has a high job satisfaction while working as a family physician. Whereas 16.7% (33) of the respondents think that they have a high job satisfaction as family doctors, 21.7% (43) of the respondents are neutral to the statement. The findings of the questionnaire of this thesis challenged the research findings in the literature (Sezgin et al., 2018; Tengilimoğlu et al., 2016). Tengilimoğlu et al. (2016) conducted a research on the family physicians in Turkey and the research revealed that the respondents generally satisfied with the Family Medicine practice in Turkey. Also, the research of the Sezgin et al. (2018) pointed out that the 33.3% of the respondents have high job satisfaction as family doctors in Turkey but the research conducted only 36 family physicians, which is not an enough number for validity and Türk Sağlık-Sen (2013) revealed in a research that 55% of the family physicians who responded to the questionnaire were partially satisfied with the Family Medicine practice in Turkey. Also, Tekin et al. (2014) observed that the family physicians and other family medicine personnel who were respondents were partially satisfied with the practice of Family Medicine System in Turkey in the research that was conducted in the province of Malatya. Whereas the findings of this thesis challenged some of the research in the literature, there is also similarities with several other research. Türkbayrak et al. (2011) found out that the 52% of the respondents who were family physicians in the province of Bursa were not satisfied with the Family Medicine System's implementation in Turkey and the findings of this thesis is parallel to that research's findings.

Question: Family Medicine Scheme provides a safe job and working environment / conditions to the family physicians.

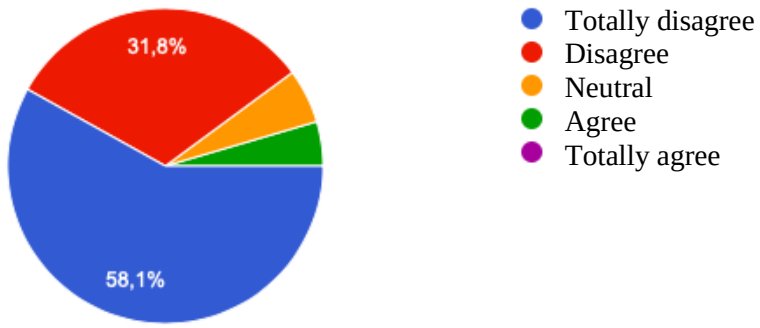

Figure 13. The thoughts of the respondents on job/ working environment provided by the Family Medicine

58.1% (115) of the family physicians attended to this questionnaire totally disagree with the statement arguing that Family Medicine Scheme offers a secure job environment and conditions while 31.8% (63) of them disagree. Also, some of the respondents addressed that the issue of security, abasement, the working conditions and environment, feeling themselves unsafe, harassment coming from patients and even violence coming from patients or their relatives are the greatest challenges that they are faced with while practicing their occupation as family physicians in Turkey. The Family Medicine Scheme initiated by the HTP and which altered the way of employing the primary health care physicians into contractual workers (Soyer et al., 2007). Before the Family Medicine Scheme foreseen by the HTP in Turkey, the general practitioners working at the primary health care services were regarded as state officers with salary-based payment but with the HTP family physicians were started to be hired as contractual workers (Güneş & Yaman, 2008). This contractual-based employment model caused family physicians in Turkey to feel themselves insecure in terms of their occupational position as several family physicians attended to the questionnaire of this thesis stated specifically that they feel themselves insecure during the work. Some of the respondents of the research of this thesis stated the violence

against family physicians as one of the reasons for them to feel insecure, which is going to be evaluated later under the open-ended question in the questionnaire is going to be analyzed.

Question: The responsibilities, duties and workload encumbered to the family physicians are quite high.

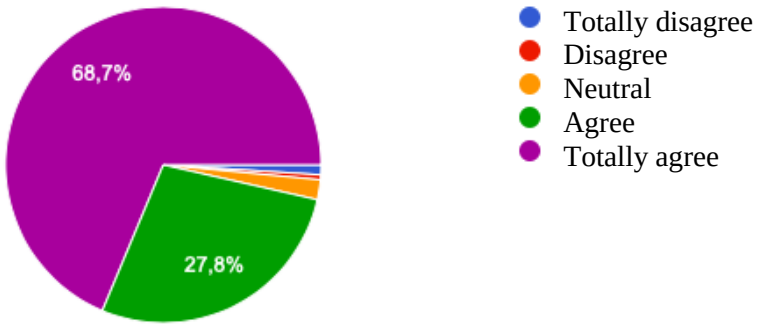

Figure 14. The thoughts of the respondents on the workload of family physicians in Turkey

Whereas the 68.7% of the respondents totally agree the statement argued that the workload and duties of the family physicians are quite high, the 27.8% (55) of the respondents agree with it. Therefore, vast majority of the respondents believe that they have a high workload while they are practicing their occupation in Turkey. Besides, many respondents replied the open-ended question which tried to address the greatest challenge of the family physicians in Turkey and they stressed that the over-workload which continues to increase day by day, drudgery work, obligation to do work which are not duty of the family physicians legally and being incapable of fulfilling basic duties due to the other unimportant work. At this point, the findings of the thesis are parallel to the previous research in the existing literature. In the research that (Öcek et al., 2014) conducted with the family physicians expressed that their workload is quite high. Also, the Family Medicine Satisfaction Questionnaire conducted by Türk Sağlık-Sen in 2013 showed that the 85% of the family physicians agreed to this.

Question: Family Medicine Model is a convenient way of provision of primary health care services to Turkey.

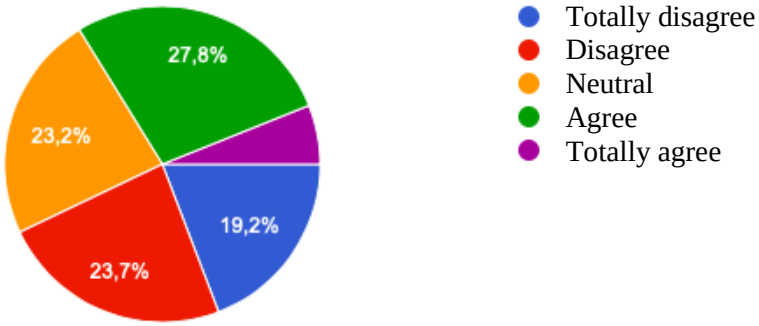

Figure 15. The thoughts of the respondents on the convenience of the Family Medicine Model to Turkey

19.2% (38) of the respondents totally disagree and 23.7% (47) of the respondents disagree the statement stating that Family Medicine Model is convenient type of provision of primary health care services in Turkey. Whereas 6.1% (12) of the respondents totally agree and 27.8% (55) of the respondents agree the statement in this question, 23.2% (46) of the respondents were neutral to the statement.

Question: Please evaluate the practice of the Family Medicine System in Turkey.

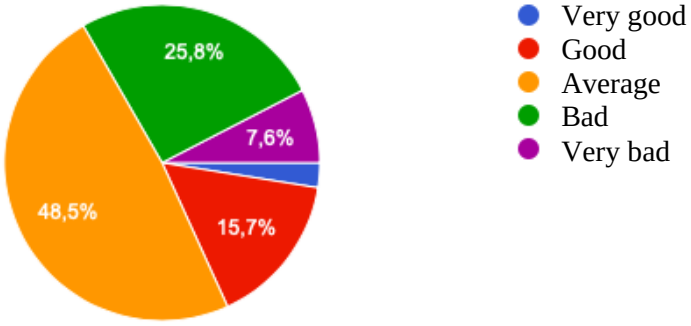

Figure 16. The overall evaluation of the practice of Family Medicine in Turkey by the respondents

The 7.6% (15) of the respondents think that the Family Medicine System's practice in Turkey is really bad and 25.8% (51) of the respondents think that it is bad. Whereas 2.5% (5) of the respondents believe the practice of Family Medicine in Turkey is really good, the 15.7% (31) of them believe it is good. However, the greatest proportion belongs to the respondents (48.5%) thinking that the Family Medicine implementation in Turkey is only average. The findings of this thesis are similar to the ones conducted before. For instance, the family physician satisfaction with the system was measured by the Türk Sağlık-Sen in 2013 and according to findings of the research, 55% of the respondents are partly satisfied with the Family Medicine's practice in Turkey (Türk Sağlık-Sen, 2013).

Question: I think of quitting my job as family physician.

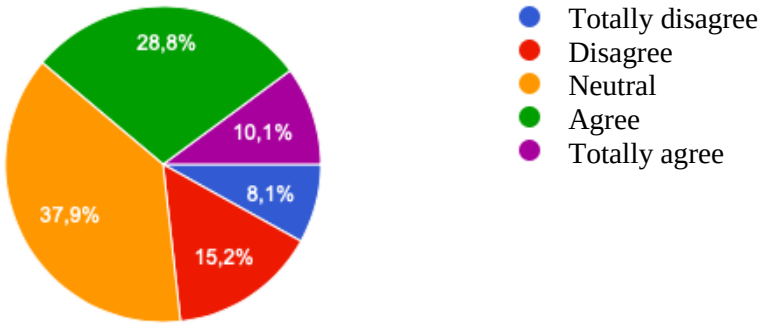

Figure 17. The thoughts of the respondents on quitting their jobs

The results of this question is complicated to analyze as vast majority could not be established. 8.1% (16) of the respondents totally do not and 15.2% (30) of the respondents do not think quitting their family physician job. Whereas 10.1% (20) of the respondents totally think of quitting their job and 28.8% (57) of the respondents think of quitting their jobs. The vast majority of the respondents are impartial / neutral to this statement. In the research conducted by Tekin et al. in 2014 on the family physicians working in the province of Malatya, the 17.5% of the participants responded that they think of quitting their job and as similar to the questionnaire

findings of this thesis, vast majority prefer to be neutral to this question. The 28.9% of the respondents who think of quitting their job stated that they consider quitting due to high-workload, 14.5% of them due to low salaries, 11.9% of them due to the approach of the administrative bodies, 7.5% of them due to the working environment / conditions and 7% of them due to occupational dissatisfaction (Tekin et al., 2014).

4.1.3. Neo-liberalism

Question: Performance-evaluation and penalties for the family physicians make family physicians feel themselves under pressure.

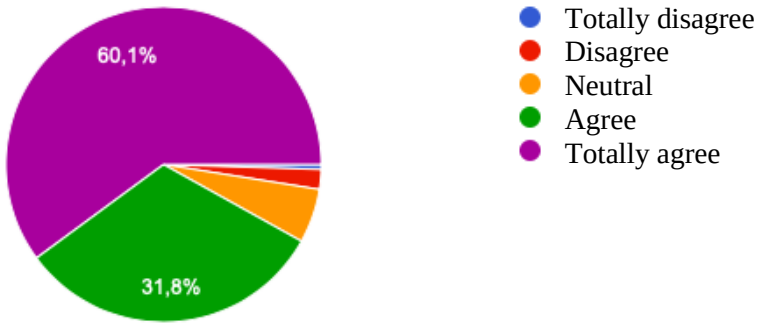

Figure 18. The thoughts of the respondents on the negative impact of the performance evaluations and given penalties to the family physicians in Turkey

The great majority, which contained 60.1% (119) of the respondents who totally agreed and 31.8% (63) agreed, think that the performance-evaluation and penalties given to them feel themselves pressured while working as family physicians. As it was mentioned in this thesis before, the salaries of the family physicians in Turkey are paid through a system based on capitation plus performance as they are working under a contracting scheme. This contracting scheme has an aspect which is the fact that the failures to meet the performance may result in salary cuts which might be up to 20% of their payments (Öcek et al., 2014). Also, repeated failures in meeting the performance targets for the family physicians might result in contract determination (Cesur et al., 2017). Due to such enforcements initiated with the neo-liberal policies

embodied in HTP make family physicians in Turkey as if they have to fulfil all the requests coming from the patients due to the fear of penalties including payment cuts (Öcek et al., 2014). One of the other issues resulting from this fear and pressure of penalties given to the family physicians in Turkey is wrong practices in terms of medicine. For instance, as Türkbayrak et al. (2011) stressed that some of the family physicians prefer to write the prescriptions that their patients would like to even if the pharmaceuticals that is prescribed are not proper or good ones for the patients' well-being. At this point, some unpleasant implementations are done by several family physicians due to the fear of penalty, losing money or their patient. Sometimes, due to this fear, family physicians might and do cause wrong or misleading data or reports in Turkey (Öcek et al., 2014). For instance, in the research prepared and conducted by Öcek et al. (2014), one of the interviewees, who was working as a family physician in Turkey, stated that s/he sometimes report the statistical data of the vaccination as 100% even if it is not after trying to reach the person who is supposed to get vaccinated but s/he could not make the patient come to the Family Health Center. This family physician confessed it and explained that s/he would not like to get penalty or salary cut (Öcek et al., 2014). Also, some of the respondents stated in the open-ended question addressing the greatest challenge of the family physicians in Turkey that sometimes they had to do some work that they do not want to just for not losing their patients or do not experience a penalty or payment cut applied after a legal complaint of the patient. At this point, as in the research conducted by Türkbayrak et al. (2011), the family physicians in the province of Bursa stated that they think the performance evaluations done by the MoH have a punishing attitude more than having a promotional one. In addition, some of the respondents stated that the fear of the penalty or performance-evaluation for the physicians inside the Family Medicine System puts pressure on them together with the fact that the enforcements are only for the physicians. For instance, if a physician is responsible for the vaccination of the patients registered to them, at this point, the patients must also share this responsibility. However, many respondents stated that they have to try hard to reach patients and make them come to the Family Health Center for the required tests, scans or vaccinations. One of the respondents of the questionnaire specifically stated that if a patient does not apply to the Family Health Center for the required vaccination for the

sake of the community health, then it is not the physician's fault and because of this reason, the enforcements must also be made for the patients instead of imposing a penalty on physician or making payment cuts. It seems that many of the family physicians who participated to the questionnaire think that the enforcements must be reciprocal including also the patient dimension because these implementations required mutual effort and respect. To sum up, the findings of this thesis on this question which is about performance-evaluations and penalties that family physicians experienced in the practice of Family Medicine in Turkey affirmed these previous researches in the literature.

Question: Family Medicine System is a result of privatization of the primary health care services.

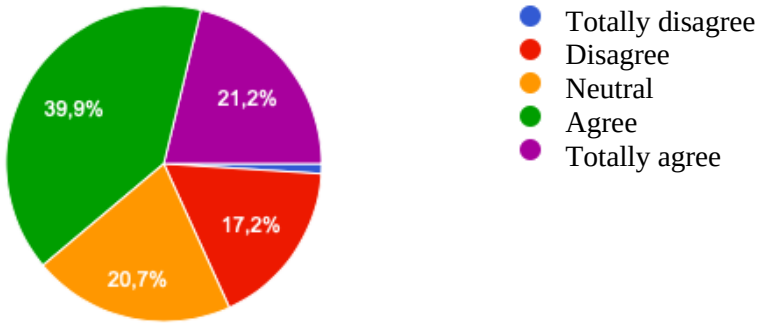

Figure 19. The thoughts of the respondents on the relevance of the Family Medicine with privatization of the health care services in Turkey

The 21.2% (42) of the respondents totally agree and 39.9% (79) of the respondents agree the argument stating that Family Medicine System is a consequence of privatization of the primary health care services. Therefore, the great majority of the respondents in this questionnaire believe that Family Medicine System in Turkey is a result of the privatization trend for the health care services which accelerated with the HTP. HTP had a privatization goal which envisioned a re-structuring of the public health sector on the basis of neo-liberal policies and which suggested making central elements of market elements and mechanisms in the organization and provision

dimensions of the health care services in Turkey (Türkbayrak et al., 2011). HTP reflected "social neo-liberal" approach through suggesting privatization and marketization policies in the health care (Ağartan, 2012; Soyer et al., 2007). The field of health care was transformed into a field in which the profit might be made and in which buying-selling might be practiced (Türkbayrak et al., 2011). The transormation in health care system in Turkey took place through privatization, promotion of private investments and MoH's withdrawal from the dimension of provision of the health care services. It might be argued that the privatization of the health care services in Turkey substiantially ourbroke within the primary health care services through the Family Medicine because as it was mentioned before in the thesis, one of the main components of the HTP is the Family Medicine Model, which was suggested under the privatization of the primary health care services (Türk Tabipleri Birliği, 2006). Türkbayrak et al. (2011) suggested that the Family Medicine Scheme in Turkey was not established accordingly to the needs of the health but it was set up for the market elements, customer satisfaction, new understanding of health which is based on consumption and it pave way to market mechanisms to grow within the primary health care services. Therefore, as Tükel (2010) suggested, HTP is a mask which initiated privatization of the health care services, notably the primary health care services via the implementation of the Family Medicine System in Turkey and majority of the respondents agree this.

Question: Family Medicine System in Turkey creates an unpleasant competition among the family physicians which affects performance of the physicians negatively and hurts the medical ethics.

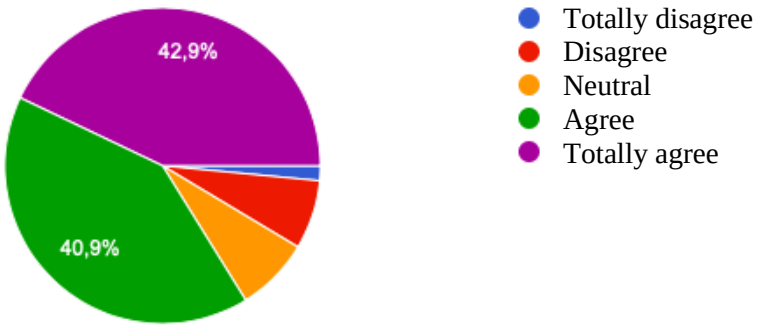

Figure 20. The thoughts of the respondents on envisioned competition among the family physicians within the practice of the Family Medicine in Turkey

The 42.9% (85) of the respondents totally agree the statement above which argues that Family Medicine practice in Turkey causes an unpleasant rivalry among the family physicians which has a negative impact on their performances and erodes the medical ethics. At this point, the great majority of the respondents believe that the competition is created by the Family Medicine Scheme and it has negative impacts on their occupational performance. TMA (2006) argued that the settled market understanding and competition environment brought unethical and even community health threatening implementations together (Türk Tabipleri Birliği, 2006). With the Family Medicine Scheme initiated by the HTP, the patient-physician relationship eroded due to the competition envisioned by the neo-liberal policies suggesting privatization. As Türkbayrak et al. (2011) suggested that the experienced problems for having the others' patients due to the competition element positioned in the Family Medicine Scheme breaks the peace in the working environment and these incidents are the reflection of the competitive attitude. Even if the MoH named such a competition as "sweet" (Türk Tabipleri Birliği, 2003), vast majority of the respondents

who are working as family physicians seemingly do not agree with that statement of the MoH and they have unpleasant feelings / thoughts on the rivalry element suggested by the neo-liberal the HTP.

4.2.The Open-ended Question:

Question: What is the biggest challenge that you are faced with while working as a family physician?

Under the title of this open-ended question, the answers given by the respondents which cannot be categorized into the other questions' topics are going to be presented and interpreted.

4.2.1. Patient-centrism of the Family Medicine System

One of the most remarkable subjects among the answers given to the open-ended question asking the greatest challenge of family physicians' in Turkey might be fit into the title of "patient-centrism of the practice of the system" in Turkey. Many family physicians attending the questionnaire addressed that the patient-centrism feature of the system as the greatest challenge that they have to face in their daily-professional lives. One of the respondents stated that the practice of the Family Medicine in Turkey is not appropriate to the European standards and it relies on almost merely a patient-satisfaction with the system as Yenimahalleli Yaşar (2011) stressed that the improving patient satisfaction is one of the main motivations behind the Family Medicine System. The nature of the system was tended to be patient centered as it was built around this satisfaction dimension of the patients in the primary health care. At this point, one of the respondents said that whereas patients have extreme rights which causes unlimited demands from the physicians, the physicians are suffered from the dimension of personal rights. Due to the fact that patient-satisfaction is one of the major components of the Family Medicine Scheme proposed by the HTP, patients sometimes have unlimited or even illegal demands from the physicians such as misleading health reports or prescription of unproper or unnecessary drugs. In such cases, as family physicians stressed that in the thesis research, patients might threaten the physicians

in terms of registering other physicians or make a legal complaint about the physician who probably have a penalty or be exposed to investigation.

Also, under this topic, several physicians responding to this questionnaire stated that they suffer from the fact that responsibilities such as vaccination, periodical medical scans and pregnancy-monitoring are regarded as one-sided in the Turkish practice of the system. Due to this patient-centric model of the primary health care services, patients have an unlimited expectations as if their all demands are mandatorily met by the family physicians; investigations, penalties and enforcements are imposed only to the physicians and the answers of the respondents depicted that many of the family physicians feel themselves suffering from this overly patient-centrism of the practice which is beyond the patient-orientation component of the philosophy of Family Medicine. Moreover, many respondents of the questionnaire think that this overly patient centrism is also combined with the dimension of bureaucracy and administrative dimensions.

4.2.2. Bureaucracy and Administrative Issues

Many physicians responded to the questionnaire think that the unlimited patient demand and patient-centrism are consolidated with the bureaucracy and the attitude of the primary health care administration institutions due to unclear bylaws, differences in the implementation of the rules in different provinces and the attitude of them towards the Family Medicine workers. In this sense, some respondents suggested that the absence of standardization in implementations is a great problem in the Turkish practice of Family Medicine Scheme. Some of the family physicians attended to the questionnaire stressed that they do not feel as if the Ministry that they are working under, do not support them. On the contrary, they stated that they feel the MoH's effort to support the patients in the most cases. One of the respondents specifically stated that s/he are not able to find addressee in the administration for the problems that they are faced with during the work. One of the other respondents addressed the absence of the undetermined common behavior and rules between the doctor and patient as a greatest challenge. Some of the respondents feels uncomfortable about the attitude of the administration towards them as administration generally supports the patients and

punishes or investigates the doctor. Some of the physicians who were part of suffer from the administration's effort to encumber the responsibilities which are not covered by the bylaw. One respondent suggested that the administration sometimes have arbitrary actions in terms of the application of the rules and bylaws in different regions due to the absence of standardization for administrators to apply sharply. Finally, one of the respondents shared that s/he suffer from the implementations that are taken into practice and enforced without consulting the family physicians who are going to put these into practice. More importantly, also many respondents addressed the violence as the greatest challenge and some of them stated that the attitude of the administration towards them might be a strengthening factor for the likelihood of exposing violence.

4.2.3. The Issue of Violence Towards Family Physicians

Several respondents confide that the violence in the health care is the major challenge that they are faced with during their daily occupation. It is significant to stress the fact that these respondents do not think the family physicians are the ones who are exposed violence, they use the word health care "workers" referring to all health care personnel. Some of the respondents of the questionnaire also mention that violence sometimes come with humiliation. One respondent specifically stressed that the family physicians generally are exposed verbal violence of the patients or their relatives in the case of not needing their illegal requests. One of the family physicians responded to the questionnaire articulated that s/he is not feeling safe during the work. One respondent enunciated that due to flaws in the implementation the practice of the system makes health care workers susceptible to violence. One of the respondents suggested that the security must be established and sustained inside the health care sector. Also, one of the respondents propound that the absence of a "Law on Violence in Health Care" is the greatest difficulty that they faced with in their occupational life as family physicians in Turkey.

4.2.4. Official Documents Given by the Family Physicians

Many respondents attending the questionnaire voiced that the subject of official documents that can be taken from the family physicians as the major difficulty in their work. Many family physicians in the questionnaire, stated that patients demand illegal documents such as medical reports and prescriptions. For instance, many of these respondents who suffer from the official medical documents issue stated that there are a host of patients who does not come and apply the physician but one of their relatives do and try to make the physician prescribe without examining the patient himself/herself. Also, some of the respondents articulated that patients sometimes request unmethodical medical reports. To illustrate, several respondents voiced that many patients demand sick leave report even if they do not have an illness but try to use the report as an excuse in their daily lives. Several respondents stated that they suffer from the greatest difficulty to explain the fact that they cannot prescribe the pharmaceuticals that patients demand under those circumstances or they cannot prepare a medical report for what the patients demand.

Besides the illegal document demands, the respondents stressed that the official paper works given as responsibility to them caused too much workload. Some of the family physicians responded to the questionnaire articulated that the medical reports are required for almost doing anything in the daily life including registering a sports center, starting to a dance course, starting for a new job and even renewal of the driving licenses. At this point, many of the respondents think that all of these are too much and unnecessary.

One of the respondents explain the situation related to official documents issue through regarding this unlimited official document demand of the patients as consumption oriented.

4.2.5. Decreasing Physician Dignity

Some of the family physicians voiced that they feel their dignity of being physician is gradually decreasing in Turkey. One of the respondents mentioned that sometimes patients do not regard them as medical doctor but patients have a

predisposition to see them as an authority for signature due to the current bureaucracy and duty of authorizing official medical documents. One of the family physicians stated that some patients consider them as workers whose salaries are paid by themselves due to the overly reliance of the system on patient satisfaction. Some of the respondents noted that they suffer from the disrespect of the patients while practicing their job as family physicians in Turkey.

CHAPTER 5

CONCLUSION

As Alma Ata Declaration (1978) stressed the significance of the primary health care services among a health care system in the sense that it is the essential health care services which can be considered as a foundation of building a health care system through indirectly shaping the other levels of the health care services and it might contribute to establishment of a cost-efficient health care system, countries have started to realize the significance of these services. In the existing literature and the medical academic environment, the Family Medicine Scheme is considered as one of the most effective ways of organizing the primary health care services due to its functions such as gatekeeping, reducing the health expenditure and costs inside the health care and patient-orientation with a detailed monitoring and examination process (World Health Organization, 1978). This comparatively new medical specialty field have been existed for over twenty years in Turkey as the departments of Family Medicine started to be established all over the Turkish universities and it started to spread. However, the Family Medicine Scheme has been difficult to apply accurately in our country due to several reasons including the fact that it is comparatively new field and the way of organizing the primary health care services, the absence of the required components to apply it effectively and the fact that it is the opposite of the opposite of the previous way of organizing the primary health care services brought by the neo-liberal positioned Health Transformation Program of 2003 (Yenimahalleli Yaşar, 2011; Ağartan 2012; Soyer et al., 2007; Türk Tabipleri Birliği, 2006).

The findings of the questionnaire show that the Family Medicine practice is not functioning well in Turkey due to the neo-liberal elements brought by the HTP and its failure to most of the objectives together with the absence of the required mechanisms. Also, the personal experiences of the family physicians attended to the questionnaire supported the argument of this thesis. The objectives of the Family Medicine such as costly effective primary health care, prevention of the accumulation

of the patients in the secondary and tertiary health care institutions and the absence of the chain of referral mechanism, together with the neo-liberal elements injected into the Turkish health care system such as performance evaluations, penalties and competition envisioned for the family physicians prevent the practice of the Family Medicine in Turkey from being a well-functioning one. As the family physicians' personal experiences supported, from the perspectives of them, the argument of the thesis on the functionality of the practice in Turkey is justifiable.

In the existing literature, there are host of research conducted on the Family Medicine practice in Turkey. Yet, these research mostly are based on the patient-satisfaction as their researchers believed that this is a determinant for the evaluation of the practice (Özata, Tekin, & Öztürk, 2016; Baltacı et al., 2011; Bostan & Havvatoğlu, 2014; Barış, Mollahaliloğlu, & Aydın, 2011). Due to such a literature gap, this thesis aimed to evaluate the practice of Family Medicine through learning whether family physicians in Turkey think that the family medicine in Turkey is a related to the privatization trend for the services which were provided publicly, the practice is functioning well or not and if they think that it does not function well, discover the reasons behind this problematic implementation. In order to achieve this, in the framework of this thesis, a questionnaire was conducted with the family physicians and family medicine specialists who currently work as family physicians in Turkey. The questionnaire was prepared through benefiting the previous research of the existing literature on the same topic and the theoretical framework revealing the components and applications required for a well-functioning family medicine practice. This questionnaire was conducted online through an online questionnaire platform and 198 family physicians and family medicine specialists who currently work as family physicians all over the Turkey responded to the questionnaire. The questionnaire consists of the questions related to the suggested components of the family medicine, problematic parts of the practice which revealed through previous research and in the light of these, potentially problematic parts of the practice that might be thought so by the physicians. The questionnaire is composed of seventeen "5 Point Likert Scale" questions and one open-ended question aiming to learn the biggest challenge family physicians in Turkey confronted in their daily professional life.

The research in thesis revealed that the family physicians in Turkey who responded to the questionnaire think that family medicine practice in Turkey provided patients with equal and easier access to the primary health care services and also a detailed patient monitoring or examination for the physicians. However, the problematic elements of the practice which considered so by the respondents outweighs the positive ones.

Most of the respondents think that a well-functioning chain of referral is prerequisite for running a well-functioning family medicine practice in a country, which was envisioned in the Turkish case with the HTP reform document at the beginning but does not exist currently in Turkish health care systems. As it was stated and clarified in this thesis before, chain of referral mechanism is quite significant for controlling the health care costs within a health care system and having a costly effective health care system as it encumbers family physicians with a role of gatekeeping (Aytekin, 2012; Çelik, 2011; Ener & Yelkikalan, 2003, Metsemakers, 2012; Starfield, 1998).

Many of the respondents are not much satisfied with their salaries as family physicians and their job satisfaction is not high.

Also, majority of the respondents think that the performance evaluation and penalties for the family physicians in Turkey brought by HTP, which is a neoliberal stance policy document, caused a competition among family physicians affecting the medical ethics and the performance of the physicians. In the open-ended questions, many respondents stated that their responsibilities and workloads are so high and as contractual employees, they are exposed performance evaluation and sometimes even get penalties including payment cuts or contract extermination. Many respondents stated that they feel themselves under pressure due to these performance evaluations done by the Ministry of Health of the Republic of Turkey together with the overly patient-centric family medicine practice in Turkey. Many respondents see this overly patient centrism as the greatest challenge that they encounter every day while working as family physicians in Turkey. Majority of the respondents stated that the patients generally have quite high expectations from them and sometimes they have illegal requests which are beyond the authorization of the physicians such as prescription or issuing official documents like reports which they are not able to do. Respondents

stressed that in such cases, they are threatened by their patients for registering another family physician or make complaint to the Ministry of Health. These respondents think that the approach of the Ministry towards themselves is not a constructive one but punishing one due to such over patient-centric understanding within the new health care system envisioned by the HTP.

Also, majority of the respondents think that the administrative issues such as the unclear definition of the duties and jurisdiction of the family physicians due to unclear by-laws and legal regulations causes the differentiation in the implementation for physicians and increasing workload for them day by day. As these respondents suggested, since the duties are not clear enough, brand new responsibilities are given to the family physicians such as new envisioned report or official document. Also, some of the respondents stated that sometimes they feel themselves as if they are a bureaucratic office issuing official documents rather than a physician diagnosing and treating the patients due to their new role with the family medicine and they argued that their patients also think so.

Whereas majority of the respondents do not believe that they have a safe working conditions and environment while working as family physicians in Turkey, many respondents suggested in the open-ended question that the safety is the greatest difficulty that they experienced.

In a question, the respondents were asked to evaluate the practice of family medicine in Turkey and majority of the respondents think that it is bad or average. Also, vast majority of the respondents think that the family medicine practice in Turkey is a result of the privatization of the health care services.

In the light of the aforementioned issues in the practice of family medicine in Turkey, policy makers might be able to re-consider the family medicine policy with its non-functioning implementations. For instance, policy makers should consider improving the conditions related to infrastructure through giving the role of providing infrastructural elements such as electricity, water, the other personnel of the health care centers. The policy makers might re-consider the privatization of the health care services and turn back to the social state understanding in which a state responsible to financing of the areas of the social policy and providing the basic infrastructure for the implementation of a policy.

Together with the infrastructural issues, the MoH and policy makers might take a measure to reduce the population of the registered patients to each family physician or they might encourage the new-graduated practitioners to choose make a career in the field of family medicine through some incentives like raise in the salaries of the family physicians or improve the conditions for them while working as many respondents of the questionnaire think that their salaries are not satisfactory. If these measures are taken, the detailed patient monitoring goal of the family medicine also can be achieved.

Also, the MoH should realize the positions of the family physicians are not sufficiently strong to lower the health care costs which is the essential goal of the family medicine. The MoH might be able to achieve this with a strengthening the position of family physicians within the Turkish health care system through allocate gatekeeping function to them and ensuring that this strong position of them is functioning well in the practice as well. Besides, as a great majority of the respondents think that a well-functioning family medicine practice requires an effective mechanism of chain of referral which currently does not exist in the Turkish family medicine practice. At this point, as one of the other ways of reducing the health care costs within the health care system, the MoH should consider establishing and sustaining a well-functioning chain of referral mechanism. The chain of referral mechanism also may contribute to the prevention of the patient accumulation in the secondary and the tertiary health care services which is one of the main targets of the family medicine model in Turkey.

Moreover, as many physicians attending the questionnaire within the framework of this thesis mentioned that the administrative bodies for the family medicine structure somehow cause uncertainties in the daily actions of the family medicine practice. Some of the respondents suggested that there is a difference in the implementations in different regions or in different family health centers due to this uncertain bylaw of the family medicine and unclear job definition. This unclear job definition of the family physicians, as they stressed, cause an increase in their workload as new duties are given to them day by day. For instance, many respondents think that the unclear definitions of the duty of family physicians, the limits of their jurisdiction and the burdening of the new duties which are not determined clearly

whose responsibility are these prevent family physicians from work functionally. At this point, many respondents continuously added official reports duties for them increases their workload and prevent them practicing their actual duties which are curative services. Also, some of the respondents mentioned that they sometimes feel that the provincial directorates are positioned against themselves with a punishing attitude more than a supporting one. The given punishments such as payment cuts and contract extermination possibility might prove the point made by the family physicians responded to the questionnaire. As it might be understood, the family physicians in Turkey need to be approached in a more motivating attitude.

Majority of the respondents stated that the system is quite patient-centric and this patient centrism together with the punishing attitude of the bureaucratic make easier for patients to have extreme demands which are not their legal rights. The punishing attitude and very extensive job definition of the family physicians creating a high workload also settle the patients' attitude towards the family physicians. These might be prevented through a change in directorates' and the MoH's attitude shaping the positions of the family physicians inside the health care system. It seems that this attitude needs to be altered because the vast majority of the respondents think that the penalties and performance evaluations, which are suggested elements of neo-liberal policies, make feel themselves under pressure while they are performing their duties. The penalties and performance evaluations also create for physicians a fear of losing their registered patients along with the losing their jobs. This fear also sometimes causes wrong actions of the doctors such as inappropriate or unnecessary prescriptions for the patients' health. Such actions increase the competition between the family physicians as some patients would like to register to the physicians who fulfil their demands. As some respondents stated, some of the family physicians take such actions in order to fulfill the patients' demands and not to lose them. At this point, the ministry might consider performing less frequently the performance evaluations and penalties given to the physicians and try to find other ways to keep the balance between the patient demands and the positions of the physicians. Otherwise, the argument of the family medicine on strengthening the patient-physician relationship cannot be improved properly.

Finally, some of the respondents stated that the violence against the health care personnel including the family physicians must be prevented. Many respondents mention that they do not feel themselves safe while they are working. Together with the risk of losing their jobs, they also do not have a great security in the family health centers. At this point, the MoH might consider issuing a regulation initiating having a mandatory security personnel in each family health center.

To conclude, absence of the complementary mechanisms of family medicine, the attitude of the Ministry towards the health care personnel, the neoliberal elements brought by HTP such competition, performance evaluation and patient centrism into the primary health care services prevent Turkish practice from being a well-functioning one.

REFERENCES

Ağartan, T. (2012). Marketization and universalism: Crafting the right balance in the Turkish healthcare system. *Current Sociology*,*60*(4), 456-471. doi:https://doi.org/10.1177/0011392112438331

Ağartan, T. I. (2015). Explaining Large-Scale Policy Change in the Turkish Health Care System: Ideas, Institutions, and Political Actors. *Journal of Health Politics, Policy and Law*, *40*(5), 971–99.

Akdağ, R. (2004). *Aile Hekimliği Türkiye Modeli* (S. Aydın, Ed.). Ankara, Türkiye: Mavi Ofset Yayıncılık.

Akdağ, R., Aydın, S., & Demirel, H. (Eds.). (2009, January). *PROGRESS REPORT Health Transformation Program in Turkey* (Rep. No. 749). Retrieved March 01, 2019, from Ministry of Health website: https://sbu.saglik.gov.tr/Ekutuphane/kitaplar/TurkeySPDEng.pdf

Akdeniz, M., Ungan, M., & Yaman, H. (2011, January). The Development of Family Medicine as a Discipline in Turkey. Retrieved December 10, 2018, from The Development of Family Medicine as a Discipline in Turkey

Akpınar, E., Saatçi, E., & Bozdemir, N. (2006). Amerika Birleşik Devletleri'nde Aile Hekimliği. *Türkiye Aile Hekimliği Dergisi, 10*(2), 79-86. Retrieved March 02, 2019, from http://www.turkailehekderg.org/makaleler/derleme/amerika-birlesik-devletlerinde-aile-hekimligi/

Aktürk, Z., Ateşoğlu, D., & Çiftçi, E. (2015). Patient satisfaction with family practice in Turkey: Three-year trend from 2010 to 2012. *European Journal of Family Practice, 21*(4). Retrieved April 11, 2019, from https://www.tandfonline.com/doi/full/10.3109/13814788.2015.1048681

Algın, K., Şahin, İ., Top, M. (2004). Türkiye'de Aile Hekimlerinin Mesleki Sorunları ve Çözüm Önerileri. Hacettepe Sağlık İdaresi Dergisi, 7 (3),. Retrieved from http://dergipark.org.tr/hacettepesid/issue/7555/99331

Arya, N., Gibson, C., Ponka, D., Haq, C., Hansel, S., Dahlman, B., & Rouleau, K. (2017). Family medicine around the world: overview by region The Besrour Papers: a series on the state of family medicine in the world. *Canadian Family Physician, 63*(6), 436–441. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5471080/

Aydın, S. (Ed.). (2007). *Genel Sağlık Sigortası ve Sağlık Bakanlığının Değişen Rolü* (Vol. Sağlıkta Dönüşüm Serisi, Ser. 6). Ankara, Türkiye: Sağlık Bakanlığı.

Ayranci, U., Yenilmez, C., Balci, Y., & Kaptanoglu, C. (2006). Identification of violence in Turkish health care settings. *Journal of Interpersonal Violence, 21*(2), 276-296. Retrieved January 03, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/16368766#

Aytekin, S. (2012). Türkiye'de Aile Hekimliği Uygulamasının Sağlık Harcamaları Üzerindeki Etkilerinin Değerlendirilmesi. *Adıyaman Üniversitesi Sosyal Bilimler Enstitüsü Dergisi,5*(9), 33-44.

Baltacı, D., Kara, İ, Bahçebaşı, T., Sayın, S., Yılmaz, A., & Çeler, A. (2011). Düzce İlinde Birinci Basamakta Sağlık Hizmeti Alan Hastaların Aile Hekimi ve Muayenehanesi Hakkındaki Görüşlerinin Belirlenmesi: Pilot Çalışma. *Konuralp Tıp Dergisi, 3*(2), 9-15. Retrieved April 01, 2019, from http://www.konuralptipdergi.duzce.edu.tr/Sayfa/1612/2011-sayi--2

Baris, E., Mollahaliloglu, S., & Aydin, S. (2011). Healthcare in Turkey: From laggard to leader. *British Medical Journal, 342*(C). doi:10.1136/bmj.c7456.

Başak, O. (Trans.). (2003). *Aile Hekimliği / Genel Pratisyenlik Avrupa Tanımı*. Wonca Europe 2002. Türkiye Aile Hekimleri Uzmanlık Derneği Yayınları 3.

Başak, O., & Güldal, D. (2014). Akademik aile hekimliği bölümlerinin 20 yılı: Gelişimsel süreç üzerine bir değerlendirme. *Türkiye Aile Hekimliği Dergisi,18*(1), 16-24. doi:10.2399/tahd.14.00016

Bentzen, B. G., Bridges-Webb, C., Carmichael, L., Ceitlin, J., Feinbloom, R., Metcalf, D., … Rajakumar, K. (1991). *The Role Of The General Practitioner/Family Physician In Health Care Systems: A Statement From Wonca, 1991*. *The Role Of The General Practitioner/Family Physician In Health Care Systems: A Statement From Wonca, 1991*.

Bıyıklıoğlu, T., & Ungan, M. (2015). Aile Hekimi/ Genel Pratisyenin Çekirdek Yeterlilikleri Toplum Yönelimi. Retrieved from https://docplayer.biz.tr/2037161-Aile-hekimi-genel-pratisyenin-cekirdek-yeterlikleri-toplum-yonelimi-aras-gor-dr-tugrul-biyiklioglu-danisman-prof-dr.html

Birinci Basamak Sağlık Hizmetlerinde Hasta Memnuniyeti (Hıfzısıhha Mektebi Müdürlüğü Araştırma Serisi-4). (2010). Ankara, Türkiye: Sağlık Bakanlığı.

Bora Başara, B., Soytutan Çağlar, İ., Aygün, A., & Özdemir, T. A. (Eds.). (2018). *Republic of Turkey of Ministry of Health Health Statistics Yearbook 2017*. Ankara: Kuban Matbaacılık Yayıncılık.

Bostan, S., & Havvatoğlu, K. (2014). Europep Aile Hekimliği Memnuniyeti Ölçeğine Göre Gümüşhane Aile Hekimliği Memnuniyet Araştırması. *GümüGhane Üniversitesi Sağlık Bilimleri Dergisi, 3*(4), 1067-1078. Retrieved January 10, 2019, from https://dergipark.org.tr/download/article-file/220123

Campos-Outcalt, D. (2004). Public health and family medicine: An opportunity. *Journal of the American Board of Family Medicine, 17*, 207-211. Retrieved February 01, 2019, from https://www.ncbi.nlm.nih.gov/m/pubmed/15226286/

Cesur, R., Güneş, P., Tekin, E., & Ülker, A. (2017). The Value of Socialized Medicine: The Impact of Universal Primary Healthcare Provision on Mortality Rates in Turkey. *Journal of Public Economics,150*(C), 75-93. doi:10.3386/w21510

Çelik, Y. (2011). *Sağlık Ekonomisi*. Ankara: Siyasal Kitabevi.

Çiçeklioğlu, M., Öcek, Z., Yücel, U., Türk, M., & Taner, Ş. (2013). *Aile Hekimliği Birinci Basamak Sağlık Ortamını Nasıl Dönüştürdü?* (1st ed.) (Z. Öcek & M. Çiçeklioğlu, Eds.). Ankara, Türkiye: Türk Tabipleri Birliği.

Dağdeviren, N., & Aktürk, Z. (2004). An evaluation of patient satisfaction in Turkey with the EUROPEP instrument. *Yonsei Medical Journal, 46*(3). Retrieved March 29, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/15004864

Deveugele, M., Derese, A., Van den Brink-Muinen, A., Bensing, J., & De Maeseneer, J. (2002). Consultation length in general practice: Cross sectional study in six

European countries. *British Medical Journal, 325*(7362). Retrieved April 11, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/12202329

Dilaver, T., Dinçer, W., Kisa, A., & Younis, M. (2016). Evaluation of the Family Medicine Practice in Ankara Province by Family Physicians. *Journal of Health and Human Services Administration,39*(2), 186-216.

Doğan, N., Şensoy, N., Mardin, E. E., & Özbalcı, T. (2013). Aile Sağlığı Merkezinde Çalışan Sağlık Personellerinin Aile Hekimliğine Bakış Açıları. *Clint Analyt Med*, *4*, 112–5.

Ener, M., & Yelkikalan, N. (2003). Gelişmekte Olan Ülkelerin Sağlık Sistemlerinin Yeniden Yapılanması ve Finansmanı: Türkiye Deneyimi. *Kocaeli Üniversitesi Sosyal Bilimler Dergisi*, (6), 99-113. Retrieved February 08, 2019, from https://dergipark.org.tr/kosbed/issue/25714/271350

Eren, N., & Öztek, Z. (1993). *Sağlık Ocağı Yönetimi*. Ankara: Palme Yayıncılık.

Ergun, C., & Dericioğulları Ergun, A. (2010). Dönüşüm mü, Piyasalaştırma mı? Türkiye'de Sağlıkta Dönüşüm Programı Üzerine Bir Tartışma. *Toplum Ve Demokrasi,4*(8-9-10), 33-54. Retrieved March 23, 2019, from https://www.academia.edu/24851771/Dönüşüm_mü_Piyasalaştırma_mı_Türkiyede_Sağlıkta_Dönüşüm_Programı_Üzerine_Bir_Tartışma

Erkoç, Y. (2012). *Health Transformation Program Assessment Report (2003-2011)*. (R. Akdağ, Ed.). Ministry of Health.

Explaining Large-Scale Policy Change in the Turkish Health Care System: Ideas, Institutions, and Political Actors. (2015). *Journal of Health Politics, Policy and Law,40*(5), 971-999. doi:10.1215/03616878-3161174.

Framework For Professional And Administrative Development Of General Practice/ Family Medicine In Europe (pp. 1-10, Rep.). (1998). Copenhagen, Denmark: World Health Organization Regional Office for Europe.

Framework for Professional and Administrative Development of General Practice/ Family Medicine in Europe. (1998). *Framework for Professional and Administrative Development of General Practice/ Family Medicine in Europe*. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0011/239924/E58474.pdf

Flexner, A. (1910). *Medical Education in the United States and Canada A Report to the Carnegie Foundation for the Advancement of Teaching*. *Medical Education in the United States and Canada A Report to the Carnegie Foundation for the Advancement of Teaching*. Madison Avenue, New York City: The Carnegie Foundation for the Advancement of Teaching.

Fulton, B., Scheffler, R., Sparkes, S., Auh, E., Vujicic, M., & Soucat, A. (2011). Health workforce skill mix and task shifting in low income countries: A review of recent evidence. *Human Resources for Health, 9*(1). doi:10.1186/1478-4491-9-1.

Glenngård, A., Anell, A., & Beckman, A. (2011). Choice of primary care provider: Results from a population survey in three Swedish counties. *Health Policy, 103*(1), 31-37. doi:10.1016/j.healthpol.2011.05.014.

Gotler, R. (2019). Unfinished Business: The Role of Research in Family Medicine. *Annals of Family Medicine,17*, 70-76. Retrieved March 19, 2019, from http://www.annfammed.org/content/17/1/70

Gutierrez, C., & Scheid, P. (2015). The History of Family Medicine and Its Impact in US Health Care Delivery. Retrieved from https://www.aafpfoundation.org/content/dam/foundation/documents/who-we-are/cfhm/FMImpactGutierrezScheid.pdf

Güneş, E., & Yaman, H. (2008). Transition to family practice in Turkey. *Journal of Continuing Education in the Health Professions,28*(2), 106-112. doi:10.1002/chp.167.

İlgün, G., & Şahin, B. (2016). Aile Hekimliği Çalışanlarının Aile Hekimliği Uygulaması Hakkındaki Görüşlerinin İncelenmesi. *Hacettepe Sağlık İdaresi Dergisi,19*(2), 115-130. Retrieved January 21, 2019, from https://dergipark.org.tr/download/article-file/225557.

Kantarcı, Y. (2015). Aile Hekimliği Uygulamasının Hasta Sağlığı Üzerine Etkisi: Nurdağı Aile Sağlığı Merkezi Örneği (Unpublished master's thesis). Sütçü İmam Üniversitesi, Kahramanmaraş, Türkiye.

Karadağ, Z. (2007). *Aile Hekimliği Uygulamasının Müşteri/Hasta Memnuniyetine Etkisi* (Master's thesis, Ankara Gazi Üniversitesi, 2007). Ankara: Gazi Üniversitesi Sosyal Bilimler Enstitüsü.

Kardeş, S. (1994). Sağlık Hizmetleri Planlamasında Hasta Tatmini. In M. Doğan, Ö. Harmancıoğlu, & Y. Yeğinboy (Eds.), *1. Ulusal Sağlık Kuruluşları ve Hastane Yönetimi Sempozyumu*. İzmir, 9 Eylül Üniversitesi.

Kılavuz, E. (2010). Sağlık Harcamalarındaki Artış Ve Temel Bakım Hizmetleri. *Sosyal Bilimler Enstitüsü Dergisi,* (29), 173-192. Retrieved January 17, 2019, from http://sbedergi.erciyes.edu.tr/sayi_29/10.pdf

Korukluoğlu, S. (2004, Nisan). *Aile Hekimliğinde Sevk Zinciri*. Sağlıkta Dönüşüm Programı Çerçevesinde Aile Hekimliği Uygulaması Toplantısı'na sunulan bildiri, Afyon.

Law no.224 on Socialization of Health Care Services 1961.

Law no.5258 on Family Medicine Pilot Implementation 2004.

Law no.5510 on Social Security and General Health Insurance 2006.

Leebov, W., & Scott, G. (1994). *Service Quality Improvement: The Customer Satisfaction Strategy for Health Care*. American Hospital Publishing.

Leeuwenhorst Media Group (1974). *The General Practitioner in Europe*. Statement by the working party appointed by the second European Conference on Teaching of General Practice, Netherlands. Retrieved from https://euract.woncaeurope.org/sites/euractdev/files/documents/archive/publications/general-practitioner-europe-statement-working-party-appointed-2nd-european-conference-teaching.pdf

Magnussen, J., Vranbaek, K., & Saltman, R. (2009). *Nordic Health Care Systems, Recent Reforms and Current Policy Challenges* (World Health Organization European Observatory on Health Care Systems Series). Open University Press.

McWhinney, I., & Freeman, T. (2012). *Textbook Of Family Medicine* (1st ed.) (D. Güldal, Trans.). İstanbul: Medikal Akademi Yayıncılık.

Metsemakers, J. (2012). Türkiye'de Aile hekimliği eğitimi: Bazı düşüncüler. *Türkiye Aile Hekimliği Dergisi,16*(1), 23-24. doi:10.2399/tahd.12.023

Mola, E., Eiksson, T., Bueno, M. J. O., Gay, B., Kersnick, J., Miftode, R., … Ram, P. (2005). *The European Definition of General Practice/ Family Medicine Short Version. The European Definition of General Practice/ Family Medicine Short Version*. European Academy of Teachers in General Practice (Network within WONCA Europe).

Mollahaliloğlu, S., Kosdak, M., Sanisoğlu, Y., Boz, D., & Bulut Demirok, A. (2010). *Birinci Basamak Sağlık Hizmetlerinde Hasta Memnuniyeti*. (R. Akdağ, Ed.). Ankara: Opus Basın Yayın ve Ambalaj Sanayi ve Ticaret Ltd. Şti. Retrieved from https://dosyaism.saglik.gov.tr/Eklenti/12293,2010-birinci-basamak-saglik-hizmetlerinde-hasta-memnuniyetipdf.pdf?0

Mutlupoyraz, F. (2010). *Adana'daki Birinci Basamak Sağlık Kurumlarına Başvuran Hastaların Memnuniyet Düzeyleri Ve Bu Kurumlarda Çalışan Hekimlerin İş Doyumunun Saptanması* (Unpublished master's thesis). T.C. Çukurova Üniversitesi Tıp Fakültesi Aile Hekimliği Anabilim Dalı.

Neil, A., Gibson, C., Ponka, D., Haq, C., Hansel, S., Dahlman, B., & Rouleau, K. (2017). Family medicine around the world: Overview by regionThe Besrour Papers: A series on the state of family medicine in the world. *Canadian Family Physician, 63*(6), 436-441. Retrieved March 13, 2019, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5471080/

Neziroğlu, İ., & Yılmaz, T. (2013). *Türkiye Büyük Millet Meclisi Hükûmetler-Programları ve Genel Kurul Görüşmeleri (11 Ocak 1999-)*. (G. Erdem Efe, Ed.) (Vol. 10). Retrieved from https://www.tbmm.gov.tr/yayinlar/hukumetler/hukumetler_cilt_10.pdf

Olesen, F., Dickinson, J., & Hjortdahl, P. (2000). General practice--time for a new definition. *British Medical Journal, 320*, 354-357. doi.org/10.1136/bmj.320.7231.354

Orhaner, E. (2006). Türkiye'de Sağlık Hizmetleri Finansmanı Ve Genel Sağlık Sigortası. *Ticaret Ve Eğitim Fakültesi Dergisi,1*.

Çiçeklioğlu, M., Öcek, Z., Yücel, U., Özdemir, R., Türk, M., & Taner, Ş. (2013). *Aile Hekimliği Birinci Basamak Sağlık Ortamını Nasıl Dönüştürdü?* (Z. Öcek & M. Çiçeklioğlu, Eds.) (1st ed.). Türk Tabipleri Birliği.

Öcek, Z. A., Çiçeklioğlu, M., Yücel, U., & Özdemir, R. (2014). Family medicine model in Turkey: A qualitative assessment from the perspectives of primary care workers. *BMC Family Practice,15*(38). doi:10.1186/s12875-015-0293-y

Özata, M., Tekin, F., & Öztürk, Y. (2016). Konya'daki Aile Hekimliği Hizmetlerinin Değerlendirilmesi. *Selçuk Üniversitesi Sosyal Bilimler Enstitüsü Dergisi,35*, 205-218.

Özata, M., Tekin, F., & Öztürk, Y. E. (2016). Konya'daki aile Hekimliği Hizmetlerinin Değerlendirilmesi. *Selçuk Üniversitesi Sosyal Bilimler Enstitüsü Dergisi*, *35*, 205–218.

Özdemir, K., & Ungan, M. (2015). Aile Hekimliği Tanımı: Çekirdek Yeterlilikleri ve Özellikleri. Retrieved from http://ailehekimi.medicine.ankara.edu.tr/wp-content/uploads/sites/581/2015/02/Aile-Hekimliği-Tanımı-Çekirdek-Yeterlilikleri-ve-Özellikleri.pdf

Pala, K. (2014). Neoliberal Sağlık Reformlarının Etkisi: Kamu Hastanelerinde Finansman Yapısı Değişiyor. *Toplum Ve Hekim,29*(6), 414-429.

Pantell, M., Marchis, E. D., Bueno, A., & Gottlieb, L. (2019). Practice Capacity to Address Patients' Social Needs and Physician Satisfaction and Perceived Quality of Care. *Annals of Family Medicine, 17*(1), 42-45. doi:10.1370/afm.2334.

Rakel, R., & Rakel, D. (2015). *Textbook of Family Medicine* (9th ed.). Elsevier Saunders.

Rouleau, K., Bourget, M., Chege, P., Couturier, F., Godoy-Ruiz, P., Grand'Maison, P., . . . Woolard, R. (2018). Strengthening Primary Care Through Family Medicine Around the World: Collaborating Toward Promising Practices. *Journal of Family Medicine*, *50*(6). doi:10.22454/FamMed.2018.210965

Saltman, R., Busse, R., & Mossialos, E. (Eds.). (2002). *Regulating Enterpreneurial Behavior in European Health Care Systems* (World Health Organization European Observatory on Health Care Systems Series). Buckingham: Open University Press.

Saran, U. (2007). Sağlıkta Aile Hekimliğinin Getirdikleri. *Aile Hekimliği Dergisi*, *1*(4), 10–15.

Saultz, J. (2000). *An Overview and History of Family Practice* (1st ed.). New York: McGraw-Hill Professional.

Savas, B., Karahan, Ö, Saka, R., & Mossialos, E. (2002). *Health Care Systems in Transition*(Vol. 4) (S. Thomson, Ed.). Copenhagen, Denmark: The European Observatory on Health Care Systems.

Sevimli, F., & İşcan, Ö. (2005). Bireysel Ve İş Ortamına Ait Etkenler Açısından İş Doyumu. *Ege Akademik Bakış Dergisi, 5*(1), 55-64. Retrieved March 11, 2019, from https://dergipark.org.tr/eab/issue/39836/472327

Soyer, A., Aslanhan, B., Bilaloğlu, E., Kılıç, G., Öztürk, O., Yavuz, C., & Zencir, M. (2007). *Sağlıkta Piyasacı Tahribatın Son Halkası: AKP* (1st ed.). Ankara, Türkiye: Türk Tabipleri Birliği Merkez Konseyi.

Soyer, A., Yazgan, A., Kılıç, B., Yavuz, C., Şeyhoğlu, C., Akyol, E., . . . Akyol, Y. (2003). *Sağlıkta Dönüşüm Programı, 2003 Türkiye'sinde Halka Ve Hekimlere/Sağlık Personeline Ne Getiriyor?* (1st ed.). Ankara, Türkiye: Türk Tabipleri Birliği Merkez Konseyi.

Sparkes, S., Atun, R., & Bärnighausen, T. (2019). The Impact of the Family Medicine Model on Patient Satisfaction in Turkey: Panel Analysis with Province Fixed Effects . *PLoS ONE*, *14*(1). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6353549/

Starfield, B. (1998). *Primary Care: Balancing Health Needs, Services, and Technology*. New York Oxford: Oxford University Press.

Stephens, G. (1982). *The Intellectual Basis of Family Practice*. Tucson: Winter Publishing.

Şahin, H. (2013, January 14). Aile Hekimliği Memnuniyet Araştırması. Retrieved from https://www.turksagliksen.org.tr/aile-hekimligi-memnuniyet-arastirmasi_arsiv_11521

T.C. Sağlık Bakanlığı Halk Sağlığı Genel Müdürlüğü Aile Hekimliği Dairesi Başkanlığı. (2017). Aile Hekiminin Tanımı. Retrieved from https://hsgm.saglik.gov.tr/tr/ailehekimligi/aile-hekiminin-tanımı.html

T.C. Sağlık Bakanlığı. (2016). Aile Hekimliği Uygulama Yönetmeliği. Retrieved from https://www.saglik.gov.tr/TR,10516/aile-hekimligi-uygulama-yonetmeligi.html

Tatar, M. (2012). Financing Health Care Services: Development of Social Health Insurance in Turkey. *Journal of Social Security*, *1*(1), 103–133.

Tatar, M., Mollahaliloglu, S., Sahin, B., Aydin, S., Maresso, A., & Hernàndez-Quevedo, C. (2011). *Turkey Health System Review* (6th ed., Vol. 13, Health Systems in Transition). Brussels: European Observatory on Health Systems and Policies.

Tekin, Ç, Bozkır, Ç, Sazak, Y., & Özer, A. (2014). Malatya İl Merkezinde Çalışan Aile Hekimleri ile Aile Sağlığı Elemanlarının, Aile Hekimliği Uygulaması Hakkındaki Görüşleri, İş Doyumu Düzeyleri ve Etkileyen Faktörler. *Fırat Tıp Dergisi, 19*(3).

Tengilimoğlu, D., Dinçer, W. M. M., Kisa, A., & Younis, M. Z. (2016). Evaluation of the Family Medicine Practice in Ankara Province by Family Physicians. *Journal of Healt and Human Services Administration*, *39*(2), 186–216. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/29388758

The Ministry of Health of Turkey. (2003). *Health Transformation Programme*. Ankara.

The organisation of primary care in Europe: Part 2 Agenda - Position paper of the European Forum for Primary Care. (2009). *Quality in Primary Care*, *17*(3), 225-234. Retrieved April 01, 2019, from https://www.researchgate.net/publication/26685864_The_organisation_of_primary_care_in_Europe_Part_2_Agenda_-_Position_paper_of_the_European_Forum_for_Primary_Care

The World Bank Human Development Sector Unit Europe and Central Asia Region. (2003). *Turkey Reforming the Health Sector for Improved Access and Efficency*. *Turkey Reforming the Health Sector for Improved Access and Efficency*(Vol. II, pp. 1–217).

Tözün, M., Çulhacı, A., & Ünsal, A. (2008). Aile Hekimliği Sisteminde Birinci Basamak Sağlık Kurumlarında Çalışan Hekimlerin İş Doyumu (Eskişehir). *TAF Preventive Medicine Bulletin*, *7*(5), 377-384. Retrieved March 03, 2003, from https://docplayer.biz.tr/24549-Aile-hekimligi-sisteminde-birinci-basamak-saglik-kurumlarinda-calisan-hekimlerin-is-doyumu-eskisehir.html

Turgu, S., Öztora, S., Çaylan, A., & Dağdeviren, H. N. (2018). Birinci Basamakta Hasta Memnuniyeti ve Hekim İş Doyumu ile İlişkisi. *Türkiye Aile Hekimliği Dergisi, 22*(2). doi: 10.15511/tahd.18.00278

Tükel, R. (2010). Sağlıkta Dönüşümde Son Aşamaya Doğru: Hastanelerin Yeniden Yapılandırılması ve Yeni Finansman Modeli. *Türkiye Psikiyatri Bülteni,13*(3), 17-21.

Türk Sağlık-Sen. (2013, January 14). Aile Hekimliği Memnuniyet Araştırması. Retrieved December 09, 2018, from https://www.turksagliksen.org.tr/aile-hekimligi-memnuniyet-arastirmasi_arsiv_11521

Türk Tabipleri Birliği. (2003). *Sağlıkta Dönüşüm Programı, 2003 Türkiye'sinde Halka ve Hekimlere/ Sağlık Personeline Ne Getiriyor?* (1st ed.). Ankara: Türk Tabipleri Birliği Merkez Konseyi.

Türk Tabipleri Birliği. (2006). *Aile Hekimliğinde Son Durum* (1st ed.). Ankara: Türk Tabipleri Birliği Merkez Konseyi.

Türk Tabipleri Birliği. (2018a, February). Sağlıkta Dönüşüm Programı Çöktü Aile Hekimliği: Ne Dediler, Ne Oldu? *Tıp Dünyası*. Retrieved from http://www.ttb.org.tr/kutuphane/aile_hekimligi_br2018.pdf

Türk Tabipleri Birliği. (2018b, March). Sağlıkta Dönüşüm Programı Çöktü Genel Sağlık Sigortası: Ne Dediler, Ne Oldu? *Tıp Dünyası*. Retrieved from http://www.ttb.org.tr/userfiles/files/14Mart2018GSS.pdf

Türkbayrak, A., Özbilgin, B., Taşçı, E., Yentürk, E., Aktaş, G., Elitez, G., . . . Ergus, K. (2011). *Bursa'da Aile Hekimliğinin İlk Yılı Ardından Tespit Ve Çözümlemeler* (pp. 1-31, Working paper). Ankara: Türk Tabipleri Birliği.

Türkiye, T. C. Başbakanlık, T.C. Başbakanlık. (2003). *T.C. 58. Hükumet Acil Eylem Planı*. Ankara.

Ünlüoğlu, İ, & Paycı, S. (2004). Dünya'da ve Türkiye'de Aile Hekimliği. In *Aile Doktorları İçin Kurs Notları 1.Aşama* (1st ed., pp. 23-30). Ankara: T.C. SAĞLIK BAKANLIĞI.

Whynes, D., & Baines, D. (2002). Primary care physicians' attitudes to health care reform in England. *Health Policy, 60*(2), 111-132. Retrieved April 12, 2019, from https://www.ncbi.nlm.nih.gov/pubmed/11897372

World Health Organization Regional Office for Europe. (1978). "Declaration of Alma Ata" from *The Conference on Primary Health Care*, Alma Ata, http://www.euro.who.int/__data/assets/pdf_file/0009/113877/E93944.pdf?ua=1
World Health Organization's Global Health Workforce Statistics, OECD. (2019). Physicians (per 1,000 people). Retrieved from https://data.worldbank.org/indicator/SH.MED.PHYS.ZS

Yaman, H., & Güneş, E. (2016). Family practice in Turkey: Observations from a pilot implementation. *Scandinavian Journal of Primary Health Care,34*(1), 81-2. doi: 10.3109/02813432.2016.1144432

Yaşar Yenimahalleli, G. (2011). 'Health transformation programme' in Turkey: An assessment. *International Journal of Health Planning and Management,26*(2), 110-33. http://dx.doi.org/10.1002/hpm.1065

Yenimahalleli Yaşar, G. (2011). 'Health transformation programme' in Turkey: an assessment. *International Journal of Health Planning and Management, 26*, 110–133. doi: 10.1002/hpm.1065

Yılmaz, V. (2013). Changing Origins of Inequalities in Access to Health Care Services in Turkey: From Occupational Status to Income. *New Perspectives on Turkey,48*, 55-77. doi.org/10.1017/S0896634600001886

APPENDICES

A. THESIS QUESTIONNAIRE METU ETHICS COMMITTEE APPROVAL

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

ORTA DOĞU TEKNİK ÜNİVERSİTESİ
MIDDLE EAST TECHNICAL UNIVERSITY

DUMLUPINAR BULVARI 06800
ÇANKAYA ANKARA/TURKEY
T: +90 312 210 22 91
F: +90 312 210 79 59
ueam@metu.edu.tr
www.ueam.metu.edu.tr

Sayı: 28620816 /177

09 Nisan 2019

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Doç.Dr. Mehmet OKYAYUZ

Danışmanlığını yaptığınız **Zeynep Deniz ŞEN'in "Sağlık Politikalarındaki Neo - Liberal Dönüşümün (Sağlıkta Dönüşüm Programı) Etkisinde Aile Hekimliği Modelinin Türkiye'ye Uyumluluğu ve Pratiğinin İncelemesi"** başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve **167-ODTÜ-2019** protokol numarası ile onaylanmıştır.

Saygılarımızla bilgilerinize sunarız

Prof. Dr. Tülin GENÇÖZ
Başkan

Prof. Dr. Ayhan SOL
Üye

Prof. Dr. Ayhan Gürbüz DEMİR (4.)
Üye

Prof. Dr. Yaşar KONDAKÇI
Üye

Doç. Dr. Emre SELÇUK
Üye

Doç. Dr. Pınar KAYGAN
Üye

Dr. Öğr. Üyesi Ali Emre TURGUT
Üye

B. QUESTIONNAIRE

Aile Hekimliği Hekim Memnuniyeti Anketi

Değerli katılımcı, bu bölümde, lütfen size en uygun gelen seçeneği, 1'den (Kesinlikle Katılmıyorum / Çok Kötü) 5'e kadar (Kesinlikle Katılıyorum / Çok İyi) derecelendirilmiş ölçek üzerinde işaretleyiniz. Lütfen ölçekte bulunan tüm ifadeleri değerlendiriniz.

1	2	3	4	5
Kesinlikle katılmıyorum	Katılmıyorum	Ne katılıyorum ne katılmıyorum	Katılıyorum	Kesinlikle katılıyorum

1.	Aile hekimliği sistemi, hekimler açısından daha detaylı bir hasta takibi (her hasta ile detaylı ilgilenebilme) fırsatı sunuyor.	1	2	3	4	5
2.	Aile hekimliği sistemi, ülkenin sağlık sistemi için daha az maliyetli bir birinci basamak sağlık hizmeti sunuyor.	1	2	3	4	5
3.	Aile hekimliği sistemi, ikinci ve üçüncü basamak sağlık servislerinde hasta yığılmasını (kalabalığını) engelliyor.	1	2	3	4	5
4.	Aile hekimliği sistemi, her vatandaşa eşit derecede erişilebilir birinci basamak sağlık hizmetleri sunuyor.	1	2	3	4	5
5.	Aile hekimliği sistemi, her vatandaşa kolay erişilebilir birinci basamak sağlık hizmetleri sunuyor.	1	2	3	4	5
6.	Aile hekimliği sistemi, etkili bir sevk zinciri mekanizmasına ihtiyaç duymaktadır.	1	2	3	4	5
7.	Aile hekimi olarak maaş tatminim yüksek.	1	2	3	4	5
8.	Aile hekimliği yaparken mesleki tatminim yüksek.	1	2	3	4	5
9.	Aile hekimliği, hekimlere güvenli bir iş / çalışma ortamı sağlıyor.	1	2	3	4	5
10.	Aile hekimliği sisteminin, hekimlere yüklediği sorumluluklar / iş yükü ağır.	1	2	3	4	5
11.	Aile hekimliği sistemindeki cezalar ve performans denetimleri, hekimlerin üzerlerinde baskı hissetmesine sebep oluyor.	1	2	3	4	5
12.	Aile hekimliği sistemi, hasta-hekim ilişkilerini iyileştirdi (güçlendirdi).	1	2	3	4	5
13.	Aile hekimliğinden ayrılmayı düşünmüyorum.	1	2	3	4	5

14.	Aile hekimliği sistemi, birinci basamak sağlık hizmetlerinin özelleştirilmesinin bir sonucudur.	1	2	3	4	5
15.	Aile hekimliği modeli Türkiye'ye uygun bir birinci basamak sağlık hizmeti sunumu şeklidir.	1	2	3	4	5
16.	Türkiye'de aile hekimliği sistemi, aile hekimleri arasında olumsuz (performansı olumsuz etkileyen ve hekimlik etiğini zora sokan) bir rekabete sebep olmaktadır.	1	2	3	4	5
17.	Türkiye'de aile hekimliği sisteminin pratiğini genel olarak değerlendiriniz.	1	2	3	4	5
Aşağıdaki soruyu lütfen kendi ifadelerinizle doldurarak cevaplayınız.						
18.	Aile hekimliği yaparken karşılaştığınız en büyük zorluk nedir? Lütfen açıklayınız.					

C. TURKISH SUMMARY / TÜRKÇE ÖZET

Temel Sağlık Hizmetleri

Mevcut literatürde daha önce yapılmış bazı araştırmalar, birinci basamak sağlık hizmetlerini sağlık sisteminin temeline konumlandıran ülkelerin, daha etkin, etkili ve eşitlikçi anlayışa sahip olabildiğini ortaya koymuştur (Metsemakers, 2012). Dolayısıyla, bir ülkenin iyi işleyen ve sağlık sisteminin merkezine yerleştirdiği temel sağlık hizmetlerine sahip olması, daha iyi sağlık göstergelerine ve daha etkili bir sağlık sistemine sahip olacağı iddia edilebilir.

Bu tezin sonraki bölümünde, temel sağlık hizmetleri sunumunun bir çeşidi olarak Aile Hekimliği Sistemi, temel bileşenleri, tarihi, amaçları ve Türkiye'deki güncel durumu ile birlikte açıklanacak ve modelin Türkiye'deki uygulaması, diğer ülkelerdeki uygulamalar ile karşılaştırılacaktır.

Aile Hekimliği'nin Dünya'daki Tarihi ve Gelişimi

1846'da "Amerikan Tıp Derneği" ve derneğin bünyesinde "Amerikan Tıp Derneği Dergisi" kurulmuştur (Gutierrez & Scheid, 2015). 1900'lerin ortalarında, tıp fakültesini yeni bitiren ve herhangi bir uzmanlık eğitimine sahip olmayan hekimlerin medikal pratiği, yükselişte olan tıpta uzmanlık anlayışı ve teknolojik gelişmeler ve hastane gibi daha komplike sağlık merkezlerinin sayısındaki artış nedeniyle miadını doldurmuş bir uygulama olarak görülmeye başlandı (Gotler, 2019). Francis Peabody (1923), tıpta uzmanlaşma eğiliminin en yüksek noktaya ulaşmış olduğunu, aşırı-uzmanlaşmanın hasta bakımını parçalanmış hale getirdiğini, hasta-hekim ilişkisini zayıflattığını ve bu yüzden de temel sağlık hizmetleri temelli sağlık sistemlerine geri dönülmesi gerektiğini savunmuştur (Rakel & Rakel, 2015). Bu dönemde genel pratisyenlik anlayışı temelli birinci basamak sağlık hizmetlerine geri dönülmesi gerekliliği Peabody tarafından vurgulanmış ve bu hizmetlerin ayrı ve yeni bir

akademik tıbbi disiplin olarak doğması ihtiyacına yol açmıştır (Saatçi, Bozdemir, & Akpınar, 2006). Aile Hekimliği'nin pozisyonu, Aile Hekimliği'nin dünya genelinde daha iyi sağlık göstergelerine ulaşılmasını sağladığının, sağlıkta eşitliği desteklediğinin ve sağlık sistemlerinin maliyetini azalttığının gözlemlenmesi ile daha da güçlenmiştir (Rouleau ve ark., 2018).

Aile Hekimliği'nin Tanımı, Amaçları ve Aile Hekiminin Görevleri

Leeuwenhorst Medya Grubu, Aile Hekimliği'ni, hastanın cinsiyeti, yaşı veya hastalığına bakılmaksızın sürekli bakım hizmeti veren birinci basamak sağlık hizmetleri örgütlenmesi biçimi olarak tanımlamıştır (Leeuwenhorst, 1974). WONCA (Dünya Aile Hekimleri Örgütü) ise ile hekimini, toplumdaki mevcut kaynaklara ve bireylerin sağlık ihtiyaçlarına göre hekimliğini icra eden tıp doktorları olarak tanımlamıştır (WONCA, 1991); Bıyıklıoğlu & Ungan, 2015). 1991'de yayınladığı bildirgede WONCA, Aile Hekimliği'nin özelliklerini kapsamlı bakım, hasta odaklılık, aile odaklılık, diğer sağlık hizmetleri ile koordinasyon, erişilebilirlik ve kaynak yönetimi ve topluma karşı sorumluluk ile hareket etmek olarak belirlemiştir (Bentzen ve ark., 1991). DSÖ (Dünya Sağlık Örgütü) ise benzer bir şekilde disiplinin özelliklerini genellik, kapsamlılık, iş birliği içinde, aile odaklı ve toplum odaklı olarak belirlemiştir (1998). 2002'de WONCA yayınlamış olduğu bir bildiride Aile Hekimliği Sistemi'nin özellikleri; sağlık sisteminde ilk temas noktasını oluşturmak, sağlık kaynaklarının etkin kullanımının sağlanması, bireylere ve ailelerine bireysel yaklaşım çerçevesinde yaklaşmak, sağlık bakımının sürekliliğinin sağlanması ve bütüncül bir tıbbi yaklaşıma sahip olmak olarak tanımlanmıştır (Bentzen ve ark., 1998; Başak & WONCA Europe, 2003).

Mevcut yerli literatürdeki tanımlar, sistemin Türkiye'deki pratiğinin anlaşılması açısından hayati önem taşımaktadır. Aile Hekimliği Uygulama Yönetmeliği'ne göre (2013) aile hekimi, Aile Sağlığı Merkezi'ni idare eden, bakanlık tarafından öngörülen koruyucu, rehabilite edici ve tedavi edici sağlık hizmetleri sunan, Toplum Sağlığı Merkezi ile uyum içerisinde çalışan, kayıtlı hastalarına sağlık

danışmanlığı yapan, hastalarının periyodik tıbbi muayene ve taramalarını yerine getiren, kendine kayıtlı hastalarını ayrım yapmaksızın tıbbi olarak takip eden, kendine kayıtlı hastalarının tıbbi kayıtlarını tutan, bakanlık tarafından öngörüldüğü şekilde rapor, reçete ve benzeri resmi tıbbi dokümanları düzenleyen ve yetkili enstitü ve yasalarca kendine verilen diğer yükümlülükleri yerine getiren birinci basamak hekimidir.

Öcek ve ark. (2014) ise Aile Hekimliği'nin dört temel fonksiyonu olduğunu belirtmiştir. Bu fonksiyonlar ise; tıbbi ilk temas noktasını oluşturmak, sağlık bakımında sürekliliği sağlamak, sağlık bakımına kapsamlı yaklaşım getirmek ve tüm seviye sağlık hizmetleri arasında koordinasyon sağlamaktır (Öcek ve ark., 2014).

Aile Hekimliği'nin Türkiye'deki Tarihi ve Gelişimi

Türkiye'de Aile Hekimliği'nin bir tıbbi uzmanlık dalı olarak tanınması ve başlatılması 1983 yılında "Tababet Uzmanlık Tüzüğü"ne mezuniyet sonrası tıbbi eğitim ile ilgili eklenen bir madde ile yer almıştır (Akdeniz ve ark., 2009; Tengilimoğlu ve ark., 2016). 1984 yılında ülkemizdeki ilk Aile Hekimliği Anabilim Dalı Gazi Üniversitesi'nde kurulmuş ve eğitim ve araştırma hastanelerinde yeni bir uzmanlık alanı olarak işlemeye başlamıştır (Akdeniz ve ark., 2009; Kantarcı, 2015). 1993 yılına gelindiğinde, Türk Sağlık Sistemi için mihenk taşı olarak kabul edilen YÖK kurulmuş ve YÖK tarafından Türkiye'deki tüm üniversitelerde Aile Hekimliği Anabilim Dalı kurulması kararı alınmıştır (Başak & Güldal, 2014). Bu gelişme, yeni disiplinin tanınmasını teşvik etmiştir (Akdeniz ve ark., 2009; Kantarcı, 2015; Tengilimoğlu ve ark., 2016).

Aile Hekimliği, SDP (2003) ile uygulamaya konulması planlanmış ve 2005 yılında, 5258 Sayılı "Aile Hekimliği Pilot Uygulaması Hakkında Kanun" (2004) ile pilot uygulamasına başlanmıştır ("5258 Sayılı Aile Hekimliği Pilot Uygulaması Hakkında Kanun," 2004). Aile hekimliği pilot uygulaması 2005 yılında Düzce ilinde

başlatılmış ve 2010 yılına kadar ülkedeki tüm şehirlere yayılmıştır ("Aile Hekimliği Kanunu," 2004; Cesur, Güneş, Tekin, & Ülker, 2017; Öcek ve ark., 2014; Özata ve ark., 2016).

Ayrıca, Aile Hekimliği Sistemi, başlangıçta öngörüldüğü gibi sevk zinciri mekanizması ile uygulanmaya konulmuş ancak üç aylık bir uygulama süresinden sonra hükümet tarafından kaldırılmıştır (Tatar ve ark., 2011).

Sağlık Hizmetlerinin Sosyalleştirilmesi (1961)

1961'deki 224 Sayılı "Sağlık Hizmetlerinin Sosyalleştirilmesi Hakkında Kanun", ülkemizde birinci basamak sağlık hizmetlerini sağlık sisteminin merkezine koyan ve günümüzde uygulanmamakta olan sevk zinciri mekanizmasını öngören bir uygulama başlatmıştır (Akdeniz ve ark., 2009). Sağlık Ocağı Sistemi, tedavi edici, önleyici ve hem kişi hem toplum odaklı sağlık hizmetlerini bölge tabanlı ve geniş kapsamlı olarak sunmuştur (İlgün & Şahin, 2016). Bu sistemde sunulan birinci basamak sağlık hizmetlerinin temel odağı, tedavi edici hizmetlerin sunumu olmuştur (İlgün & Şahin, 2016).

Sağlıkta Dönüşüm Programı (SDP)

Sağlık Bakanlığı, yukarıda sözü edilen Sağlık Ocağı Sistemi'nin, artık güncel talepleri karşılayamadığı gerekçesiyle, birinci basamak sağlık hizmetleri örgütlenmesine Aile Hekimliği uygulamasına geçilmesi gerektiğini vurgulamıştır (Sağlık Bakanlığı, 2004). Bu hususta, Türk Sağlık Sistemi'ni yeniden yapılandıran, sağlık reformlarını öngören, SDP (2003) hazırlanmıştır. SDP, halen "neo-liberal" duruşlu veya başka bir deyişle, neo-liberal anlayışa uygun temeldeki sağlık politikaları öneren bir sağlık reformu olarak görülmektedir (Ergun & Dericioğulları Ergun, 2010; Pala, 2014). SDP'nin yola çıkış noktası "kolay erişilebilir ve güler yüzlü" sağlık hizmetleri sunumu olarak belirtilmiş olup, aile hekimliği uygulaması ile birinci basamak sağlık hizmetlerinin güçlendirilmesi, iyi işleyen bir sevk zinciri mekanizması

uygulaması ve hastanelere idari ve finansal özerklik verilmesini içermektedir (Türk Tabipleri Birliği, 2018a). SDP, Sağlık Bakanlığı'na yeni bir rol vermiş ve bu hususta, Sağlık Babanlığı'nın, hizmetin sunum ve finansman boyutlarından çekilip, düzenleyici ve denetleyici bir mekanizma olmasını öngörmüştür (Yenimahalleli Yaşar, 2011).

SDP, önerdiği özelleştirme ve piyasalaştırma perçinli sağlık reformları ile, özellikle de birinci basamak sağlık hizmetleri sunumu içerisindeki Aile Hekimliği uygulaması ve getirdikleri ile, halen neoliberal bir politika dokümanı olarak görülmektedir (Ağartan, 2012). Bu yönüyle SDP, sağlık sektöründeki en temel sorunlara işaret eden "59. Hükumet Planı" ile beraber, sağlık politikasının "liberalizasyonu" olarak yorumlanmıştır (Ergun & Dericioğulları Ergun, 2010).

Bu hususta, SDP'nin yola çıkış noktası olarak belirlediği en temel amacına ulaşamamış olduğu savunulabilir. SDP, ortaya konulan temel hedeflerinin ötesinde, sağlık hizmetlerinde, özellikle de birinci basamak sağlık hizmetlerinde, özelleştirme ve piyasalaştırma mekanizmalarının neoliberal politikalar aracılığıyla özel sektör payının artırılmasının teşvikinin bir perdesi olarak görülmektedir (Tükel, 2010). SDP'nin öngördüğü sağlık reformları içerisinde en astronomik değişikliklerin birinci basamak sağlık hizmetleri içerisinde, Aile Hekimliği uygulaması ile yaşandığı söylenebilir (Yenimahalleli Yaşar, 2011). Ayrıca, SDP ile öngörülen Aile Hekimliği uygulaması piyasa ve özel sektör dinamikleriyle, hastaları "müşteriye" çevirmiş ve hekimler arası olması gerektiği savunulan rekabet anlayışı, sağlık sistemini aşırı derecede müşteri memnuniyeti (hasta memnuniyeti) odaklı hale getirmiştir (Özata ve ark., 2016; Türk Tabipleri Birliği, 2018).

Genel Sağlık Sigortası

Genel Sağlık Sigortası, Türkiye'de sağlık hizmetleri sunumundaki karmaşıklıklar ve sağlık sisteminin eşitsiz yapısına çözüm olarak görülmüştür (Türk Tabipleri Birliği, 2006). Bu temel sorunların çözümü, ülkede tam sigorta kapsamına ulaşılması olarak açıklanmıştır ve katkı payı ödeyemeyecek durumdaki vatandaşların sağlık sigortasının diğer ödemeler ile telafi edilmesi ve dengelenmesi olarak

sunulmuştur (Türk Tabipleri Birliği, 2006). Genel Sağlık Sigortası, sağlık sigortası ile emeklilik fonlarının birleştirilmesi ve daha sonrasında da üç sigorta şemasının tek çatı altında toplanıp Sosyal Güvenlik Kurumu'nun (SGK) kurulmasını içermektedir (Aydın, 2007). Sosyal Güvenlik Kurumu, vatandaşların istihdam ve gelir durumu göz önünde bulundurulmaksızın, her vatandaşın Genel Sağlık Sigortası kapsamına dahil edileceğini açıklamıştır ve katkı payı ödeyemeyecek durumdaki vatandaşların sağlık sigortasının diğer ödemeler ile telafi edilmesi ve dengelenmesi öngörülmüştür (Türk Tabipleri Birliği, 2006). Bu hususta, Sağlık Sigortası uygulamalarının, bir ülkedeki sağlık hizmetlerinin finansman yollarından biri olduğunu belirtmek faydalı olacaktır (Tatar, 2011). Çoğu ülkede olduğu gibi Türkiye'de de sağlık hizmetleri finansmanı karma yönteme göre gerçekleştirilmektedir ancak Türkiye sağlık hizmetleri finansmanında kullanılan metotlarda Sosyal Güvenlik Modeli yani sağlık sigortası uygulaması ağır basmaktadır (Tatar, 2011). Dolayısıyla, Genel Sağlık Sigortası reformu, SDP ile tamamlayıcı nitelikte olup, özel sağlık sigortalarının gelişimini destekleyen özelleştirme teşviki ile ülkedeki sağlık hizmetlerinin finansman modelinin değiştirilmesi anlamına gelmektedir (Türk Tabipleri Birliği, 2018b).

TTB, GSS'yi, en temel amaçlarını gerçekleştiremediği düşüncesiyle eleştirmiştir. TTB, Sağlık Bakanlığı'nın, GSS uygulaması ile sağlık harcamalarını azaltma hedefine ulaşamadığını, tam tersine, sağlık harcamalarının GSS'den sonra arttığını vurgulamıştır (Türk Tabipleri Birliği, 2018b). GSS'nin hedefi ve bileşenleri, SDP ile paralel olup, Aile Hekimliği uygulaması, iki doküman için de önemli bir bileşen olarak karşımıza çıkmıştır. Ancak, TTB'nin de vurguladığı üzere, GSS de SDP ve bileşenleri gibi, ulaşmayı hedeflediğini açıkladığı noktalara ulaşamamıştır.

Aile Hekimliği Dünyadaki Uygulamalar ile Türkiye Karşılaştırması

Başak ve Güldal (2014), ülkedeki Aile Hekimliği Ana Bilim Dalı kürsülerinin sayısının, sisteme atfedilen değeri ve disiplinin ülke içindeki gelişimini görmek açısından önemli bir faktör olduğunu vurgulamıştır. Avrupa'da Aile Hekimliği Sistemi uygulayan ülkelerin çoğunda, Aile Hekimliği Ana Bilim Dalı kürsülerinin hemen

hemen her üniversitede var olduğu görülmekte iken, Güney Avrupa ve Akdeniz ülkelerinde durumun böyle olmadığı görülmektedir (Başak & Güldal, 2014). Güney Avrupa ve Akdeniz ülkelerinin tersine, Avrupa'nın geri kalanındaki ülkelerin, Aile Hekimliği disiplinine büyük bir önem verdiği düşünülmektedir (Başak & Güldal, 2014).

Almanya'da tüm popülasyon sağlık sigortası kapsamındadır ve aile hekimlerine yüklenmiş bir kapı tutuculuk fonksiyonu yoktur ve bu yüzden tüm seviye sağlık hizmetlerine direkt hasta başvurusu yapılabilmektedir (Kantarcı, 2015).

Batı Avrupa ülkeleri içinde, Hollanda, teoride sistemin bileşenlerine ve olmazsa olmazları olarak belirtilen mekanizmalara sahip olmasından dolayı, aile hekimliği uygulamasını etkili bir biçimde yürüttüğü söylenebilecek belirgin ülkelerden biridir. Hollanda'da aile hekimlerinin pozisyonu güçlü ve sağlam olup, kendilerine, sevk zinciri uygulamasını kullanarak bütün sağlık sisteminin iyi yönetimini sağlayabilmelerinden ötürü büyük bir önem atfedilmiştir (Metsemakers, 2012). Hollanda sağlık sistemi içinde, etkili bir sevk zinciri mekanizması uygulanmakta olup, acil durumlar (kaza ve benzeri) haricinde, hastalar ilk başvuru noktası olarak aile hekimlerine başvurmak durumundadır (Metsemakers, 2012; Kantarcı, 2015). Starfield'ın (1998) da vurgulamış olduğu gibi, Hollanda'da sağlık hizmetlerinin çok pahalı olmaması ve sağlık harcamalarının daha az olması, uygulanmakta olan etkili sevk zinciri mekanizmasına bağlıdır (Metsemakers, 2012). Hollanda'da, tam gün çalışan bir aile hekiminin ortalama 2.300-2.500 civarı kayıtlı hastası bulunmaktadır (Korukluoğlu, 2004 (Kantarcı'dan)) ve bu, bir aile hekiminin, efektif çalışabileceği optimal sayıdır (Metsemakers, 2012). Hollanda'da aile hekimlerinin maaşları, kendilerine kayıtlı hasta başına ve yaptıkları bazı tıbbi işlemlerin (tıbbi taramalar, analizler, aşılama vs) başına olmak üzere toplamda belirlenmektedir ve aile hekimlerinin aldığı maaş aile sağlığı merkezini idame etmelerine ve yanlarında çalışanların maaşlarını ödemeye yetecek düzeydedir (Metsemakers, 2012). Ayrıca, Hollanda'da aile hekimleri yarı zamanlı olarak da çalışabilmekte olup, bu istihdam edilme şekli tıp fakültesinden yeni mezun olup uzmanlığa hazırlanan hekimler ve özellikle yeni doğum yapmış kadın hekimlerin

çalışmaya devam etmek için sıkça tercih edilmeye başlanmıştır (Arya ve ark., 2017). Bunlara ek olarak, Hollanda, gayrısafi milli hasılasının %9'unu sağlık hizmetlerine ayırırken, ayrılan bu yüzdenin neredeyse yarısı olan %4'ü sadece Aile Hekimliği uygulamasına ayrılmaktadır (Arya ve ark., 2017). Bu durum, bir ülkenin, aile hekimliği uygulamasına verdiği önemin en önemli göstergelerinden biri olarak sayılabilmektedir. Yukarıda sayılan sebeplerden ötürü, Hollanda'daki aile hekimliği uygulaması, etkili ve iyi işleyen aile hekimliği sistem pratiği örneklerinden biri olarak sayılabilmekte olup, ülkemizdeki uygulamadan birçok noktada farklı olduğu görülmektedir.

Yöntem

Aile Hekimliği ile ilgili mevcut literatürdeki araştırmaları genel olarak iki temel başlıkta sınıflandırabiliriz. İlk kategorideki araştırmalar, Aile Hekimliği Sistemi'ni hasta memnuniyeti açısından değerlendirmektedir (Örneğin, Özata ve ark., 2016; Baltacı ve ark., 2011; Baston & Havvatoğlu, 2014; Barış ve ark., 2011). Aile Hekimliği uygulamasını, hasta memnuniyeti temelinde değerlendiren araştırmaların bir kısmı EUROPEP (Avrupalı Hastalar Genel / Aile Pratiğini Değerlendiriyor) ölçeğinden faydalanarak değerlendirme yapmıştır (Mollahaliloğlu ve ark., 2010; Turgu et al., 2018; Sparkes, Atun & Bärnighausen, 2019; Aktürk, Ateşoğlu, & Çiftçi, 2015; Mollahaliloğlu ve ark., 2010). Aile Hekimliği Sistemi ile ilgili yapılmış olan ikinci araştırma kategorisindeki araştırmalar, aile hekimliği pratiğinin değerlendirilmesinde aile hekimlerinin görüşlerine yer vermiştir. Bu araştırmalardan bazıları, spesifik olarak, aile hekimlerinin mesleki tatmini çerçevesinde sistemin pratiğini değerlendirmeyi amaçlamıştır (Doğan ve ark., 2013; Tözün ve ark., 2008; Sevimli & İşcan, 2005; Özaltın ve ark., 2002; Türkbayrak ve ark., 2011; Türk Sağlık-Sen, 2013; Tekin ve ark., 2014; Pantell, Marchis, Bueno ve Gottlieb, 2019; Yaman & Güneş, 2016; Mutlupoyraz, 2010). Aile hekimlerinin aile hekimliği uygulaması ile ilgili görüşlerini temel değerlendirme ölçütü olarak alan araştırmaların bazıları ise, aile hekimlerinin mesleklerini icra ederken karşılaştıkları zorlukları ortaya koyarak

değerlendirme yapmayı amaçlamıştır (İlgün & Şahin, 2016; Öcek ve ark., 2014; Algın ve ark., 2004). Bazı araştırmalar ise (Örneğin, Tengilimoğlu ve ark., 2016) Türkiye'deki aile hekimlerinin, Aile Hekimliği Sistemi'nin Türkiye'ye uygunluğu ile ilgili görüşlerini ortaya koyabilmek amacıyla yapılmıştır. Ayrıca, konu ile ilgili mevcut literatürde aile hekimlerine şiddet ile ilgili araştırmalar (Örneğin, Ayrancı ve ark., 2006) yapılmıştır.

Mevcut literatüre bakıldığında, Türkiye'de aile hekimliği ile ilgili yapılmış olan çoğu araştırmanın, hasta memnuniyeti temelinde aile hekimliğinin fonksiyonelliğini ölçmeyi amaçladığı görülmüştür. Ayrıca, mevcut literatürde, Türkiye'de aile hekimliği pratiğinin iyi işleyip işlemediğini ortaya koymayı amaçlayan spesifik bir araştırmanın yürütülmediği görülmüştür. İlgün ve Şahin'in (2016) vurguladığı üzere, mevcut literatürde, aile hekimliği uygulamasını aile hekimlerinin bakış açılarını temel dayanak noktası alarak değerlendirmeyi amaçlayan çalışmalarının sayısının sınırlı olduğu görülmüştür.

Araştırma

Bu tez kapsamında, Türkiye'deki Aile Hekimliği pratiği ile ilgili görüşlerini öğrenmek ve bu bilgiler ışığında değerlendirmek amacıyla, aile hekimlerine internet ortamı üzerinden uygulanmak üzere bir anket hazırlanmıştır. Daha kolay bir data toplama aracı olması ve nispeten diğer araçlara göre daha az zaman gerektirmesi gibi sebeplerden ötürü, data toplama aracı olarak anket tercih edilmiştir. Konu üzerine yapılmış diğer çoğu araştırmanın anketlerinden farklı olarak, bu tezin araştırma anketinin asıl amacı, aile hekimlerinin Türkiye'deki Aile Hekimliği uygulaması çerçevesinde modelin ülkemiz ile uyumluluğu, işleyişi ve özelleştirme ile olan ilişkisi hakkındaki düşünceleri anlaşılmaya çalışılmıştır. Ayrıca, anketin diğer bir amacı ise, eğer aile hekimleri Aile Hekimliği'nin Türkiye'deki uygulamasının iyi işlemediğini düşünüyorlar ise, bunların sebeplerini ve eksik ya da yanlış olan faktörlerin neler olduğunu veya olabileceğini öğrenmektir.

Bu çalışmadaki anket hazırlanırken, mevcut literatürde konu ile ilgili yapılmış diğer araştırmaların anket sorularından, konu ile ilgili önemli organizasyon ve kurumların (TTB, Sağlık Bakanlığı vb) makalelerinden ve daha önce başka araştırmalarca Aile Hekimliği uygulaması kapsamında problematik olarak belirlenmiş olan ögelerden faydalanılmıştır. Veri analizi yöntemi olarak verilerin nitel değerlendirmesi yapılacak olup, anket kapsamında elde edilen cevaplar ve teorideki bilgiler ışığında nitel yorumlamaya başvurulmuştur. Bu yüzden, bu tez kapsamında veriler değerlendirilirken, herhangi bir bilgisayar programı (SPSS ve benzeri) kullanılmamıştır. Anketin örneklemi, güncel olarak Türkiye'de mesleklerini icra etmekte olan aile hekimleri ve uzman aile hekimleri olarak belirlenmiş olup, ankete 198 hekim cevap vermiştir. Anket internet ortamı üzerinden uygulanmış olup, Türkiye genelinden hekimler ankete katılmıştır.

Bulgular

Anket bulgularına göre, araştırmaya katılan hekimlerin çoğunluğu aile hekimliği uygulamasının, Türkiye'de hekimler açısından daha detaylı hasta takibine olanak sağladığını düşünmektedir. Bu noktada, bu bulgu, Öcek ve arkadaşlarının 2013 yılında yapmış olduğu benzer bir araştırma sonuçlarına ters düşmektedir. Öcek ve arkadaşları (2013), yaptıkları röportajlarda aile hekimlerinin kayıtlı yüksek nüfus ve iş yükü fazlalığından ötürü, hastalarına detaylı zaman ayıramadığını ve dolayısı ile detaylı hasta takibi yapamadıklarını düşündüklerini ortaya çıkarmıştır. Deveguele ve arkadaşları (2002), altı Avrupa ülkesinde yapmış oldukları araştırmada, her bir hastaya aile hekimlerince ayrılan muayene sürelerinin Almanya (7.6 dakika) ile İsviçre (15.6 dakika) arasında değiştiğini ortaya koymuştur. Öcek ve arkadaşlarının (2013) yapmış olduğu araştırmada, bir aile hekimi, her hastasına maksimum ortalama beş dakika ayırabildiğini ifade etmiştir. Öcek ve arkadaşları (2013), Türkiye'deki aile hekimi muayenelerinin ortalama süresinin Avrupa ülkeleri ortalamasından (10.7 dakika) çok daha az olduğuna dikkat çekmiş ve bu durumun sağlık hizmetlerinin kalitesini etkileyebilecek bir faktör olduğunu vurgulamıştır. Ancak, bu tezin anket bulgularına

göre, Öcek ve arkadaşlarının (2013) bulgularına ters olarak, ankete katılan Türkiye'deki aile hekimlerinin çoğu, hastalarını detaylı olarak takip edebildiklerini ve dolayısı ile hastalarına yeterli vakit ayırabildiklerini düşünmektedir.

Ankete katılan aile hekimlerinin çoğunluğu, aile hekimliği uygulamasının Türkiye'de daha az maliyetli birinci basamak hizmetleri sunumu sağladığını düşünmektedir. Bir katılımcı, soru ile ilgili yorum yapmış olup, sevk zinciri mekanizmasının kurulması ve yürütülmesi durumunda, sağlık maliyetlerinin ve harcamalarının daha da azalacağını vurgulamıştır. Daha önce de bu tezde belirtilmiş olduğu üzere, Aile Hekimliği Modeli'nin en önemli amaç ve bileşenlerinden birisi de daha az maliyetli bir birinci basamak sağlık hizmeti örgütlenmesi sunumu olarak belirtilmekte olup, aile hekimlerinin sevk zinciri ve kapı tutuculuk görevi gibi tamamlayıcı faktörler ile bunun ulaşılabilecek bir hedef olduğu açıklanmıştır (Bentzen ve ark., 1991; Bıyıklıoğlu & Ungan, 2015; Kantarcı, 2015; Özdemir & Ungan, 2015; Başak & WONCA Europe, 2003; Olesen, 2000). Bu hususta, ankete katılan aile hekimlerinin çoğu, aile hekimliği Türkiye uygulamasının daha az maliyetli bir temel sağlık hizmeti sunumu şekli olduğunu düşünmektedir.

Daha az maliyetli temel sağlık hizmetleri sunumuna, aile hekimliği pratiği ile ulaşabilmek için, etkili bir şekilde işleyen sevk zinciri mekanizmasına ihtiyaç vardır (Aytekin, 2012; Çelik, 2011; Ener & Yelkikalan, 2003, Metsemakers, 2012; Starfield, 1998). Ayrıca, SDP'de belirtilen, aile hekimliği uygulamasının en önemli bileşenlerinden biri olarak belirtilmiş olan sevk zinciri mekanizması, aile hekimlerine kapı tutuculuk görevi addetmekte ve sevk zincirini uygulayarak, sağlık sistemi arasındaki koordinasyonu sağlayıp sistemin maliyet açısından daha etkin olmasına katkıda bulunmasını sağlamaktadır (Metsemakers, 2012; Starfield, 1998). Ankete katılan aile hekimlerinin büyük çoğunluğu, aile hekimliği uygulamasının, etkili bir sevk zinciri mekanizmasının varlığına ihtiyaç duyduğunu düşünmektedir. Ankete katılan aile hekimlerinin bazıları, etkili bir sevk zinciri mekanizmasının olmamasını, Türkiye'de aile hekimliği uygulamasında mesleklerini icra ederken karşılaştıkları en büyük zorluk olarak belirtilmiştir. Algın ve arkadaşları (2014) yapmış oldukları araştırmada, araştırmaya katılan aile hekimlerinin çoğunun, aile hekimliği Türkiye

uygulamasında sevk zincirinin olmayışının en büyük problem olduğunu düşündüklerini ortaya koymuştur ve tez anketinin bulguları bu araştırma ile paraleldir.

Aile hekimliği uygulamasının en önemli savlarından bir tanesi olan, ikinci ve üçüncü basamak sağlık hizmetlerinde hasta yığılmasını engellemek ve böylelikle hastane ve benzeri sağlık kurumlarının hasta yükünü hafifletmek olarak ifade edilmiştir (Akdağ et al., 2009; Dağdeviren & Aktürk, 2004; Fulton ve ark., 2011). Ancak, bu iddianın tam tersine, "Sağlık Bakanlığı Sağlık Yıllığı" (2017) verileri, ikinci ve üçüncü basamak sağlık kuruluşlarına yapılan hasta başvurularının, 2017 yılında 2002 yılına göre 3 kat arttığını göstermektedir. Ayrıca, yine Sağlık Bakanlığı'nın bu kaynağındaki başka bir dataya göre, 2017 yılındaki ikinci ve üçüncü basamak sağlık hizmetlerine başvuru sayısının, birinci basamak sağlık hizmetlerine yapılan hasta başvurusunun sayısının yaklaşık üç katını bulmuştur. Tez kapsamında yapılmış olan ankete katılan hekimlerin çoğu, Türkiye'de aile hekimliği uygulamasının ikinci ve üçüncü basamak sağlık servislerine başvuruları azaltmadığını ve bu kurumlarda hasta yığılmasını engelleyemediğini düşünmektedirler.

SDP'de de belirtildiği üzere, aile hekimliği uygulamasının diğer önemli amaçlarından biri de her vatandaşa eşit derecede ve kolay erişilebilir temel sağlık hizmetleri sunmak olarak belirtilmiştir (Bentzen ve ark., 1991; World Health Organization, 1978; Sağlıkta Dönüşüm Programı, 2003). Tez kapsamında yapılan ankete katılan aile hekimlerinin çoğu, teorik çerçeveye paralel olarak, Türkiye'de aile hekimliği uygulamasının vatandaşlara eşit derecede ve kolay erişilebilir temel sağlık hizmetleri sunduğunu düşünmektedir.

Tez anketine katılan aile hekimlerinin büyük çoğunluğu maaş tatminlerinin düşük olduğunu düşünmektedir. Ankete katılan aile hekimlerinin çoğu, aile hekimliği yaparken mesleki tatminlerinin düşük olduğunu düşünmektedir. 198 katılımcıdan yalnızca bir tanesi Türkiye'de aile hekimliği yaparken mesleki tatmininin yüksek olduğunu söylemiştir. Bu anketin bulguları, bu konuda daha önceden yapılmış olan araştırmaların (Sezgin ve ark., 2018; Tengilimoğlu ve ark., 2016) sonuçlarına ters düşmektedir.

Araştırmaya katılan aile hekimlerinin büyük çoğunluğu, Aile Hekimliği Sistemi'nin hekimlere güvenli bir iş / çalışma ortamı sunmadığını düşünmektedir. Ankete katılan aile hekimlerinin bazıları kendilerini güvende hissetmediklerini belirtmiştir Katılımcıların çoğu, aile hekimliği yaparken kendilerini güvende hissetmemektedir.

Anket bulgularına göre, katılımcıların çoğu, aile hekimliği Türkiye uygulamasındaki performans denetimleri ve cezaların, hekimlerin çalışırlarken kendilerini baskı altında hissetmelerine sebep olduğunu düşünmektedir. Bazı hataların, hatta hastaların istatistiksel verilerinin sisteme eksik girilmesi veya periyodik taramalar için hastalara ulaşılamaması ve benzeri durumlarda aile hekimlerinin maaşlarında kesintiler yapılabilmektedir (Öcek ve ark., 2014). Tekrar edilen hataların performans yeterliliklerini karşılayamaması durumunda aile hekimlerinin sözleşmeleri feshedilebilmektedir (Cesur ve ark., 2017). Hekimler üzerinde oluşan bu baskı, Türkbayrak ve arkadaşlarının (2011) da yaptıkları bir araştırmada ortaya çıkardıkları gibi bazı hekimlerin işlerini veya maaşlarını kaybetme korkusu ile zaman zaman yanlış ya da doğru olmayan uygulamalara (örneğin hastayı muayene etmeden ilaç yazma, rapor verme ve benzeri uygulamaları yasadışı olsa da yapmak durumunda kalmaları gibi) sebebiyet verdikleri görülmektedir. Türkbayrak ve arkadaşlarının 2011'de aile hekimleri ile yapmış olduğu araştırmada, aile hekimleri Sağlık Bakanlığı tarafından yapılan performans değerlendirmelerinin ve bazen uygulanan cezaların, Sağlık Bakanlığı'nın kendilerine karşı yapıcı olmaktan çok cezalandırıcı bir yaklaşımı olduğunu düşünmelerine sebep olduğunu söylemişlerdir. Bu tez kapsamında uygulanmış olan anketin bu konudaki bulguları da paraleldir.

Tez kapsamında uygulanmış olan anketin bulgularına göre, ankete katılan aile hekimlerinin çok büyük çoğunluğu, aile hekimliği uygulamasının kendilerine yüklediği sorumluluklar ve işi yükünün çok ağır olduğunu düşünmektedir. Ayrıca, anketi cevaplayan aile hekimlerinin bazıları, mesleklerini icra ederken karşılaştıkları en büyük zorluğun iş yükü ağırlığı olduğunu, açık uçlu soruyu cevaplayarak ifade etmişlerdir. Bu tezin anket bulguları bu konuda Öcek ve arkadaşlarının (2014) yapmış olduğu araştırmanın bulguları ile paralellik göstermektedir.

Katılımcıların büyük bir çoğunluğu, Türkiye'deki aile hekimliği uygulamasının, birinci basamak sağlık hizmetlerinin özelleştirilmesinin bir sonucu olduğunu düşünmektedir. Türkiye'de özelleştirmeler, özellikle de sağlık alanında yapılan özelleştirmeler SDP ile birlikte teşvik edilmiştir (Türkbayrak ve ark., 2011). SDP, bileşenleri ve sağlık reformu kapsamındaki teşvikleri ile neo-liberal bir görüş yansıtmakta olup özelleştirmeyi sağlık alanına yerleştirmiştir (Ağartan, 2012; Soyer ve ark., 2007). Araştırmaya katılan hekimlerin çoğu da Türkiye'de aile hekimliği uygulamasının, sağlık hizmetlerinin özelleştirme sonucu olduğunu düşünmektedir.

Başka bir soruda ise katılımcılara, aile hekimliğinin Türkiye'ye uyumlu bir temel sağlık hizmetleri sunumu şekli olup olmadığı hakkındaki görüşleri sorulmuş olup, bu soru ile ilgili birbirine yakın yüzdeler ile verilmiş olan çeşitli cevaplar bulunmaktadır. Net bir çoğunluk sağlanamamış olmakla birlikte, bu önermeye katılan, katılmayan ve çekimser kalan katılımcıların sayısı birbirine çok yakındır.

Araştırmaya katılan aile hekimlerinin büyük çoğunluğu, aile hekimliği uygulamasının Türkiye'de hekimler arasında olumsuz (performansı ve tıbbi etiği olumsuz yönde etkileyecek) bir rekabete sebep olduğunu düşünmektedir. TTB, SDP'nin neo-liberal anlayışı ile aile hekimliğine yerleştirilen rekabet ve benzeri elementlerin, aile hekimlerinin mesleklerini icra etmelerini ve tıp etiğini zora soktuğunu iddia etmektedir (Türk Tabipleri Birliği, 2006). Sağlık Bakanlığı aile hekimleri arasında olması gerektiğini iddia ettiği rekabeti "tatlı rekabet" olarak addetmiş olsa da bu araştırmaya katılan katılımcıların büyük bir çoğunluğu, aile hekimliği uygulamasının hekimler arasında olumsuz bir rekabet oluşturduğunu düşünmektedir (Türk Tabipleri Birliği, 2006).

Araştırma kapsamında, katılımcılardan Türkiye'deki aile hekimliği uygulamasını değerlendirmeleri istenmiştir. Katılımcıların neredeyse yarıya yakını uygulamayı "ortalama" olarak değerlendirmiş olup, uygulamayı "kötü" ve "çok kötü" olarak değerlendiren katılımcılar "iyi" ve "çok iyi" olduğunu düşünenlere göre çoğunluktadır. Bu bulgular, literatürde daha önce yapılmış olan araştırma bulguları ile paralellik göstermektedir (Türk Sağlık-Sen, 2013).

Son olarak, katılımcılara açık uçlu soru yoluyla Türkiye'de aile hekimliği yaparken karşılaştıkları en büyük zorluğun ne olduğu ve bunu kendi ifadeleri ile yazarak cevaplamaları istenmiştir. Katılımcıların bu soruya yanıt olarak en çok verdikleri konular konu başlıkları altında şu şekilde toplanmıştır; aşırı hasta odaklı bir aile hekimliği uygulaması olması, bürokrasi ve yönetimsel problemler, hekimlere şiddet, aile hekimleri tarafından verilmesi gereken belgelerin yarattığı problemler ve azalan hekim saygınlığı.

Bu tezin amacı, Türkiye'deki aile hekimliği uygulamasını hem teorik çerçevede belirtildiği bileşenlerin veya mekanizmaların varlığı ve işlerliği, özellikle de neo-liberal nitelikte görülen sağlık politikaları / reformları (SDP ve GSS) ışığında hem de aile hekimliği yapmakta olan hekimlerin görüşlerine de başvurarak değerlendirmektir. Tezin bulgularına göre, Türkiye'deki aile hekimliği uygulaması, sağlık hizmetlerinin özelleştirilmesinin bir sonucu olarak yorumlanabilmekte olup, modelin iyi uygulanabilmesi için gerekli olduğu düşünülen sevk zinciri ve benzeri bazı mekanizmaların eksikliği ve hekimlerin bu sistemde hekim olmaktan ve güncel pozisyonları / çalışma şekillerinden memnun olmamalarından da dolayı, çok iyi bir şekilde işlememekte olan bir uygulama olduğu görülebilmektedir.

D. THESIS PERMISSION FORM / TEZ İZİN FORMU

ENSTİTÜ / INSTITUTE

Fen Bilimleri Enstitüsü / Graduate School of Natural and Applied Sciences ☐

Sosyal Bilimler Enstitüsü / Graduate School of Social Sciences ☒

Uygulamalı Matematik Enstitüsü / Graduate School of Applied Mathematics ☐

Enformatik Enstitüsü / Graduate School of Informatics ☐

Deniz Bilimleri Enstitüsü / Graduate School of Marine Sciences ☐

YAZARIN / AUTHOR

Soyadı / Surname :Şen
Adı / Name :Zeynep Deniz
Bölümü / Department :Siyaset Bilimi ve Kamu Yönetimi/ Political Science and Public Administration

TEZİN ADI / TITLE OF THE THESIS (**İngilizce** / English) : The Family Medicine Practice In Turkey From The Perspectives Of The Physicians Within The Framework Of Neo-Liberalism

TEZİN TÜRÜ / DEGREE**:** **Yüksek Lisans** / Master ☒ **Doktora** / PhD ☐

1. **Tezin tamamı dünya çapında erişime açılacaktır. /** Release the entire work immediately for access worldwide. ☒
2. **Tez iki yıl süreyle erişime kapalı olacaktır.** / Secure the entire work for patent and/or proprietary purposes for a period of **two years. *** ☐
3. **Tez altı ay süreyle erişime kapalı olacaktır.** / Secure the entire work for period of **six months**. ***** ☐

***** *Enstitü Yönetim Kurulu kararının basılı kopyası tezle birlikte kütüphaneye teslim edilecektir.*
A copy of the decision of the Institute Administrative Committee will be delivered to the library together with the printed thesis.

Yazarın imzası / Signature ..... **Tarih** / Date ……